10/28/10 acceptable POC, approved

MENT OF HEALTH AND HUMAN SERVICES
RS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

| ENT OF DEFICIENCIES AN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535038 | A. BUILDING _____ B. WING _____ | 09/15/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ROCKY MOUNTAIN CARE - EVANSTON | 475 YELLOW CREEK ROAD EVANSTON, WY 82930 |

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| F 000 | INITIAL COMMENTS<br><br>The following common abbreviations and acronyms are used throughout this document:<br><br>RN - Registered Nurse<br>DNS - Director of Nursing Service<br>CNA - Certified Nursing Assistant<br>LPN - Licensed Practical Nurse<br>MDS - Minimum Data Set<br>SDC - Staff Development Coordinator, who is also the interim MDS coordinator<br>RAP - Resident Assessment Protocol<br><br>Less commonly used abbreviations will be annotated in each deficiency where used. | F 000 | **F 226**<br><br>The facility will follow policy and procedure that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This will be achieved by : | 10/25/2010 |
| F 226 SS=D | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, staff interview, review of policies and procedures, and review of facility investigations, the facility failed to perform a thorough investigation for 1 of 3 known allegations requiring investigation. The facility failed to investigate an allegation for resident #31 that involved misappropriation of property. The findings were:<br><br>During a review of the medical record for resident #31, a nurses note written on 8/14/10 showed a family member reported the resident's wedding ring had been missing since 8/8/10. The note also | F 226 | 1. An informal, undocumented investigation was completed on the missing ring for resident #31 by the Administrator. The investigation included staff interviews, family interview, room searches (including resident #31's room and other rooms in the area, dining room, activity room, laundry, and sink p-traps).<br>2. Written documentation was completed regarding the informal investigation on 10/8/2010.<br>3. All staff will receive a memo from the Administrator on 10/25/2010 reminding them of the process for reporting missing/lost resident items.<br>4. The facility Administrator will ensure that any other items that are reported missing will be reported and formally investigated per policy. The formal investigation will include written documentation and notification to ombudsman, WY Dept. of Health, and DFS/APS case worker. Per policy, the facility will encourage residents on admission to RMC, to not bring valuable items. | |

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

ADMINISTRATOR 10-8-10

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
Wyoming Dept of Health



10/25/10 POC accepted. PA Telephone call to Evanston

OCT 25 2010
Office of Healthcare Licensing and Surveys

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| F 226 | Continued From page 1<br>stated this information was shared with the administrator and other staff. Review of facility investigations showed there was no investigation related to this allegation. During interview with the administrator on 9/15/10 at 1 PM, she expressed awareness of the resident's missing wedding ring. She stated there was no written investigation because residents often misplace items. She further stated she did not interview staff because she did not believe anyone took the resident's ring. Review of the revised June 2009 facility policies and procedures concerning abuse investigations showed misappropriation of resident's property needed to be investigated, and may include interview and supporting documentation. | F 226 | 5. Incidents requiring investigation will be reviewed quarterly in Quality Assurance (QA) Meeting. | |
| F 272 SS=D | 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>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:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status; | F 272 | F 272<br><br>The facility must conduct initially And periodically a comprehensive, Accurate, standardized, reproducible Assessment of each resident's Functional capacity. This will be Achieved by:<br><br>1. The comprehensive assessments for resident #31 addressing ADLs, communication, and dehydration were reviewed and revised to accurately reflect the resident's current functional abilities, current communication patterns/abilities, and dehydration prevention needs on 10/7/2010 by the acting MDS coordinator. The care plans for resident #31 were reviewed and revised to reflect his/her current needs.<br>2. The comprehensive Assessments for resident #9 were reviewed, revised, and completed for all areas mentioned (cognitive loss, ADL function/rehab potential, urinary incontinence, behavior symptoms, falls, dehydration/fluid maintenance, oral/dental care, pressure ulcers, and psychotropic drug use). Care plans for resident #9 were also Reviewed and revised to reflect His/her current needs. | 10/8/10 |

