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 _____	02/02/2006

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

APR 26 2006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 159 SS=D	483.10(c)(2)-(5) PROTECTION OF RESIDENT FUNDS	F 159	This plan of correction constitutes our allegation of compliance.	3/19/06

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the

AMENDED PLAN OF CORRECTION

6 h d

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anita Cox-Mills | TITLE: Administrator | (X6) DATE: 3/28/06

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

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F 159	Continued From page 1 SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on review of trust fund accounts and staff interview, the facility failed to refund personal monies after resident discharge for 1 (#84) supplemental resident who was discharged. The findings were: Review of the list of resident trust fund accounts dated 2/1/06 revealed non-sample resident #84 had a balance of $15.04. Interview with the business office manager on 2/2/06 at 10:05 AM confirmed the resident was discharged from the facility on 8/24/05 and the money should have been refunded.	F 159	The money owed to non-sample resident #84 was refunded. The newly hired business office manager is reviewing all discharged residents and refunding money owed. The newly hired business offce manager will complete monthly audits to ensure this does not happen again to other residents. This will be monitored through QI and the facility administrator	3/19/06
F 161 SS=F	483.10(c)(7) ASSURANCE OF FINANCIAL SECURITY The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on review of the certificate of property insurance and staff interview, the facility failed to assure the security of personal resident funds for	F 161	A new surety bond will be implemented that will address and meet the federal guidelines. This will be reviewed yearly by the facility administrator.	3/19/06 3/19/06

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F 161	Continued From page 2 77 of 77 residents with trust accounts who were residing in the facility and 5 who were no longer at the facility, but still had funds managed there. At the time of the survey, the facility census was 80. The findings were: Review of the certificate of property insurance revealed the effective date was 7/1/05 through 7/1/06. Further review revealed it was an employee dishonesty policy instead of a surety bond. The coverage provided under the employee dishonesty policy was $3,000,000; however, there was a $25,000 deductible. The total amount of the resident trust funds managed by the facility on 2/1/06 was $59,372.58. The policy listed the insured as the "State of Wyoming Risk Management," and there was no evidence residents would collect any money in the case of loss or theft. Interview with the facility administrator on 2/2/06 at 9:54 AM revealed she had contacted the chief financial officer of the facility, and they did not have a surety bond.	F 161		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure 1 of 1 sample resident with a trunk restraint was restrained in the least restrictive manner. The restraint was not released according to plan. Findings were:	F 221	All staff working in the secure care unit were In-serviced on 2/2/06 regarding restraint release for resident #21 according to the individualized care plan. A policy and procedure will be written for use of restraints in the SCU. 3/19/06	

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F 221	Continued From page 3 1. Random observations of resident #21 on 1/31/06 revealed the resident used a cross-over loop lap belt restraint. The observations also revealed the restraint was not released during a scheduled, supervised activity that occurred from 2 PM to 2:26 PM, when the observation ended. Interview with certified nurse aide (CNA) #67 on 1/31/06 at 1:51 PM revealed the resident used the lap belt for safety awareness, and it was to be released during meals and during direct supervision. Review of the resident's medical record revealed a care plan dated 2/23/05 that instructed staff to remove the lap belt during one-to-one supervised activities and meals.	F 221	Other staff members will be In-serviced regarding proper release of prev loop restraint by resident care managers, education coordinator and the director of nursing. Follow up with quarterly QA's reviewing list from minimum data set program identifying residents with restraints. A quarterly retraint assessment will be performed for those identified. Monitor for sustained corrective action by random monthly audits by resident care managers and reported in QI meetings quarterly.	3/19/06
F 242 SS=D	483.15(b) SELF-DETERMINATION AND PARTICIPATION The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation; resident, family, and staff interviews; medical record review; and review of posted information, the facility failed to ascertain or honor the choices of 1 (#16) non-sample resident related to aspects of care which were preferred by that resident. The findings were: During an interview on 2/1/06 at 4:40 PM, a family	F 242	The facility will ensure that the resident has the right to choose activities. schedules, and health care consistent with his or her interests, assessments and plans of care; interact with members of the community both inside and outside of facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This will be accomplished by: 1) North resident care manager spoke with resident #16 and his family members. Resident requested his family members to be present during personal cares. 2) Resident care manager has removed previous posted information regarding personal cares.	2/2/06 2/2/06

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

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F 242	Continued From page 4 member stated resident #16 wanted family members present during personal cares. The family member pointed out posted personal care for resident #16, information that the family found offensive. When asked if s/he had objected to having the information posted, the family member replied, "I didn't know I had a choice." Further interview revealed the family was not allowed to be present during care because a second family member was outspoken and wanted the resident seated on a cushion in the recliner and transferred with a gait belt. The family member reported staff refused to use the gait belt during a transfer and the resident's shoulder "popped" and hurt. The family member further stated a nurse recently "pushed" medications through the feeding tube with a syringe, despite the family member's request at the time that the nurse administer medications by gravity flow, as the resident could not tolerate "pushing" them. The family member stated the resident became ill and required "a shot" about 30 minutes later. The following concerns were identified: a. Interview with the resident on 2/1/06 at 4:45 PM revealed s/he wanted family present during care. The resident repeated that statement twice. Observation during the interview verified the resident had a feeding tube. Interview with the administrator on 2/2/06 at 9:15 AM and review of the 1/18/06 admission Minimum Data Set (MDS) assessment confirmed the resident was alert and oriented with no cognitive impairment. b. Observation of posted information the family found offensive revealed it had been copied from individual cards onto a sheet of white paper, backed with black construction paper, inserted between clear plastic sheets which were stapled shut, and taped to the wall by the resident's bed. Review of the document revealed	F 242	3) Resident care manager has individualized resident #16's plan of care regarding resident's request of his family members being present during personal cares. Resident #16 and spouse have received and approved written information. 2/2/06 4) Physical and occupational therapistsssassessed resident #16 for transfer with mechanical lift. The advice of therapists of using Sara lift will be followed by nursing staff. 2/22/06 5) Director of Nursing in-serviced nurse on following the facility's policy and procedure on administering medications via PEG tube. 2/14/06 6) Nursing staff in-serviced by director of nurses and education specialist on resident #16's right to have his family members present during personal cares and to monitor room for written information pertaining to resident care that is clearly visable, and to report any infractions to charge nurse for corrections. 3/19/06 7) Nursing staff will be in-serviced by director of nurses and education specialist about transferring resident #16 by the use of Sara lift. 3/19/06	

