Reviewed & approved w changes on pages 2, 13, 17, 21, 29 & 31 after discussion w Cindy Rankin DON on 7/26/06 @ 10:38 AM Linda Brown RN

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING _____ B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	1330 PRAIRIE AVENUE CHEYENNE, WY 82009

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F 241 SS=D	483.15(a) DIGNITY 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 and staff interview, the facility failed to ensure urinary catheter bags were handled in a dignified manner for one (#127) non sample resident and two (#66, #68) of seven sample residents who utilized urinary catheters. The findings were: 1. Observation on 6/27/06 at 8 AM showed resident #127 was ambulating in a hallway with a front wheeled walker and the assistance of a physical therapist. The resident's urinary catheter bag was hanging from the walker near the floor, however, there was no cover on the bag and the urine was visible. Observation on 6/29/06 at 9:30 AM revealed the resident was in the physical therapy room seated in a wheelchair. The resident's urinary catheter bag was attached to the bottom of the wheelchair. However, there was no cover on the bag and the urine was visible. 2. Periodic observations throughout the 3 days of survey revealed the catheter bag for resident #66 was not covered. Periodic observations on 6/27/06 and 6/28/06 also revealed the catheter bag for resident #68 was uncovered. Interview with the assistant director of nursing on 6/29/06 at 2:33 PM confirmed that urinary catheter bags should be covered.	F 241	This plan of correction constitutes Life Care Center of Cheyenne's credible allegation of compliance with CMS regulations. F241 The facility will 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. A) Catheter bag covers have been provided for residents #s 66, 68 and 127. These are used in and out of their rooms so that the catheter drainage bags are not visible to anyone. B) Catheter bag covers are being used for all other residents with catheters. These are being used in the resident's rooms and out of their rooms so that catheter drainage bags are not visible to anyone. C) Random audits will occur to ensure that no catheter drainage bags are visible to anyone. These random audits will include residents #s 66, 68, and 127. D) A Performance Improvement Audit Tool will be utilized for random audits. Any problems identified will result in immediate education of staff.	9/07/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ED — (X6) DATE: 7/24/06

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 246 SS=E	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interview, the facility failed to reasonably accommodate the mobility needs of 5 residents (#29, #56, #69, #143, #36) who utilized wheelchairs. The findings were: Observation on 6/29/06 at 7:15 AM revealed resident #29 was independently maneuvering his/her wheelchair in the hallway outside the main dining room. When the resident's wheelchair reached the raised floor strip between the transition from the carpet in the hallway and the linoleum in the dining room, the wheelchair stopped. The resident called out, "Will someone help me?" Resident #62 responded by pushing the wheelchair over the raised floor strip and into the dining room. When questioned at that time by the surveyor about residents ability to independently propel their wheelchairs over the raised floor strip, resident #62 commented, "Quite a few people have a hard time." Further observation and interview with resident #29 on 6/29/06 at 9:20 AM confirmed s/he was able to independently propel his/her wheelchair; however, s/he required help to get the wheelchair over the raised floor strip.	F 246	Random audits will be performed by the Nurse Managers and Charge Nurses. E) The Director of Nursing will conduct an inservice for all nursing staff regarding the issue of dignity and catheter drainage bags. This will be accomplished on or before September 7, 2006. F) The Director of Nursing will report the results of audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. Reporting will occur for a period of no less than three months or until ongoing compliance has been achieved. F246 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs. A) The raised floor strip will be removed between the hallway and the main dining room. to address the mobility needs of residents #29, #56, #69, #143, #36 and any other resident B) The executive director will ask if there are any other areas that impede mobility at the next resident council meeting and family night meeting.	9/07/06

mobility needs added per request of DON on 7/26/06 LB

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F 246	Continued From page 2 Observation on 6/27/06 during the evening meal revealed 4 residents (#56, #69, #143, #36) who utilized wheelchairs experienced difficulty negotiating the raised floor strip at the transition of the linoleum floor in the dining room and the carpet in the hallway. The residents were impeded by the raised surface and required assistance from staff or other residents to maneuver their wheelchairs over the strip. Interview with activities staff #1 and #2 on 6/29/06 at 2:10 PM confirmed the raised floor strip impeded the mobility of some residents who utilized wheelchairs and staff assistance was required to assist those residents to negotiate the raised area on the floor.	F 246	C) Any mobility issues will be brought to the Performance Improvement meeting for three months or until compliance is achieved.	
F 250 SS=E	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to provide adequate social services to three (#9, #66, #75) of 14 residents with signs and symptoms of depression. The findings were: 1. According to the June 2006 physician's orders, resident #66 had diagnoses including multiple	F 250		

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F 250	Continued From page 3 sclerosis, quadriplegia and depression. Further medical record review documented a history and physical dated 6/7/06 with a diagnosis of "major depression." The following concerns were noted: a. Periodic observations throughout the days of survey showed the resident remained in bed in his/her room. Interview with licensed practical nurse (LPN) #4 on 6/27/06 at 5:25 PM, revealed the resident refused to leave his/her room. Interview with the restorative nurse on 6/27/06 at 5:30 PM revealed the resident also refused to be repositioned, and would not allow the staff to transfer him/her into a chair. b. Review of the care plan dated 12/1/05 revealed "[Resident's name] has a diagnosis of depression and receives Effexor [an antidepressant medication] daily. Does have mood and psychosocial difficulties....expresses feelings of loneliness and anger about MS [multiple sclerosis] at times." A listed approach on the care plan was to "Counsel with [resident's name] regarding feelings; be supportive." c. Medical record review failed to show the provision of counseling services for this resident. d. Interview with the social services director on 6/29/06 at 1:30 PM revealed "...a limited availability of counselors..." Therefore, counseling services were not provided. 2. Medical record review showed resident #9 was re-admitted to the facility on 5/10/06 after being hospitalized with a hip fracture. S/he had diagnoses including depression and received Lexapro (an antidepressant medication) 10 milligrams daily. The following concerns were identified: a. Interview with the resident on 6/28/06 at 1:15 PM revealed s/he was depressed and sad	F 250		