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| F 272 | Continued From page 2<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure assessments were comprehensive in a variety of areas for 2 of 9 sample residents (#9, #31). The findings were:<br><br>1. Review of the 2/11/10 admission MDS assessment showed resident #31 required comprehensive assessments for activities of daily living (ADLs), communication, and dehydration. Review of the assessment information revealed the assessment for ADLs did not include the resident's functional abilities but rather focused on medications. The assessment for communication failed to address the fact that the resident was from another country, and spoke words from his/her native country daily. The assessment for dehydration failed to describe the resident's fluid needs and the cognitive limitations the resident had in meeting his/her own needs related to hydration. Interview with the acting MDS coordinator on 9/15/10 at 2:40 PM verified these assessments were not comprehensive.<br><br>2. Review of the 8/24/10 significant change MDS assessment, Section V, for resident #9 showed | F 272 | 3. On 10/1/2010, MDS 3.0 was implemented with a new software program. The MDS coordinator and acting MDS coordinator will ensure that any care area triggers (CATs) will be addressed completely and comprehensively on the care area assessments (CAAs). Chart audits will be conducted weekly for six weeks and as needed thereafter to ensure comprehensive assessment is completed and accurate. Any concerns will be reported to the QA committee at least Quarterly. | |

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| F 272 | Continued From page 3<br>the resident required further assessment in a variety of areas including cognitive loss, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, behavioral symptoms, falls, dehydration/fluid maintenance, oral/dental care, pressure ulcers, and psychotropic drug use. On Section V, required assessment areas were referred to the RAPs key. Review of the RAPs showed they were not comprehensive. During an interview with the MDS coordinator on 9/15/10 at 2:30 PM, she stated the RAPs for the resident were incomplete, and no other assessments were completed for the required areas. | F 272 | **F 274**<br><br>The facility will ensure that a comprehensive assessment is conducted within 14 days after determining that there has been a significant change in a resident's physical or mental condition. This will be achieved by:<br><br>1. The MDS for resident #30, done on 9/11/2010, manifests the change in resident condition and accurately reflects his/her current level of function.<br>2. The facility IDT team will monitor residents for change in condition and will ensure that a change of condition MDS is completed on those who require it within 14 days after determining that there has been a significant change (for better or worse) in a resident's condition.<br>3. Residents who are experiencing a change of condition will be discussed in census meeting and will be monitored for the need to completed a change of condition MDS. The MDS coordinator and/or facility administrator will ensure change of condition MDSs are being completed and will report any concerns to the QA committee at least quarterly. | 10/8/10 |
| F 274 SS=D | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE<br><br>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review and staff interview, the facility failed to complete a significant change MDS assessment for 1 of 6 sample residents (#30) who required such | F 274 | | |

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| F 274 | Continued From page 4<br>assessment. The findings were:<br><br>Review of the 6/15/10 admission MDS for resident #30 showed the resident had a percutaneous endoscopic gastrostomy (feeding) tube and urinary catheter. Observations on 9/13/10 - 9/14/10 showed the resident did not have a feeding tube or urinary catheter. Review of the physician's orders showed the feeding tube had been discontinued on 8/5/10 and the urinary catheter had been discontinued on 8/7/10. During an interview on 9/14/10 at 3:15 PM, the DNS acknowledged the assessment coding error and stated a significant change assessment should have been completed due to the change in the resident's condition. | F 274 | | |
| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual | F 278 | **F278**<br><br>The assessment must accurately reflect the resident's status. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. This will be achieved by:<br><br>1. Resident #9's MDS was revised to reflect him/her not having a pressure ulcer on or before 10/15/2010. Resident #34's MDS assessment was revised on or before 10/15/2010 to reflect his/her current functional ability.<br>2. The MDS coordinator and/or the acting MDS coordinator will be diligent in making sure that each MDS assessment completed is done accurately. The MDS coordinator will conduct weekly chart audits for six weeks and as needed thereafter to ensure accuracy of the MDS. Any concerns will be addressed immediately and will be reported to the QA committee at least quarterly. | 10/15/10 |

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| F 278 | Continued From page 5<br>to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, resident interview, and staff interview, the facility failed to ensure all areas of MDS assessments were coded accurately for 2 of 9 sample residents (#9, #34). The findings were:<br><br>Review of the 8/24/10 significant change MDS assessment and corresponding RAP for resident #9 showed s/he had a stage II pressure ulcer. However, according to the documentation in the treatment administration records, weekly skin assessment, nurses notes, and 7/8/10 Braden pressure ulcer risk assessment; the resident did not have a pressure ulcer. During an interview on 9/14/10 at 10 AM, the resident stated s/he did not have, and never had, a pressure ulcer. An interview with LPN #1 on 9/15/10 at 1:55 PM, also confirmed the resident did not have a pressure ulcer. During observation at 2 PM, no pressure ulcers were observed when the LPN assessed the resident's skin. During an interview with the MDS coordinator on 9/15/10 at 2:30 PM, she stated the 8/24/10 significant change MDS assessment and corresponding RAP were inaccurate concerning a pressure ulcer on the resident's coccyx.<br><br>Review of the 5/7/10 annual MDS assessment for | F 278 | | |

