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535033	A. BUILDING _____ B. WING _____	02/23/2007

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F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to assure personal privacy during care for one (#25) of 12 open sample residents and one (#36) non-sample resident. The findings were:	F 164	483.10(e), 483.75(1) (4) Privacy and Confidentiality: The facility will ensure the resident's right to personal privacy and confidentiality. This standard will be accomplished by the following: (including but not limited to): A) A mandatory in-service for all CRCC employees regarding Resident Rights will be conducted the third Wednesday of March. The agenda will include review of the privacy policy including curtain/door closed for invasive techniques. Individual in-services for nursing staff caring for resident #25 and resident #36 will be conducted to assure that the privacy and confidentiality will be ensured. A quality monitoring tool (Attachment # 1) will be utilized to ensure that residents # 25 and # 36 are provided with privacy and confidentiality. B) A quality monitoring tool will be completed on random residents every week regarding resident privacy and confidentiality (personal privacy, no body parts are to be unnecessarily exposed, only staff directly giving care or treatment are to be present, privacy is maintained for personal care, residents have the right to visit with others in privacy, right to	~~3/21/07~~

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

Administrator 3-15-07

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.

RECEIVED
MAR 19 2007
Wyoming Dept of Health
Licensing and Surveys

Accepted, Reviewed with Changes; per conversation w/ ADON Crystal Hawkes. on 3/22/07 @ 10AM
DOC - 4/9/07
Sheila Russo, RD

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F 164	Continued From page 1 Observation during the initial tour on 2/20/07 at 3:10 PM revealed the corridor door to room #12 was shut. Inside the room, resident #36 was inside the bathroom, seated on the toilet, with the bathroom door shut. Without knocking, certified nurse aide (CNA) #1 opened the corridor door and came inside the room. Then, without knocking, the CNA opened the bathroom door. Upon seeing the resident on the toilet, the CNA said "Oh, sorry, I didn't know anybody was in here," and shut the door. On 2/22/07 at 4:21 PM the resident stated "some do" when asked if staff knock on doors before entering resident rooms or bathrooms. During an interview with the assistant director of nursing on 2/23/07 at 9:30 AM, she stated that staff were expected to knock on resident doors prior to entering. Observation on 2/21/07 at 4:30 PM revealed registered nurse (RN) #1 raised the blouse of resident #25 in her room and injected insulin into his/her abdomen . Observation further revealed the RN did not close the door or pull the curtain shut to protect the resident ' s privacy. Review of the facility policy, undated, on medication administration revealed instructions that included " Curtain/door closed for invasive techniques. " Interview with the assistant director of nursing on 2/23/07 at 9:30 AM verified that the facility's expectation was that the RN should have closed the door or pulled the curtain to protect the resident ' s privacy.	F 164	privacy regarding mail, information regarding the resident is confidential, including medical and financial). 4/9/07 C) The results of the Quality Monitoring Tool will be reported to the Quality Assurance Committee. 4/9/07 D) The Director of Nursing Services is responsible for compliance with this standard. This refers to who will Conduct the monitoring & Report to QA. This is Consistant throughout the POC.	
F 170 SS=C	483.10(i)(1) MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.	F 170	483.10(i)(1) Mail: The facility will ensure the resident's right to privacy in written communications, including the right to send and promptly receive mail this is unopened will be provided. This standard will be accomplished by (including but not limited to):	

