POC accepted 9/6/11 @ 8:25am JC

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

PRINTED: 08/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A051	A. BUILDING _____ B. WING _____	07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: RN: registered nurse CNA: certified nursing assistant DON: director of nursing MAR: medication administration record MDS: Minimum Data Set CAA: Care Area Assessment RAP: Resident Assesement Protocol Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 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.	F 164	South Lincoln Nursing Center will maintain the Residents' rights and personal privacy as defined by F164 and maintain confidentiality of his/her personal and clinical records. 1.) Since the date of the survey Resident #4 has been provided privacy in her room. 2.) Stop signs have been posted on resident #4 as well as the rest of the residents' doors to protect the privacy of all residents. 3.) The nursing staff will conduct an assessment of resident #17 wandering. 4.) An activity assessment will be conducted by John Clift, MTRS, MSW. 5.) A multidisciplinary care conference will then be held and a care plan will be developed to address resident #17 wandering and methods to be used to redirect her. 6.) Staff will educated on the interventions that have be care planned for resident#17 when she is wandering.	~~7/28/11~~ ~~8/8/11~~ ~~8/25/11~~ ~~8/19/11~~ ~~8/25/11~~ ~~8/26/11~~

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Eric Boley, Administrator — TITLE: CEO — (X6) DATE: 08/21/2011

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ZPSG11 Facility ID: WY0041 If continuation sheet Page 1 of 34

Changes made per Eric Boley, CEO on 9/6/11 @ 8:25am with Janelle Cook, ONL

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WyomingDeptofHealth
SEP 13 2011
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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on random observation, resident and staff interview, and medical record review, the facility failed to ensure the right to personal privacy and confidentiality was maintained for one non-sample resident (#4). The findings were: During an interview with resident #4 in his/her room on 7/26/11 at 11:30 AM, resident #17 was observed to wander into the room. Resident #17 was asked to leave; however, the resident stayed in the room and attempted to touch the injured arm of resident #4. Further observation showed resident #17 attempted to remove a shirt from a chair and was repeatedly asked to not remove the item. Interview with resident #4 at that time, revealed resident #17 comes into his/her room "frequently" and when asked to leave, resident #17 does not always comply. Review of the behavior monitoring sheets for June and July 2011 showed resident #17 had wandering behaviors, and would steal/rummage through other residents' belongings. According to the monitoring sheets, the resident exhibited these behaviors 19 times during these two months. Interview with the DON on 7/28/11 at 8:10 AM revealed the facility had not tried	F 164	7.)Staff were educated at the monthly staff meeting on resident's privacy and confidentiality. 8.) The Director of Nursing will implement a quality monitoring tool to ensure privacy from wandering elders. 9.) The results of the monitor will be reported at the monthly QA/QI meeting and the monthly Medical Director meeting.	~~8/10/11~~ ~~8/18/11~~ 9/13/11

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F 164	Continued From page 2 anything to prevent the resident from wandering into areas where s/he did not belong; the approach used was to re-direct him/her.	F 164		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure 1 of 9 sample residents (#8) were treated in a manner which maintained their dignity. The findings were: Review of the 6/10/11 quarterly MDS assessment for resident #8 showed s/he required extensive assistance of one staff member for transferring, dressing, and toileting. This assessment also showed the resident was totally dependent on staff for brushing his/her teeth, washing/drying his/her face and hands, and for combing his/her hair. Observation on 7/26/11 from 10:12 AM until 10:34 AM showed CNA #2 washed the resident's face and hands and brushed the resident's teeth while the resident was seated on the toilet having a bowel movement and urinating. While the resident was not interviewable, the reasonable person would not want their face and hands washed or teeth brushed while toileting. Interview with the CNA on 7/28/11 at 9:32 AM revealed she usually performed resident care in this manner because it was "easier" for her. The CNA said	F 241	South Lincoln Nursing Center will maintain the resident's right to dignity and respect of individuality as defined in F241. 1.) Since the date of the survey elder #8 has been provided care that provides dignity and respect by the nursing staff. 2.) CNA #2 was educated on providing care while maintaining the residents dignity and respect. 3.) All staff were educated on how to provide resident care while maintaining dignity and respect of the resident at the monthly staff meeting. 4.) Since the date of the survey if it is noted by the charge nurse the elders dignity and respect is not maintained while resident care is provided the charge nurse will provide an immediate in-service and corrective action taken with the CNA involved. 5.) The Director of Nursing will develop a quality monitoring tool for doing random surveillance of the staff while they are providing care to the residents. 6.) The results of the surveillance will be reported at the monthly QA/QI meeting and the monthly Medical Director meeting.	7/28/11 7/28/11 8/10/11 7/28/11 8/18/11 9/13/11

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F 241	Continued From page 3 she had not thought about it being undignified but agreed that it was. Interview with the DON on 7/26/11 at 10:10 AM revealed the resident should have been provided perineal care then transferred back to the wheelchair prior to receiving morning care.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide a meaningful plan of activities for 5 of 9 sample residents (#2, #6, #17, #18, #19). The findings were: 1. Review of the 3/25/11 quarterly MDS assessment for resident #18 showed pets were very important to him/her. Review of the activity assessment also showed the resident was moderately impaired for decision making and his/her cognitive status interfered with activity participation. Review of the 7/23/11 activity progress notes showed the resident still enjoyed pets, playing cards, and going on rides. The following concerns were identified: a. Review of the care plan showed there were no measurable goals identified, but did refer to one-to-one visits as needed. However, review of the activity attendance record showed no	F 248	South Lincoln Nursing Center will provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. 1.) John Clift, MTRS will complete a new activities assessment on residents (#2, #6, #17, #18, and #19) as well as on existing residents on a quarterly basis as the MDS is due and on new resident admissions. 2.) A new care plan with measurable goals identified will be completed on residents (#2, #6, #17, #18, and #19). Care plans for each resident will be reviewed and revised on a quarterly basis as the MDS is due and they will include measurable goals. 3.) John Clift, MTRS or the MDS coordinator will update each resident's care plan and review progress notes on a quarterly basis in conjunction with the activity aide. 4.) The activity aid has been instructed to make sure she is doing one-to-one activities with the residents that this need has been identified and care planned. 5.)The activity aide has also been instructed on the importance of documenting when she does do one-to-one activities with the resident's. 6.) The Director of Nursing will implement a quality monitoring tool to ensure the activity assessments completed, the care plan has	8/19/11 8/19/11 8/19/11 8/18/11 8/18/11