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| F 278 | Continued From page 6<br>resident #34 showed the resident had limited range of motion and full loss of voluntary movement in one foot. However, according to the 7/28/10 quarterly MDS assessment the resident's functional ability had declined. This assessment showed the resident's limited range of motion and full loss of voluntary movement, affected both feet and one leg. In an interview with the resident on 9/13/10 at 5:35 PM, s/he stated that s/he had not experienced a decline in functional ability "in years." In an interview on 9/14/10 at 2:45 PM, restorative aide #1 verified the resident's range of motion and voluntary movement had not changed from 5/7/10 - 7/28/10. During an interview on 9/14/10 at 3:10 PM, the DNS acknowledged the error in the assessment and stated the resident had not experienced any changes in his/her functional ability. | F 278 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. | F 280 | F 280<br>The resident has the right to participate In planning care and treatment or changes In care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment. This will be achieved by:<br><br>1. The care plans for resident #9 were updated to reflect his/her current level of functioning. The care plan for pressure ulcer care was discontinued on 10/4/2010.<br>2. The care plan dated 6/30/10 for resident #30 addressing the feeding tube and the urinary catheter were discontinued on 10/4/2010.<br>3. Care plans will be reviewed on a quarterly basis, for every resident, in the interdisciplinary team meeting. The care plans will be reviewed and updated for accuracy and appropriateness.<br>4. The DNS and /or MDS Coordinator will ensure that care plans are accurate and are being updated to accurately reflect resident's current level of care. Weekly checks of resident care plans will be conducted by the DNS for a period of three months, to ensure accuracy, and as needed there after. Any concerns will be reported to the QA committee at least quarterly. | 10/8/10 |

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| F 280 | Continued From page 7<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and medical record review, the facility failed to ensure the care plan was updated to reflect the current condition for 2 of 9 sample residents (#9, #30). The findings were:<br><br>Review of the 8/24/10 pressure ulcer care plan for resident #9 showed the resident had a stage II pressure ulcer on his/her coccyx. However, according to the documentation in the treatment administration records, weekly skin assessment, nurses notes, and 7/8/10 Braden pressure ulcer risk assessment; the resident did not have a pressure ulcer. During an interview with the MDS coordinator on 9/15/10 at 2:30 PM, she acknowledged the 8/24/10 pressure ulcer care plan was inaccurate.<br><br>Review of the care plan, dated 6/30/10, for resident #30 showed interventions for care of a percutaneous endoscopic gastrostomy (feeding) tube and urinary catheter. Observation of the resident on 9/13/10 -9/14/10 showed the resident did not have a feeding tube or urinary catheter. Review of the physician's orders showed the feeding tube had been discontinued on 8/5/10 and the urinary catheter had been discontinued on 8/7/10. During an interview on 9/14/10 at 3:15 PM, the DNS acknowledged the error and stated the care plan should have been updated to show the changes in care. | F 280 | F 282<br><br>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 will be accomplished by:<br><br>1. The care plans for resident #5 and resident #29 were reviewed and revised to reflect his/her current incontinence needs.<br>2. Resident #5 and #29 will receive incontinence care per care plan.<br>3. C.N.A. assignment sheets were modified to reflect those residents who need assistance with toileting per each resident's care plan. The charge nurse will be verifying with C.N.A. staff that residents with incontinence care plans are being checked on a regular basis.<br>4. An in-service for C.N.A. staff on incontinence care will be held on 10/15/2010.<br>5. C.N.A. assignment sheets will be audited for two weeks by the DNS and as needed thereafter to ensure compliance. Any concerns will be reported to The QA committee at least quarterly. | 10/15/10 |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN | F 282 | | |