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F 242	Continued From page 5 it provided information about oral care and suctioning to anyone who read it, along with the information that staff could ask family or visitors to leave the room during care. During an interview on 2/2/06 at 7:50 AM, a family member reiterated s/he was unaware they could ask to have the posted information removed. c. Review of nursing notes dated 1/28/06 for the 3 to 11 shift showed, "During course of moving resident from commode to bed, 2100 [9 PM], by holding [him/her] under the arms, a popping sound was heard from L [left] shoulder. Resident c/o [complained of] pain and burning sensation." A note sent to the physician on 1/28/06 at 9 PM verified the injury occurred while staff were lifting the resident from the recliner with their arms placed underneath the resident's arms. Review of a communication form from the north unit manager, dated 1/30/06, showed "Gait belt to be properly used for transfers." Interview with the north unit manager on 2/2/06 at 8:30 AM confirmed staff should have used a gait belt with the transfer. d. Review of nursing documentation dated 1/29/06 at 9 AM confirmed staff administered Tylenol with the AM medications "via syringe c [with] plunger." Further review of nursing documentation dated 1/29/06 at 7 PM revealed "family upset, res. [resident] nauseated, states because 1800 [6 PM] meds [medications] given c [with] piston syringe - done slowly following 360 + of thickened liq [liquid] for dinner...Inapsine [anesthetic used to suppress nausea]..IM [intramuscular] L deltoid." Interview with the administrator on 2/2/06 at 9:15 AM revealed she was unaware staff pushed the resident's medications with a syringe.	F 242	All residents are at risk. All professional nursing staff will be in-serviced by director of nursing and education specialist on facility's policy and procedure on administering medications through PEG tube. 3/19/06 Education specialist will in-service nursing staff on resident's right of self determination and participation in making choices about apects of their life in facility. 3/19/06 Physical and occupational therapists or their designee will screen residents on admission, yearly and as needed for the proper transfer technique for the residents. 3/19/06 Education specialist will develop "checklist" for reisdents on admission, quarterly and as needed in gathering information on life style choices. This will be evaluated by interdisciplinary team for implementation and included/ updated in residents' plan of care. Any problems with residents, residents' responsible parties or staff compliance will be discussed with the interdisciplinary team for solution. Changes to the care plan will be made by the team. 3/19/06	
F 248	483.15(f)(1) ACTIVITIES	F 248		

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F 248	483.15(f)(1) ACTIVITIES	F 248		

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F 248 SS=E	Continued From page 6 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, staff interview, and review of activity schedules, the facility failed to ensure one of four scheduled activities in the special care unit (SCU) occurred as scheduled for nine residents. In addition, based on staff and resident interview and review of resident council minutes, the facility failed to provide enough activity staff to ensure the activity interests of residents were met. The facility census was 80. The findings were: 1. Review of the SCU activity schedule on 1/31/06 at 9:49 AM revealed activities for the day included the following: 9 AM - Catholic Service, 10:30 AM - Snack and Chat, 11:30 AM - Creative time, and 2:30 PM- Activity by CNA (certified nurse aide). The following concerns were found when observations were made at activity times: a. At the scheduled 9 AM activity, only one of nine SCU residents went to the Catholic service. No other activity was scheduled for the remaining eight residents. CNA #67 was the only staff member in the unit and was providing residents with personal care. b. At the scheduled 10:30 AM "snack and chat," CNA #67 provided residents with a snack, but no interaction or "chat" was offered or initiated. Instead the CNA was assisting dependent residents with toileting.	F 248	A temporary employee will be hired to provide activities for residents in the SCU, until a permanent employee can be hired to fill the vacant position. Activities will be restructured so that all residents in the SCU can have an opportunity to attend. Staff working the SCU will receive training on group activities and the process of initiating activities. Random audits will be conducted by the Activities Director and reported through QI and the Facility Administrator.	3/19/06

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F 248	Continued From page 7 Interview with CNA #67 at 2:09 PM on 1/31/06 revealed the facility was attempting to increase staff in the unit to two CNAs so that one could concentrate on resident care while the other provided other needs. The CNA stated the observed staffing was atypical and the unit was staffed with one CNA about 25% of the time. The CNA stated nursing staff were responsible for all activities in the SCU except the 11 AM or 11:30 AM daily activity, which was the responsibly of the activity staff. She stated that morning's 'chat' did not occur related to the need for resident care, such as baths and toileting. 2. Review of Resident Council minutes for 9/29/06 revealed residents provided activity staff with suggestions related to desired activities. Group interview on 1/31/06 at 1:30 PM revealed residents provided input related to the desire for more activities, but the residents stated activity availability was limited due to lack of activity staff. Interview with the activity director on 2/1/06 at 10:46 AM revealed the facility lost two full time activity aides in December, 2005. The director stated the a request to fill the vacancies was submitted. However, due to the slow hiring process within the state, she hoped to be able to fill the positions by March, 2006. The director stated that the current activity schedule was met; however, she was unable to add more activities related to the limited resources.	F 248		
F 272	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272	The director of nursing has scheduled specific times for the B&B nurse to conduct B&B assessments for resident #5, #9, #36 and other residents to ensure the assessments are	3/19/06