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F 250	Continued From page 4 about her diminished health, and had "bawled" over some up-coming family gatherings s/he wouldn't be taken to. b. Review of the social service notes dated 5/12/06 showed the resident had some confusion and short-term memory deficit and "social services will continue to monitor...moods and behaviors remain stable...continues to receive Lexapro for diagnosis of depression." The most current social service note dated 5/25/06 revealed "social services is continuing to monitor changes in cognition. Moods and behaviors are stable." Review of the resident care plan dated 5/17/06 for depression showed, "...social services to monitor and visit 1:1 [one to one] as needed." c. Interview with the social service assistant on 6/29/06 at 3 PM revealed the one to one visits for the resident were not documented, and the last time she remembered "sitting down to talk" to the resident was "about one month ago." The social service assistant further stated she was unaware of any concerns the resident was having. 3. Observation and interview with resident #75 on 6/27/06 at 11:35 AM revealed the resident was emotionally upset. Certified nurse aide (CNA) #8 assisted the resident up to a wheelchair, and when the surveyor asked how s/he was doing, the resident talked about a step-father and said s/he had just "gotten word" he passed away. The resident cried and talked about how s/he missed this person. CNA #8 listened and rubbed the resident's hand. The resident stopped crying and complained of a headache. The CNA relayed the resident's complaints of a headache to a nurse in the hallway. However, he did not mention the emotional behavior.	F 250	F250 The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 1. Social services will document the provision of counseling services for resident #66 in the social services section of the chart. Social services will continue to approach and counsel with the resident regarding feelings and be supportive as listed on the care plan. Social services will document the provision of 1:1 visits for resident #9. The nursing staff will be educated on the importance of communicating unusual behavior of resident #75 to supervisors and social services. Social services will document the provision of services for psychosocial well being. 2. The social services director will randomly audit care plans to see who receives counseling from social services and identify potential documentation issues on an audit tool. Any issues identified in the audit will lead to immediate education and correction.	9/07/06

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F 250	Continued From page 5 Interview with CNA #8 on 6/27/06 at 11:50 AM revealed resident #75 was confused at times however, crying was unusual behavior and he was unaware of any recent death in this resident's family. Review of the 9/20/05 admission Minimum Data Set (MDS) assessment showed the resident triggered for psychosocial well-being and mood. According to the psychosocial well-being Resident Assessment Protocol (RAP) note dated 9/21/05, the resident had a "...decrease in mood status...has a strong identification with past roles in life..." Interview with the social service director on 6/28/06 at 11:30 AM revealed she was unaware of the tearful and upset mood and behavior exhibited by this resident. After contacting the family she confirmed there was not any step-father related to resident #75. However, she stated it would be expected that the CNA would report or document the behavior as it could be an indicator of a "UTI [urinary tract infection] or something else."	F 250	3. The social services department will be educated on the importance of documenting all provisions of counseling. All staff will be educated regarding the importance of communicating to social services any changes in mood or behavior. 4. Any findings of audits will be reported at Quality Assurance meeting for three months or until ongoing compliance is established.	

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F 251 SS=E	483.15(g)(2)&(3) QUALIFICATIONS OF A SOCIAL WORKER A facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is an individual with a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and one year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of previous work experience, the facility failed to ensure that the social service director met the necessary qualifications. The findings were: Interview with the social service director (SSD) on 6/29/06 at 1:35 PM revealed she had been in the position for about six months. She further stated she was a licensed practical nurse (LPN) and had a Bachelor of Science degree in Social Science. Review of the SSD personnel file revealed she lacked one year of supervised social work experience in a health care setting working directly with individuals. Interview with the administrator on 6/29/06 at 1:50 PM confirmed the SSD was moved to this position about six months ago and prior to that had worked as an LPN in the facility for three years. However, the administrator was unable to provide a work history that included previous socialwork experience.	F 251	F251 A facility with more that 120 residents must employ a qualified social worker on a full-time basis. 1. The facility has entered into an agreement with the Social Services Director from Westview Care Center in Sheridan, Wyoming to provide consultation, expertise, mentoring, provide and auditing services for six months. The executive director, who has eleven years experience in long-term care, will also help provide supervised social work experience. 2. The consulting social services director and the executive director will randomly audit the performance of the social services director. Any issues will result in education for the social services director. 3. The findings of audits will be reported at Quality Assurance meeting for three months or until ongoing compliance is established	9/07/06

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F 272 SS=E	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. 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 staff interview, and medical record review, the facility failed to ensure a	F 272	F272 Comprehensive Assessments The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A) The Social Services Director will readdress RAPs for residents #s 9, 19, 20, 66, 109, and 137 to ensure that the assessments are comprehensive, accurate, standardized and reproducible. B) The Director of Nursing will conduct random audits of other resident RAPs to ensure that they meet the guidelines. If not, they will also be readdressed. C) The Director of Nursing and the MDS Coordinator will conduct an inservice for all Social Service Department associates about developing RAPs according to the guidelines. This will be completed on or before September 7, 2006. D) A Performance Improvement Auditing Tool will be utilized for random audits. Any problems will be identified and immediate education will take place. The audits will be completed by the Director of Nursing and the MDS Coordinator.	9/07/06

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F 272	Continued From page 8 comprehensive assessment was done in a variety of areas for 6 (#9, #19, #20, #66, #109, #137) of 21 sample residents. The findings were: 1. Review of the annual Minimum Data Set (MDS) assessment dated 12/1/05 for resident #66 revealed diagnoses including multiple sclerosis, quadriplegia and depression. Section E of the assessment, "Mood and Behavior Patterns" documented that within the 30 day observation period the resident exhibited sad, pained, worried facial expression as well as crying and tearfulness up to five days a week. Review of Section V "Resident Assessment Protocol (RAP) Summary" showed the area of mood state was checked as triggered for further assessment. Review of the "Mood State RAP Module" dated 12/1/05 revealed the following assessment summary: "...has had a sad face and one episode of crying on this last review. Social service will closely monitor, but do not proceed to care plan at this time." Interview with the social services director and social services assistant #1 on 6/29/06 at 1:35 PM confirmed the social service RAP summaries were brief, and lacked a detailed comprehensive assessment. 2. Review of the 5/16/06 RAP summary for resident #9 revealed s/he required comprehensive assessments in various areas including delirium and mood. Further review of the RAP summary revealed the assessments for these areas were located in the 5/18/06 RAP note. However, review of these RAP notes revealed there was not a comprehensive assessment completed for these areas. Interview with the social service director, and social service assistant on 6/29/06 at 1:35 PM confirmed the	F 272	E) The Director of Nursing will report results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of no less than three months or until ongoing compliance has been achieved.	