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| F 282 | Continued From page 8<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and medical record review, the facility failed to follow the care plans for 2 random non-sample residents (#5, #29) whose care plans were reviewed. The findings were:<br><br>Refer to F315 for information regarding the facility's failure to follow the care plan for providing incontinence care for resident #5.<br><br>Refer to F315 for information regarding the facility's failure to follow the care plan for providing incontinence care for resident #29. | F 282 | | |
| F 309 SS=G | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, medical record review, and resident interview, the facility failed to ensure pain management was provided | F 309 | **F 309**<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This will be accomplished by:<br><br>1. Resident #31 was re-assessed for pain management and a pain assessment sheet completed for seven days, from 10/1/2010 to 10/7/2010. | 10/15/10 |

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

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| F 309 | Continued From page 9<br>in an effective manner for 1 of 4 sample residents (#31) who were identified by the facility as having pain. By not assessing the resident in a timely manner, resident #31 experienced avoidable pain resulting in harm. In addition, the facility failed to ensure care was provided in a timely manner to prevent bowel incontinence for one non-sample resident (#5). The findings were:<br><br>According to the medical history, resident #31 was admitted to the facility on 1/30/10 with diagnoses including dementia and a past right hip replacement. The resident resided on the facility's secure unit, and was able to make him/herself understood according to the 7/31/10 quarterly MDS assessment. Review of the July, August and September 2010 pain flow sheets, and the MARs showed resident #31 was being treated for pain on a regular basis (fourteen days in July, eleven days in August, and ten days so far in September). The physician's orders for pain relief were Lortab 5/500 mg, or Tylenol 650 mg as needed every four hours. Further review of the medical record showed a pain assessment had not been completed since admission, and that assessment showed the resident had no pain. However, review of the careplan dated 7/28/10 showed pain was a problem, and the interventions included medication and assessing pain every shift and as needed. Interview on 9/14/10 at 4:30 PM with CNA #1 who worked on the secure unit, revealed the resident had frequent leg pain. The CNA stated she could tell when the resident was having pain because s/he would start walking the hallway pacing carefully along a line on the tile. She also stated the resident would sometimes tell her s/he was hurting. The following concerns were identified:<br>a. Observation on 9/13/10 at 4:34 PM until | F 309 | 2. Resident #31's care plan was reviewed and revised on 10/8/2010 based on the seven days of pain assessments.<br>3. Existing pain management policy was reviewed and revised to include weekly pain assessments. Licensed nursing staff will be in-serviced on the new pain policy, the FLACC scale and assessment tools on 10/15/2010. Continuing pain in-services will be held throughout the coming year.<br>4. All PRN pain medication will be tracked on "pain flow sheet" located in the medication administration record. nursing staff in-serviced on use of pain flow sheet on 10/5/2010.<br>5. A line item will be added to the treatment administration record (TAR) on or before 10/15/2010 to ensure that pain is assessed every shift.<br>6. Pharmacy consultant and/or DNS will conduct monthly audits to ensure adequate pain management for residents. Weekly pain assessments will be audited by the DNS for three weeks and as needed thereafter. Any concerns will be reported to the QA committee at least quarterly.<br><br>1. The care plan for resident #5 was reviewed and revised to reflect his/her current incontinence needs.<br>2. Resident #5 will receive incontinence care per care plan. | |

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| F 309 | Continued From page 10<br>6:34 PM showed the resident appeared to be in pain. The resident was pacing, was holding his/her back area, was having facial grimacing, and was holding his/her breath. At 5:13 PM that day (9/13) interview with the resident revealed s/he was having pain in the lower back and right hip area.<br>b. Continued observation showed RN #1 entered the unit to pass medications during the evening meal. At 6:34 PM the RN approached the resident to administer medication, she told the resident the medication was for her leg pain and to help her sleep. The resident at first refused the medication, telling the nurse no, and pushing her hand away. The nurse persisted and persuaded the resident to take the medication, again telling her it would help her rest. Interview with the RN at 6:37 PM revealed the only medication she administered was Xanax for the resident's anxiety. She stated there was no pain medication given, and she had not assessed the resident for pain at that time. When asked why she had mentioned pain relief to the resident when no pain medication was provided, the nurse stated she was trying to encourage the resident to take the medication rather than refusing. Review of the September MAR at that time showed the resident had received Lortab 5/500 mg each evening at 5:30 PM for 10 days from 9/2 to 9/11.<br>c. On 9/13/10 at 6:58 PM a pain assessment of the resident was requested by the surveyor. At that time RN #1 reported she had just done one, and the resident refused to take anything. Record review the next day on 9/14/10 failed to show any evidence that a pain assessment was completed or that the resident refused any medication.<br>d. Interview with the DNS on 9/14/10 at 2:30 PM revealed staff should be aware of non-verbal signs/symptoms of pain. The DNS then verified | F 309 | 3. C.N.A. assignment sheets will be modified to reflect those residents who need assistance with toileting per care plan. The charge nurse will verify with C.N.A. staff that residents with incontinence care plans are being checked on a regular basis.<br>4. An in-service on incontinence care will be held on 10/15/2010. Topics covered will include: effects of incontinence on skin, continence care and products selection to promote dignity, tips for toileting, and timely continence care.<br>5. Any resident using incontinence products were assessed for appropriate incontinence product selection and proper fit to promote dignity.<br>6. C.N.A. assignment sheets will be audited two weeks by the DNS and as needed thereafter until compliance with care plans for incontinence is achieved. Any concerns will be reported to the QA committee at least quarterly. | |