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F 272	Continued From page 8 A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide comprehensive assessments in various areas for 4 (#5, #9, #31, #36) of 16 sample residents. The findings were: 1. Review of the 6/2/05 significant change Minimum Data Set (MDS) assessment showed resident #5 required comprehensive assessments for activities and bowel and bladder incontinence.	F 272	completed in a timely manner. Resident care managers will complete a quarterly bowel and bladder assessment if a current assessment is not done by the B&B nurse when a MDS is due for completion. Monthly audits of random charts will be done by resident care managers and reported to QI quarterly. Resident #14 was not individually addressed, but was combined with Rap #6 documentation. Each Rap will have individual documentation. Resident #36-Rap #14 was not answered properly on 1/6/06 assessment. A change of condition was done for 2/4/06 and information was correctly entered in Rap Doc #14 identifying resident at risk for dehydration.	3/19/06 3/19/06

Ammended Plan of Correction

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F 272	Continued From page 9 According to Section V of that MDS, the comprehensive assessment for activities was located in Resident Assessment Protocol (RAP) #10 (no date indicated). Review of the medical record revealed the assessment information was lacking. Interview with the north MDS coordinator on 1/31/06 at 3:10 PM confirmed the assessment was not completed. According to Section V of the MDS, the comprehensive assessment for bowel and bladder was a 6/2/05 nurse assessment and CNA flow sheets. Review of this additional assessment information revealed the assessment was incomplete. When asked on 2/2/06 at 8:05 AM to provide their bowel and bladder assessment, the north MDS coordinator was unable to produce a comprehensive assessment. 2. Review of the 8/12/05 annual MDS assessment showed resident #9 required comprehensive assessments for bowel and bladder incontinence. According to Section V of that MDS, the comprehensive assessment for urinary incontinence was located in the RAP summary and CNA flow sheets dated "7/23-8/5/05." Review of the medical record, and interview with the north MDS coordinator on 2/1/06 at 3:15 PM, revealed a comprehensive assessment had not been completed. 3. Review of the 9/16/05 significant change MDS assessment showed resident #31 required further assessment in the area of hydration. According to Section V of that MDS, the information was located in nursing notes dated 9/2/05 through 9/9/05 and RAP summary #14. Review of RAP #14 revealed that it referred to RAP #6, Urinary Incontinence. However, review of RAP #6 and the aforementioned nursing notes revealed the facility failed to complete a comprehensive assessment	F 272	A random full assessment will be reviewed monthly by resident care managers to ensure completion of Rap documentation and report findings to QI quarterly.	3/19/06

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F 272	Continued From page 10 of the resident's hydration status. During an interview on 1/31/06 at 3:30 PM, the MDS coordinator stated she did not complete assessments for hydration status. 4. According to the 1/6/06 significant change MDS assessment, resident #36 required further assessment for bowel and bladder incontinence and for possible dehydration. Review of Section V of that MDS showed: "takes Lasix [a diuretic], has edema, CHF [congestive heart failure] - not at risk for dehydrati [dehydration]." No further information related to the resident's risk for dehydration was available for the 1/6/06 assessment. Interview with the MDS coordinator on 1/31/06 at 3:30 PM confirmed the facility did not complete the assessment. Further review of the medical record revealed a comprehensive assessment for urinary incontinence was lacking and a bowel assessment was not completed. Interview with the MDS coordinator on 2/1/06 at 3:10 PM confirmed the lack of assessments.	F 272		
F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278	Resident #31's minimum data set (MDS) of 9/16/05 did not accurately reflect the residents change in condition, modification of MDS to show change was performed on 2/23/06. Resident #36 MDS of 1/6/06 did not accurately reflect resident change of condition. Modification of the MDS to show change performed was done on 2/1/06.	3/19/06

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F 278	Continued From page 11 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 medical record review and staff interview, the facility failed to assure the accuracy and completeness of the Minimum Data Set (MDS) assessments for 3 (#31, #36, #53) of 16 sample residents. The findings were: 1. The following concerns with accurate completion of significant change assessments for residents #31 and #36 were identified: a. Review of the medical record showed the facility completed a significant change Minimum Data Set (MDS) assessment for resident #31 on 9/16/05. According to that assessment, the resident required less staff assistance with bed mobility, improved in ability to complete personal hygiene, declined in range of motion, and experienced a significant weight loss. However, the facility coded Section G9 (resident's ability to self-perform activities of daily living) as "No change." In addition, the facility coded Section Q2 (overall change in care needs) as "No change."	F 278	Resident #53 MDS for quarterly assessment dated 1/20/06 was lacking the assessment reference date when reviewed. MDS was printed prior to total completion of assessment reference date by South resident care manager and signed by staff. MDS was then reprinted with the assessment reference date indicated and placed to resident record. MDS coordinator will review significant change assessments for section G&Q accuracy prior to transmission. MDS coordinator will print out assessments after transmission is completed to ensure all dates have been entered. Random audits of completed MDS's will be done quarterly and results reported at quarterly QI meetings. A report of all significant change assessments will be reviewed at QI meetings quarterly.	3/19/06

