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

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
	535022	A. BUILDING _____ B. WING _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 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 maintain or enhance dining dignity for one resident (#80) during one of two meal observations in the secure unit. The findings were: Observation on 12/12/05 at 5:10 PM revealed certified nurse aide (CNA) #20 was standing next to the resident to assist with dining. CNA #21 was seated and assisting another resident with dining. When CNA #21 noticed that CNA #20 was standing, he/she told a third CNA (#22) who was walking around filling water glasses, "we're supposed to be at eye level when feeding". That CNA then looked for an extra chair to provide to CNA #20 but was unable to find one. CNA #20 continued to stand while assisting the resident for the duration of the meal (12 minutes). Interview with the director of nursing on 12/15/05 at 8:25 AM revealed her expectation was that aides would sit when assisting residents with dining.	F 241	F241 The facility will ensure that residents are cared for in a manner and in an environment that maintains or enhances their dignity and respect. This will be accomplished by: A/E) All Charge Nurses will observe aides assisting residents during meals. If an aide is observed standing while assisting a resident with their meal, the Charge Nurse will instruct the aide to sit next to the resident during meals. If a chair is not available, the nurse and/or aide will retrieve a chair. The Clinical Supervisors and Director of Nursing will randomly observe aides assisting residents during meals. If a resident's dignity is violated, immediate in-servicing and corrective action will be taken with the nursing staff member. C) The Director of Nursing will provide specific education on resident dignity with emphasis on proper conduct while assisting with meals. The Director of Nursing will also provide education to the nurses on resident dignity and proper conduct of nursing staff while assisting residents with meals. D) A quality monitoring tool will be implemented to ensure resident dignity during meals. This monitor will be completed monthly and reported quarterly at the Pioneer Manor Quality Assurance meeting by the Director of Nursing.	1/30/06
F 248 SS=D	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248		

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

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.

JAN. 12. 2006 5:53PM DEPT_HEALTH NO. 4817 P. 5

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	536022	A. BUILDING _____ B. WING _____	12/15/2005

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PIONEER MANOR NURSING HOME	900 W 6TH ST GILLETTE, WY 82716

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F 248	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview, and medical record review, the facility failed to ensure individualized one-to-one activities for one (#61) of 10 sample residents who required one-to-one activities. The findings were: Intermittent observations of resident #61 on 12/13/05 from 7:58 AM to 5:22 PM revealed the resident was totally dependant for care and required extensive respiratory care and mechanical feeding assistance, which was done in the resident's room. The observations also revealed the resident did not attend any activities. The resident did have a TV, which was positioned at the the foot of the bed and remained tuned in to a national news channel the entire day. The resident was turned by staff regularly and when on his/her side, was unable to see the TV. The bed was not adjusted so the resident could watch the TV if he/she choose to. Intermittent observations were done on 12/14/05 from 9:08 AM, when the resident was assisted to bed after bathing, to 5:23 PM when the observations ended. The observations revealed the TV again remained on the entire day, tuned to a national news channel. When the resident was turned to the left or right side, the bed was not re-positioned so that the resident could watch the TV. Interview on 12/14/05 at 9:15 AM with two certified nurse aides (CNAs) who provided care for the resident revealed the resident was able to hear the TV, but the CNAs were unsure how well the resident saw. Neither CNA knew of other activities provided for the resident and stated the family pictures on the ceiling of the resident room	F 248	F248 The facility will ensure that residents who require one-to-one activities receive individualized one-to-one activities. This will be accomplished by: A) The Director of the Activity Department will review and revise the one-to-one activity plan for resident #61. The revised activity plan will reflect the facility's policies for number of one-to-one activities per week for residents not attending out of the room activities. The activity plans will identify resident-specific meaningful interactions for the one-to-one activities. Background noise will be provided by a radio or stereo unless the resident or family indicate they would prefer the TV to be on. B) The Director of the Activity Department will review each resident and their participation in activities. Residents identified as not meeting the policy requirements for number of activities for a week, will be offered an increased number of one-to-one activities. The care plan will be revised and the activity tally sheet will be updated. The Director of the Activity Department will observe the activities provided to residents identified as staying in their room most or all of the day to assure appropriate activities are offered and that activity staff is compliant with the facility's policy. C) The Director of the Activity Department will review and if necessary revise the activity policy regarding number of activities provided to residents weekly. The	1/30/06

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	516622	A. BUILDING _____ B. WING _____	12/15/2005