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F 248	Continued From page 4 one-to-one activities occurred or were offered during the month of July 2011. Review further revealed there was no assessment to evaluate the need for PRN one-to-one visits. b. During an interview with the activity aide on 7/27/11 at 11:10 AM, she verified there were not specific activity goals defined for the resident, or documentation related to the one-to-one participation. Random observations during the survey on 7/26/11, 7/26/11 and 7/27/11 showed the resident spent much of his/her time seated in the dining room. 2. Review of the 4/29/11 admission MDS assessment for resident #19 showed visiting with family and friends was very important to him/her. Review of the activity assessment also showed the resident was moderately impaired for decision making and his/her cognitive status interfered with activity participation. The 7/23/11 activity progress notes showed the resident had changed little during the past month and that s/he slept 90% of the time. The notes indicated activity staff would continue to work with and provide one-to-one visits with the resident. The following concerns were identified: a. Review of the care plan showed there were no measurable goals identified, but did refer to one-to-one visits as needed. However, review of the July 2011 activity attendance record showed no one-to-one activities occurred, or were offered during the month. Review further revealed there was no assessment to evaluate the need for PRN one-to-one visits. b. During an interview with the activities aide on 7/27/11 at 11:10 AM, she verified there were no specific activity goals defined for the resident, or documentation related to the one-to-one	F 248	has measurable goals, and one-to-one activities done with the residents are documented. 7.) The results of the monitor will be reported at the monthly QA/QI meeting and the monthly Medical Director meeting.	9/11/11

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F 248	Continued From page 5 participation. Random observations during the survey on 7/25/11, 7/26/11 and 7/27/11 showed the resident spent most of his/her time in bed. 3. Review of the 11/26/10 annual MDS assessment for resident #2 showed listening to music, going outside in good weather, and religious practices were very important to him/her. Review of the activity assessment also showed the resident was moderately impaired for decision making. The following concerns were identified: a. Review of the care plan showed there were no measurable goals identified, but did refer to one-to-one visits as needed. However, review of the activity attendance record showed no one-to-one activities occurred or were offered during the month of July 2011. Review further revealed there was no assessment to evaluate the need for PRN one-to-one visits. In addition, the resident was not offered any music activities. b. During an interview with the activities aide on 7/27/11 at 11:10 AM, she verified there were no specific activity goals defined for the resident, or documentation related to the one-to-one participation. Random observations during the survey on 7/25/11, 7/26/11 and 7/27/11 showed the resident spent much of his/her time in bed or napping.	F 248		
	4. Review of the undated admission activity assessment for resident #17 showed the resident had current interest in cards/games, arts/crafts, spiritual/religious activities, outdoors, gardening, helping others, and animals and pets. The assessment also showed the resident was moderately impaired for decision making and his/her cognitive status interfered with activity participation. The assessment failed to analyze			

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F 248	Continued From page 6 this information to create a meaningful plan for the residents activities. The following concerns were identified: a. Review of the care plan showed there was not an identified goal related to activities, although throughout the resident care plan it referred to one-to-one visits as needed. b. Interview with the activity aide on 7/27/11 at 11:10 am, revealed the resident was not able to pursue his/her own activities and required one-to-one visits and encouragement to participate in small groups. The activity aide further verified there was no specific activity goals defined for the resident, or documentation related to the one-to-one participation and the resident's response to these activities. c. Random observations during the survey on 7/26, 7/26 and 7/27/11 showed the resident spent most of his/her time wandering the facility and napping. 5. Review of the 3/18/11 admission MDS assessment showed resident #6 triggered for activities. The CAA for activities showed due to his/her cognition the resident was unable to pay attention in a structured activity and one-to-one time would be spent with the resident. The assessment failed to identify any meaningful activities that could be arranged for the resident. The following concerns were identified: a. Review of the care plan for activities showed it was dated 9/10/09. The care plan showed "reviewed continue next 90 days" however, there was no date to show when it was last reviewed. Further, the care plan failed to include any measurable activity goals, the only goal was for the resident to maintain current self directed activities. The approaches for reaching	F 248		

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F 248	Continued From page 7 this goal was to provide a large activity calendar, notify the resident 10 minutes prior to the start of an activity and encourage the resident to participate in activities, and to provide one-to-one activities as needed. b. Interview with the activity director on 7/27/11 at 12:45 PM verified the assessment was not well enough developed. He further verified the goals and activities provided needed to be more detailed. c. Random observation on 7/27/11 from 12:45 PM to 6:15 PM showed the resident was not provided any activities. Interview with the activity aide on 7/27/11 at 11:10 AM verified there was no documentation to show what kind of one-to-one activities were provided, or how the resident responded to the activities.	F 248		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272	South Lincoln Nursing Center will ensure that upon admission and quarterly a comprehensive, accurate, standardized, reproducible, assessment of each resident's functional capacity as defined by F248 is completed. 1.) A comprehensive assessment for activities, pain, and pressure ulcers has been completed for resident #6. 8/19/11 2.) A comprehensive pain assessment will be completed for resident #19 and the care plan updated to reflect meaningful approaches for the resident's pain. 8/19/11 3.) Residents current MDS assessment includes comprehensive assessment for each triggered areas. CAA's will reflect information obtained in the assessment as well as where the information can be found. 8/16/11 Missing assessments for Res # 1 and #8 have been completed. dc	