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F 272	Continued From page 9 assessments were not comprehensive. 3. Review of the June 2006 physician's orders revealed resident #19 had diagnoses including: depressive disorder, multiple sclerosis, diabetes, decubitus ulcer, and chronic urinary tract infections. Review of the 6/2/06 RAP summary revealed s/he triggered for comprehensive review mood state and cognitive loss. Review of the 6/2/06 RAP module for cognitive loss revealed the RAP summary did not include causes, risk factors, complications, and factors that were required to develop an individualized care plan. In addition, review of the 6/2/06 RAP module for mood state revealed there was no evaluation that supported the decision not to proceed with care planning for this area. 4. Review of the June 2006 physician's orders revealed resident #20 was admitted with a diagnosis of depressive disorder. Review of the 6/2/06 RAP summary revealed s/he required a comprehensive assessment in behavioral symptoms and mood state. Review of the behavior problems RAP module revealed the RAP summary did not include causes, risk factors, complications, and factors that were required to develop an individualized care plan for the resident. Additionally, review of the 6/2/06 mood state RAP module revealed there was no evaluation that supported the decision not to proceed with care planning for this area. 5. Review of the 5/22/06 RAP summary for resident #109 revealed s/he required a comprehensive assessment for mood state. Review of the mood state RAP module revealed the summary did not include causes, risk factors,	F 272		

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F 272	Continued From page 10 complications, and factors that were required to develop an individualized care plan. 6. Review of the June 2006 physician's orders for resident #137 revealed s/he was under the age of 50 admitted with diagnoses including end stage renal disease, renal dialysis, pulmonary insufficiency, and diabetes. Review of the medication orders revealed the resident received Lexapro (antidepressant) for depression. Review of the 2/10/06 RAP summary revealed the resident required a comprehensive assessment for mood state. Review of the RAP module revealed there was no evaluation that supported the decision not to proceed with care planning for this area.	F 272		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure professional standards of practice were followed in regard to security and safety of the medication cart. The census was 155. The findings were: Observation on 6/28/06 at 7:20 AM revealed the medication cart on unit MHN was left unlocked and the top drawer was partially open. No staff were present and non sample resident #144 was seated next the open cart. The following medications were available: one bottle of Mapap	F 281	F281 The services provided or arranged by the facility will meet professional standards of quality. A) All Licensed Nursing Staff will be re-educated regarding medication carts being locked when left unattended. This inservice will be conducted by the Director of Nursing and will take place on or before September 7, 2006. B) Random audits of medication carts will be conducted weekly. C) A Performance Improvement Audit Tool will be utilized to conduct the random audits. The audits will be conducted by the	9/07/06

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F 281	Continued From page 11 (analgesic, antipyretic), two bottles of Mucinex (decongestant), one bottle of Calcium 600 milligrams (mg) plus vitamin D, One bottle of Senna (laxative), one bottle of FeoSul 325 mg (iron tablet), one bottle of Diphenhydramine 25 mg (antihistamine), Lantus insulin, Novolog Insulin, Humulin R insulin, Novolin N insulin, Zinc sulfate 220 mg, two bottles of Vitamin B 12 Complex, one bottle of Ibuprophen (analgesic), Vitamin D, Vitamin E, one box of Nitro patches 0.2 mg, Duonebs (for respiratory inhalation), Advair inhaler (for asthma), Fleets enema , Colace (stool softener), Thera M Multivitamin, Milk of Magnesia (laxative), TUMS (antacid), Tylenol 325 mg (analgesic) Benadryl (antihistamine), Nystatin ointment (antifungal), and all prescribed medications for residents in rooms 410 through 417. According to the Medication Guide for the Long-Term Care Nurse, sixth edition, by Thomas R. Clark, RPh, MHS, page 67, "The medication cart should be kept locked when unattended." Interview with the director of nursing on 6/28/06 at 7:30 AM revealed staff were to keep the medication carts locked when not in attendance.	F 281	Nurse Managers, the Assistant Director of Nursing, and the Director of Nursing . If any problem is noted immediate education will take place. D) The Director of Nursing will report results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of no less than three months or until ongoing compliance has been achieved.	

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	535032	A. BUILDING _____ B. WING _____	06/29/2006

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F 283 SS=B	483.20(l)(1)&(2) DISCHARGE SUMMARY When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a discharge summary for 1 (#156) of 1 sample resident who was discharged to another facility. The findings were: Review of the closed medical record showed resident #156 was discharged to an assisted living facility on 6/12/06. Further medical record review revealed there was no discharge summary that included a recapitulation of the resident's stay and a final summary of the resident's status. Interview on 6/29/06 at 10:25 AM with the director of health information services, confirmed the discharge summary was not in the medical record.	F 283	F283 When the facility anticipates discharge, a resident must have a discharge summary that includes a recapitulation of the resident's stay: and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. A) The discharge summary for resident # 156 has been completed. B) Random audits will be performed on the medical records of discharged residents to ensure that the discharge summaries have been completed. C) The Director of Nursing will provide education to all disciplines regarding the expected completion of discharge summaries. This education will be completed on or before September 7, 2006. D) A Performance Improvement Auditing Tool will be utilized for random audits. Any problems will be identified and immediate education will take place. The audits will be conducted by the Health Information Director. added per request DON 7/26/06	9/07/06