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| F 309 | Continued From page 11<br>that a comprehensive pain assessment had not been completed to identify indicators of pain for the resident.<br><br>Refer to F315 for information regarding the facility's failure to provide care in a timely manner to prevent bowel incontinence for resident #5. | F 309 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff and family interviews, and medical record review, the facility failed to ensure adequate dining assistance was provided for non-sample residents (#5, #17, #29, #36) in 1 of 4 dining rooms. The findings were:<br><br>Review of the most recent MDS assessments for residents #5, #17, #29 and #36 showed all required total or extensive assistance with eating. Observation on 9/14/10 at 8:05 AM revealed the residents were served breakfast in the room 200 dining room. Continuous observation revealed CNA #2 assisted the residents by walking from one resident to another giving each one prompting and bites or spoonfuls of food. The CNA stated that sitting beside the residents to provide dining assistance was not a manageable task during times when she was responsible for feeding more than two residents. At 8:40 AM (thirty-five minutes later), the CNA placed the | F 312 | **F 312**<br><br>A resident who is unable to carry out activities of daily living (ADLs) received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This will be accomplished by:<br><br>1. Resident #5, #17, and #29 are currently sitting at an assisted dining table where staff can assist them during meal times. Resident #36 has been discharged from the facility.<br>2. The facility will ensure that residents who require assistance with eating have adequate time and staff assistance to achieve the highest practicable level of well-being.<br>3. The facility will be adding an additional C.N.A. staff member, beginning on 10/18/2010, on the morning and afternoon shifts that will assist with meal times and with ADL care.<br>4. The DNS and/or ADON will continue to monitor staffing needs and will ensure adequate staffing to meet the resident's needs. Any concerns will be reported to the QA committee at least quarterly. | 10/18/10 |

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| F 312 | Continued From page 12<br>partially eaten trays of food in the food cart and wheeled the residents out of the dining room. Observation of the food consumption for the residents revealed one resident ate more than 25% of his/her breakfast and each of the other three residents ate less than 25%. Interview on 9/14/10 at 12:15 PM with a family member of one of the residents revealed this family member visited at least four times a week during mealtimes. The family member also stated that the residents in the room 200 dining room needed "quite a bit of time" and assistance to complete their meals; and they usually ate better when they received this. | F 312 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an 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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, medical record review, and staff interview, the facility failed to ensure appropriate care and services were provided for 2 non-sample residents (#5, #29) who were randomly observed for care of bladder incontinence. The findings were:<br><br>Review of the 7/21/10 quarterly MDS assessment | F 315 | **F 315**<br><br>The facility must ensure that a resident who enters the facility without an 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 will be achieved by:<br><br>1. The care plans for resident #5 and resident #29 were reviewed and revised to reflect his/her current incontinence needs.<br>2. Resident #5 and #29 will receive incontinence care per care plan. | 10/15/10 |