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F 272	Continued From page 8 Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments were completed in a variety of areas for 4 of 9 sample residents (#1, #6, #8, #18). The findings were: 1. Review of the admission MDS assessment dated 3/18/11 for resident #6 showed s/he triggered for a comprehensive assessment that included the areas of activities, pain and pressure ulcers. Review of the CAAs all dated 3/18/11 for these areas showed they failed to include sufficient information and analysis to develop measurable goals and meaningful approaches on the resident's plan of care.	F 272	4.) The Director of Nursing will implement a quality monitoring tool to ensure a comprehensive assessment is performed for each resident and the CAA's include sufficient information and analysis to develop measurable goals and meaningful approaches on each resident's plan of care. 5.) The results of the monitoring will be reported at the monthly QI/QI meeting and the Medical Director meeting.	8/18/11 9/11/11

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F 272	Continued From page 9 2. Review of the 4/29/11 admission MDS assessment for resident #19 showed s/he triggered for comprehensive pain assessment. Review of the CAAs; however, showed no evidence a comprehensive pain assessment was performed. Interview with the DON on 7/28/11 at 10:10 AM revealed she was unsure why a pain CAA was not performed. 3. Review of the annual MDS assessment dated 8/12/10 for resident #1 showed the resident triggered for a comprehensive assessment that included the areas of psychosocial well-being and dehydration/fluid maintenance. Review of the RAP dated 8/18/10 showed it was not comprehensive. The information showed the resident had mild depression and the facility would care plan. In addition, the 8/18/10 RAP for dehydration was not comprehensive, it only showed that the resident received a diuretic. 4. Review of the annual MDS assessment dated 9/16/10 for resident #8 showed the resident triggered for a comprehensive assessment that included the areas of cognitive loss, visual function, communication and mood state. Review of the RAPs for these areas dated 9/17/10 showed they were not comprehensive. The RAPs failed to include sufficient information and analysis to develop measurable goals and meaningful approaches on the resident's care plan.	F 272		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278	South Lincoln Nursing Center will ensure that each assessment will accurately reflect each resident's status as defined by F278. 1.) Since the date of the survey section V of the MDS assessment that have been submitted contains the location and the contributing	7/28/11

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F 278	Continued From page 10 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 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure the MDS assessments were accurate for 6 of 9 sample residents (#1, #2, #8, #18, #19, #20). The findings were: 1. Review of the 11/26/10 admission MDS assessment for resident #2, the 3/25/11 admission MDS assessment for resident #18, the 4/29/11 admission MDS assessment for resident	F 278	factors, risks, and additional information used in the CAA analysis. 2.) A comprehensive pain assessment has been performed on resident #19. 3.) The 8/11/11 MDS assessment for resident #1 reflects comprehensive assessment for each area triggered and the CAA's reflect a comprehensive analysis of the assessment information and where the information was collected from is documented in Section V. 4.) The Director of Nursing will implement a quality monitoring tool to ensure assessment accuracy/coordination. 5.) The results of the quality monitor will be reported at the monthly QA/QI meeting and at the Medical Director meeting.	8/19/11 8/11/11 8/18/11 9/11/11

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	53A051	A. BUILDING _____ B. WING _____	07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

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F 278	Continued From page 11 #19, the 8/12/10 annual MDS assessment for #1, and the 9/16/10 annual MDS assessment for #8 showed section V did not identify the location of the assessment data utilized in the CAA/RAP summaries. The location information documented only indicated the CAA/RAP summary, not where the contributing factors, risks, and additional information used in the analysis were located. 2. Review of the 7/6/11 admission MDS assessment for resident #20 showed section V was not completed. The section to show if the triggered care areas would be addressed in the care plan, and the location and date of CAA information, was left blank. 3. Interview with the DON on 7/28/11 at 10:05 AM revealed the MDS coordinator was unavailable but that she would speak with the coordinator upon her return regarding the concerns about MDS inaccuracies.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280	South Lincoln Nursing Center will ensure the elder's right to participate in planning care/ revising care plan will be maintained as defined in F280. 1.) The care plan for elder #1 has been updated to reflect the treatment of her pressure ulcer and the interventions to prevent new pressure ulcers. 2.) The area on resident #6 is healed. 3.) Resident #17 care plan will be updated to identify interventions to address her wandering behavior after a 7 day assessment on her wandering has been completed by the nursing staff. 4. All residents will have a care plan developed that addresses the residents area of need, interventions, and goals.	~~7/29/11~~ 8/25/11 9/11/11

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F 280	Continued From page 12 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to review and revise the care plans for 3 of 9 sample residents (#1, #6, #17) who needed such revisions to show a change in status. The findings were: 1. Review of the nurses' note dated 6/27/11 for resident #1 showed his/her coccyx had a reddened area with a "slight rough" appearance. On 6/30/11, breakdown was noted on the coccyx and bag balm was applied. Further review showed on 7/14/11 Mepilex Border (dressing used to promote wound healing) was applied for a stage II pressure ulcer. Review of the care plan, last reviewed on 2/11/11, showed the resident was at risk for developing a pressure ulcer. However, the care plan had not been updated to show the development of an actual pressure ulcer and the needed treatment. Interview with the DON on 7/28/11 at 8:20 AM acknowledged the need to update care plans to reflect the resident's current care needs. 2. Review of the 6/17/11 care plan for resident #6 showed potential pressure ulcer development was identified as a problem area. The resident was at risk related to decreased mobility, and risk for dehydration and incontinence. Review of	F 280	5.) The Director of Nursing will implement a quality monitoring tool to ensure residents care plans are up dated in a timely manner to reflect interventions and goals. 6.) The results of the quality monitoring tool will be reported at the monthly QA/QI meeting and the Medical Director meeting.	8/18/11 9/11/11