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F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of the 6/29/06 physician visit notes, the facility failed to ensure adequate care, services, and follow-up were provided for one (#9) of one sample residents who had a nonpressure sore. The findings were: Observation on 6/27/06 at 6:15 PM, accompanied by the assistant director of nursing (ADON), revealed resident #9 had a wound on his/her right great toe. Interview with the resident revealed s/he had seen a doctor in March for the wound and he had made a "model" of his/her toe for a shoe insert. The resident stated the doctor said he would see him/her again in a "couple of months" to fit the shoe insert and to see if any further treatment or surgery was required. The resident further stated s/he had not received the insert and there had been no follow-up since then. Observation at that time revealed there was no insert for the resident's shoe. Interview with registered nurse #3 on 6/29/06 at 11 AM confirmed the insole was never received. Interview with the ADON on 6/27/06 at 6:15 PM revealed she was unaware of the wound on the resident's great toe. Interview with the resident on	F 309	E) The Health Information Director will report results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of at least three months or until ongoing compliance has been achieved. F309 Each resident will receive and the facility will 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. A) Resident #9 has seen the podiatrist again since 6/29/06. He discontinued the order for an insert and has fashioned an "accomodating pad" to put under his/her right great toe. The wound is healed and there is a follow up appointment made for him/her with the podiatrist. B) Nursing staff will be re-educated about the system of identification of skin issues in this facility, where to document these issues and how to communicate these issues. The Director	9/07/06

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F 309	Continued From page 14 6/28/06 at 1:15 PM revealed the resident had tried to get a nurse to look at the toe approximately one week ago. The nurse (unidentified) said she would meet the resident after lunch to look at the toe; however, the nurse did not return to assess the wound. Interview with the ADON on 6/29/06 at 2:30 PM revealed the resident was seen by a podiatrist on 6/29/06 and the wound was diagnosed as a callus at the distal end of the right great toe that had started to fissure due to peripheral vascular disease.	F 309	of Nursing will conduct the inservice, which will be held on or before September 7, 2006. C) Random audits of skin assessments and the notification log on each unit will be performed. Resident #9 will be included in these random audits. D) The facility will utilize a Performance Improvement Auditing Tool to perform the random audits. These audits will be performed by the Assistant Director of Nursing and/or the Wound Nurse. When a problem is noted immediate education will take place. E) The Director of Nursing will report results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of at least three months or until ongoing compliance has been achieved.	
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to provide dining assistance for one (#4) non sample resident who required assistance. The findings were: Observation of the noon meal on 6/29/06 from 11:50 AM until 12:12 PM showed resident #4 was seated at an assisted table with three other residents who required assistance. Certified nurse aide (CNA) #2 was seated at the table to assist the residents with eating. The meal was served to resident #4 at 11:52 AM and	F 312	F312 Activities of Daily Living A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	9/07/06

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F 312	Continued From page 15 observation revealed the resident independently took two bites of the food. However, during the remainder of the observation the resident was never cued by the aide or assisted in anyway to continue eating. The resident did not take another bite of food, and at 12:10 PM took off his/her clothing protector and placed it in the plate. At 12:12 PM CNA #2 assisted the resident to leave the table. Interview with the registered dietitian on 6/29/06 at 12:15 PM revealed resident #4 was always seated at the assisted table. She stated, the resident "can pretty much eat on [his/her] own just needs cueing to keep food intake up." Review of the 3/9/06 nutrition care plan for resident #4 revealed s/he was an "assisted diner" and required extensive assist with meal intake at times.	F 312	A) Resident #4 will receive cueing at meals, and assistance when necessary in order to maximize her oral intake. B) Random audits will be conducted during mealtimes to ensure that all diners are receiving the appropriate level of cueing and/or assistance. These random audits will include resident #4. C) The Director of Nursing will provide education to all nursing staff regarding the importance of providing cueing and assistance to diners in order to maximize their oral intake. The inservice will be conducted on or before September 7, 2006. D) The facility will utilize a Performance Improvement Auditing Tool to perform the random audits. When a problem is noted immediate education will take place. These audits will be conducted by various department managers during their assigned dining room duty. E) The Director of Nursing will report the results of these audits at the monthly Performance Improvement	
F 314 SS=G	483.25(c) 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 observation, staff interview, review of in-service records, and medical record review, the facility failed to provide timely repositioning, apply	F 314		

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F 314	Continued From page 16 pressure-reducing devices, and/or follow physician treatment orders for 2 (#3, #68) of 7 sample residents who were identified as having pressure ulcers and were at risk for the development of additional pressure ulcers. The findings were: 1. Review of the quarterly Minimum Data Set (MDS) assessment dated 6/6/06 showed resident #68 required extensive assistance with transferring and bed mobility, had an indwelling catheter, and was incontinent of bowel all, or almost all, of the time. The assessment further documented 3 stage II and 1 stage IV pressure ulcers. The following concerns were identified: a. Observation on 6/27/06 at 9:35 AM revealed the resident was sitting up in bed, eating breakfast. Further observation at 9:55 AM showed the resident was in bed on his/her back sleeping. Observation at 10:39 AM revealed the resident was in his/her room seated in a wheelchair. Interview with certified nurse aide (CNA) #3 at that time revealed CNA #4 and CNA #5 had just transferred the resident from the bed into the wheelchair. Additional observations at 10:42 AM, 11:05 AM, 11:15 AM, 11:20 AM, 11:50 AM and 1:10 PM revealed the resident remained in his/her room seated in the wheelchair. At 1:10 PM, a room tray was delivered and placed on a bedside table. The resident's wheelchair was pushed up to the bedside table and the tray was set-up for the resident to eat. Further observation at 2:40 PM revealed the resident was still in the wheelchair. In addition, the wheelchair and the bedside table with the lunch tray, were all in the exact same location as observed at 1:10 PM. Observation at 2:52 PM revealed the meal tray was removed from the room; however, the	F 314	Meeting. The report will include any problems and/or trends noted. This will occur for a period of at least three months or until ongoing compliance has been achieved F314 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. A) Resident # 68 will be repositioned at least every two hours, wear heel protectors at all times and have lower extremities elevated when in his/her bed or wheelchair. The Stage II pressure ulcer on resident # 3's left lateral ankle has healed. B) Random audits will be conducted weekly of residents who have pressure ulcers to ensure that interventions on the care plans are being followed. These random weekly audits will include resident # 68. and #3 added per request of DON	9/07/06