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F 170	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and resident interview, the facility failed to assure residents received mail delivery on Saturdays. The findings were: Observation on 2/20/07 at 5:05 PM revealed a sign at the front office that read "No mail delivery on Saturday." During a confidential interview on 2/21/07 at 3:15 PM, ten residents stated they only received mail Monday through Friday. On 2/22/07 at 8:50 AM, the activity director stated the administrative assistant was the person who delivered mail to residents. During an interview on 2/22/07 at 8:52 AM, the administrative assistant stated she delivered mail to residents Monday through Friday. She stated the community received mail on Saturdays, but the facility did not receive mail on Saturdays because there was no office staff working to receive it.	F 170	A) Residents will receive mail Monday through Saturday at Castle Rock Convalescent Center (CRCC). During the week days the Administrative Office staff will receive and deliver the mail to the residents. On Saturday the Activities Department will pick up CRCC resident' mail from the Villa and deliver it to the residents. B) A quality measuring tool (Attachment # 2) will be completed every week to assure that mail is being delivered to CRCC residents. C) The results of the quality monitoring tool will be reported to the Quality Assurance Committee. D) The Director of Nursing Services is responsible for compliance with this standard.	4/9/07 4/9/07 4/9/07
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;	F 272	483.20, 483.20(b) Comprehensive Assessments: The facility will ensure that initially and periodically residents will receive comprehensive and, accurate assessments. This standard will be accomplished by (including but not limited to): A) Resident #12 will receive a comprehensive assessment including a safety assessment to determine that less restrictive safety measures	

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F 272	Continued From page 3 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 observation, staff interview, and medical record review, the facility failed to ensure a comprehensive assessment of all identified problems was completed for three (#5, #7, #12) of 12 sample residents and 2 closed records. The findings were: Observation on 2/21/07 at 7:45 AM and at 1:25 PM revealed resident #12 was in bed. There were two half middle side rails up on both sides of the bed. Review of physician's orders revealed that on 2/14/07 side rails were ordered. Review of a 2/15/07 care conference note showed the resident's family had requested the side rails. The facility staff documented concern that side rails could cause harm. Review of a 2/20/07 fall progress note documented, "per family request middle side rails are ordered per Dr._____	F 272	are effective and assessment of the risks and benefits for the use of assistive devices. A comprehensive assessment will be completed on resident # 12 (Attachment # 3: Comprehensive Assessment for Use of Restraints or Assistive Devices). . Resident # 12 will be reviewed quarterly and as status changes by the Restorative Nurse and the IDT team. B) A quality monitoring tool (Attachment # 4) will be completed each month on random residents regarding completion of appropriate assessments for restraints and assistive devices. C) The results of the quality monitoring tool will be presented to the Quality Assurance Committee. D) Resident # 5 received a Pain Assessment Worksheet and a Pain Assessment Initial Guide. He will receive his quarterly review assessment of pain control as well as when he has an increase in his pain. E) A quality monitoring tool will (Attachment #5) will be completed monthly on random residents to assure that pain management is being addressed effectively. Inservicing will be provided to IDT team + Rehab team on assessments for pain, Restraints	4/9/07 4/9/07 4/9/07 2/28/07 4/9/07

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F 272	Continued From page 4 for safety..." Review of the authorization for the use of the side rails dated 2/15/07 showed "...per Castle Rock policy, a comprehensive assessment, including a safety assessment has been completed and that less restrictive measures have been evaluated for effectiveness..." Review of the medical record, however, revealed no comprehensive assessment to determine whether or not side rails were the least restrictive safety intervention for this resident. Furthermore, the facility had not evaluated the effectiveness of prior interventions. During an interview on 2/22/07 at 2:50 PM, the assistant director of nursing (ADON) stated the side rails were in use for this resident because of family insistence. The ADON stated, "I don't think the facility feels side rails are in the best interest of the resident." During an interview on 2/22/07 at 4:35 PM, the nurse responsible for physical restraints (licensed practical nurse #8) stated the family had requested the side rails. She further stated there had been no comprehensive assessment of the risks and benefits of the rails. Review of the 10/2/06 initial and the 12/27/07 quarterly Minimum Data Set (MDS) assessments for resident #5 revealed s/he experienced moderate pain in his/her feet and legs daily. Review of the medical record revealed the facility completed a pain assessment on 9/25/06 that indicated the resident had pain in both feet. Review of the 1/15/07 first quarter MDS summary revealed the resident had an order dated 11/26/06 for MS Contin (narcotic pain medication - Morphine) 30 milligrams (mg) every morning. Further review of this document revealed the MS Contin 30 mg was increased to twice daily on 12/14/06. Review of the 2/07 physician ' s orders	F 272	F) The results of the quality monitoring tool will be presented to the Quality Assurance Committee. G) Resident # 7 will receive a Comprehensive Assessment for Use of Restraints or Assistive Devices. Resident # 7 will be reviewed quarterly and as status changes by the Restorative Nurse and the IDT team. H) Results of quality monitoring tools will be reported to Quality Assurance Committee I) The Director of Nursing Services is responsible for compliance with this standard.	4/9/07 4/9/07 4/9/07