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F 248	Continued From page 2 were placed by the family. The following concerns were noted related to the resident's lack of activities: a. Review of the medical record revealed an activity assessment dated 6/9/04 which identified the resident's preference for activities such as bingo, trivia, sports, movies, radio, TV, conversation, and a variety of music. A significant change resident assessment instrument (RAI) dated 2/2/05 documented the resident was awake in the mornings and afternoon and preferred to have activities in his/her own room and the day/activity room. The assessment documented music, going outdoors, watching TV, and conversation as the preferred activities. The assessment also documented the area of activities triggered for additional assessment information. The facility documented this information in a resident assessment protocol narrative report dated 1/28/05. The facility noted the activities triggered due to the resident's withdrawal and lack of participation in activities outside his room. Review of the facility's documentation of one-to-one activities revealed activity staff scheduled the resident for visits once a week for the months of September, October, and November 2005. Each visit lasted 10 minutes for a monthly total of 40 minutes. Review of activity tally sheets revealed one time in October when the resident attended an outside church service. b. Interview with the activity director on 12/14/05 at 3:02 PM revealed the amount of one-to-one activities were based on a formula derived from the number of facility scheduled activities the resident attended. The director stated that this resident utilized the TV for "background" noise. The director stated independent activities, such as family visits and	F 248	policy will be reviewed with the activity staff at the January meeting. The director will review the Activity Tally sheets weekly and activity staff will be counseled if the minimum number of weekly activities have not been offered and appropriate documentation entered into the medical record. D) A quality monitoring tool will be developed to ensure the residents are receiving the weekly activities as per policy. The data will be collected weekly and reported quarterly to the Pioneer Manor Quality Assurance meeting by the Activity Director.	

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	535022	A. BUILDING _____ B. WING _____	12/16/2005

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F 248	Continued From page 3 TV, were not considered activities. According the facility's one-to-one activity guideline sheet, if a resident was attending an average of 12 to 16 activities per month, a minimum of 'one', one-to-one visit per week would occur. As previously stated, in the prior three months, the resident had attended only one activity. c. Further interview with the activity aide for the resident and the activity director on 12/14/05 at 3:15 PM revealed no set goals for the resident's once a week visit. Although the activity aide identified golf as a past interest for the resident, she stated she had not visited with the resident or provided TV programs related to his/her interest. d. Interview with one of the resident's family members on 12/14/05 at 5:30 PM revealed the family was unable to visit often. The family member stated their concern for the resident always being in his/her room. The family member stated the resident was no longer able to "walk, talk, eat, or drink, but (resident name) understood" and his/her mind "was good."	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of posted instructions, and review of policies and procedures, the facility failed to assure staff provided proper sanitation during one of two tub cleanings. The findings were:	F 253		

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F 253	Continued From page 4 Observation on 12/13/05 at 7:50 AM showed a certified nurse aide rinsed the whirlpool tub on Neighborhood 4, sloshed disinfectant in varying places onto the tub, filled it to within four inches of the top with water, and turned on the jets. During the observation, the CNA stated the jets could run from 1 to 10 minutes, but she chose to run them for 5 minutes while scrubbing the tub. The CNA further stated she had no idea how much water the tub held. After locating and reading the cleaning instructions posted on the wall beside the tub, the CNA stated, "Maybe I had it wrong." However, she continued to drain and rinse the tub after five minutes contact time for the disinfectant. The following concerns were identified: a. Review of the posted cleaning instructions showed staff were to use a dilution of 1:3 for cleaning the tub. According to the hand written label on the bottle, and the posted instructions, the disinfectant was already diluted to a ratio of 1:3 before it was placed in the tub room. However, review of the manufacturer's label revealed the minimum dilution of the disinfectant was 2 ounces of disinfectant to one gallon of water (1:64). Since the CNA had no idea how much water the tub held, she had no idea if the strength of the disinfectant solution met the minimum requirements. b. Further review of the posted instructions showed staff should squirt the diluted disinfectant onto all surfaces of the tub, including "directly into the inlet portlet for aeration," and allow 10 minutes contact time. After 10 minutes, the whirlpool outlet should be backflushed with the pump agitating for 15 to 60 seconds. c. Review of the facility's 8/14/05 policy and procedure, "Bath, Century Tub .Disinfection," verified the posted instructions.	F 253	F253 The facility will ensure housekeeping and maintenance services are provided to maintain a sanitary, orderly and comfortable interior. This will be accomplished by: A) The Director of Nursing reviewed the tub cleaning policy for the Neighborhood 4 tub to assure correct dilution for the size of the tub, contact time and backflush/rinsing time follow the manufacturer's recommendations. The Director of Nursing will assure the cleaning instructions are updated, written for ease in understanding and posted in a prominent place in the tub room. B) The Director of Nursing will review the tub cleaning policies for cleaning of the tubs on Neighborhood 1 and Neighborhood 5 to assure the correct dilution for the size of the tub, contact time and backflush/rinsing time follows the manufacturer's recommendations. The Director of Nursing will assure the cleaning instructions are updated if necessary, written for ease in understanding and posted in a prominent place in the tub rooms. C) The Director of Nursing will in service all nursing staff on the proper method of cleaning the tubs following the manufacturer's recommendations which will include correct dilution, amount of water to be added to the tub, contact time of the chemical to the tub surface and backflushing/rinsing of the tub. The in service education will be provided at the monthly nurses meeting and monthly aide meeting in	1/30/06