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F 280	Continued From page 13 nurse's notes, dated 7/13/11, revealed an open area was identified on the resident's right sacrum. The care plan was not updated to show the actual pressure ulcer and the treatment. 3. Review of the care plan for resident #17 revealed wandering behavior was a problem. Observation on 7/25/11 and 7/26/11 showed the resident wore two separate wanderguard devices on the back of his/her shirt. Interview with the DON on 7/26/11 at 8:10 AM revealed two were used to ensure the exit door sensor would be activated, the resident was known to remove the devices if s/he could reach them. In addition, a motion sensing alarm that played music had been placed in the resident's room to alert staff of his/her movements. According to nursing notes, the movement sensor alarm had been in use since 6/1/11. Finally, the 3/29/11 CAA assessment related to behaviors showed there were 30 minute checks done on the resident to ensure safety. Review of the care plan dated 6/24/11 failed to show these updated approaches the facility had implemented.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure staff followed the care plan for 3 of 9 sample	F 282	South Lincoln Nursing Center will ensure staff follow the residents care plan as defined by F282. 1.) Nine pressure reduction mattresses, 6 pressure reduction cushions and two ROHO cushions were ordered. 2.) Pressure reduction mattresses were put on the bed of resident #6, and #8. 3.) #6 has had a pressure reduction cushion placed in wheelchair. 4.) All the residents who are found to be at risk for pressure ulcers will be provided pressure reduction devices. 5.) If it is noted staff fails to follow the care plan instruction will be provided immediately to staff	~~8/9/11~~ ~~8/18/11~~ ~~8/18/11~~ 8/18/11 7/28/11

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F 282	Continued From page 14 residents (#6, #8, #19). The findings were: 1. Review of the 4/29/11 care plan for resident #19 showed pain was identified as a problem related to the resident's arthritis, past hip fracture, and right leg amputation. The care plan included multiple interventions that were not being followed. Refer to F309 for details regarding the staff's lack of implementing the care plan interventions on a consistent basis. Interview with the DON on 7/28/11 at 8:20 AM revealed staff should follow the care plan for each resident. 2. Review of the 6/17/11 updated care plan for resident #6 showed s/he was at risk for developing pressure ulcers. The approaches for prevention included a pressure reducing device to the resident's bed. Observation on 7/28/11 at 9:35 AM revealed there was no pressure reducing cushion/device on the residents bed. Interview on 7/28/11 at 12:20 PM with the DON verified the care plan needed to be followed and the pressure reducing devices should be used. 3. Observation on 7/26/11 at 10:12 AM showed resident #8 did not have a cushion in the seat of his/her wheelchair. Review of the care plan last reviewed 6/10/11 showed the resident was at moderate risk for developing pressure ulcers. The care plan interventions showed the resident was to have a Roho or gel cushion in his/her wheelchair. Interview with the DON on 7/28/11 at 10:10 AM revealed the resident had a pressure reducing cushion for his/her wheelchair. Further, she was not certain of the cushion's location at that time, but verified the resident was to have one in his/her wheelchair.	F 282	involved by the charge nurse. 6.) The Director of Nursing will implement a quality monitoring tool to ensure that the pressure reduction devices are in place and care plans are followed. 7.) The results of the quality monitoring tool will be reported at the monthly QA/QI meeting and at the monthly Medical Director meeting. the care plan for pain will be followed for Pt #19. jc	8/18/11 9/11/11
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=E	Continued From page 15 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 observation, staff and resident interview, and medical record review, the facility failed to ensure all necessary assessments, and monitoring were implemented for preventive pain management for 4 of 7 sample residents (#2, #3, #6, #19) who had pain. The findings were: 1. Review of the 6/17/11 quarterly MDS assessment for resident #6 showed s/he had frequent pain with vocal complaints of pain, facial expressions and protective body movements. Further review of the medical record revealed there was no assessment to show the intensity of the resident's pain, or what the acceptable levels of pain would be for the resident. Review of the July 2011 MAR showed the resident was on a scheduled pain medication, oxycodone ER 10 mg given at 8 AM each morning. In addition, there were orders for PRN (as needed) Tylenol 325 mg 1-2 tabs every four to six hours, and PRN oxycodone HCL 5 mg 1 tab every three hours. Observation on 7/27/11 at 6 PM revealed the resident was having pain. At that time the resident approached one of the surveyors complaining of a "terrible headache" the resident	F 309	South Lincoln Nursing Center will ensure resident's receive the necessary care an services to attain, maintain, the highest practicable physical, mental, and psychosocial well being in accordance to the comprehensive assessment and plan of care as defined in F309. 1.) Licensed nursing staff were educated on the need to perform an assessment for pain that includes the level of pain prior to medication administration, frequency, intensity, exacerbating factors, non-verbal indicators of pain, non medication interventions, and follow-up assessment of pain after an intervention as been implemented. ~~8/10/11~~ 2.) Since the survey residents #2,#3,#6, and #19 have had assessment for pain performed describing the resident's pain, frequency, and intensity after a pain intervention has been completed. ~~7/28/11~~ 3.) A comprehensive pain assessment was completed for resident #3. ~~8/11/11~~ 4.) The Director of nursing will implement a quality monitoring tool to ensure residents are assessed for intensity, frequency, exacerbation factors, and reassessment of pain following interventions taken to alleviate the pain. ~~8/18/11~~ 5.) The results of the quality monitoring tool will be reported at the monthly QA/QI meeting and the monthly Medical Director meeting. 9/11/11	

