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

PRINTED: 08/27/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	08/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 788, 333 N BRIDGER AVE PINEDALE, WY 82941

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=D	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 medical record review, and resident and staff interviews, the facility failed to complete a comprehensive assessment of all needed areas for 2 (#11, #18,) of 11 sample residents. The	F 272	The facility will ensure a comprehensive assessment will be done within 72 hours of admission, and quarterly thereafter for each resident. This will be accomplished by: all residents will have a comprehensive nurse assessment completed, if indicated. BD 1) Bowel Assessments a. Resident #11 expired on 8/18/07 before a comprehensive bowel assessment could be completed. b. The admitting charge nurse will start a bowel tracking form on the day of admission. The bowel habit will be tracked every hour for a 72 hour period. At the end of the 72 hour period if the resident is incontinent of bowel and the resident is able to follow a bowel training program, the resident will be placed on a bowel training program. as part of the comprehensive assessment. BD 2) Catheter Assessments a. Resident #18 will be assessed by a urologist to determine the appropriate diagnosis and treatments options. b. During admission and/or during quarterly assessments, for a resident with an indwelling catheter, the charge nurse assigned to this resident will perform an investigation for a proper diagnosis for the indwelling catheter. If there is no diagnosis for the indwelling catheter, the charge nurse will contact the resident's physician to have a comprehensive assessment by an urologist or the resident's physician as to whether or not the indwelling catheter will remain in place. as part of the comprehensive assessment. BD The Director of Nursing will perform quarterly chart reviews to ensure bowel	8/29/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah A. Wood
TITLE: Administrator
(X6) DATE: 9-7-07

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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SEP 07 2007
Upcoming Dept of Health

This POC accepted call additions & corrections on 9/10/07 at 1420 per phone call between D. Wood, Adm, & B. Jelson, Surveyor. B. Jelson, RN

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F 272	Continued From page 1 findings were; 1. According to the 3/20/07 admission and 6/19/07 quarterly Minimum Data Set (MDS) assessments, resident #11 was occasionally incontinent of bowel (less than weekly) and required a comprehensive assessment of his/her bowel status. Review of the medical record showed that assessment was lacking. On 8/15/07 at 10:16 AM, the MDS coordinator confirmed a comprehensive bowel assessment was not completed. 2. Review of the 7/17/07 significant change assessment showed resident #18 required a comprehensive assessment for an indwelling urinary catheter. Review of the assessment completed by the facility showed the diagnosis of kidney disorder was listed as the medical rationale for use of the catheter. When questioned, the MDS coordinator stated she did not know what kind of kidney disorder was involved. On 8/15/07 at 12:40 PM, the coordinator stated she was unable to find a comprehensive assessment for the indwelling urinary catheter.	F 272	assessments are being done and to ensure the necessity of the indwelling catheter has been substantiated. Results of these chart reviews will be reported to the Administrator and summarized for the quarterly Quality Assessment and Assurance (QAA) meetings.	
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329	The facility will ensure a comprehensive assessment will be performed on residents taking hypnotic medications to ensure no unnecessary drugs are being used. This will be accomplished as follows: 1) The charge nurse assigned to resident #12 and #20 will perform a sleep diary study to ensure the hypnotic medication is necessary.	9/17/07

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F 329	Continued From page 2 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review, and resident and staff interviews, the facility failed to assure the drug regimen was free of unnecessary drugs for 2 (#12, #20) of 11 sample residents. The findings were: 1. Review of physician's orders revealed resident #20 had an order, dated 3/16/07, for Tylenol PM 500/25 milligrams (mg) one to two tablets at bedtime. The diagnosis code for the medication was generalized pain; there was not a diagnosis of insomnia. However, review of the 3/29/07 psychotropic medication Resident Assessment Protocol (RAP) summary revealed the resident received Tylenol PM to help him/her sleep. Review of the medication administration record (MAR) for July 2007 showed the resident received Tylenol PM every night except 7/16/07. However, a monthly nursing summary dated 7/23/07 documented the resident slept at night, but did not document whether or not the resident required medication for sleep. The August 2007 MAR through 8/14/07 showed that through	F 329	2) Patients on hypnotic medications will be identified and a sleep diary will be created. The sleep diary will include documentation as to the hours the resident is awake and asleep, whether or not non-pharmacological interventions were used such as warm milk, back rub, turning TV off, making sure resident isn't in any pain, whether or not noise was a contributing factor, etc. 3) After the sleep diary has been completed, the charge nurse will inform the resident's physician of the results and obtain ~~a diagnosis for insomnia and the proper drug regime necessary to ensure the resident's drug regime is suitable.~~ any necessary orders w/ Dx & Rx The Director of Nursing will meet with the pharmacist consultant quarterly to ensure the residents are not receiving any unnecessary drugs. The consulting pharmacist will review all new admission medication lists to identify hypnotic medication use. The D.O.N. will inform the Administrator of findings and summarize for the quarterly QAA meetings. dicp possible unnecessary	