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F 253	Continued From page 6 d. Interview with a licensed practical nurse on 12/15/05 at 8:15 AM revealed 39 residents from both Neighborhoods 3 and 4 received baths in that specific tub.	F 253	January. The Clinical Supervisors will observe and monitor the cleaning of the tubs in their areas. Results of monitor will be implemented into a quality assurance study. D) Results from the tub cleaning quality assurance monitoring will be provided monthly to the Director of Nursing and she will report quarterly at the Pioneer Manor Quality Assurance meeting.	
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interviews, the facility failed to assure staff followed the care plan for one (#87) of one sample resident at risk for seizures. The findings were: Review of the 6/29/05 significant change Minimum Data Set (MDS) assessment revealed resident #87 had diagnoses which included seizures and end stage renal failure with dialysis three times a week. Review of nursing notes after each dialysis session showed the resident was lethargic and confused at times. According to the intervention dated 7/21/04 on the current care plan, the resident was to have two full padded side rails. Observations on 12/13/05 at 9:10 AM and 11:20 AM and on 12/14/05 at 12:15 PM showed two full raised side rails were in place, but only the back one against the wall was padded. Interview with licensed practical nurse (LPN) #5 on 12/14/05 at 6:40 PM confirmed the resident had seizures in the past, but that a second	F 282	F282 The facility will ensure services are provided or arranged to be provided by a qualified person in accordance with each resident's written care plan. This will be accomplished by: A) Resident #87's bed was supplied with two padded side rails. The pocket care plan was updated to reflect the safety intervention. B) Each resident's care plan will be reviewed to assure all interventions are in place as per care plan. C) The Clinical Supervisor for resident #87 will in service all direct care staff on the unit of the requirements for the two padded side rails and monitor compliance with the care plan. The Director of Nursing will provide in-service training to the nursing staff on the importance of following the care plan and implementing the interventions identified for the resident's safety as well as independence. D) The Director of Nursing will implement a quality monitoring tool to ensure interventions identified in the care plan are in place. This monitor will be completed monthly and reported quarterly to the Pioneer Manor Quality Assurance meeting by the Director of Nursing.	1/30/06

JAN. 12. 2006 5:57PM DEPT_HEALTH NO. 4677 P. 10

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F 282	Continued From page 6 padded side rail was never used. Interview with an LPN on 12/15/05 at 8:14 AM revealed she was unaware of the planned intervention. The LPN stated the resident should use the second pad due to the history of seizures and confusion after dialysis.	F 282		
F 329 SS=D	483.25(l)(1) 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. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policies and procedures, the facility failed to assure the drug regimen for two (#11, #31) of 21 sample residents was free of unnecessary drugs. The findings were: 1. Review of admission orders showed the physician ordered Ativan (antianxiety medication) 1 milligram (mg) every six hours on 1/4/05 for resident #11. This order was continued unchanged every month through December 2005, a time period of 11 months. Review of the medication administration records (MARs) from January 4, 2005 through December 15, 2005 confirmed the resident received the medication. Review of the current care plan revealed an	F 329		

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F 329	Continued From page 7 Intervention developed on 1/17/05 to attempt a dosage reduction of psychotropic medications every six months per the facility's policy. According to the facility's 8/14/05 policy and procedure, "Restraint, Chemical," antianxiety medications were included with "psychopharmacologic drugs" and staff " will...reduce dosage to the minimum required..." Review of the entire medical record failed to show any attempt to reduce the dose or any documentation from the physician that the benefits the resident received from the psychotropic medication outweighed the risks of taking it. On 12/15/05 at 8:05 AM, interview with registered nurse (RN) #8 confirmed lack of the physician's statement. 2. Review of the 12/28/04 physician's orders showed resident #31 was to receive Xanax (antianxiety medication) 0.5 mg every evening. Further review showed the order remained unchanged from 12/28/04 through 12/13/05. Review of the MARs from December 28, 2004 through December 13, 2005 showed the resident received the medication while in the facility. According to the facility's 8/14/05 policy, "Restraint, Chemical," antianxiety medications were included with "psychopharmacologic drugs" and staff " will...reduce dosage to the minimum required..." Review of the entire medical record failed to produce documentation from the physician that the benefits the resident received outweighed the risks of taking the psychotropic medication. An interim order was sent to the physician on 8/15/05 informing him/her that per facility policy, "psychotropic meds [medications] must be re-evaluated q [every] 6 mo [months]. Resident is currently taking Xanax 0.5 mg q HS [hour of	F 329	F 329 The facility will ensure each resident's drug regimen is free from unnecessary drugs. This will be accomplished by: A1) The Clinical Supervisor for resident #11 will visit with the attending physician to obtain a determination from the physician, that if he chooses to continue the Ativan medication, that the physician documents in the medical record that the benefits outweigh the risks of taking it. A2) The Clinical Supervisor for resident #31 will visit with the attending physician to obtain a determination from the physician, that if he chooses to continue the Xanax medication, that the physician documents in the medical record that the benefits outweigh the risks of taking it. B) All charts for residents on psychotropic medications will be reviewed by the Director of Nursing to assure that the "Restraint, Chemical" policy is followed and that the physicians are notified every six months and attempts are made to reduce the dosage of psychotropic medications or receive documentation from the physician that the benefits the resident received from the psychotropic medication outweighed the risks of taking. The Clinical Supervisors will visit with the physicians to determine the physician's preference of keeping the resident on the psychotropic medication. If the physician orders continuation of the medication, the Clinical Supervisor will obtain documentation from the physician that the benefits outweigh the risks of taking it. C) The Director of Nursing, Administrator and Pharmacist will	1/30/06