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F 309	Continued From page 16 was grimacing and holding her head. The surveyor relayed the information to the nurse who provided pain medication. The following concerns were identified with the assessment and re-assessment of the resident's pain: a. When reviewed on 7/28/11 the July 2011 pain management flow record showed the nurse provided the resident "oxy" for a headache on 7/27/11 at 6:05 PM; however, it showed nothing further, there was no pain rating or re-assessment for effectiveness. In addition, the July 2011 pain management flow record showed five other times when the resident was provided PRN pain medication. The pain flow record failed to show the resident's pain level prior to the medication, and also failed to show any relief or effectiveness four out of those five times. b. Interview with the DON on 7/28/11 at 8:15 AM revealed the resident had complaints of headaches and would show non-verbal signs of pain, and was able to vocalize his/her pain. The DON verified the pain flow sheets needed to be completed to show the assessment of the pain and also if the treatment was effective. 2. Review of the 7/5/11 history and physical for resident #2 showed s/he had diagnoses including Parkinson's disease and an old fracture of the spine and pelvis. Review of the 5/27/11 quarterly MDS assessment showed the resident frequently experienced moderate pain. Review of the physician's orders showed an order for two tablets of Tylenol 325 mg, as needed for pain. The following concerns were identified: a. Review of the July 2011 MAR showed the resident received two Tylenol tablets for pain on 7/3/11 at 8:26 AM, on 7/4/11 at 4:15 PM, on 7/5/11 at 8:14 AM, and on 7/14/11 at 4:25 PM	F 309		

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F 309	Continued From page 17 with no evidence an assessment describing the pain, frequency and intensity was performed. In addition, the pain medication was not documented on the pain flow sheet or in the nursing notes. Finally, review of the medical record revealed there was no evidence the resident's pain was re-assessed to determine the effectiveness of the medication in resolving the resident's pain. b. Review of the pain management flow sheet showed two Tylenol tablets were administered at 11:35 AM on 7/10/11 and at 9 AM on 7/14/11 without evidence an assessment was performed describing the resident's pain, frequency, and intensity. c. Interview with the DON on 7/28/11 at 8:20 AM revealed nursing staff should have assessed and re-assessed the resident's pain and documented the findings on the pain management flow sheet. 3. Review of the 4/29/11 admission MDS assessment for resident #19 showed s/he triggered for frequent pain. Review of the 4/29/11 care plan showed pain was identified as a problem for the resident due to diagnoses including arthritis, past hip fracture and right leg amputation. Review of the pain care plan interventions included monitoring the elements of pain which included: frequency, intensity, and location, assessing the resident one to two hours after medication administration to determine the effectiveness of the intervention, documenting the pain rating before and after interventions, and to utilize the pain management flow sheet. Review of the July 2011 MAR showed the resident was administered a PRN Tylenol 325 mg tablet on 7/4/11 at 5:45 AM, on 7/10/11 at 11:39 PM, and	F 309		

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F 309	Continued From page 18 on 7/19/11 at 12:29 PM. The following concerns were identified: a. Review of the physician's order showed the order was for one to two tablets of Tylenol 325 mg every four to six hours as needed. Review of the MAR showed the maximum amount of Tylenol in a 24 hour period was limited to 3000 milligrams. Continued review of the MAR showed the number of tablets was not documented. Therefore, an accurate account of the milligrams administered could not be monitored to ensure the 3000 mg limit was not exceeded. b. Review of the pain management flow sheet showed the Tylenol administered on the aforementioned dates and times, were not documented on the flow sheet, only on the MAR. Review of the pain management flow sheet and the nursing notes showed no evidence an assessment describing the pain, frequency and intensity was performed. Finally, review of the medical record revealed there was no evidence the resident's pain was re-assessed to determine the effectiveness of the medication in resolving the resident's pain. c. Review of the pain management flow sheet showed the resident was administered two Tylenol for pain at 8:45 AM on 7/3/11, however, there were no assessment or re-assessment findings noted on the flow sheet. d. Interview with the DON on 7/28/11 at 8:20 AM revealed nursing staff should have assessed and re-assessed the resident's pain and documented the findings on the pain management flow sheet. 4. Review of the 5/12/11 quarterly MDS assessment showed resident #3 had pain. Review of the 2/17/11 care plan showed the	F 309		

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F 309	Continued From page 19 resident's pain was related to a previous cerebral vascular accident. Review of the care plan also showed non-medical interventions for pain included massage and application of heat or cold. Review of the physician's orders dated 4/27/09 showed an order for Tylenol 325 mg one tablet every four hours as needed for pain. Continued review of physician's orders showed the Tylenol was increased to 500 mg one tablet as needed for pain on 7/19/11. Further review showed no routine pain medication was ordered. The following concerns were identified: a. Review of the July 2011 MAR showed the resident received Tylenol 325 mg 22 times. Review revealed the resident's pain was not described as to type or intensity 16 of the 22 times (73%). In addition, 21 of the 23 times (91%) there was no evidence the pain was re-assessed to determine the effectiveness of the medication. b. Further review of the July 2011 MAR showed the resident was administered the increased dose of Tylenol 500 mg 15 times. Review of the pain management flow sheet showed the resident was not assessed in regard to pain intensity, using a pain scale of 0 to 10 with 10 being the worst, 13 times (87%). Review of the pain management flow sheet also showed that 47% of the time (7 of 13) there was no evidence a pain re-assessment was performed to determine the effectiveness of the pain medication in relieving the resident's pain. c. Interview with the resident on 7/27/11 at 2 PM revealed the Tylenol 325 mg did not relieve the pain so s/he requested something additional. The Tylenol was then increased to 500 mg but the resident continued to have pain without relief. d. During an interview with the DON on 7/28/11 at 8:20 AM, she acknowledged the	F 309		