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F 272	Continued From page 5 revealed the MS Contin 30 mg was increased to three times per day on 1/23/07. Review of the entire medical record revealed there had been no pain assessment since the initial admission assessment despite the need for increased pain medication twice within four months. Interview with the ADON on 2/23/07 at 9:230 AM and the director of nursing on 2/23/07 at 11:15 AM confirmed there should have been a quarterly pain assessment completed. Review of the 11/1/06 quarterly MDS assessment revealed resident #7 had a trunk restraint (lap cushion). Periodic observations from 2/21/07 through 2/23/07 revealed the resident was restrained with a lap cushion (lap "buddy") when in a wheelchair. Interview with LPN #8 on 2/22/07 at 5:15 PM confirmed the resident utilized a lap buddy restraint whenever s/he was in a wheelchair. Review of the restraint progress notes of 6/29/06 revealed the lap buddy was placed after the resident fell on 6/28/06. Review of the entire medical record revealed there had been no comprehensive assessment to include risks vs. benefits for the utilization of this type of restraint.	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, staff interview, medical record review, and review of facility policies, the facility failed to ensure physician's orders were followed for 1 (#5) of 12 sample residents. In addition, the facility failed to ensure staff followed	F 281	483.20(k) (3)(i) Comprehensive Care Plans: The facility will ensure the resident's right to privacy in written physician orders is followed. This standard will be accomplished by (including but not limited to): A) Resident # 5 weights will be monitored and reported to the physician on a weekly basis as ordered by the physician. The weight flow sheet will be monitored weekly through a quality monitoring tool (Attachment #6). B) An in-service on will be provided for nursing staff, regarding effective monitoring of residents on diuretics and following physician orders.	4/9/07 3/14/07 3/28/07

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F 281	Continued From page 6 professional standards for medication labeling and storage on 1of 2 medication carts. The findings were: 1. Review of the 1/15/07 first quarter Minimum Data Set (MDS) summary for resident #5 revealed the resident experienced fluctuating edema of the lower extremities. Review of the 10/2/06 initial MDS assessment documented the resident's edema. Review of the 10/2/06 nutritional assessment revealed the resident had 2 to 3+ edema in both lower extremities. Review of the 10/9/06 nutritional assessment revealed the resident had trace to moderate fluctuating edema to both of the lower extremities. Review of the 12/26/06 quarterly nutritional assessment revealed the resident had fluctuating up to 2+ edema in both lower extremities. Review of the 2/07 physician's orders revealed an order dated 11/9/06 for staff to obtain the resident's weight every other day. The following concerns were identified: a. Review of the weight records revealed it was eight days (11/17/06) before the resident was initially weighed after the 11/9/06 order for "every other day" weights. b. Review of the weight records revealed there were 16 incidents from 11/17/06 through 2/20/07 in which the resident was not weighed "every other day." Review of the weight records revealed the elapsed time between weights ranged from 3 to 10 days. c. Interview with the assistant director of nursing (ADON) on 2/23/07 at 9:30 AM revealed she was unsure of the reason weights were not taken as ordered by the physician. According to the Wyoming Nursing Practice Act, July 2003, and Administrative Rules and	F 281	C) A quality measuring tool (Attachment #6) will be completed every month to evaluate residents on diuretics and ensure that physician orders are being followed. D) The quality monitoring tool will be reported to the Quality Assurance Committee. E) The Director of Nursing Services is responsible for compliance with this standard.	4/9/07 4/9/07