JAN 12 2006 6:11PM DEPT_HEALTH NO. 4277 P. 12

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F 329	Continued From page 8 sleep] for dx [diagnosis] anxiety. Cont [continues] to have occasional restlessness/anxious episodes, but usually is easily re-directed." On 8/16/05 all the the physician wrote was "Less anxiety" when asked to list the benefits that outweighed the risks of using the medication. On 12/12/05 the physician wrote, "Continue c [with] it." On 12/14/05 at 9:15 AM, RN #7 confirmed that was the only documentation from the physician related to Xanax, and it failed to describe the benefits versus the risks of taking the psychotropic medication. Interview with RN #9 on 12/14/05 at 3:20 PM revealed physicians were "not good" at documenting the benefits versus the risks of taking psychotropic medication.	F 329	attend the Campbell County Memorial Hospital Department of Medicine meeting in January 2006 to in service the physicians on the federal requirements of ensuring that each resident's drug regimen is free from unnecessary drugs and the documentation requirements for continuation of unnecessary medications. D) A quality monitoring tool will be developed to track the use of unnecessary drugs and the documentation/interventions required of physicians to continue on unnecessary drugs. The results of this monitoring will be completed monthly and reported quarterly to the Pioneer Manor Quality Assurance meeting by the Director of Nursing.	
F 331 SS=D	483.25(l)(2)(ii) ANTIPSYCHOTIC DRUGS Based on a comprehensive assessment of a resident, the facility must ensure that 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, staff interview, and review of facility policy and procedure, the facility failed to ensure two (#11, #43) of seven sample residents receiving antipsychotic medications received dose reductions, or provide evidence that a dose reduction was contraindicated. The findings were: 1. Review of the medical record revealed resident #43 had a physician's order dated 3/24/03 for	F 331		

JAN 12 2006 6:12PM DEPT_HEALTH NO. 4577 P. 13

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F 331	Continued From page 9 Zyprexa (an antipsychotic medication) 5 mg to be given at 8 AM and 8 PM daily. According to the December 2005 medication administration record, the resident was currently receiving the medication as ordered for a diagnosis of psychosis disorder. Further review of the medical record revealed physicians interim orders dated, 6/18/03, 12/2/04, 6/15/05, and 12/8/05. All of these interim orders asked the physician to re-evaluate the Zyprexa, and on all of them, the physician marked "yes", he/she wished to continue the medication at the same dose. Additionally, on the 6/18/03, 12/2/04, and the 6/15/05 interm orders the nurse requesting the evaluation of the Zyprexa also asked the physician to "please list benefits that outweigh risks of using these meds [medications]." With the exception of the 6/18/03 order, there was no evidence in the medical record that the physician listed any benefits or contraindications to a dose reduction of the Zyprexa. According to the facility's 6/14/05 policy, that addressed chemical restraints, residents on antipsychotic medications "must receive gradual dose reductions, unless clinically contraindicated in an effort to discontinue use of such drugs." Further review revealed clinically contraindicated "means that a resident need not undergo a 'gradual dose reduction'...if: a. The resident's physician provides a justification why the continued use of the drug and the dose is clinically appropriate." Interview with the director of nursing on 12/15/05 at 8 AM confirmed lack of a physician's statement that dose reduction was clinically contraindicated since 6/18/03. 2. Review of admission orders showed the physician ordered Thorazine (antipsychotic	F 331	F 331 The facility will ensure residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This will be accomplished by: A1) The Clinical Supervisor for resident #43 will visit with the attending physician to obtain a determination from the physician, that if he chooses to continue the Zyprexa, that the physician lists in the medical record that the benefits outweigh the risks of taking it. A2) The Clinical Supervisor for resident #11 will visit with the attending physician to obtain a determination from the physician, that if he chooses to continue the Thorazine, that the physician documents in the medical record that the benefits outweigh the risks of taking it. B) All charts for residents on antipsychotic drugs will be reviewed by the pharmacist and attempts will be made to reduce the dosage of psychotropic drugs and behavioral interventions, unless clinically indicated, every six months per facility's policy. The Clinical Supervisors will visit with the physicians to determine the physician's preference of keeping the resident on the psychotropic medication. If the physician orders continuation of the medication, the Clinical Supervisor will obtain documentation from the physician that the benefits outweigh the risks of taking it. C) The Director of Nursing, Administrator and Pharmacist will attend the Campbell County Memorial Hospital Department of Medicine	1/30/06

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	530022	A. BUILDING _____ B. WING _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 6TH ST GILLETTE, WY 82716