7/26/06

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F 314	Continued From page 17 resident remained in the wheelchair until staff were asked by the surveyor to place him/her in bed at 3:50 PM (5 hours and 11 minutes). b. Interview on 6/27/06 at 3:25 PM with CNA #6, revealed the resident remained in his/her wheelchair and had not been repositioned since she came on duty at 2 PM. Further interview on 6/29/06 at 8:10 AM with CNA #7, who was assigned to the resident during the day shift on 6/27/06, confirmed the resident was not repositioned between the time s/he was transferred into the wheelchair at 10:42 AM until the resident was assessed at 3:50 PM by the assistant director of nursing (ADON). Further interview on 6/28/06 with CNA's #4 and #5 revealed the resident had a "sore on [his/her] bottom" and "could not tolerate being up for more than 1 hour..." or the resident would complain of his/her bottom hurting. c. Observation with the ADON, licensed practical nurse (LPN) #4, and LPN #5 on 6/27/06 at 3:50 PM revealed the resident had pressure sores on his/her left upper foot, on the left shin, and the left heel was "mushy and black" (per statement of LPN #4). The surveyor observed dressing changes for the pressure sore on the left upper foot. After the dressing change, LPN #5 started to push the resident back into the hallway in his/her wheelchair. The surveyor asked how long the resident had remained seated in the wheelchair, and LPN #5 said it depended on how busy staff were, but usually the resident was placed in the wheelchair before lunch (around 11:30 AM) and remained in the wheelchair until after dinner time. The surveyor asked LPN #5 if the resident was able to reposition him/herself, the LPN stated no, the resident had no lower body movement ability at all.	F 314	C) The nursing staff will be re-educated regarding the care and prevention of pressure ulcers including repositioning, placing such things as soft heelers, bridging heels, dressing wounds, etc. This inservice will be conducted by the Director of Nursing on or before September 7, 2006. D) A Performance Improvement Auditing Tool will be utilized to conduct random weekly audits of residents with pressure ulcers to ensure that interventions are being followed. These audits will be conducted by the Director of Nursing, Assistant Director of Nursing (ADON), Wound Nurse and/or Nurse Managers. When a problem is noted immediate education will take place. E) The Director of Nursing will report the results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of no less than three months or until ongoing compliance has been achieved.	

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F 314	Continued From page 18 After the dressing change on the left foot, the surveyor asked staff to assist the resident to his/her bed to observe the stage III pressure sore on the resident's left ischium. Upon the request, LPN #4 and LPN#5 removed the resident's shoes and transferred the resident from the wheelchair to the bed. Observation revealed the resident's entire buttocks and ischial areas were red. Further observation revealed the dressing on the stage III pressure sore had come loose. In addition, a pressure sore approximately the size of a nickel was observed on the left hip near the ischium. At that time the ADON exited the room to ask the wound nurse to redress the the stage III wound. The wound nurse and the ADON returned to the resident's room and changed the dressing on the left ischium. Interview with both the ADON and the wound nurse at that time revealed the nickel size area on the left hip near the ischium was new. Review of facility in-service records specific for this resident and dated 6/28/06, revealed 5 CNAs, 2 licensed practical nurses, 1graduate nurse, and 4 registered nurses were instructed to apply heel protectors at all times, elevate the heels when in bed or wheelchair, and turn the resident every 1 - 2 hours. 2. Observation with the wound nurse on 6/27/06 at 4:48 PM revealed resident #3 had a stage II pressure ulcer on his/her left lateral ankle. Observation further revealed there was no dressing on the wound when the wound nurse removed the resident's stocking. The wound nurse stated the resident was supposed to have a dressing on it. Review of the "Weekly Report for Pressure Wounds," dated 6/25/06, revealed a	F 314		

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F 314	Continued From page 19 replicare, santyl dressing covering was to be on the wound. Additionally, medical record review revealed a physician's order dated 6/14/06 that stated: "1. L [left] lateral ankle stage II..." " 2. Soft heelers to feet B [both], elevate feet while in bed (to promote wound healing)." Review of the resident care plan dated 3/31/06 showed the resident was to wear soft heel protectors on both feet while in bed. Interview with RN #3 on 6/29/06 at 8 AM confirmed the resident should wear soft heeler booties when in bed. The following concern was identified: a. Observation on 6/29/06 at 10:45 AM revealed resident #3 was asleep on his/her bed without any soft heeler booties on. b. Observation on 6/29/06 at 12:20 PM revealed the resident was assisted by two aides to get up for lunch, however, the resident was without the booties.	F 314		
F 317 SS=D	483.25(e)(1) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and staff interview, the facility failed to assure one (#50) of five sample residents who entered the	F 317	F317 Range of Motion Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. A) Resident #50 has a Nursing Rehab plan for range of motion. The resident is consistently	9/07/06

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F 317	Continued From page 20 facility without a limited range of motion, did not experience a reduction in range of motion. The findings were: Review of the June 2006 physician orders showed resident #50 had diagnoses including myasthenia gravis and dementia. Review of the 7/3/06 quarterly Minimum Data Set (MDS) assessment revealed the resident required extensive assistance with transferring and walking in the room. Observation on all days of survey revealed the resident utilized a wheelchair for locomotion outside of the room. Review of the admission MDS assessment dated 8/10/04 revealed the resident had no limitation in range of motion. Review of the 12/23/05 significant change, and the 9/20/05 and 7/3/06 MDS assessments showed the resident was assessed as having a decline in range of motion in one hand and both legs. The following concerns were identified: Medical record review showed no evidence the resident was receiving services to address the decline in range of motion. Interview with the restorative nurse on 6/29/06 at 8:40 AM confirmed services were not being provided. The restorative nurse further commented "[s/he] is probably a candidate for range of motion if [s/he] will allow it. We will try for a couple of months."	F 317	refusing to participate for more than a few minutes at a time. B) A random audit will be performed of any residents showing a decline in range of motion in order to ensure that all appropriate residents are receiving range of motion exercises when appropriate. This information will be obtained from the QI/QM report. C) The nursing staff and especially the Nursing Rehab Director will be re-educated regarding the importance of maintaining resident's functional ability utilizing range of motion. This inservice will be held on or before September 7, 2006. D) A Performance Improvement Auditing Tool will be utilized to conduct random weekly audits of residents with declines in range of motion according to the QI/QM reports to ensure that the facility is providing range of motion programs for them. These audits will be conducted by the Director of Nursing, Assistant Director of Nursing (ADON), and/or Nurse Managers. When a problem is noted immediate education will take place. E) The Director of Nursing will report the results of these audits at the monthly Performance Improvement Meeting. The report will include any problems	* see below

added per request of DON 7/26/06 JB

* This resident has end stage dementia so education of risks / benefits of therapeutic exercises was not possible. Discussion w DPOA (son) and he requested staff respect his mom's declination of services when she doesn't want to do them.