Ammended Plan of COrrection

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F 278	Continued From page 12 b. According to the significant change MDS assessment completed on 1/6/06, resident #36 declined in the ability to perform the following activities of daily living (ADLs): transferring, ambulation, dressing, personal hygiene, and balance. In addition, the resident sustained a significant weight loss. Despite completion of a significant change assessment, the documented declines in ability to complete ADLs, and the weight loss, the facility coded Sections G9 and Q2 as "No change." According to the Centers for Medicare & Medicaid Services Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, December 2002, Section G9 should "document any changes occurring in the resident's overall ADL self-performance as compared to status ...since last assessment." Section Q2 should "monitor the resident's overall progress at the facility over time." 2. Review of the 1/20/06 quarterly MDS assessment for resident #53 revealed the assessment reference date (ARD) was lacking. According to the Centers for Medicare & Medicaid Services Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, December 2002, "the ARD is the common date on which all MDS observation periods end."	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279	Resident #81 now deceased. Interim careplan was not completed. Interim care plans on new residents will be completed with in 24 hours of admission. 3/19/06	

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

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F 279	Continued From page 13 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on review of a closed medical record and staff interview, the facility failed to develop an interim care plan that addressed the potential for falls for one (#81) of one sample resident who was identified as a fall risk shortly after admission. The findings were: Review of the medical record for resident #81 revealed s/he was admitted on 9/7/05 and discharged on 9/16/05. According to a physical therapy evaluation dated 9/8/05, and a physician's progress note dated 9/13/05, the resident was identified as a fall risk. Review of the initial resident care plan revealed it was incomplete and did not show the resident as a fall risk or list any interventions to protect the resident. Review of the record failed to show evidence an interim plan of care had been developed to adderss this resident's identified problem for potential falls. Interview with the north MDS coordinator on	F 279	Resident care managers will address interim careplans with in 24 hours to ensure completion. Medical records to do chart audit on next working day to ensure completion in a timely manner. Audit results to be presented at QI meetings quarterly.	3/19/06

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F 279	Continued From page 14 2/2/06 at 8:30 AM evidenced that, although some safety interventions were in place for this resident, the facility had not developed the interim care plan for falls, and one should have been developed.	F 279		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to ensure resident care plans were followed for one (#21) of 13 sample residents. The findings were: 1. Random observations of resident #21 on 1/31/06 revealed the resident used a cross-over loop lap belt restraint. The observations also revealed the restraint was not released during a scheduled, supervised activity which occurred from 2 PM to 2:26 PM when the observation ended. Interview with certified nurse aide (CNA) #67 on 1/31/06 at 1:51 PM revealed the resident used the lap belt for safety awareness and it was released during meals and during direct supervision. Review of the resident's medical record revealed a care plan dated 2/23/05 that instructed staff to remove the lap belt during one-to-one, supervised activities, and meals.	F 282	All staff working in the secure care unit have been inserviced on restraint release for resident #21 according to individualized care plan. All staff present is secure care unit in-serviced on restraint release by resident care manager on 2/2/06. A policy and procedure will be written for use of restraints in SCU. 3/19/06 Other staff members will be in-serviced for proper release of grey loop restraint by resident care managers, education coordinator, and director of nursing. Follow up with quarterly QA's reviewing list from MDS program identifying residents with restraints. A quarterly restraint assessment will be performed for those identified. Monitor for sustained corrective action by random audits by resident care managers and reported in QI meetings quarterly. 3/19/06	

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F 286	Continued From page 15	F 286		
F 286 SS=D	483.20(d) RESIDENT ASSESSMENT - USE 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, staff interview, and review of facility policies and procedures, the facility failed to maintain assessment information as required in the resident's active record for 2 (#5, #45) of 16 sample residents. The findings were: 1. Review of Section V of the 6/3/05 significant change Minimum Data Set (MDS) assessment for resident #5 revealed a 6/2/05 nurses' assessment as the location for additional assessment information on the following triggered areas: visual function, communication, activities of daily living (ADLs) function, urinary incontinence, falls, dehydration/fluid maintenance, pressure ulcers, and psychotropic drug use. Review of the medical record revealed the 6/2/05 nurses' assessment was not included. When asked on 1/31/06 at 3:10 PM, the north MDS coordinator located the 6/2/05 nurses assessment. However, she confirmed it was not in the resident's active record; it was found with purged medical records. 2. Review of the 12/21/05 annual Minimum Data Set (MDS) assessment showed resident #45 triggered for further assessment in activities. However, that assessment was not in the resident's active medical record. Interview with the activities director (AD) on 2/2/06 at 10:10 AM verified the assessment was not in the record.	F 286	The assessment information was replaced back into resident #5 and #45's medical record. The Health Information Department's purging policy/ procedure will be revised. 10% of charts will be audited q month. Monitored through QI and the Facility Administrator.	3/19/06

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F 286	Continued From page 16 The AD stated it was in her office files and immediately produced it. The AD further stated her office was locked when she was not in the facility so the information was not accessible to all professional staff members who might need to review it. 3. Review of the facility's 4/00 policy and procedure, "Minimum Data Set Resident Assessment," R - 23, revealed, "All completed resident assessments within the last two years will be maintained in the active resident medical record."	F 286		
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and family interview; the facility failed to ensure supervision for one (#29) of five sample residents with falls. In addition, the facility failed to assure one (#45) of four sample residents who required a mechanical standing lift for transfer was evaluated and/or capable of transferring safely in the lift. The findings were: 1. Random observations of resident #29 on 1/31/06 revealed the resident ambulated with one to two staff assist for balance, would self-ambulate short distances in the dining area under direct staff supervision, and used a motion alarm when in a recliner in his/her room and in	F 324	For resident #29 safety alarms were not properly used for this resident. The resident will be reassessed re the alarms. Resident #45 is deceased. Resident care plans address use of alarms per individual needs. Staff in-serviced on use of safety alarms by education coordinator. Therapy department will screen residents for proper transfer device on admission, yearly, and prn. Monthly audits by resident care managers will be done to ensure proper alarm use is done, as well as proper transfers. This will be reported to QI on a quarterly basis.	3/19/06