(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 331	Continued From page 10 medication) 50 milligram (mg) daily on 1/4/05 for resident #11. This order was continued unchanged every month through December 2005, a time period of 11 months. Review of the medication administration records (MARs) from January 4, 2005 through December 15, 2005 confirmed the resident received the medication. Review of the current care plan revealed an intervention developed on 1/17/05 to attempt a dosage reduction of psychotropic medications every six months per the facility's policy. According to the facility's 9/14/05 policy and procedure, "Restraint, Chemical," residents on antipsychotic medications "must receive gradual dose reductions, unless clinically contraindicated in an effort to discontinue use of such drugs." Further review revealed clinically contraindicated "means that a resident need not undergo a 'gradual dose reduction'...if: c. The resident's physician provides a justification why the continued use of the drug and the dose is clinically appropriate." Review of the entire medical record failed to show any attempt to reduce the dose or any documentation from the physician that the benefits the resident received from the psychotropic medication outweighed the risks of taking it. On 12/15/05 at 9:05 AM, interview with registered nurse (RN) #8 confirmed lack of the physician's statement.	F 331	meeting in January 2006 to in service the physicians on the federal requirements of ensuring that each resident who uses antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated in an effort to discontinue these drugs. D) A quality monitoring tool will be developed to track the use of unnecessary drugs and the documentation requirement by physicians to continue on antipsychotic drugs. The results of this monitoring will be completed monthly and reported quarterly to the Pioneer Manor Quality Assurance meeting by the Director of Nursing	
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	12/16/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 6TH ST GILLETTE, WY 82716

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F 363	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the facility menu, the facility failed to follow the menu serving sizes during one of two meal service observations for 17 residents receiving pureed diets. In addition, the menu being used for one of two meal observation was not approved by the registered dietitian, and 10 residents receiving high protein diets did not get additional protein on that day. The findings were: 1. Observation of the lunch meal service on 12/14/05 at 11:25 AM revealed staff used a #10 scoop (3.2 ounces) to serve the pureed cauliflower. An observation at 8:28 AM revealed staff used a #10 scoop to dish up the pureed lettuce salad that was also served. According to the menu, the cauliflower and lettuce salad for the pureed diets was listed as a 1/2 cup (4 ounce) serving. Interview with the dietary manager and the registered dietitian (RD) on 12/15/05 at 9:30 AM confirmed the serving size on the menu should be followed. Review of the week one winter, 2005 facility menu being used by staff, for Tuesday (12/13/05) revealed the only extra protein for residents on high protein diets was an extra egg (two eggs) at the breakfast meal. Interview with the RD on 12/15/05 at 8:30 AM revealed the menu being used for that day was different than the one she had signed and approved as nutritionally adequate. Observation of the approved menu for that day revealed extra protein was served at breakfast (two eggs), and an additional ounce of meat should have been served at both the lunch and supper meal.	F 363	F363 The facility will ensure that menus meet the nutritional needs of residents in accordance with the recommended dietary allowances, be prepared in advance and be followed. This will be accomplished by: A/B) A four week cycle of the current menu cycle will be reviewed by the Registered Dietician for nutritional adequacy based on RDA's. Flow sheets will be updated by the Registered Dietician for appropriate serving sizes including the pureed foods and extra protein requirements. Menu substitutions will be made per diet manual guidelines and documented by the dietary supervisor and reviewed and approved by the Registered Dietician. If inappropriate substitutions are identified by the RD, immediate education will be given to the cooks and supervisors C) In service training will be given by the dietician in the following areas to the appropriate dietary staff: cooks - appropriate serving sizes (small and large portions) based on the flow sheets, cooks and supervisors - determining appropriate menu substitutions, supervisors – responsibilities for approving menu substitutions and verifying correct portions served. D) A quality monitoring tool will be implemented utilizing the dietary supervisor's daily work flow sheet. The monitor will be completed monthly and reported quarterly at Pioneer Manor's Quality Assurance meeting by the dietary supervisor.	1/30/06

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

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F 363	Continued From page 12 Further interview with the RD confirmed it was her expectation that extra protein would be served at each meal of the day for those on high protein diets. In addition, she revealed there have been previous occasions where the menu has been changed with out her knowledge or approval.	F 363	F 364 The facility will ensure that each resident receives food prepared by methods that conserve nutritive value, flavor and appearance; and that food is palatable, attractive and at the proper temperature. This will be accomplished by: A/B) The nutritional supervisor will revise the food preparation time schedule and work assignments to allow for more appropriate cooking time to preserve quality and nutrients. C) In service training will be provided by the Registered Dietician and nutritional supervisor for the cooks to assure appropriate cooking methods are used when preparing vegetables in an effort to conserve nutrients. The RD and nutritional supervisor will review appropriate cooking times for vegetables and provide written guidelines for pureed food consistency. The cooks will be in serviced on available resources to utilize which includes steamer operating manual and "Food for Fifty". Additional equipment will be purchased to assist in preparing the pureed food. D) A quality monitoring tool will be developed and implemented to ensure residents receive food prepared by methods that conserve nutritive value flavor and appearance. This monitor will be completed monthly and reported quarterly at the Pioneer Manor Quality Assurance meeting by the dietary supervisor.	1/30/06
F 364 SS=C	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 and staff interview, the facility failed to ensure vegetables were prepared by methods to conserve nutritive value. The resident census was 121. The findings were: Observation on 12/14/05 at 8:12 AM revealed the cook was preparing the pureed items for the lunch meal. The cook spooned servings of cauliflower into a blender, as she touched the cauliflower with the spoon it was mushy. When asked the cook revealed they used frozen cauliflower, and she started it steaming that morning at about 7:30 AM. Further discussion revealed the cook usually started to puree items at about 8 AM for the lunch meal that was scheduled at 10:50 AM (4 hours, 50 minutes later). The cook pureed the cauliflower and put it back into the steamer where it continued to cook.	F 364		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	836022	A. BUILDING _____ B. WING _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 6TH ST GILLETTE, WY 82716