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F 281	Continued From page 7 Regulations, November 2003, page 3-6, nurses function under the direction of a licensed physician. 2. Observation of one medication cart during medication pass on 2/20/07 from 5:05 PM until 5:35 PM revealed there was a 30 cc (cubic centimeters) vial of Heparin (anticoagulant) flush medication placed on top of the cart. Observation further revealed the vial did not have the date it was opened or the resident's name on the label. Review of the facility's undated policy on medication administration revealed labels were to include name of drug, strength, expiration date and resident name. In addition, multi-dose vials were to be labeled with the date the vial was opened and were considered expired 28 days after that date. Review of the undated facility policy regarding medication carts, revealed instructions that included all medications be clearly labeled with the resident's name and medications in vials must be dated and initialed when opened. Interview with registered nurse #1 on 2/20/07 at 5:35 PM revealed the vial of Heparin flush was labeled on the box when it was received from the pharmacy. She stated nursing had removed the vial from the box and placed it on top of the medication cart for later use. She also stated the medication should have been labeled with the resident's name and dated when it was removed from the box and opened. According to "Clinical Nursing Skills," Sixth Edition, by Smith, Duell, and Martin, 2004, page 527: "Clearly label ...medicines... and Keep all medicines in locked carts or cabinets."	F 281		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility	F 282	483.20(k)(3)(ii) Comprehensive Care Plans The facility will assure the services provided by the facility will be provided by qualified person's according to the resident's plan of care. This will be accomplished by (including but not limited to): A) Restorative nurse will inform all nursing staff verbally and in writing of the up-to-date toilet program. For resident #44. A quality assurance tool regarding toileting for resident # 44 will be completed each week to assure that the care plan is being followed.	4/9/07

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F 282	Continued From page 8 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 interview, the facility failed to assure care was provided in accordance with the written plans of care for 2 (#20, #44) of 12 sample residents. The findings were: Review of the 1/5/07 significant change Minimum Data Set (MDS) assessment showed resident #44 was incontinent of bladder multiple times daily. According to the current care plan (revised 2/14/07), the resident was on a prompted toilet program and staff were to assist the resident to the toilet every two to three hours. However, observation on 2/21/07 from 7:01 AM until 10:40 AM showed the resident was not checked for incontinence, nor taken to the toilet. At 10:40 AM, certified nurse aide (CNA) #2 and student nurse #1 assisted the resident to the toilet. The CNA stated staff wrote the time the resident was checked for incontinence on the incontinence brief. Observation of the brief and interview with the CNA at that time revealed the resident was last checked at 6:40 AM (4 hours earlier). The CNA stated the resident's brief was "damp". During an interview on 2/23/07 at 8:10 AM, the assistant director of nursing (ADON) stated the care plan was current.	F 282	B) In addition a quality measuring tool will be completed every week on a random number of residents to assure all residents are being toileted according to their plan of care. C) Results of the quality management tools will be reported to the Quality Assurance Committee. D) An in-service will be provided on March 28, 2007 to review the bowel and bladder policies and stress the importance of following the plan of care for all residents E) The Director of Nursing Services is responsible for compliance with this standard.	4/9/07 4/9/07 3/28/07
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315	483.25(d) Urinary Incontinence: The facility will ensure that resident's who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and restore as much normal bladder function as possible. These actions will be accomplished by (including but not limited to):	

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F 315	Continued From page 9 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of facility policies, the facility failed to ensure appropriate care was provided to promote continence to the extent possible for 2 (#20, #44) of 12 sample residents with incontinence. The findings were: Review of the 8/15/06 annual, the 9/18/06 significant change, and the 12/13/06 quarterly MDS assessments for resident #20 revealed the resident was incontinent of bladder all or almost all of the time and required extensive assistance of staff for incontinence care. Review of the 12/21/06 care plan for self care deficit revealed the resident was on a scheduled toileting program which required assistance to and from the toilet every 2.5 to 3 hours and as requested. The following concerns were identified: a. Observation on 2/21/07 at 8:10 AM revealed the resident ' s incontinence brief was wet with urine. Observation of the incontinence brief revealed it was dated as last changed at 4 AM.There was no evidence the resident was checked or changed from 4 AM until 8:10 AM (4 hours and 10 minutes). b. Interview with licensed practical nurse #11on 2/21/07 at 8:10 AM confirmed there was no evidence the resident had been checked or	F 315	A) Restorative nurse will verbally and in writing inform and instruct the nursing staff regarding the toileting schedules of residents # 20 and resident # 44. A quality measuring tool (Attachment #8) will completed weekly regarding toileting for resident #20 and resident # 44. B) A quality measuring tool will be completed every week on a random number of residents to ensure that all resident are receiving appropriate care of their bowel protocol. Bowel & bladder C) The results of the quality measuring tool will be reported to Quality Assurance Committee. D) An in-service will be completed on March 28, 2007. The agenda will include the importance of toileting residents per plan of care, providing appropriate peri-care, catheter care, bowel and bladder policy (prompted toileting) and prevention of UTIs. E) The Director of Nursing Services is responsible for compliance with this standard.	4/9/07 4/9/07 4/9/07 3/28/07