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F 309 F 312 SS=D	Continued From page 20 resident needed further assessment for pain. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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, medical record review and staff interview, the facility failed to ensure adequate incontinence care for sample residents (#2, #8) during 2 of 6 random observations. The findings were: 1. Observation on 7/26/11 at 8:30 AM showed resident #2 was transferred from his/her wheelchair to the bathroom using a sit-to-stand lift assisted by CNAs #2 and #3. When the incontinence brief was removed, it showed the resident had been incontinent of urine. CNA #3 failed to clean the anterior pubic area when providing incontinence care. 2. Review of the 6/10/11 quarterly MDS assessment for resident #8 showed the resident was incontinent of urine all of the time and was totally dependent upon staff for personal hygiene. Observation on 7/26/11 at 10:12 AM revealed the resident was incontinent of urine and bowel. Continued observation showed CNA #2 did not cleanse the anterior perineal area which was in contact with the urine. Interview with the CNA on 7/26/11 at 9:32 AM revealed she was aware of	F 309 F 312	South Lincoln Nursing Center will ensure that residents receive the necessary services to maintain good nutrition, grooming, personal, and oral hygiene as defined by F312. 1.) Staff were instructed on proper technique for perineal care for incontinent residents at the monthly staff meeting. 2.) The Director of Nursing will implement a quality monitoring tool for randomly observation of perineal care being performed to ensure that the residents receive proper perineal care. 3.) The results of the quality monitoring will be reported at the monthly QA/QI meeting and at the monthly Medical Director meeting.	~~8/10/11~~ ~~8/18/11~~ 9/11/11

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	53A051	A. BUILDING _____ B. WING _____	07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

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F 312	Continued From page 21 the proper technique for providing perineal care, including cleansing all areas that were in contact with the urine.	F 312		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 medical record review, observation and staff interview, the facility failed to ensure 3 of 8 sample residents (#1 #6, #8) who had pressure ulcers or were at risk for pressure ulcers had preventative measures implemented. In addition, the facility failed to ensure preventative measures for 1 non-sample resident (#24) who was at risk for pressure ulcers. The findings were: 1. Review of the 6/17/11 quarterly MDS assessment showed resident #6 was independent for bed mobility; however, required extensive assistance for transfers. The MDS assessment also showed the resident used a wheelchair for mobility and was at risk for developing pressure ulcers. According to the 3/18/11 CAA for pressure ulcers, the resident was at risk due to being in a wheelchair most of the day and due to incontinence. The following	F 314	South Lincoln Nursing Center will ensure residents receive treatment and services to prevent/heal pressure sores as defined by F314. 1.) Resident #1,#6 and #8has been provided a pressure reduction mattress. 8/18/11 2.) Licensed nursing staff were instructed on the need to notify the medical provider of any changes in the resident's condition and to obtain orders for treatments at the monthly staff meeting. 8/10/11 8/18/11 3.) A pressure reduction cushion has been placed in resident #1 and #6 chair. 4.) Resident #24 has a pressure reduction cushion in the chair in the common area. 8/18/11 5.) The cushion for resident #8 roho cushion was located and placed in the residents chair. 7/28/11 6.) Staff were instructed on the need to ensure pressure relieving devices are properly placed at all times at the monthly staff meeting. 8/10/11 7.) If it is noted a resident has no pressure relieving device when it is care planned, staff will be counseled immediately on the need to follow the care plan and on the importance of having pressure relieving devices in place. 9/11/11 8.) The Director of Nursing will implement a quality monitoring tool to ensure pressure relieving devices are properly in place. 8/18/11 9.) The results of the quality monitoring tool	

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F 314	Continued From page 22 concerns were identified: a. Review of the resident's 6/17/11 updated care plan showed there were approaches developed to prevent the development of pressure ulcers. The approaches included a pressure reducing device to the resident's bed. However, there was nothing related to the wheelchair. b. Observation of the resident's bed showed there was no pressure relieving device being used. c. Observation on 7/27/11 at 6:15 PM and on 7/28/11 at 9:05 AM revealed the resident did not have any cushion on the wheelchair seat. Interview with the restorative aide on 7/28/11 at 9:05 AM revealed the resident did not have any pressure relieving device in the wheelchair because s/he would slide out of the chair when a cushion was used. Further interview with the DON on 7/28/11 at 9:15 AM verified this reasoning, and she further revealed, they had not tried various cushions or any adjustments to the wheelchair in order to provide a pressure reducing device without the risk of falls. d. Review of nurse's notes dated 7/13/11 at 11:05 PM showed a skin assessment was completed with a small open area noted to the resident's right buttock. e. The nurses' notes on 7/13/11 at 11:05 AM and 7/14/11 at 12:01 PM showed bag balm was applied to the open area. Review of the physician orders failed to show any orders for the bag balm or any other treatment orders for the open area. 2. Review of the quarterly MDS assessment dated 5/12/11 for resident #1 showed s/he was not at risk for pressure ulcers. However, review of the care plan last reviewed 2/11/11 showed the	F 314	will be reported at the monthly QA/QI meeting and at the monthly Medical Director meeting.	9/11/11

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F 314	Continued From page 23 resident was at risk for the development of pressure ulcers due to his/her history. The following concerns were identified: a. Review of the nurse's notes dated 6/26/11 at 11:01 AM showed the resident had developed a redden area with scab formation. The nurse's notes dated 6/23/11 at 4:50 PM showed there was breakdown noted on the coccyx, and bag balm was applied. Further, on 7/6/11 at 6:37 AM, notes revealed skin breakdown was located on the left gluteal cleft and a dressing to promote wound healing was applied to the stage II pressure ulcer on 7/14/11. b. Review of the nurses' notes from 6/26/11-7/26/11 did not indicate the resident's provider was notified of the pressure ulcer. c. Observation on 7/27/11 at 9:05 AM showed the resident did not have pressure relieving devices on either his/her bed or chair. d. Interview with the DON on 7/26/11 at 9:05 AM acknowledged the resident needed preventive devices in place and the care plan needed to reflect the resident's current condition. 3. Observation on 7/26/11 at 9:05 AM showed resident # 24 transferred from his/her wheel chair to a lounge chair in the common area using a sit-to-stand lift. The resident had only a flat pad in the seat of the wheelchair. Review of the care plan showed s/he was at moderate risk for developing pressure ulcers and was to have a pressure-reliving device in the chair. Interview with the DON on 7/28/11 at 8:15 AM revealed a cushion was not used in the resident's wheelchair due to a risk of falls. The DON further revealed they had not tried various cushions or any adjustments to the wheelchair in order to provide a pressure reducing device without the risk of	F 314		