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| F 315 | Continued From page 13<br>for resident #5, revealed the resident had bladder incontinence daily and bowel incontinence two to three times a week. Review of the assessment also revealed the resident required extensive assistance for toileting. Review of the 8/2/10 care plan showed approaches included: check the resident every two to three hours for incontinence. Continuous observation on 9/14/10 from 8:05 AM until 12:15 PM (over four hours) revealed the resident was not checked for incontinence or provided toileting assistance. During that time, the resident ate breakfast, attended the morning activities, visited with his/her spouse and ate lunch. Interview with the spouse on 9/14/10 at 11:15 AM revealed staff had not assessed the resident for incontinence or provided toileting assistance during the spouse's visit. The spouse also stated the resident was totally dependent on staff for incontinence care; because the spouse was not physically able to provide this care. Interview with CNA #2 at 1:30 PM revealed the resident's spouse had transferred the resident to bed after lunch and the CNA and LPN #1 were preparing to assist the resident to the toilet. Observation at that time (over five hours had elapsed) revealed the resident had been incontinent and his/her clothing were soiled with feces and urine.<br><br>Review of the 4/20/10 RAPs for resident #29 showed staff were instructed to check the resident every two to three hours for incontinence. Review of the 7/14/10 quarterly MDS assessment revealed the resident had multiple daily episodes of urinary incontinence and was totally dependent on staff for toileting assistance. Review of the 7/22/10 care plan showed care plan approaches included: provide incontinent care after each episode. Observation | F 315 | 3. C.N.A. assignment sheets will be modified to reflect those residents who need assistance with toileting per care plan. The charge nurse will verify with C.N.A. staff that residents with incontinence care plans are being checked on a regular basis.<br>4. An in-service on incontinence care will be held on 10/15/2010. Topics covered will include: effects of incontinence on skin, continence care and products selection to promote dignity, tips for toileting, and timely continence care.<br>5. Any resident using incontinence products were assessed for appropriate incontinence product selection and proper fit to promote dignity.<br>6. C.N.A. assignment sheets will be audited two weeks by the DNS and as needed thereafter until Compliance with care plans for Incontinence is achieved. Any concerns will be reported to the QA committee at least quarterly. | |

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| F 315 | Continued From page 14<br>on 9/14/10 from 8:05 AM until 11:35 AM (three and half hours) revealed staff did not check, change or provide toileting assistance for the resident. Further observation on 9/14/10, revealed CNA #3 and CNA #4 removed the resident's urine soiled disposable brief at 11:35 AM.<br><br>During interview on 9/14/10 at 12:30 PM, the DNS stated that both residents (#5, #29) should have received toileting assistance and/or incontinence care at least every two to three hours. The DNS stated the facility did not have a system for overseeing and ensuring staff provided this care in a timely manner. The DNS also stated that the untimely care was partially due to not having enough CNAs on duty and staff reassignments due to the temporary environmental changes related to remodeling the dining room. | F 315 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review and staff interview, the facility failed to ensure adequate supervision in the secure unit for 2 of 6 sample residents (#31, #33) who were identified as needing increased supervision. The findings were: | F 323 | F 323<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>1. Resident #33 was evaluated by the IDT team and found not to be at risk due to exit-seeking behaviors. His/her care plan was updated to reflect this assessment. He/she was moved to a room near the nurses station where he/she can be monitored. He/she will be monitored closely for to ensure safety in the new environment. In moving resident #33, there are no longer residents who are aggressive to one another in the secure unit. | 10/18/10 |

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| F 323 | Continued From page 15<br><br>Review of the 8/19/10 care plan for resident #33 showed s/he was a risk for injuries related to exit-seeking behaviors, and his/her whereabouts were to be monitored. The resident also had a history of falls according to the 8/19/10 care plan, and staff were to "observe for safety." During observation of the secure unit on 9/13/10 at 4:30 PM the resident was being assisted out the door into an enclosed courtyard area by another resident (non-sample #10). Resident #33 was seated in his/her wheelchair, and resident #10 was trying, with difficulty to get the wheelchair over the door jam. There were no staff in the area to help the residents. A few minutes later, at 4:32 PM CNA #1, who was in another room with three residents, came to the dining room area to introduce herself. At that time she became aware of the two residents struggling to get out the door. The CNA assisted resident #33 outside. After staying outside with the resident for a minute or two, the CNA returned inside leaving resident #33 outside unsupervised until 4:45 PM (10-11 minutes). Interview with CNA #1 on 9/14/10 at 4:30 PM revealed she was unsure if it was safe for the resident to be outside unattended. She then stated there was only one aide working in the unit, and it was "hard to be in two places at once." She revealed it was seldom that all six residents who resided in the secured unit were in the same room, and there were not enough staff to "be with the residents."<br><br>Interview with CNA #1 while on the secure unit 9/13/10 at 4:40 PM revealed two sample residents (#33 and #31) did not get along with one another; she stated there were multiple instances where the two would physically lash out and try to hit or kick one another. She further | F 323 | 2. Staff will be instructed to keep watch on residents when in common areas with others. An in-service will be held to discuss supervision in the secure unit on 10/15/2010.<br>3. Staff will be added to day and afternoon shifts beginning on 10/18/2010. They will be available to assist in the secure unit should the need arise.<br>4. Charge nurse on shift will monitor supervision of residents in the secure unit and will be available to assist as needed. DNS and ADON will continue to monitor staffing levels and the supervision of residents in the secure unit. Any concerns will be reported to the QA Committee at least quarterly. | |