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F 329	Continued From page 3 8/14/07 the resident received the medication every night. During an interview on 8/15/07 at 1:55 PM, the resident confirmed he/she received "something for sleep." The resident stated prior to admission in the facility, he/she only had problems sleeping "sometimes." Review of the medical record revealed no evidence a comprehensive sleep assessment was completed to determine the resident's usual sleep pattern/disturbance and possible reasons for insomnia such as noise, pain, side effects of medication, stress, depression, etc. Review of the care plan dated 6/26/07 revealed insomnia was not identified as a problem for this resident. Further review of the medical record revealed no evidence other non-pharmacological interventions were tried. On 8/15/07 at 1:50 PM, the director of nursing (DON) confirmed a comprehensive sleep assessment had not been completed for this resident. In addition, there was no evidence that alternative interventions had been tried. 2. Review of physician's orders revealed resident #12 had had an order since 8/10/05 for Tylenol PM 500/25 mg, two tablets at bedtime. The physician's order sheet included a diagnosis of insomnia. Review of the 8/21/06 psychotropic medication RAP summary showed the resident received Tylenol PM nightly at bedtime. Review of the July 2007 MAR showed the resident had received Tylenol PM every night except 7/21/07. Review of the August 2007 MAR through 8/14/07 showed the resident received the medication each night. Review of the medical record revealed no evidence a comprehensive sleep assessment was ever completed in order to determine the resident's usual sleep pattern/disturbance and	F 329		

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F 329	Continued From page 4 causative or contributing factors to the problem of insomnia. Review of the care plan dated 5/19/07 showed insomnia was not addressed. In addition, review showed the medical record lacked evidence that any non-pharmacological interventions were tried. On 8/15/07 at 1:50 PM, the DON confirmed a comprehensive sleep assessment was not done for this resident in order to determine reasons for insomnia. The DON also confirmed there lacked evidence alternative interventions were tried.	F 329		
F 334 SS=C	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical	F 334	The facility will ensure that there is a policy and procedure in place for the education, consent, and documentation in the resident's medical record of ~~Immunization~~ administration of the influenza and pneumococcal vaccine including if the immunizations are medically contraindicated: 1) A policy and procedure will be written for the administration of the influenza and pneumococcal vaccine. 2) Each resident will be offered an influenza immunization October 1 through March 31 annually unless medically contraindicated, the resident refuses, or the resident has been immunized during this time frame. 3) Each resident will be offered the pneumococcal vaccine if resident has not received the immunization, cannot remember if ever receiving the immunization, per the Center of Disease Control guidelines, and if there is no record of the immunization with his/her	9/7/07

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F 334	Continued From page 6 contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced	F 334	private physician, clinic or with the public health department. 4) As an alternative, based on assessment and the resident's attending physician 's recommendations, a second pneumococcal immunization maybe given after five years following the initial pneumococcal immunization unless it is medically contraindicated, or the resident or resident's legal representative refuses the second immunization. 5) Education material will be given to the resident or the resident's legal representative regarding the influenza and pneumococcal vaccines stating the benefits and potential side effects of each of these vaccines prior to the immunization. The practitoner will answer all questions regarding each vaccine prior to immunization. 6) Documentation of education, consent, and immunization will be documented in each resident's medical record. Also, the medical contraindication and/or refusal of immunization of either the influenza and/or pneumococcal vaccine will be included in the medical record. 7) The Infection Control Coordinator will monitor using the "Resident's Vaccination" Logbook to track the resident's who have and have not taken the flu and/or pneumococcal vaccine and reason for refusal. The resident's attending physician will be notified of the resident's refusal of either vaccine. These will include refusals by the resident's legal representative. The reasons for refusals will be reviewed and presented in a quarterly QAA meeting.	