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F 314	Continued From page 24 falls. 4. Review of the care plan last reviewed 6/10/11 showed resident #8 had a Braden score (tool used to predict pressure ulcer risk) of 14, indicating a moderate risk for developing pressure ulcers. An intervention to prevent pressure ulcer development was to have a Roho or gel cushion in his/her wheelchair. Observation on 7/26/11 at 10:12 AM showed the resident did not have a cushion in the seat of his/her wheelchair. Interview with the DON on 7/28/11 at 10:10 AM revealed the resident had a pressure reducing cushion, but it was not currently in place. The DON was not certain of the cushion's location at that time, but verified the resident was to have one in his/her wheelchair.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure adequate supervision to minimize accidents for 1 of 9 sample residents (#17). The findings were: Observation on 7/27/11 from 5:20 PM until 5:24 PM showed the medication cart was left unlocked	F 323	South Lincoln Nursing Center will ensure residents environment is free of accident hazards as defined by F323. 1.) The Charge nurse were instructed to keep the medication cart locked at all times when it is not in use and unattended. 2.) All of the nurses were instructed to keep the medication cart locked at all times when it is not in use and unattended at the monthly staff meeting. 3.) The Director of Nursing will implement a quality monitoring tool to do random checks of the medication cart to ensure that it is locked at all times when it is not in use and unattended. 4.) The results of the random checks will be reported at the monthly QA/QI meeting and the monthly Medical Director meeting.	7/27/11 8/10/11 8/18/11 9/11/11

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F 323	Continued From page 25 In the nursing station. Observation further revealed resident #17, who was cognitively impaired based on the 6/24/11 quarterly MDS assessment, was seated at the nursing desk facing towards the medication cart. Observation showed only one staff member was in the vicinity at the time, but she had her back turned away from the resident and the medication cart. While the observation showed the resident did not try to open the medication cart at this time, an earlier observation on that same day, showed the resident was attempting to open the medication cart. Interview with RN #1 on 7/27/11 at 5:24 PM revealed the cart should not be left unlocked unless there was a nurse in the nursing station to watch it. Interview with the DON on 7/28/11 at 9:37 AM revealed the medication cart should be kept locked when not in use.	F 329		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329	South Lincoln Nursing Center will ensure the resident's drug regimen is free from unnecessary drugs as defined by F329. 1.) At the next psychotropic drug review meeting resident #2 will have the celexa reviewed and dose reduction and risk benefit discussed and a recommendation made to the medical provider. 9/11/11 2.) At the next Medical Staff meeting the Medical Director will educate the medical staff about drug regimen free of unnecessary drugs as defined by F329. 9/11/11 3. The Director of Nursing will implement a quality monitoring tool to ensure the resident's drug regimen is free of unnecessary drugs. ~~8/18/11~~ 4.) The result of the quality monitoring tool	

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F 329	Continued From page 26 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary drugs for 2 of 9 sample residents (#2, #8). The findings were: 1. Review of the medical record for resident #2 showed s/he had diagnoses which included mood disorder. Review of the July 2011 recapitulation of physician's orders showed an order for Celexa (antidepressant)10 milligrams (mg) daily ordered on 11/24/09. Further review of the medical record showed the facility failed to attempt a gradual dose reduction. During an interview with the DON on 7/28/11 at 8:20 AM, she said the Celexa was discussed in their monthly psychotropic drug meetings. However, review of these meeting minutes showed no evidence a gradual dose reduction was attempted or was contra-indicated. 2. Review of the medical record for resident #8 showed s/he had an increase of fentanyl (medication for pain) from 50 mcg to 75 mcg on 4/19/11. In addition to fentanyl, the resident received the following pain medications: hydrocodone 7.5 mg/acetaminophen 500 mg one daily, and acetaminophen 325 mg two tablets every 4-6 hours as needed (prn) for pain. The	F 329	will be reported at the monthly QA/QI meeting and the monthly Medical Director meeting. The physician will review the pain medication for res #8. JC	9/11/11

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F 329	Continued From page 27 following concerns were identified: a. Review of the April 2011 nurses' notes and the pain flow record prior to the increase of fentanyl, showed no indication for the increase in pain medication. b. Review of the 3/16/11 and 4/21/11 physician provider notes showed no documented reason or indication for the increase in the pain medication. c. Interview with the DON on 7/26/11 at 8:20 AM revealed she would try to locate the justification for the increase; however, as of 8/1/11 nothing had been found.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain kitchen/food equipment in a sanitary manner. The findings were: Observation on 7/25/11 at 4:17 PM revealed the ovens, range top, fryer, hood and vents were not maintained in a clean manner. The hood system and its vents had noticeable build-up of grease and dust. The range top and ovens has a build-up	F 371	South Lincoln Nursing Center will ensure that food will be stored, prepared, distributed, and served under sanitary conditions in accordance with Federal, State or Local authorities. 1.) The Dietary Manager ordered a Filter Baffle Boss lift tool to help increase ease of cleaning hood filters. 2.) A very thorough and deep cleaning of the range top has been performed. 3.) A very thorough and deep cleaning of the grill top has been performed. 4.) The Dietary Manager held an in-service to educate staff on the need for cleanliness and how to clean hood, vents, range top, fryer, and ovens. 5.) The Dietary Manager will develop a quality monitoring tool to ensure weekly cleaning of the hood, vents, range top, fryers, and ovens. 6.) The results of the quality monitoring tool will be reported at the monthly QA/QI meeting.	7/28/11 8/3/11 8/6/11 8/5/11 8/18/11 9/11/11