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F 324	Continued From page 17	F 324		

the resident lounge recliners. An observation at 11:58 AM revealed the only staff member in the unit was an activity staff member who assisted the resident to a lounge recliner from the dining room. Although a motion alarm was connected and available for use, the activity staff member did not turn it on. The staff member returned to the activity in the dining area, a separate area from the lounge, and did not have visual supervision of the resident. The resident attempted to get up several times and scooted to the edge of the recliner. A second observation at 1:44 PM revealed CNA #67 left the resident lounge area to assist resident #21 in the bathroom. The CNA was the only staff member on the unit. Observation of resident #29 revealed s/he scooted to the edge of the recliner in the lounge area, and grabbed another resident's walker. The resident attempted several times to stand. A motion alarm, which was available on the recliner was switched to the "off" position. The CNA was visibly unable to monitor the resident's attempts at ambulation. The following concerns were found related to the resident's unsupervised ambulation attempts:

a. Interview with CNA #67 at 1:51 PM on 1/31/06 revealed the resident was unsteady on his/her feet, needed direct supervision, and should have a motion alarm on to notify staff of self-ambulation.

b. Review of the medical record revealed a care plan dated 11/22/05, which instructed staff to monitor the resident's gait. Staff were also instructed to use a motion alarm for the in-room recliner and when the resident used a wheelchair. The care plan documented the resident had recent falls, had removed safety alarms in the past, and demonstrated poor safety judgement. Nurses' notes documented falls on 11/17/05 in

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F 324	Continued From page 18	F 324		

the bathroom, 11/23/05 in the bathroom, 11/18/05 in the dining room, 12/1/05 in the resident lounge, and 12/15/06 in the dining room. None of the falls were documented as witnessed.

2. Observation on 1/31/06 at 3:35 PM showed certified nurse aides #38 and #70 transferred resident #45 from a recliner to the wheelchair by using a "SARA" lift (mechanical lift in which a resident is required to stand with a knee support and is partially lifted by a sling going around the back and under the arms). Observation also showed CNAs # 38 and #60 transferred the resident with the 'SARA' lift on 2/1/06 at 3:40 PM and 3:50 PM. During observation of the transfer on 1/31/06, the CNAs stated the resident was usually combative and was unsafe with the 'SARA' lift. The CNAs further stated they tried a maxi (total) lift but went back to the 'SARA' lift as the family did not "like how [s/he] looked" in the maxi lift. The following concerns related to safety of the resident during transfer with the 'SARA' lift were identified:

a. During the transfer on 1/31/06, the resident's arms were placed around the sling but s/he was unable to hold onto the bars. The CNAs replaced the resident's hands onto the bar and held them in place. Furthermore, the resident was unable to bear weight on his/her feet, and hung from the sling.

b. On 2/1/06 at 3:40 PM, the CNAs lifted the resident's arms around the sling and placed his/her hands on the bars. The resident was unable to hold onto the bars, so the CNAs replaced the hands and held them in place. In addition, the resident had no weight on his/her feet, but hung from the sling while transferred to the toilet. When transferred from the toilet at 3:50 PM, the resident's feet had slid to the front edge

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F 324	Continued From page 19 of the foot tray and were approximately three feet in front of the hips. Both the hips and knees were bent at almost a 90 degree angle. The resident was unable to use the knee support and hung from the sling which had slightly elevated his/her arms during the transfer. c. Review of the medical record failed to show evidence of a safety assessment for the "SARA' lift. Interview with the unit manager on 2/2/06 at 8:30 AM revealed the facility did not assess the lifts for safety. The unit manager further stated it was up to the CNAs to determine which lift to use based on the resident's condition at the time. d. Interview with the administrator on 2/2/06 at 9:15 AM revealed she was unaware staff used the 'SARA' lift to transfer the resident. The administrator confirmed the 'SARA' lift was an unsafe method of transfer for this resident.	F 324		
F 371 SS=F	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy, the facility failed to ensure dietary staff used proper hand washing techniques, removed a soiled apron when handling clean dishes, and properly stored foods. In addition, the facility failed to implement their policy for identifying outdated health shakes. The findings were:	F 371	1-1 counseling was done with the dietary aide #1 regarding removing the dirty apron and washing her hands before handling clean dishware. This same dietary aide was also counseled re proper handwashing practices. Dietary aide #2 self-terminated. Food items that were uncovered were covered at the time of survey. Items that were not labeled or dated were done so at the time of the survey.	3/19/06