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F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure 1 (#68) of 9 sample residents with a limited range of motion received services to maintain or improve their functional status. The findings were: According to the 6/6/06 quarterly Minimum Data Set (MDS) assessment, resident #68 required extensive assistance with transferring, did not walk in his/her room or the corridor, and was totally dependent for locomotion. Review of the 1/5/06 admission MDS assessment, as well as the 3/21/06 significant change and 6/6/06 quarterly MDS assessments, showed the resident had limited range of motion in one leg. Review of the care plan dated 3/17/06 revealed the resident "...has impaired ADL [activities of daily living] function, decreased functional mobility d/t [due to] contractures bi-lateral knees. Status is deteriorating and is needing more support." Further medical record review revealed a 3/7/06 rehabilitation services progress note stating the resident was being discharged from skilled physical therapy services due to refusal to participate and lack of progress. The following concerns were identified: Medical record review showed no	F 318	and/or trends noted. This will occur for a period of at least three months or until ongoing compliance has been achieved. F318 Range of Motion Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. A) Resident #68 has a Nursing Rehab plan for range of motion and he is participating in the program. B) A random audit will be performed of any residents showing a decline in range of motion in order to ensure that all appropriate residents are receiving range of motion exercises when appropriate. This information will be obtained from the QI/QM report. C) The nursing staff and especially the Nursing Rehab Director will be re-educated regarding the importance of maintaining resident's functional ability utilizing range of motion. This inservice will be held on or before September 7, 2006. D) A Performance Improvement Auditing Tool will be utilized to conduct random weekly audits	9/07/06

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F 318	Continued From page 22 documented evidence the resident was receiving services to maintain or improve range of motion. Interview with the restorative nurse on 6/29/06 at 8:40 AM, confirmed the resident was not receiving restorative nursing services. The nurse further commented that physical therapy will typically let restorative nursing attempt to work with the resident at the time skilled services are discontinued. The nurse stated, "We will try today."	F 318	of residents with declines in range of motion according to the QI/QM reports to ensure that the facility is providing range of motion programs for them. These audits will be conducted by the Director of Nursing, Assistant Director of Nursing (ADON), and/or Nurse Managers. When a problem is noted immediate education will take place. E) The Director of Nursing will report the results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of at least three months or until ongoing compliance has been achieved.	
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe and secure environment for residents. The census was 155. The findings were: Observation on 6/28/06 at 7:20 AM revealed the medication cart on unit MHN was left unlocked and the top drawer was partially open. Observation revealed no staff were present and non sample resident #144 was seated next the open cart. The following medications were available: one bottle of Mapap (analgesic, antipyretic), two bottles of Mucinex (decongestant), one bottle of Calcium 600 milligrams (mg) plus vitamin D, One bottle of Senna (laxative), one bottle of FeoSul 325 mg (iron tablet), one bottle of Diphenhydramine 25	F 323	F 323 Accidents The facility will ensure that the resident environment remains as free as is possible. A) All Licensed Nursing Staff will be re-educated regarding medication carts being locked when left unattended. This inservice will be conducted by the Director of Nursing and will take place on or before September 7, 2006. E) Random audits of medication carts will be conducted weekly.	9/07/06

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F 323	Continued From page 23 mg (antihistamine), Lantus insulin, Novolog Insulin, Humulin R insulin, Novolin N insulin, zinc sulfate 220 mg, two bottles of vitamin B 12 complex, one bottle of ibuprophen (analgesic), vitamin D, vitamin E, one box of Nitro patches 0.2 mg, Duonebs (for respiratory inhalation), Advair inhaler (for asthma), Fleets enema , Colace (stool softener), Thera M multivitamin, Milk of Magnesia (laxative), TUMS (antacid), Tylenol 325 mg (analgesic) Benadryl (antihistamine), Nystatin ointment (antifungal), and all prescribed medications for residents in rooms 410 through 417. Interview with the director of nursing on 6/28/06 at 7:30 AM revealed staff were to keep the medication carts locked when not in attendance.	F 323	F) A Performance Improvement Audit Tool will be utilized to conduct the random audits. The audits will be conducted by the Nurse Managers, the Assistant Director of Nursing, and the Director of Nursing . If any problem is noted immediate education will take place. B) The Director of Nursing will report results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of no less than three months or until ongoing compliance has been achieved.	
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure the medication error rate was not five percent or greater. The medication error rate was 6.6% out of 45 opportunities. The findings were: 1. Observation on 6/28/06 at 7:05 AM revealed LPN #1 did not administer Folbee S/F DF 2.5-25 milligrams (mg) to resident #42 as ordered. The LPN stated the Medication Administration Record	F 332	F332 Medication Errors The facility will ensure that it is free of medication error rates of five percent or greater. A) Random audits will be conducted to ensure that residents are receiving their medications as ordered. These audits will include residents #s 42, 143, and 142. B) All licensed nurses will be re-educated regarding the importance of administering medications per physician orders. This inservice will be	9/07/06

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F 332	Continued From page 24 (MAR) listed Folic acid and she was unsure if it was equivalent to the Folbee S/F DF. She further stated she would call the pharmacist to check and then administer the medication. Review of the MAR at 4:35 PM on 6/28/06 revealed the medication had not been given. Interview with RN #1 at this time revealed the LPN had not called the pharmacist or physician to clarify the order and had omitted the medication. 2. Observation on 6/28/06 at 7:50 AM revealed LPN #2 administered one 500 mg tablet of Metforman (diabetic medication) to resident #143. Review of the 2/16/06 physician's orders revealed the order was for Metforman 1000 mg (two 500 mg tablets) twice daily. Review of the June 2006 physician's orders confirmed the order was for Metforman 1000 mg twice daily. Interview with RN#2 on 6/29/06 at 2:30 PM confirmed the resident should have received two tablets instead of one. 3. Observation on 6/29/06 at 7:15 AM revealed LPN #3 did not administer Lasix (diuretic) 40 mg to resident #142. Interview with the LPN at that time revealed she could not give it because it was not available. The surveyor asked when the medication would become available, she said the pharmacy would not deliver the medication until 8 or 9 PM in the evening. She stated the Lasix would not be given that late but would be restarted the next morning.	F 332	conducted by the Director of Nursing and will occur on or before September 7, 2006. C) A Performance Improvement Audit Tool will be utilized to conduct the random audits. If any problem is noted immediate education will take place. The audits will be conducted by the Nurse Managers, the Assistant Director of Nursing, and/or the Director of Nursing. D) The Director of Nursing will report results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of no less than three months or until ongoing compliance has been achieved.	