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F 364	Continued From page 13 At about 10:45 AM (3 hours and 16 minutes later) the cauliflower was taken out of the steamer and put into the steam table for service. A test tray of the regular and the pureed meals was done on 12/14/05 at 11:43 AM revealing the cauliflower on the regular tray was soft, not having much form, and mushy when touched with the fork. According to the 2006 twelfth edition of "Food For Fifty" by Mary Molt, the timetable for steaming frozen cauliflower is 5 to 15 minutes depending on the pounds per square inch of pressure delivered by the steamer. Additionally, the author states, "Proper preparation and cooking [of vegetables] are essential to preserving the nutritive value..." Interview with the dietary manager and registered dietician (RD) on 12/15/05 at 8:35 AM revealed they were unaware the foods for pureed diets were being cooked so far in advance. Further, the RD confirmed the pureed cauliflower had "no nutritional value" remaining after being cooked for such a long period of time.	F 364		
F 371 SS=F	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy, the facility failed to ensure proper handwashing techniques. In addition, the facility failed to develop or implement a system for identifying outdated health shakes. The findings were:	F 371		

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	535022	A. BUILDING _____ B. WING _____	12/15/2005

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PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

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F 371	Continued From page 14 1. The following concerns were noted with hand washing: a. Observation on 12/13/05 from 7:45 AM until 7:55 AM revealed dietary aide #1 was in the dishroom loading dirty dishes into the dishmachine while wearing disposable gloves. During the 10 minute observation the dietary aide went from handling the dirty dishes to handling clean dishes three times without changing gloves or washing her hands. b. Additional observation on 12/14/05 at 7:40 AM revealed dietary aide #1 was wearing disposable gloves while loading dirty dishes into the dish machine. Without removing the gloves, or washing her hands, the dietary aide went to the clean side of the dishmachine and put clean glasses onto a storage shelf. c. Observation on 2/13/05 at 10:25 AM revealed dietary aide #2 was wearing disposable gloves and arranging clean paper napkins next to a bin of clean silver ware. The dietary aide coughed into her hands twice, rubbed her nose, and without changing gloves or washing her hands continued to arrange the napkins. Subsequent observation at 10:35 AM revealed dietary aide #1 using the napkins to roll-up silverware for resident use. d. Observation on 2/14/05 at 8:35 AM revealed dietary aide #3 removing the garbage can lid to dispose of her soiled gloves. The dietary aide then proceeded to place pans of cooked cobbler onto a rack, and without washing her hands, put on new gloves and began to dish up servings of the cobbler onto plates. e. Review of the September 2005 facility policy on handwashing for nutrition services showed "Hands must be washed at the following	F 371	F 371 The facility will ensure that food is stored, prepared, distributed and served under sanitary conditions. This will be accomplished by: A/B) Staff will remove gloves and wash hands when moving from the dirty side of the dish room to the clean side. Dietary staff will dispose of gloves and wash hands and change gloves whenever they cough or sneeze into their gloved hand. If the clean dishes, utensils or napkins have been contaminated by the cough/sneeze particles, the napkins will be discarded and the dishes and/or utensils washed in the dishwasher and not used until properly sanitized. Staff will discard gloves, wash hands and put new gloves on before serving food or touching clean dishes if they have touched a garbage can. C) The in-service coordinator will provide all dietary staff with an in service on infection control precautions and procedures to be used in the dietary department. Areas to be covered include proper hand washing procedure and spread of germ through coughing and sneezing. The nutritional service manager will provide all dietary staff with an in-service on proper use of gloves in the department. D) A quality monitoring tool will be implemented to ensure food is stored, prepared and distributed and served under sanitary condition. The dietary supervisors will observe dietary staff for compliance with infection control policies of the dietary department. Data will be collected monthly and reported quarterly at the Pioneer Manor Quality Assurance meeting by the dietary manager.	1/30/06

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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1/13/06

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	535022	A. BUILDING _____ B. WING _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 6TH ST GILLETTE, WY 82716

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F 371	Continued From page 15 times...D. After blowing or wiping nose...E. After coughing or sneezing into hands or handkerchief... I. After handling garbage...N. Whenever going from dirty to clean end of dishmachine..." Interview with the dietary manager and registered dietitian on 12/15/05 at 8:35 AM confirmed it was their expectation that the policy on handwashing be followed at all times. According to Food Code 2005, U.S. Public Health Service, 2-301.14: Food employees shall clean their hands and exposed portions of their arms ...(E) After handling soiled equipment or utensils;...(H) Before donning gloves for working with food; and (I) After engaging in other activities that contaminate the hands. 2. The following concerns were noted with the dating of health shakes: a. Observation on 12/12/05 at 3:06 PM revealed in the walk in refrigerator there were two trays full of thawed cartons of health shakes (about 50 total). In addition, there were two cases containing cartons of partially frozen health shakes. None of the health shakes, the cases, or the trays were dated to indicate either an expiration date or a thaw date. According to the product information printed on each individual carton, the product should be discarded after 14 days of being thawed. b. Observation of the neighborhood 5 refrigerator on 12/12/05 at 5:05 PM revealed 14 thawed health shakes without a thaw date. A second observation of the refrigerator on 12/13/05 at 9:20 AM revealed 12 health shakes remained. c. Observation on 12/13/05 at approximately 5:15 PM revealed four undated health shakes in the resident refrigerator located off the main	F 371	all health shakes will be marked with date of expiration at the time taken out of the freezer. Dietary supervisors will monitor on a weekly basis. (added on 1/13/06 @ 1451 per phone with Sara Delahoyde, edun.)	