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F 371	Continued From page 20 1. The following concerns were noted in the dish room: Observation on 1/31/06 at 9:20 AM revealed dietary aide #1 was working on the dirty side of the dish room loading dishes into the dish machine. She was wearing a white disposable apron and disposable gloves. When going from the dirty side to the clean side, she tucked the end of the disposable white apron up into the neck of her shirt, revealing a cloth apron underneath it. She then dipped her gloved hands into a bucket containing a solution of chlorine bleach sanitizer. As the dietary aide continued to work with the clean dishes, the white disposable apron came loose several times. Each time the dirty apron fell down, it came in contact with the clean dishes, and the aide tucked it out of the way again. After handling the dirty apron, the aide did not wash or sanitize her hands before touching clean dishes again. According to the facility policy C-03-A: "Moving from Dirty Side to Clean Side of Dish Room" with a review date of 1/26/05 staff should, "Remove disposable apron when un-racking clean dishes. Staff will have on a clean cloth apron...Hands/gloves are to be washed in bucket of soapy water, dried and sanitized after racking the soiled dishes and before moving to the clean side of dish room." Interview with the registered dietitian (RD) and dietary manager on 2/1/06 at 10 AM confirmed the policy should have been followed. 2. The following concerns were noted with hand washing in the kitchen: a. Observation on 1/31/06 at 11:30 AM revealed dietary aide #1 entered the kitchen and, without washing her hands, took bowls of pureed fruit out of the reach-in cooler and placed them	F 371	An inservice was held on 2/9/06 re handwashing & review of the "shake policy." All staff were instructed to label and date all shakes including when they are pulled from the freezer. Staff were instructed to cover all items in the cooler and dessert rack. Audits will be performed for one week, then weekly, then monthly. This will be given to QI quarterly for review.	3/19/06

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F 371	Continued From page 21 onto resident trays. At 11:35 AM she left the kitchen. At 11:40 AM she returned to the kitchen and, again without washing her hands, took three clean water pitchers from a shelf and filled them with ice and water. b. Observation on 1/31/06 at 11:45 AM revealed dietary aide #2 poured beverages and labeled them for resident use. Dietary aide #2 coughed onto her hand, wiped her mouth and, without washing her hands continued to open and pour another beverage. Review of a sign posted above the hand washing sink in the kitchen revealed hands should be washed "before you touch or serve food...After you cough, sneeze or blow your nose..." According to Food Code 2005, U.S. Public Health Service, 2-301.14: "Food employees shall clean their hands and exposed portions of their arms...immediately before engaging in food preparation...(I) After engaging in other activities that contaminate the hands." Interview with the RD and dietary manager on 2/1/06 at 10 AM confirmed staff should have washed their hands. 3. Observation on 1/30/06 at 4:25 PM and again on 1/31/06 at 9:10 AM revealed approximately 36 thawed health shakes in the walk-in refrigerator without any date to indicate when they were thawed, or when they should be discarded. According to each individual carton, the health shakes should be discarded after 14 days of being thawed. Interview with the dietary manager on 1/31/06 at 10 AM confirmed she would expect a date on the case or cartons to indicate when they were taken out of the freezer. Review of the facility policy and procedure dated 1/18/05, "Frozen Supplements Labeling and Dating," showed "when the product begins to be thawed,	F 371		3/19/06

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F 371	Continued From page 22 date the container with the thaw date." Interview with the RD and dietary manager on 2/1/06 at 10 AM confirmed the policy should have been followed. 4. Observation on 1/30/06 at 4:25 PM and again on 1/31/06 at 9:10 AM revealed an uncovered 20 pound container of margarine in the walk-in refrigerator. The margarine contained a large metal spoon. Additionally, observation on 1/31/06 at 11 AM revealed a uncovered rack with trays containing 40 uncovered servings of fruit cobbler and 3 uncovered apple pies located in a production area, under a ceiling air vent. According to Food Code 2005, U.S. Public Health Service, 3-305.11: "Food shall be protected from contamination by storing the food: (2) where it is not exposed to splash, dust, or other contamination..." Interview with the RD and dietary manager on 2/1/06 at 10 AM confirmed it was their expectation that these items would be covered to protect them from contamination.	F 371		
F 454 SS=F	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff maintained it in a safe manner. The findings were: Observation on 1/31/06 at 8:45 AM revealed the door in the north Special Care Unit leading from	F 454	The half inch hole in the SCU door was repaired. The privacy curtains in the therapy room have been replaced. The electrical outlet in room #213 has been fixed. Random audits by the maintenance supervisor will be completed monthly. Thorough audits will be completed once a quarter by the maintenance supervisor. This will be monitored through QI and the facility administrator.	3/19/06

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F 454	Continued From page 23	F 454		

the main corridor into the dining area failed to resist the passage of smoke, thus violating the National Fire Prevention Association (NFPA) 101 Life Safety Code. The door had a half inch hole through its entire width. The hole was several inches above the door handle.

Observation of four patient privacy curtains in the physical therapy room on 1/31/06 at 3:10 PM and again on 2/1/06 at 4:15 PM revealed, that when two of the privacy curtains were closed, they obstructed the water discharge flow pattern of the overhead sprinkler heads. According to NFPA 13, curtains around sprinkler heads must have an 18 inch mesh top panel to allow proper sprinkler spray pattern.

Observation in resident room 213 on 2/1/06 at 3:45 PM revealed an electrical outlet located behind the resident's bed. Plugged into the outlet were two cords: one originating from the bed elevator motor and the other from the resident's enteral feeding machine. The wall outlet box was floating loose in the wall; i.e., the connector (nail or screw) attaching the outlet box to the wall stud behind the dry wall was loose. On the floor underneath the outlet was a small slat of wood (approximately 2 inches x 8 inches) that prevented the wheel of the bed from coming into contact with the cords coming out of the outlet. On the wall directly above the outlet was a handwritten piece of paper taped to the wall reading, "Watch the wall plug. Do not pass this point." A figure of an arrow pointing downward was at the bottom of the sign. Interview with a family member on 2/2/06 at 8:30 AM revealed a second family member put both the sign on the wall and the piece of wood on the floor in order to prevent the resident's metal bed frame from