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F 315	Continued From page 10 changed since 4 AM. Review of the 1/5/07 significant change Minimum Data Set (MDS) assessment showed resident #44 was incontinent of bladder multiple times daily. The 1/5/07 Resident Assessment Protocol (RAP) for incontinence documented the resident relied on staff for toileting cares and was on a prompted toileting program. According to the current care plan (revised 2/14/07), the resident was on a prompted toilet program and staff were to assist the resident to the toilet every two to three hours. During an interview on 2/23/07 at 8:10 AM, the assistant director of nursing (ADON) stated the care plan was current. Observation on 2/21/07 from 7:01 AM until 10:40 AM showed the resident was not checked for incontinence, nor taken to the toilet. At 10:40 AM, certified nurse aide (CNA) #2 and student nurse #1 assisted the resident to the toilet. The CNA stated staff wrote the time the resident was checked for incontinence on the incontinence brief. Observation of the brief and interview with the CNA at that time revealed the resident was last checked at 6:40 AM (4 hours earlier). The CNA stated the resident's brief was "damp". Review of the 2/8/05 facility policy on scheduled toileting revealed scheduled voiding was suppose to be a program that involves toileting the resident at regular and fixed intervals, usually every 2 hours with the goal of preventing an incontinent episode. In addition, the policy documented that the goal was for the staff to intervene and toilet the resident prior to involuntary urine loss, thus keeping the resident dry.	F 315		
F 323 SS=D	483.25(h)(1) ACCIDENTS	F 323	483.25(h)(1) Accidents: The facility will ensure that the resident's environment remain free of accident hazards. This standard will be accomplished by (including but not limited to):	

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F 323	Continued From page 11 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, review of facility policy, and staff interview, the facility failed to ensure one of two medication carts were free of safety hazards. The findings were: Observation of one of the medication carts during a medication pass on 2/20/07 from 5:05 PM until 5:35 PM revealed there was a 30 cc (cubic centimeters) vial of Heparin (anticoagulant) flush medication placed on top of the cart. Observation during that time revealed the medication cart was located outside the dining room in the resident lobby area. Observation further revealed residents were passing by the medication cart on their way into the dining room and had access to the vial of medication while the cart was unattended at 5:05 PM, 5:10 PM, 5:15 PM, and 5:30 PM. Review of the facility's policy on medication administration revealed all drugs and biologicals were to be stored in locked compartments. Interview with registered nurse #1 on 2/20/07 at 5:35 PM stated the vial of Heparin flush should have been placed in a locked drawer. According to "Clinical Nursing Skills" by Smith, Duell, and Martin, Sixth Edition, 2004, page 257: "Keep all medicines in locked carts or cabinets." According to "Medication Guide for the Long-Term Care Nurse" by Thomas R. Clark, RPh, MHS, Sixth Edition, page 67: "...medications should not be left on top of the medication cart."	F 323	A) Nursing staff will be in-serviced on safe medication pass and the appropriate storage of medications. B) A quality measuring tool (Attachment # 7) will be completed monthly to ensure that the nurses are following standards of practice for administration of medications. C) The results of the quality measuring tool will be reported to the Quality Assurance Committee. D) The Director of Nursing Services is responsible for compliance with this standard.	4/9/07 4/9/07 4/9/07