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| F 323 | Continued From page 16<br>stated staff were instructed to keep them separated. During observations that evening (9/13/10) from 4:30 PM to 6:34 PM, the two residents were together and unsupervised in a dining room area on the unit on multiple occasions. Interview with the DNS on 9/14/10 at 2:20 PM revealed he had concerns about the secure unit related to staffing. The facility's administration was actively trying to eliminate the secure unit to better utilize staff and provide care to the residents. | F 323 | | |
| F 353 S5=E | 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS<br><br>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.<br><br>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br><br>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.<br><br>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br><br>This REQUIREMENT is not met as evidenced by: | F 353 | F 353<br><br>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. This will be achieved by:<br><br>1. The facility has hired three additional C.N.A.s as of 10/7/2010 and will continue to hire staff to assist with resident needs.<br>2. An additional C.N.A. staff member will be added to the day and afternoon shifts beginning on 10/18/2010.<br>3. Staffing levels will be monitored daily by the DNS and/or ADON and changes, if needed, will be made immediately to ensure adequate staffing to meet the needs of each resident. Staffing will be monitored based on the acuity of residents and if/when additional staff is warranted, based on acuity, it will be added. Any concerns will be reported to the QA committee at least quarterly. | 10/18/10 |

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| F 353 | Continued From page 17<br>Based on observation, staff, resident, and family interview, and medical record review, the facility failed to ensure staff were available to provide adequate ADL assistance for 4 non sample residents (#5, #17, #29, #36). In addition, a lack of staffing contributed to safety concerns in the secure unit for 2 sample residents (#31, #33) and the failure to provide incontinence care in a timely manner for 2 (#5, #29) non-sample residents. The findings were:<br>a. Interview on 9/15/10 at 2:40 PM with the SDC who made the schedule for the CNAs revealed it was a challenge to make a schedule due to the lack of people to work. According to the SDC, many residents required a high level of care, and four CNAs were needed to provide the needed care on the day and afternoon shifts. However, she was only able to schedule three aides. She then stated this was in part due to the formula she had to use which did not take the acuity of the residents into account.<br>b. Interview with residents during the days of survey from 9/13/10 - 9/15/10 revealed they were concerned with the lack of CNAs to help residents with toileting needs. Two residents revealed they had to wait for an hour or more to have their call light answered and be provided assistance, especially around meal times.<br>c. Interview with the DNS on 9/14/10 at 2:20 PM revealed the facility was struggling to get CNAs hired. They were "spread too thin." The DNS also stated they were using a formula approach to staffing rather than basing numbers on the acuity of the thirty-six residents at the time of survey. He further stated the administration was working on eliminating the secure unit so staff could be better utilized.<br>d. Refer to F309 for details regarding the facility's failure to ensure sufficient staff to provide | F 353 | | |

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| F 353 | Continued From page 18<br>fecal incontinence care and toileting in a timely manner for resident #5.<br>e. Refer to F315 for details regarding the facility's failure to ensure sufficient staff to provide urinary incontinence care in a timely manner for residents #5 and #29.<br>f. Refer to F312 for details related to a lack of staff to provide assistance with dining for residents #5, #17, #29, and #36.<br>g. Refer to F323 for details related to a lack of staff supervision in the secure unit for residents #31 and #33. | F 353 | | |
| F 363 SS=F | 483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and review of the menu spreadsheet, the facility failed to ensure the planned amount of food was served for 29 of 29 residents (#1, #2, #3, #5, #6, #7, #8, #9, #12, #13 #14, #15, #16, #17, #18, #19, #22, #23, #24, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36) who had regular portioned diets provided for the noon meal on 9/14/10. The findings were:<br><br>Review of the menu spreadsheet showed the beef stew for the noon meal on 9/14/10 was planned as an eight ounce regular portion and an eight ounce portion for the pureed diets as well. | F 363 | F 363<br><br>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. This will be accomplished by:<br><br>1. Two eight ounce serving scoops were placed in the kitchen for the staff to have access to.<br>2. The menus were reviewed by the Dietary Manager and any eight ounce portion sizes were noted.<br>3. Larger 12 ounce bowls were purchased on 10/4/2010 to accommodate better for the eight ounce serving size. The larger bowls will be used when the menu calls for an eight ounce serving and when the regular bowls can't accommodate the required serving size.<br>4. The kitchen staff was in-serviced on 9/30/2010 and will be in-serviced again on 10/15/2010 regarding serving sizes and the importance of following the menu.<br>5. The dietary manager will ensure that proper serving sizes are being served and will report any concerns to the QA committee at least quarterly. | 10/15/10 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535038 | A. BUILDING _____ B. WING _____ | 09/15/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ROCKY MOUNTAIN CARE - EVANSTON | 475 YELLOW CREEK ROAD EVANSTON, WY 82930 |