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F 454	Continued From page 24 coming into contact with the wall outlet. Interview with the facility maintenance supervisor on 2/2/06 at 10:15 AM confirmed the above findings.	F 454		
F 465 SS=C	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe environment for residents, staff and visitors. The findings were: 1. On 1/31/06 at 3:15 PM and on 2/1/06 at 4:25 PM, observation of the soiled utility room in the south gold unit revealed an approximate 6 inch piece of the metal cover of the baseboard heating unit was missing, exposing two sharp metal connectors. In addition, a 2 x 5 ft. plastic ceiling light cover was dangling approximately 10 inches from the ceiling. Observation of the elevator car throughout the survey revealed an approximate 8 x 24 inch piece of linoleum missing on the floor at the entry to the car. Several inches of intact linoleum surrounding the missing piece were starting to come loose from the elevator car floor, resulting in a trip hazard. Interview with the administrator on 2/2/06 at 9:10 AM revealed both staff and residents used the elevator. 2. Throughout the duration of the survey from 1/30/06 to 2/2/06, observation of the public drinking water fountain, located in the main	F 465	The baseboard heating unit in the soiled utility room on the South Gold Unit has been fixed. The plastic ceiling light cover has been fixed. New flooring has been put on the elevator floor. The public drinking fountain has been fixed. Random audits will be conducted monthly by the Maintenance Supervisor. Thorough audits will be conducted quarterly by the Maintenance Supervisor. Data will be submitted to QI quarterly and monitored by facility administrator.	3/19/06

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F 465	Continued From page 25 hallway next to the door leading into the facility administration office, revealed approximately half of the water stream flowed directly onto the floor beneath the water fountain each time the water was turned on. Further observation revealed the water then flowed onto the hallway floor creating a safety hazard for residents, staff, and visitors.	F 465		
F 468 SS=B	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a section of firmly secured handrail to the north corridor wall. The findings were: Observation on 2/1/06 at 4 PM showed an unidentified resident used the handrail to pull him/herself along in a wheelchair. When the resident reached a section missing from the wall on the north corridor next to the public water fountain, s/he had to use his/her feet to 'walk' the wheelchair to the next section of handrail. Random observations from 1/30/06 through 2/2/06 showed many residents used the handrail while traveling to and from the north wing and the dining room. Measurements taken by two surveyors on 2/1/06 at 4:10 PM revealed the missing section was 49 inches long. The facility administrator was present during the observation at 4:10 PM and verified that the handrail should	F 468	A section of handrail has been placed on the wall on the North corridor next to the public water fountain. Random audits by maintenance will include handrails in the facility. This will be monitored through QI and the facility administrator. 3/19/06	

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F 468	Continued From page 26 extend the full distance of the uninterrupted wall space.	F 468		
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS 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. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and interview with the medical director, the facility failed to maintain medical records for 5 (#5, #29, #31, #36 and #53) of 13 open sample residents and 2 (#35 and #40) non-sample residents in accordance with accepted standards and practices. Medical records were unorganized, incomplete, and/or contained another resident's assessment information. The findings were: 1. Review of the medical record for resident #5 revealed restorative information related to the resident's bowel and bladder status was lacking. When asked on 2/2/06 at 8:05 AM the north Minimum Data Set (MDS) coordinator provided the most current bowel and bladder notes dated	F 514	For resident #53, a follow-up uric acid was not included in the transfer information that was sent from the previous facility. A follow-up uric acid test was not requested of the primary MD for the resident. Resident care managers now receive copies of all resident history, labs, etc. and will make MD aware of abnormal values and questionable information received. Information is faxed to primary care physician and a copy of faxes are placed in the residents charts.	3/19/06

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F 514	Continued From page 27 11/28/05 and confirmed they were found in the resident's purged medical record. 2. Review of assessment information for resident #29 was done on 2/1/06 at 3:16 PM. During the review, assessment information for resident #40 was found in the medical record of resident #29. Since the record for resident #40 was missing assessment documentation, it was incomplete. 3. While going through the folder containing MDS assessments for sample resident #31, the surveyor found an MDS assessment for non-sample resident #35. Since the MDS was complete, but filed incorrectly, the medical record for resident #35 was incomplete. 4. Review of laboratory results revealed a digoxin level dated 11/1/04 for resident #36 was filed a year out of date. It was underneath, but on the same page as, the results of a urinalysis dated 8/10/05 and a potassium level dated 9/27/05. The preceding pages in the section were a radiology report dated 12/27/05 and the results of a chemistry panel dated 11/7/05. 5. Review of the medical record revealed resident #53 was admitted from another hospital in July 2005. In the history and physical (H&P) dated July 8, 2005, a physician at the sending hospital documented that the resident "denies a history of gout. Will check a uric acid and if that is normal we could stop the allopurinol [medication for gout] and reassess [his/her] uric acid level in a week or two but I doubt that [s/he] needs the allopurinol at this point." A uric acid level was not included in the transfer information sent to the present facility. No one at the present facility acknowledged the information in the H&P from	F 514	It will be up to the primary care physicain for follow up orders. The medical record information was replaced back into resident #5. #29, #31 and #36. The Health Information Department purging and active chart order [illegible] policy/ procedure will be revised and reviewed annually. 10% of charts will be audited q month. Training will be provided to Health Information designees per new hire orientation. New charts and rack will be ordered with chart system revamped. Monitored through QI and facility administrator.	3/19/06