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F 364 SS=E	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the scheduled meal times, the facility failed to prepare selected hot food items for 2 of 2 lunch meals in a manner that would conserve the nutritive value of the food. The findings were: 1. The following concerns were noted with the extended length of time between cooking and serving the food to the residents: a. Observation on 6/27/06 at 7:45 AM revealed cook #1 removed a pan containing carrots and cabbage from the steamer. After taking the temperature of the cooked vegetables, the cook placed the pan in a warming unit. Interview with the cook at that time revealed the vegetables were heated for about 12 minutes resulting in a temperature of 180 degrees Fahrenheit. The cook further stated the vegetables would remain in the warmer until either served or pureed. b. Observation on 6/28/06 at 7:35 AM revealed cook #2 was taking 2 pans out of the oven that contained pieces of baked unbreaded veal and chicken. In addition, tomato and chicken noodle soup were in the steamer. Interview with the cook at that time revealed he routinely prepared food along this same timeline; beginning between 7 AM and 7:30 AM for the lunch meal. The cook further stated the food would then be	F 364	F364 Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor and appearance; and food that is palatable, attractive, and at the proper temperature. 1. The dietary staff will prepare foods in a way that preserves vitamins. Foods will not be held in the warmer excessive amounts of time. Noon meals will not be prepared before breakfast. 2. The dietician and the dietary director will randomly audit how the food is prepared ensuring vitamins are preserved. Any food found to be prepared too early or held in the warmer too long will result in corrective action. 3. Any findings of audits will be reported at Quality Assurance meeting for three months or until ongoing compliance is established.	9/07/06

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F 364	Continued From page 26 held in warming units until served at approximately 11:15 AM. c. Review of the scheduled meal times revealed the residents began lunch at 11:30 AM; therefore, the food was prepared between 3 hours and 30 minutes and 3 hours and 45 minutes prior to the start of the tray line. 2. Interview with the dietary manager and registered dietitian on 6/29/06 at 10:15 AM revealed the timeline between preparing and serving the lunch meal was too long. Both agreed the nutritional value of the vegetables were markedly reduced after being cooked and held for such a long period of time. 3. According to the American Dietetic Association, December 26, 2005: Preserving Your Vitamins, "Cook vegetables just until tender and crisp. Vitamins B and C are destroyed easily by the heat. The shorter the cooking time, the more nutrients are retained.	F 364		
F 371 SS=E	483.35(i)(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 and staff interview, the facility failed to label nutritional supplements in a manner that clearly identified the expiration of the	F 371		

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F 371	Continued From page 27 product. The findings were: Observation in the walk-in refrigerator on 6/27/06 at 7:14 AM revealed 3 partial boxes of nutritional supplements (MightyShakes, Hormel Health Labs). The outside of each box was hand-labeled "6-21-06"; the individual cartons inside each box were not labeled. Interview at that time with the dietary manager revealed the date on the box corresponded to the day the box was removed from the freezer. When asked, the dietary manager added that when stored in the refrigerator, the product expired 14 days after thawing. The following confusion was noted in regard to the expiration date of the supplements: a. Observation of the kitchen tray line on 6/28/06 at 7:23 AM revealed 9 MightyShakes in a bowl with ice; the individual cartons were not labeled with a date. When asked at that time, the breakfast cook #3 stated she was "...not exactly sure when they expire...", but added it did not matter because "...we use them all up within a week..." Observation on 6/29/06 at 1:35 PM revealed 21 supplements remained in the walk-in refrigerator in the box labeled "6-21-06"; 8 days beyond the thaw date. b. Observation on 6/28/06 at 8:21 AM in the arrowhead dining room revealed 7 MightyShakes in the unit refrigerator, each labeled "6-21." When asked, licensed practical nurse (LPN) #6 stated she was unaware of the expiration date of the supplement and was confused with regard to the significance of the label; "6-21" on each carton. When asked by the surveyor if the handwritten date might be the expiration date, she replied, "...I don't know, I sure hope not...that's from last week." At 9:41 AM on that same day, LPN #6 reported to the surveyor she had discussed the	F 371	F371 The facility must store, prepare, distribute, and serve food under sanitary conditions. 1. Nutritional supplements will be marked with the appropriate expiration date on the individual packages when they are taken from the cases by the dietary. All staff have been educated on what the expiration dates mean and the appropriate times to throw away nutritional supplements. 2. The dietician and dietary manager will randomly audit to ensure no expired nutritional supplements are being stored. Staff will be immediately inserviced if any expired supplements are found. 3. Any findings from auditswill be reported at Quality Assurance meeting for three months or until ongoing compliance is established.	9/07/06

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F 371	Continued From page 28 nutritional supplements with the dietary manager and now understood the cartons were labeled with the thaw date, not the expiration date. According to the manufacture's instructions on the individual cartons, the shelf life of a MightyShake is up to 14 days after being thawed.	F 371		
F 426 SS=D	483.60(a) PHARMACY SERVICES - PROCEDURES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure pharmacy services met the needs of one (#142) non sample resident observed during medication pass. The findings were: Observation on 6/29/06 at 7:15 AM revealed LPN #3 did not administer Lasix (diuretic) 40 mg to resident #142. Interview with the LPN at that time revealed she could not give it because it was not available. The surveyor asked when the medication would become available, she said the pharmacy would not deliver the medication until 8 or 9 PM in the evening. She stated the Lasix would not be given that late but would be restarted the next morning.	F 426	F426 Pharmacy Services – Procedures The facility will provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. A) Random audits will be conducted to ensure that medications are available to facilitate residents receiving their medications as ordered. These audits will include resident # 142. B) All licensed nurses will be re-educated regarding the importance of ensuring that medications are available to facilitate residents receiving their medications per physician orders. This inservice will be conducted by the Director of Nursing and will occur on or before September 7, 2006.	9/07/06