| (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 |
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| F 363 | Continued From page 19<br>Observation of the noon meal on 9/14/10 showed the cook had prepared beef stew. During the serving process, beginning at 11:50 AM, the cook dished up six ounces of stew for each resident meal. When serving the pureed meals, the cook used a #6 scoop which is equivalent to four ounces. She dished up one and one-half scoops of the pureed stew yielding a portion of six ounces. During the observation, the cook stated six ounces was the portion being served to the residents, and at no time during the observation did she review the menu spreadsheet to verify the planned portion. Interview with the dietary manager on 9/14/10 at 12:10 PM stated the menu should be followed, and she then verified the portion size should have been eight ounces for the regular portion of beef stew. | F 363 | | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and review of maintenance service records, the facility failed to ensure food contact equipment, and stored frozen food was maintained in a sanitary condition. The findings were: | F 371 | F 371<br>The facility must procure food from sources approved or considered satisfactory by Federal, State, or local authorities and must store, prepare, distribute and serve food under sanitary conditions. This will be achieved by:<br><br>1. The ice machine was drained, cleaned, and disinfected on the afternoon of 9/14/2010 and the yellow substance was cleaned off completely.<br>2. The ice machine will be sanitized once per month in accordance with the service records. This task will be shared by the maintenance staff and the dietary staff.<br>3. The maintenance director will ensure the ice machine is being cleaned & sanitized every month and will report any concerns to the QA committee at least quarterly. | 10/18/10 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535038 | A. BUILDING _____ B. WING _____ | 09/15/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ROCKY MOUNTAIN CARE - EVANSTON | 475 YELLOW CREEK ROAD EVANSTON, WY 82930 |

| (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 |
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| F 371 | Continued From page 20<br>Observation on 9/13/10 at 3:10 PM and again on 9/14/10 at 12:35 PM revealed the ice machine in the kitchen was not sanitary. Inside the ice machine, the white part of the "ice maker" was soiled with a yellow slimy substance that covered an area fourteen inches wide. Interview with the dietary manager on 9/14/10 at 11:35 AM revealed the maintenance person routinely sanitized the ice machine, and she was unable to identify the yellowish substance. Review of the service records for the ice machine, showed the interior was last sanitized on 9/3/10. Interview and observation of the ice machine with the administrator on 9/14/10 at 12:35 PM verified the substance could likely contaminate the ice, and needed to be cleaned. According to Food Code 2009, U.S. Public Health Service: 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch.<br><br>Observation on 9/13/10 at 3:10 PM and again on 9/14/10 at 12:35 PM revealed the condenser unit in the walk-in freezer was leaking and there was ice accumulated on a bag of roll dough. Interview with the dietary manager on 9/14/10 at 11:35 AM revealed the condenser unit had been leaking for about three weeks. She stated there was a professional in at some point to determine the problem; however, she did not know the status of when it would be repaired. She was not aware ice was accumulating on the package of food in the freezer. According to Food Code 2009, U.S. Public Health Service: 3-305.11 "(A) Except as specified in ¶¶ (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other | F 371 | 1. A request was called into a contractor on 10/6/2010 to repair the condenser unit in the walk-in freezer. The contractor will be here on 10/12/2010.<br>2. The freezer will be repaired based on the recommendation of the contractor.<br>3. In accordance with maintenance department service records, the walk-in freezer will be inspected monthly by a member of the maintenance staff to ensure proper functioning. Any concerns will be reported to the QA committee at least quarterly. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 535038 | A. BUILDING _____ B. WING _____ | 09/15/2010 |

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| F 371 | Continued From page 21<br>contamination;" | F 371 | | |