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	535022	A. BUILDING _____ B. WING _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 16 dining room. Interview at that time with a licensed practical nurse revealed she was unaware of how to tell if the health shakes were expired, she reported it was the dietary staffs responsibility. d. Observation on 12/15/05 at 8:25 AM revealed eight cartons of health shakes in a resident refrigerator located off the main dining room. None of the eight cartons had any date printed on them. e. Interview with the dietary manager on 12/12/05 at 3:10 PM confirmed dietary staff did not put any date on the health shakes, she said they knew when to discard them based on the manufacturer's date printed on the carton. However, when asked to point out that date she was unable to because it did not exist. Further interview with the dietary manager and dietitian on 12/15/05 at 8:35 AM confirmed health shakes were stored in other refrigerators in the facility, and nursing staff as well as dietary staff needed to know when the product was expired.	F 371		
F 429 SS=D	483.60(c)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities to the attending physician and the director of nursing. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policies and procedures, the facility failed to assure the pharmacist identified and reported irregularities to the physician and director of nursing (DON) for one (#11) of one sample residents with unidentified irregularities. The findings were:	F 429		

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F 429	Continued From page 17 According to the physician's orders, resident #11 was to receive Thorazine (antipsychotic medication) 50 milligrams (mg) daily and Ativan (antianxiety) 1 mg every six hours from 1/4/05 through 12/14/05. Review of the medication administration records (MARs) for that period of time confirmed staff administered the medications as ordered. Review of the entire medical record failed to reveal attempted dose reductions or a physician's statement that the benefits outweighed the risks of taking the psychotropic medications. Refer to F 329 and F 331 for additional information. Interview with registered nurse #8 on 12/15/05 at 8:05 AM confirmed lack of a physician's statement or attempted dose reductions. According to the facility's 8/14/05 policy and procedure, "Restraint, Chemical," both antipsychotic and antianxiety medications are psychopharmacologic drugs. Further review showed the pharmacy consultant "will review resident medication records on a monthly basis for documentation/justification for drug use and will recommend dosage reductions or modification" of psychopharmologic drugs. However, review of the monthly drug regimen reviews from January 2005 through December 2005 revealed the pharmacist did not identify the continued use of the medications as irregularities, even though a dosage reduction was not attempted nor was a physician's statement of benefits versus risks included in the medical record. Interview with pharmacist #8 on 12/15/05 at 8:45 AM confirmed she had not identified or reported the psychotropic medications as irregularities.	F 429	F 429 The facility will ensure that the pharmacist report any drug irregularities to the physician and the director of nursing. This will be accomplished by: A1) The pharmacist will perform a drug review on Resident #11 chart and will communicate with the attending physician and the director of nursing the need to evaluate the continued use of Thorazine. The physician will be asked to consider a dosage change or obtain a statement from the physician that the benefits outweigh the risks of taking the psychtropic medication. B) All charts for residents on psychotropic medications will be reviewed by the pharmacist to ensure irregularities are reported to the physicians and the director of nursing. If irregularities are identified by the pharmacist, this will be reported to the physician and the director of nursing and a request will be made to evaluate the continued use of the psychotropic drug or request documentation from the physician that the benefits outweigh the risks of taking it. C) The pharmacy department will be provided with updated federal regulations concerning drug regimen review. Drug irregularities will be discussed monthly at the Pharmacy meeting which includes the director of nursing, administrator, pharmacist and clinical supervisors. D) A quality monitoring tool will be developed to track the pharmacist compliance with reporting drug irregularities to the physician and the director of nursing. The results of this monitoring will be completed monthly and reported quarterly to the Pioneer	1/30/06
F 430	483.60(c)(2) DRUG REGIMEN REVIEW	F 430		

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

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	535022	A. BUILDING _____ B. WING _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

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F 430	Continued From page 18	F430 #429	Manor Quality Assurance meeting by the Director of Nursing.	
88=D	The pharmacist must report any irregularities and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policies and procedures, the facility failed to assure the physician acted upon reported irregularities for 2 (#87, #88) of 21 sample residents. The findings were: 1. According to the October 2005 physician's monthly recapitulation of orders, diagnoses for resident #88 included presenile dementia, depression, and agitation. Review of the December 2005 medication administration record confirmed the resident was receiving Haldol, Zoloft, Risperdal, and Buspar (all psychopharmacologic medications) as part of a treatment program. Review of the medical record revealed nursing staff had filled out a physicians interim order dated 8/8/05 that listed the aforementioned medications and asked the physician, "Do you wish to continue these medications at the same dosages?" and "Do you feel that the benefits outweigh the risks?" There was no response made by the physician on this order form, or any evidence of new orders for changes in dosages. According to the June 2004 consultant pharmacy services policy, procedures include: "e. communicating to the responsible physician, through nursing interim orders...". Interview with the director of nursing on 12/15/05 at 8:05 AM confirmed the lack of physician response to the request.			