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F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to utilize infection control surveillance data in acting upon a microbiologic culture and initiating effective antimicrobial therapy for 1 (#64) of 21 sample residents. The findings were: Medical record review revealed resident #64 was placed on a 10-day regimen of Levaquin (levofloxacin antibiotic) on 4/9/06 for the treatment of an upper respiratory infection (URI). According to the record, a sample of urine was obtained from the resident on that same day and submitted to the laboratory for culture and antimicrobial sensitivity. The record showed that on 4/11/06 the results of the urine culture were reported by the laboratory to be positive for the bacterium Escherichia coli and the pattern of antimicrobial sensitivity showed the isolated organism to be resistant to levofloxicin at clinically relevant levels. The following concerns were identified: Review of the interdisciplinary team progress	F 441	C) A Performance Improvement Audit Tool will be utilized to conduct the random audits. If any problem is noted immediate education will take place. The audits will be conducted by the Nurse Managers, the Assistant Director of Nursing, and/or the Director of Nursing. D) The Director of Nursing will report results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of no less than three months or until ongoing compliance has been achieved. F441 Infection Control The facility will establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility will establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.	9/07/06

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F 441	Continued From page 30 notes dated 4/9/06 showed the microbiology report dated 4/12/06 documented the laboratory results were faxed to the attending physician, specifically annotated with a handwritten note highlighting the resistance of the cultured bacterium to levofloxacin. Further review of the medical record showed no change was made to the resident's medications and s/he continued to receive levofloxacin. Review of the interdisciplinary progress notes dated 4/17/06 revealed a second attempt was made to fax the microbiology report to the resident's physician, at which time the antibiotic therapy was augmented to include Rocephin and Macrobid, antimicrobial agents effective against the Escherichia coli isolate. The intervening 6 day period, from 4/11/06 to 4/17/06, the resident was not effectively treated for his/her urinary tract infection (UTI), despite the fact the facility infection control program clearly showed the timelines, antibiotic treatments, and culture results for the resident. Interview with the director of nursing on 6/28/06 at 2:30 PM confirmed the lack of timely and effective treatment for this resident.	F 441	Resident # 64 infection has completely resolved A) Random audits will be performed of residents listed on the form "Line Listing of Patient Infections" in order to ensure that residents with infections are receiving the appropriate treatment in a timely manner. B) All licensed nurses will be re-educated regarding infection control policies and the importance of timely follow up with physicians for treatment of any resident with an infection. This inservice will be conducted by the Director of Nursing and will occur on or before September 7, 2006. C) A Performance Improvement Audit Tool will be utilized to conduct the random audits. If any problem is noted immediate education will take place. The audits will be conducted by the Director of Nursing. D) The Director of Nursing will report results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of no less than three months or until ongoing compliance has been achieved.	added per request of DSW 7/26/06 LB
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory 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	F 502	F502 Laboratory Services The facility will provide or obtain laboratory services to meet the needs of its residents. The facility is	9/07/06

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F 502	Continued From page 31 review, the facility failed to ensure laboratory tests were completed as ordered for 1 (#105) of 21 sample residents. The findings were: Review of the 5/12/06 physician's orders for resident #105 revealed a CBC (complete blood count), a transferrin, protein, serum zinc, albumin, and prealbumin were ordered. Review of the laboratory reports in the medical record revealed there were results for a basic metabolic panel, prealbumin, CBC with differential and platelets tests performed on 5/4/06. Additionally, there were test results for a CBC and platelets that was performed on 5/19/06. However, review of the entire medical record revealed no evidence the tests ordered on 5/12/06 were performed. Interview with the assistant director of nursing on 6/29/06 at 11 AM revealed there were no test results available for 5/12/06.	F 502	responsible for the quality and timeliness of the services. A) Resident #105 is currently in the hospital. B) Random audits of lab tests ordered by physicians will be conducted to ensure that all lab tests ordered are being performed. C) All licensed nurses will be re-educated regarding the importance of ensuring that all lab tests ordered are completed. This inservice will be conducted by the Director of Nursing and will occur on or before September 7, 2006. D) A Performance Improvement Audit Tool will be utilized to conduct the random audits. If any problem is noted immediate education will take place. The audits will be conducted by the Director of Nursing. E) The Director of Nursing will report results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of no less than three months or until ongoing compliance has been achieved.	
F 507 SS=D	483.75(j)(2)(iv) LABORATORY SERVICES The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure laboratory results were in the medical record for 2 (#20, #137) of 21 sample residents. The findings were: 1. Review of the 6/5/06 physician's orders for resident #20 revealed an order for total iron	F 507	F507 Laboratory Services The facility will file in the resident's clinical record laboratory reports that are	9/07/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING _____ B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	1330 PRAIRIE AVENUE CHEYENNE, WY 82009

(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 507	Continued From page 32 binding capacity and a ferritin level. Review of the entire medical record revealed the results of these tests were not in the medical record. Interview with the assistant director of nursing (ADON) on 6/29/06 at 11 AM revealed she had called that day to obtain the results from the hospital. She further stated the facility had been having trouble getting test results from the hospital. 2. Review of the 2/3/06 physician's orders for resident #137 revealed CBC, protein, serum zinc, transferrin, albumin, and prealbumin tests were ordered. Review of the entire medical record revealed the results of these tests were not in the record. Interview with the ADON on 6/29/06 at 11 AM revealed she had called the hospital that day to obtain the results. She further stated the facility had been having trouble getting test results from the hospital.	F 507	dated and contain the name and address of the testing laboratory. A) Lab test results sited for residents #s 20 and 137 are now in their clinical records. B) Random audits of resident's clinical records will be performed in order to ensure that any ordered lab results are filed in the record. C) All licensed nurses will be re-educated regarding the importance of ensuring that all lab tests ordered are completed and filed in the clinical record. This inservice will be conducted by the Director of Nursing and will occur on or before September 7, 2006. D) A Performance Improvement Audit Tool will be utilized to conduct the random audits. If any problem is noted immediate education will take place. The audits will be conducted by the Director of Nursing, Assistant Director of Nursing and/or Nurse Managers. E) The Director of Nursing will report results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of no less than three months or until ongoing compliance has been achieved.	