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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 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	F 334	483.25 (n) Influenza and pneumococcal immunization. The facility will ensure that the policies for influenza/pneumonia immunizations are followed. This will be accomplished by (but not limited to): A) Develop a policy. on Immunizations and educational 3/12/07 ~~3/12/07~~ all concents. B) Provide residents and their family members with educational information regarding flu/pneumonia vaccine. prior to next vaccination Including Resp. #5, 10, 25, 28, 38, 4/9/07 C) Prior to receiving immunizations, residents and family members will be provided documentation consent forms. 4/9/07 D) A quality monitoring tool (Attachment # 9) will be completed each month during the recommended time period when the vaccines are being given. 4/9/07 E) The Quality Assurance Committee will monitor this tool. 4/9/07 F) The Director of Nursing Services is compliant with the standard.	

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F 334	Continued From page 13 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 by: Based on medical record review and staff interview, the facility failed to assure the medical record contained documentation of education for influenza vaccinations for five (#5, #10, #25, #28, #38) of five sample residents reviewed for vaccination status. The findings were: 1. Review of nursing notes showed on 10/18/06 resident #38 received the influenza vaccine. Further review of the medical record showed no documentation the resident (or family) received	F 334		

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F 334	Continued From page 14 education regarding the vaccination. 2. Review of nursing notes showed on 10/20/06 resident #28 received the influenza vaccine. The nursing notes did not document the resident (or family) received education regarding the vaccination. The medical record did contain an influenza vaccine consent form dated 10/14/04, however the form was not signed. 3. Review of the nursing notes showed resident #5 received the influenza vaccine on 10/18/06. Review of the entire medical record revealed there was no evidence the resident or family received education regarding the vaccination. 4. Review of the nursing notes revealed resident #25 received the influenza vaccine on 10/18/06. Review of the entire medical record revealed there was no evidence the resident or family received education regarding the vaccination. 5. Review of the nursing notes for resident #10 revealed s/he received the influenza vaccine on 10/18/06. Review of the medical record revealed there was no evidence the resident or family received education regarding the vaccination. On 2/22/07 at 2:50 PM, the assistant director of nursing (ADON) stated the medical records did not contain documentation of education for vaccinations.	F 334		
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.	F 371	483.35 (i)(2) **Sanitary Conditions – Food prep and services: The facility will ensure that the food will be stored, prepared, and served under sanitary conditions. This standard will be accomplished by (including but not limited to):**	

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F 371	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure all food items were covered and labeled during two of two observations of the reach-in refrigerator and freezer. In addition, the facility failed to ensure there were no expired food items during one of one observations of the walk-in refrigerator. The findings were: 1. Observation of the kitchen on 2/20/07 at 3:15 PM revealed there were five uncovered and unlabeled bowls of ice cream in the reach in freezer. In addition, there was one dixie cup of ice cream that was broken on the edge exposing the ice cream product to the environment. Observation of the reach-in refrigerator at this same time revealed there were 10 pudding cups, 13 glasses of milk, 2 glasses of grapefruit juice, one glass of apple juice, and two bowls of prunes that were uncovered and unlabeled. Observation on 2/21/07 at 10:30 AM revealed there were 4 uncovered and unlabeled, bowls of ice cream in the reach in freezer. Observation also revealed there were seven glasses of orange juice and four bowls of pudding uncovered and unlabeled in the reach-in refrigerator. Interview with the registered dietitian (RD) at that time confirmed all food items should have been covered and labeled. According to page 75 of the 2001 U.S. Public Health Service Food Code section 3-602.11 Food Labels, "(A) FOOD PACKAGED in a FOOD ESTAHLISHMENT, shall be labeled as specified	F 371	A) 1. The Dietary staff will be in-serviced by the RD and the Dietary Manager on: a. Proper covering, labeling and dating of all stored foods and beverages. b. Proper disposition of out-of-date items. B) Periodic refrigerator audits will be conducted to identify that all stored foods and beverages are properly covered, labeled, and dated. a. No out-of-date items are in the refrigerators. C) Audits will be reviews by the QA committee quarterly. D) The RD is responsible for the implementation of these procedures.	4/9/07 4/9/07 4/9/07