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1/12/06

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PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 430	Continued From page 19 2. According to the physician's monthly recapitulation of orders, diagnoses for resident #87 included hypothyroidism, and the resident was on Synthyroid for control of the disease. Review of the monthly drug regimen reviews showed the pharmacist recommended the level of thyroid stimulating hormone (TSH) be obtained for the resident in March 2005. The physician did not indicate in any way that he was aware of the recommendation. The pharmacist made the same recommendation in April 2005. Again, there was no evidence the physician was aware of it. Review of the documented drug regimen review on 6/30/05 revealed the following note, "Please consider rechecking labs [laboratory work] due to pt's [patient's] fragile health. Also, Promethazine has not been used for >6 mo [above six months] - may we D/C [discontinue] this med [medication]?" Review of the drug regimen review note dated 7/20/05 revealed the request was repeated. There was no evidence the physician acted upon either request. A TSH level, finally completed on 8/3/05, showed a result of 5.68 (normal range - 0.27 to 4.20) which indicated the dose of Synthyroid was incorrect. According to the 19th edition of Taber's Cyclopedic Medical Dictionary, 2001, TSH levels are usually high in hypothyroidism. On 12/14/05 at 3:15 PM pharmacist #8 and registered nurse (RN) #9 agreed there was no evidence the physician read, or acted upon, the pharmacist's recommendations from March through July 2005. 3. Interview with pharmacist #8 and RN #9 on 12/14/05 at 3:20 PM revealed the facility had trouble getting physicians to sign the pharmacists' recommendations. The pharmacist questioned, "If the physicians don't respond, why do this?"	F 430	F 430 The facility will ensure that the pharmacist report any drug irregularities and these reports will be acted upon by the physician. This will be accomplished by: A1) The pharmacist will perform a drug review on Resident #88, findings from this drug review will be reported to the physician and director of nursing. Resident #88's Clinical Supervisor will visit with the physician and obtain any order changes for the psychopharmacological medications or documentation that the benefits outweigh the risks to continue the drug. A2) The pharmacist will perform a drug review on Resident # 87, findings from this drug review will be reported to the physician and director of nursing. If there is indication for the need of physician intervention at the time of the review, the Clinical Supervisor will visit with the physician and obtain the appropriate orders or documentation. B) All charts for residents with irregularities as identified by the pharmacist will be reported to the attending physician as well as the director of nursing. The clinical supervisors will visit with the attending physicians to assure follow up is obtained by the attending physician. C) The pharmacist, director of nursing and administrator will attend the January 2006 Campbell County Memorial Hospital Department of Medicine monthly meeting to discuss the physician's responsibility of addressing irregularities as identified by the pharmacist in a timely manner. Drug irregularities will be discussed at the monthly Pharmacy meeting. The	1/30/06

F430

committee will also review physician documentation and follow up from pharmacy reports.

D) A quality monitoring tool will be developed to track the physician compliance to responding to irregularities identified by pharmacy. The results of this monitoring will be completed monthly and reported quarterly to the Pioneer Manor Quality Assurance meeting by the Director of Nursing. Results will also be made available to the medical director.

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

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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
	535022	A. BUILDING _____ B. WING _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 454	Continued From page 20	F 454	F 454	
F 454 SS=E	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a Christmas display in the main lobby was maintained in a safe manner. The findings were: Observation on 12/12/05 at 5:30 PM and again on 12/14/05 at 6:45 PM revealed a Christmas display in the main lobby next to the resident's television. The display consisted of a lighted artificial Christmas tree approximately six feet tall, and a stand-alone lighted artificial wreath approximately five feet tall. The electric cord extending from the wreath was plugged into an orange extension cord, which was in turn plugged into a surge protector (#1). Surge protector #1 was plugged into another surge protector (#2) which was plugged into a single electrical wall outlet behind the television. According to the National Fire Prevention Association, Electric Code (NFPA 70), piggy backing extension cords is not acceptable. Interview with the administrator on 12/15/05 at approximately 10:45 AM confirmed the extension cords and surge protectors should not have been used.	F 454	The facility will ensure the design, construction, equipment and maintenance is kept up to code to protect the health and safety of residents, personnel and public. This will be accomplished by: A/B) Surge protector #1 was unplugged from surge protector #2. The plant operations department will survey the entire facility for inappropriate use of surge protectors. C) The administrator will inservice staff on the appropriate use of surge protectors and that piggybacking extension cords is not acceptable. D) A quality monitoring tool will be implemented to assure extension cords/surge protectors are used appropriately. This monitor will be completed monthly and reported quarterly at the Pioneer Manor Quality Assurance meeting by the Plant Operation Technician.	1/30/06