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F 371	Continued From page 28 of burned on food debris. Observation on 7/27/11 at 6:26 PM revealed the equipment remained in the same un-clean condition. Interview with the dietary manager on 7/28/11 at 9 AM verified these items were on a cleaning schedule and were expected to be cleaned at least monthly. The dietary manager then verified the schedules were not always signed off as being completed and they needed better frequency of cleaning. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441	South Lincoln Nursing Center will ensure the prevention and transmission of disease and infection as defined by F441. 1.) CNA#2 was counseled on proper hand-washing technique and acceptable professional practice. 2.) All staff were instructed on proper hand-washing techniques and professional practice at the monthly staff meeting. 3.) The Director of Nursing will implement a quality monitoring tool to ensure proper handwashing technique and professional standards. 4.) The results of the quality monitoring tool will be reported at the monthly QA/QI meeting and at the monthly Medical Director meeting.	7/27/11 ~~8/10/11~~ ~~8/18/11~~ 9/11/11

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F 441	Continued From page 29 (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: Based on observation and staff interview, the facility failed to ensure staff followed appropriate infection control practices regarding hand hygiene during 3 of 3 random observations. The findings were: 1. During observation on 7/26/11 at 10:12 AM, CNA #2 provided morning care and incontinence care for resident #8. The CNA did not change her gloves while she assisted the resident on the toilet, removed the incontinence brief which was soiled with urine and feces, washed the resident's face and hands, brushed the resident's teeth, provided perineal care, dressed the resident in clean clothing, and finally, transferred him/her to the wheelchair. It was not until all of these tasks	F 441		

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F 441	Continued From page 30 were completed, in the order aforementioned, the CNA removed her soiled gloves. During an interview with CNA #2 on 7/28/11 at 9:32 AM, she said she should have removed her gloves between dirty and clean tasks. Interview with the director of operations, who had oversight over the infection control program, on 7/28/11 at 9:37 AM revealed the CNA should have removed the soiled gloves, washed her hands, then donned a clean set of gloves when going between dirty and clean tasks. 2. Observation on 7/26/11 at 10:20 AM showed CNA #1 wore disposable gloves while passing snacks between residents. While she was wearing the gloves, the CNA handled the refrigerator door located in the main dining room. Without removing her gloves or cleansing her hands the CNA continued to pass snacks to residents, opening the wrappers and touching the residents clothes and wheelchairs. 3. Observation on 7/26/11 at 1:55 PM showed CNAs #1 and #4 wearing gloves while passing water to individual residents in rooms 105, 106, and 107. The CNAs removed the used water pitchers from each of the rooms, filled with ice from an ice bucket using a plastic cup and then returned the pitchers to the resident's room. In addition, the CNAs were passing clean linens at the same time as the water. During this process the CNAs failed to change gloves or cleanse their hands. The same gloves were worn between rooms, handling the used water pitchers and the clean linens.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory	F 502	South Lincoln Nursing Center will provide or obtain laboratory services to meet the needs of its residents as defined by F502.	

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F 502	Continued From page 31 services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure laboratory tests were performed as ordered for 1 of 9 sample residents (#19) who had laboratory tests ordered. The findings were: Review of the physician's July 2011 recapitulation orders for resident #19 showed a thyroid stimulating hormone test and a prostate-specific antigen test were ordered annually during the health fair in February 2011. Review of the entire medical record showed these tests were not performed as ordered. Interview with the DON on 7/28/11 at 10 AM confirmed the tests were not performed.	F 502	1.) The order for the PSA and TSH was clarified with the medical provider. 2.) All the residents will have medical orders reviewed nightly by the charge nurse and will be clarified as needed. 3.) The Director of Nursing will implement a quality monitoring tool to ensure the review of standing and current orders and then clarified as needed. 4.) The results of the quality monitoring tool will be reported at the monthly QA/QI meeting and the monthly Medical Director meeting.	8/15/11 7/28/11 8/18/11 9/11/11
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	South Lincoln Nursing Center will maintain clinical records on each resident in accordance with accepted professional standards and practices as defined by F514. 1.) Physician progress notes on residents #1, #3, #6, #8, #18, #19 have been added to the residents medical record. 2.) The Medical Staff will be instructed on how to copy and paste progress notes from the Allscripts EMR to the resident EMR in Health Land at the next Medical Staff Meeting. 3.) The Director of Nursing will implement a quality monitoring tool to ensure progress notes	8/16/11 9/11/11 8/18/11

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A061	A. BUILDING _____ B. WING _____	07/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

(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 514	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to include physician progress notes in the medical record for 6 of 9 sample residents (#1, #3, #6, #8, #18, #19). The findings were: Review of the medical records for residents #1, #3, #6, #8, #18, #19 showed progress notes from the physicians and mid-level practitioners were lacking. Interview with the DON on 7/26/11 at 4:05 PM revealed the progress notes were maintained in computer system that was separate from the resident record system. The DON was able to produce copies of these notes; however, she verified the nursing home staff were unable to access the system with the notes, and they were not usually placed into the residents' records.	F 514	are in the residents medical record. 4.) The results of the quality monitoring tool will be reported at the monthly QA/QI meeting and at the monthly Medical Director meeting.	9/11/11
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 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. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of	F 520	South Lincoln Nursing Center will ensure the designated physician will attend the QA/QI meeting on a quarterly basis as defined by F520. 1.) The Administrator educated the Chief of Staff on the need to attend the QA/QI meeting on a quarterly basis. 2.) The Director of Nursing will implement a quality monitoring tool to ensure the attendance of the Chief of Staff to the monthly QA/QI meeting at least quarterly. 3.) The results of the quality monitoring tool will be reported at the monthly QA/QI meeting and at the monthly Medical Director meeting.	8/16/11 8/18/11 9/11/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A051	A. BUILDING _____ B. WING _____	07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

(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 520	Continued From page 33 action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of Quality Assurance/Quality Improvement (QA/QI) documents, the facility failed to ensure the physician member of the committee was in attendance for 7 of 7 meetings held in 2011. The findings were: Review of the 2011 QA/QI meeting attendance monthly meeting sheet showed no physician had attended any of the meetings. Interview with the DON on 7/28/11 at 9:37 AM verified the physician member of the committee had not participated in any of their QA/QI meetings.	F 520		