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F 371	Continued From page 16 in LAW, including 21 CFR 101- Food Labeling, and 9 CFR 317 Labeling, Marking Devices, and Containers. (B) Label information shall include: (1) The common name of the FOOD..." According to pages 48-49 of the 2001 U.S. Public Health Service Food Code section 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. " (A) FOOD shall be protected from cross contamination by: (4) ....storing the FOOD in packages, covered containers, or wrappings; " 2. Observation of the walk-in refrigerator on 2/21/07 at 10:45 AM revealed there were two cartons of cultured lowfat buttermilk that had expired on 2/15/07 and 2/18/07, respectively. Interview with the RD at that time revealed the cartons should have been discarded or labeled "do not use." According to page 69 of the 2001 U.S. Public Health Service Food Code section 3-501.18 Ready-to-Eat, Potentially hazardous Food, Disposition. "(A) A FOOD specified in 3-501.17 (A) or (B) shall be discarded if it: (1) Exceed either of the temperature and time combinations ..."	F 371		
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by:	F 444	483.65(b)(3) Preventing Spread of Infection: The facility will ensure that all staff members wash their hands after each direct contact with residents for which hand washing is indicated by accepted professional practice. This standard will be accomplished by (including but not limited to):	

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F 444	Continued From page 17 Based on observation, facility policy and procedure review, and staff interview, the facility failed to ensure accepted handwashing practices were followed during four random observations. The findings were: 1. Observation on 2/20/07 at 5 PM revealed licensed practical nurse (LPN) #8 picked a nasal cannula up off the floor in the dining room and placed it on a concentrator. Continued observation revealed she then returned to the medication cart and prepared medications for non sample resident #53 without washing her hands. Interview with the assistant director of nursing (ADON) on 2/23/07 at 9:30 AM revealed the LPN should have washed her hands prior to administering the next resident's medications. 2. Observation on 2/20/07 at 5:10 PM revealed LPN #8 placed two medications (Senna S-laxative and Sertraline HCL-antidepressant) in the hand of non sample resident #35. The resident then dropped the Senna S tablet on the floor. Observation revealed LPN #8 felt around with her hands on the floor underneath the medication cart to find the dropped medication. Once the medication was found the LPN discarded it, but did not wash sanitize her hands prior to administering the resident another Senna S tablet. Interview with the ADON on 2/23/07 at 9:30 AM revealed the LPN should have washed her hands prior to administering the next resident's medications. 3. Observation on 2/21/07 at 5:35 PM revealed LPN #12 dropped a Methodone HCL (narcotic analgesic) tablet in the bottom of the medication cart drawer. Observation revealed LPN #13 searched in the drawer and picked up the tablet, placed it into the medication cup and LPN #12 administered it to non sample resident #29.	F 444	A) A Nursing/CNA in-service will be provided March 28, 2007 to address appropriate hand washing and hand washing and indications for hand washing. The agenda will include infection control, appropriate hand washing techniques, washing hands after each contact with a resident, washing hands after utilizing resident's equipment, appropriate handling of dropped medications including hand washing or sanitation, and when to change gloves during care of residents. B) A quality measuring tool (attachment # 9) will be completed every week to ensure that hand washing is being appropriately completed. C) The results of the quality measuring tool will be reported to the Quality Assurance Committee. D) The Director of Nursing Services is responsible for compliance with this standard.	3/28/07 4/9/07 4/9/07