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F 334	Continued From page 6 by: Based on review of immunization documentation and staff interview, the facility failed to assure the medical record contained documentation of education and administration of influenza and pneumococcal vaccinations for 5 (#1, #11, #12, #18, #20) of 5 sample residents reviewed for immunization status. In addition, the facility failed to develop policies for influenza and pneumococcal immunizations. The findings were: During an interview on 8/15/07 at 1:25 PM, the infection control nurse stated the facility had not developed written policies for influenza and pneumococcal immunizations. During the same interview, the infection control nurse showed the surveyor the immunization book, which contained evidence of vaccinations (or refusals) for residents, including residents #1, #11, #12, #18, and #20. However, the infection control nurse stated the documentation was not part of the medical record. In addition, she stated there were no consents or documentation that education had been provided prior to the administration of the vaccinations.	F 334		
F 356 SS=B	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses, - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides.	F 356	The facility will ensure the nurse staffing data will be posted at the beginning of each shift as evidenced by: 1) The charge nurse of each shift will post the nurse staffing data at the beginning of each shift. 2) The Director of Nursing conducted a licensed nursing staff in-service to review the deficiencies from the State Survey. The licensed nursing staff was instructed by the Director of Nursing	9/14/07

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F 356	Continued From page 7 o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the specified nurse staffing data at the beginning of each shift. The findings were: Observation on 8/13/07 at 6:45 PM and on 8/15/07 at 12:40 PM revealed the nurse staffing data was posted for a 24 hour period. During the 12:40 PM observation, the director of nursing (DON) stated that the nurse on the night shift posted the data for the upcoming 24 hours. The DON stated she was unaware of the requirement that the data be posted at the beginning of each shift.	F 356	to post the nurse staffing data at the beginning of each shift. The Director of Nursing will keep a hard copy of the 24 hour nurse staffing data for up to 18 months. The Administrator and/or the D.O.N. will conduct random checks to monitor staff postings and to ensure accuracy of information. Findings will be discussed at the quarterly QAA meetings.	
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431	The facility will ensure that all medications in two of two medication carts and in the medication room are not expired and	9/7/07

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F 431	Continued From page 8 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that all medications in two of two medication carts and in the medication room had not expired, contained expiration dates, or were properly labeled. The findings were:	F 431	readily available to the residents. This will be evidenced by: 1) All expired medication and medications lacking proper labeling will be removed by the Director of Nursing. 2) The Director of Nursing or a licensed nurse designee will perform weekly checks on all medications stored in two medication carts, the emergency med box, and medication cabinets. The consulting pharmacist will perform monthly checks on medications stored in two medication carts, the emergency med box, and the medication cabinets. 3) All medications delivered from the pharmacy and brought from home by the residents will have the label checked at time of delivery. The charge nurse will ensure the label contains an expiration date. If there is no expiration date, the charge nurse will call the pharmacy and inquire as to the expiration and request proper labeling. The charge nurse will not administer the medication until it is properly labeled. 4) During weekly inspection of the medication carts, any medications (prescriptions) found with out a pharmacy label containing the resident's name, name of the medication, directions of how to take the medication, and the expiration date, will be discarded or returned to the pharmacy for proper relabeling. 5) Inspection results will be reported to the Administrator and summarized for reporting at the quarterly QAA meetings.	

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F 431	Continued From page 9	F 431		

1. Observation on 8/15/07 at 3:30 PM showed the following expired medications were located in the medication room and were available for resident use:

a. A stock can of Saline Wound Wash, expired 11/04. The director of nursing (DON) verified the expiration date during the observation.

b. Diazepam 5 milligrams (mg) located in the emergency medication box, expired November 2006. Since the label also contained instructions to discard the medication after 6/29/06, the DON called the pharmacy. She reported the pharmacist confirmed the expiration date for the entire lot was 11/06. The date of 6/29/06 was one year after the pharmacist filled the container for the facility; however, the medication had already expired.

c. A 1000 milliliter bag of 5 % Dextrose /0.45% Normal Saline (D5 1/2 NS), expired 5/07. Registered nurse (RN) #10 confirmed the intravenous solution was available for resident use.

2. Observation of one medication cart on 8/15/07 at 3:30 PM revealed the following medications for resident #26 lacked expiration dates: Potassium 20 mg, Hydrodiuril 50 mg, Aricept 10 mg, and Enalapril. Interview with the DON and RN #10 during the observation confirmed the lack of expiration dates and revealed the resident was currently taking the medications.

3. Observation of the second medication cart on 8/15/07 at 3:45 PM revealed a tube of Clotrimazole which lacked a pharmacy label and an expiration date. The first name of a resident was written across the tube in black ink, but there

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F 431	Continued From page 10 were no instructions for use. During the observation, RN #10 verified the medication lacked a label and expiration date.	F 431		