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F 514	Continued From page 28 the sending hospital, or realized the test result was missing, so no additional records were subsequently obtained by the present facility and testing for gout was not completed. Interview with the medical director on 2/2/06 at 8:40 AM revealed he expected the primary care physician to at least acknowledge other physician's recommendations. 6. Interview with the medical director on 2/2/06 at 8:40 AM revealed the chart make-up was "frustrating," communication was a problem, and the records were misfiled. During the interview, the medical director stated that "patient information flow is poor." 7. Interview with the MDS assessment coordinator on 2/1/06 at 3:29 PM revealed, that due to a staff leave of absence, other staff had assumed the filing duties. Therefore, items were incorrectly filed. According to the American Health Information Management Association (www.ahima.org) update (copyright 2005) titled "Maintaining a Legally Sound Health Record - Paper and Electronic," medical records must reflect the continuous chronology of the patient's healthcare, retained according to Federal and State laws, stored to prevent loss, destruction, or unauthorized use, and purged in a consistent manner. The update further stated record integrity processes and procedures are required to ensure accuracy and completeness of the health record.	F 514		
F 520 SS=C	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520		

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F 520	Continued From page 29 facility; and at least 3 other members of the facility's staff. This REQUIREMENT is not met as evidenced by: Based on review of quality assurance committee minutes, staff interview, and medical director interview, the facility failed to ensure the quality assurance committee included participation by a facility designated physician. The findings were: Review of quality assurance committee minutes dated 12/22/05, 8/25/05, 6/24/05, and 4/21/05 failed to reveal a physician was present at the quarterly committee meetings. Interview with the administrator and staff development coordinator on 2/1/06 at 5:15 PM revealed the facility appointed physician for the committee was the medical director. Both stated the medical director was not physically present during the meeting. Interview with the medical director on 2/2/06 at 8:37 AM confirmed he had been unable to attend the facility's scheduled meetings, and the facility had not offered the option of tele-communication technology for active, timely participation.	F 520	Quarterly QI meetings will now be held at Washakie Medical Center after the medial Director finishes in surgery. He will be available at this site on the 1st Wednesday q month. This will ensure face to face communication with members of the QI committee. This will be monitored through QI and the facility Administrator.	3/19/06
F 521 SS=E	483.75(o)(2)-(4) QUALITY ASSESSMENT AND ASSURANCE 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 action to correct identified quality deficiencies. A State or the Secretary may not require	F 521	Resident #5's B&B assessment will be completed. Resident #9's B&B assessment will be completed. Resident #31's MDS significant change date 1/6/06 Rap #14 was not individually addressed, but was combined with Rap #6 documentation. Each Rap will have individual documentation.	3/19/06

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F 521	Continued From page 30 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 review of data from the Centers for Medicare and Medicaid Services (CMS), medical record review, and staff interview, the facility failed to ensure evidence of an ongoing quality assurance effort in the area of resident assessment. Comprehensive resident assessments were lacking for 4 (#5, #9, #31, #36) of 16 residents during the 2006 annual survey. The findings were: Review of Oscar 3 data compiled by CMS revealed federal deficiencies were cited at 483.20, (F272) resident assessments, during annual facility surveys in 2004 and 2005. During the annual survey conducted 1/30/06 through 2/2/06, the following concerns were identified for four residents who required assessments: a. Medical record review for resident #5 revealed a significant change Minimum Data Set (MDS) assessment dated 6/2/05 which showed the resident needed additional assessment information for activities and bowel and bladder status. Review of the medical record failed to reveal the additional assessment information. Interview with the north unit MDS coordinator on 2/1/06 at 3:10 PM revealed the record was lacking the additional assessment information.	F 521	Resident #36's significant change dated 1/6/06 requiring a B&B assessment will have one completed. This resident's Rap #14 was not answered properly on the 1/6/06 assessment. A change of condition assessment was done for 2/4/06 and information was correctly entered in Rap Doc #14 identifying resident as a risk for dehydration. Resident care managers will complete quarterly B&B assessment if a current assessment is not done by the B&B nurse when an MDS is due for completion.	3/19/06

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F 521	Continued From page 31 b. Review of the annual 8/12/05 MDS assessment showed resident #9 required additional assessment in the areas of bowel and bladder incontinence. Upon further review of the record, comprehensive assessments were not found. On 2/1/06 at 3:15 PM, interview and medical record review with the north unit MDS coordinator confirmed the information was not in the record. c. Review of the 9/16/05 significant change MDS assessment showed resident #31 required further assessment in the area of hydration. Review of the assessment areas directed by section V failed to reveal a comprehensive assessment. Interview with the MDS coordinator on 1/31/06 at 3:30 PM revealed she had not done assessments for hydration status. d. Medical record review for resident #36 revealed a significant change MDS assessment dated 1/6/06 which documented the resident needed further assessment for bowel and bladder incontinence and dehydration. Further record review failed to reveal additional assessments or comprehensive assessment information for these areas. Interview on 2/1/06 at 3:10 PM with the MDS coordinator revealed the record was missing the additional information. Refer to F272 for additional detailed information. On 2/2/06 at 8:15 AM, the survey team requested additional information from the facility administrator regarding their quality assurance plan and activities to ensure compliance with comprehensive assessments. On 2/2/06 at 1:25 PM, the north unit MDS coordinator met with the survey team and stated there was no documentation related to audits or monitoring, goals, outcomes, re-assessment, and/or training to ensure quality improvement in the area of	F 521	A random full assessment will be reviewed monthly by resident care managers to ensure completion of Rap documentation and report findings to QI quarterly monthly audits of random charts will be done by resident care managers and reported to QI quarterly. Monitored by QI and the facility administrator.	3/19/06

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F 521	Continued From page 32 resident assessment.	F 521		