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F 444	Continued From page 18 Observation revealed LPN #13 did not wash or sanitize her hands prior to or after retrieving the medication from the bottom of the drawer. Interview with the ADON on 2/23/07 at 9:30 AM revealed the LPN should have washed or sanitized her hands prior to administering the next resident's medications. 4. Review of the undated facility policy on medication administration revealed instructions that included "Use Antibacterial gel between residents....", "Do not touch medication with your bare hands...." "If a pill or pills are dropped on the floor, discard them..., AND WASH YOUR HANDS." 5. Observation on 2/21/07 at 8:10 AM revealed LPN #11 reached into the incontinence brief of resident #20 to check for incontinence. The LPN stated the resident was incontinent of urine. Continued observation revealed the LPN then sat the resident on the edge of the bed and removed the nasal cannula from his/her nose. Observation revealed the LPN did not remove her soiled gloves used to check for incontinence prior to removing the nasal cannula from the resident's nose. Interview with the ADON on 2/23/07 at 9:30 AM revealed the LPN should have removed her gloves and washed her hands after checking the resident's incontinence brief and prior to performing other personal care. 6. Review of the facility hand washing policy dated 1/30/96 revealed instructions that included "Employees should always wash their hands: 1. Before and after performing invasive procedures." The policy also instructed employees to "Always wash your hands: 1. After handling a resident and ...belongings.	F 444		
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in	F 492	483.75 (b)Administration. The facility will ensure that we are compliant to the Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services. This standard will be accomplished by (but not limited to):	

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F 492	Continued From page 19 compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure certified nurse aides (CNAs) only performed tasks which were within their scope of practice according to the Wyoming Board of Nursing for one (#12) of 12 sample residents. The findings were: Review of physician's orders showed resident #12 was ordered "Albuterol 0.083% sol inh inhalation" every four hours. Observation on 2/21/07 at 7:45 AM showed the resident was in bed, receiving a nebulizer treatment via an oxygen mask. At 7:46 AM, CNA #2 entered the resident's room. The CNA took the mask off the resident's face, and shut off the machine (discontinuing the treatment). The CNA then asked the surveyor if that was within his/her scope of practice. During an interview with the assistant director of nursing on 2/23/07 at 9:30 AM, she stated CNA's were not allowed to discontinue nebulizer treatments. She further stated the CNA should have called the nurse to discontinue the treatment. Review of the Wyoming Board of Nursing Nursing Practice Act (July 2005) and Administrative Rules and Regulations (November 2003), Chapter VII Certified Nursing Assistant/Nurse Aide, showed discontinuing a nebulizer treatment was not a	F 492	A) All CNA staff will be in-serviced on scope of practice. B) Scope of practice will be reviewed at CNA orientation. C) A quality monitoring tool (Attachment #11) to ensure scope of practice is being followed by the CNA's will be completed monthly. D) The quality monitoring tool will be reported to the Quality Assurance Committee. E) Director of Nursing will be responsible for implementation.	~~3/28/07~~ 4/9/07 4/9/07 4/9/07

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F 492 F 507 SS=D	Continued From page 20 basic nursing function that may be delegated. 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 medical record review and staff interview, the facility failed to assure all laboratory results were filed in the medical record for one (#28) of 12 sample residents and 2 closed records. The findings were: Review of physician orders for resident #28 showed a liver panel (laboratory test) was ordered every four months. Review of laboratory results in the medical record showed the last liver panel was dated 9/5/06. On 2/22/07 at 5:26 PM, after looking through the medical record, the assistant director of nursing (ADON) confirmed the last liver panel results in the medical record was dated 9/5/06. The ADON looked at the laboratory scheduling calendar and said another liver panel was drawn on 1/5/07. On 2/23/07 at 8:10 AM, the ADON showed the surveyor a copy of the 1/5/07 liver panel laboratory results. The ADON stated she had requested the laboratory fax the facility a copy of the results.	F 492 F 507	483.75(j) 23)(iv) Laboratory Services: The facility will ensure that resident's clinical record laboratory reports are dated, contain the name and address of the testing laboratory, and are filed in the residents chart. This standard will be accomplished by (including but not limited to): The lab Result for res #28 was placed in the medical Record. A) Periodic audits (Attachment # 12) will be conducted to assure that results from labs that are drawn are received and placed in the chart in a timely manner. B) A quality monitoring tool (Attachment #13) will be completed each month on a random number of residents regarding compliance to laboratory reports. C) Reports of the quality monitoring tool will be reported to the Quality Assurance Committee. D) The Director of Nursing Services is compliant with the standard.	4/9/07 4/9/07 4/9/07