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 _____	R-C 05/06/2005

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 PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=D	483.20(b) RESIDENT ASSESSMENT A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding	F 272	POC was reviewed and accepted. with changes made by Peggy Duran, RN, DON & Karen Womack, RN, Health surveyor 5/25/05 at 1420: MAY 24 2005	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/24/05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to perform a comprehensive assessment for one (#25) of four sample residents in the area of bowel care. The findings were: Review of the admission face sheet and 5/05 physician's orders revealed resident #25 was admitted with diagnoses including constipation. Review of the 10/22/04 annual Minimum Data Set (MDS) assessment revealed he/she was occasionally (once weekly) incontinent of bowel. Review of the 1/20/05 quarterly MDS assessment revealed he/she had declined in bowel continence to frequently incontinent (2-3 times per week). Review of assessments revealed no comprehensive bowel assessment was completed after the decline in bowel continence. Interview with the director of nursing (DON) on 5/6/05 at 12:15 PM confirmed no bowel assessment was completed.	F 272	F272 The facility will make a comprehensive assessment of a resident's needs, using the RAI specified by the state. This will be accomplished by: 1. Weekly care plan meetings with the D.O.N., MDS Coordinator, dietary manager, and social services designee. The meetings will be held to update care plans and identify changes in residents such as bowel and bladder, nutrition, skin and fall assessments. 2. Resident #25 will be assessed for immediate and unique needs, the care plan will be updated to correlate with the MDS assessment and bowel assessment. 3. The assessment process will be monitored by DON to ensure ongoing compliance and report to QA meeting quarterly.	05/17/05
{F 278} SS=D	483.20(g) - (h) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	{F 278}		

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{F 278}	Continued From page 2 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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 Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to ensure each resident's assessment was accurate for two (#27, #35) of seven sample residents. The findings were: 1. Review of the admission face sheet revealed resident #27 was admitted on 9/1/04. Review further revealed a Minimum Data Set (MDS) assessment dated 9/14/04 was not coded as an admission MDS assessment. 2. Review of the admission face sheet for resident #35 revealed he/she was admitted on 7/19/04. Review further revealed an MDS assessment dated 8/1/04 was not coded as an admission MDS assessment.	{F 278}	F278 The facility must, by a Registered Nurse, provide an assessment which accurately reflects the resident's status, this will be accomplished by: 1. Minimum data sets for residents #27 and #35 will be recoded and submitted to Medicare as a correction in coding for an admission assessment. 2. The MDS Coordinator will ensure her section has been complete and accurate assessments on each resident with accurate coding on each Minimum Data Set ongoing. 3. MDS Coordinator and D.O.N. will monitor complete random chart audits completing a chart check list. Audits will be reviewed quarterly by the QA Committee to insure ongoing compliance.	05/07/05

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{F 278}	Continued From page 3 3. Interview with the director of nursing and the MDS coordinator on 3/2/5 at 10 AM confirmed the 9/14/05 MDS assessment for resident #27 and the 8/1/04 MDS assessment for resident #35 were coded inaccurately.	{F 278}		
{F 279} SS=D	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and medical record review, the facility failed to develop an individualized nutritional care plan for one (#27) of seven sample residents. The findings were: Review of the February 2005 physician's order sheet for resident #27 revealed the resident was	{F 279}	F279 The facility will ensure that a comprehensive care plan for each resident that includes measurable objectives and time tables to meet the resident's nutritional care is completed, this will be accomplished by: 1. Weekly weight meetings with the D.O.N., MDS Coordinator, Dietary Manager and Social Services Designee will be held to identify resident's at risk for nutritional defects.	05/07/05

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{F 279}	Continued From page 4 admitted with diagnoses including cachexia (malnutrition, wasting). Review of the 12/28/04 dietary progress notes revealed the resident had a five percent weight weight loss in the past 90 days. Review of the 12/29/04 significant change Minimum Data Set (MDS) assessment revealed the resident had a weight loss of five percent or more in the past 30 days or 10 percent or more in the past 180 days. Interview with the resident on 3/1/05 at 9:17 AM revealed he/she had lost weight recently. Review of the medical record revealed there was no care plan to address the resident's weight loss. Interview with the dietary manager on 3/2/05 at 1:15 PM confirmed there was no nutritional care plan developed for the resident and that it must have been an "oversight."	{F 279}	2. Any resident that has weight loss of 5% in 30 days or 10% in 180 days will have an individualized nutritional care plan implemented by the Dietary Manager and the Dietician. 3. The Dietary Manager and Dietician will be responsible for quarterly chart audits for ongoing compliance. 4. Resident #27 with diagnosis Cachexia identified as weight loss of 10% in the past 180 days has a care plan implemented and placed in the chart. 5. Weekly weights and weight meetings will be reviewed by Q.A. Committee quarterly.	
{F 281} SS=D	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record review, the facility failed to assure staff followed physician's orders for four (#2, #3, #11, #33) of seven sample residents. The findings were: 1. Review of the medical record for resident #2 revealed he/she had diagnoses including constipation. Review of the facility's bowel tracking report for February and March 2005 revealed the resident went from 2/19/05 through 3/1/05 (11 days) without a bowel movement. Review of the February 2005 care plan revealed	{F 281}	F281 The facility must meet professional standards of quality of care by resident assessment, this will be accomplished by: 1. The charge nurse will attain daily information from the Care Tracker System n residents that have not had a BM in the last 9 shifts. The charge nurse will follow doctor's standing orders for those residents.	05/07/05

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(F 281)	Continued From page 5 elimination had been identified as a problem with a goal for the resident to have a bowel movement every two to three days. Further review of the care plan revealed approaches included administering a laxative according to standing orders for no bowel movement in three days. Review of the February 2005 physician's orders revealed an order for medications according to standing orders dated 1/27/04. Review of the standing orders for constipation included Milk of Magnesia (laxative) 30 cubic centimeters (cc) PRN (as needed) if no bowel movement for three days, bisacodyl (laxative) suppository one daily PRN if no bowel movement for three days, tap water enema (solution to stimulate bowel activity) or Fleets enema PRN if no results from the suppository, and notify the physician for chronic constipation. Review of the Medication Administration Record (MAR) for February and March 2005 revealed no PRN laxatives were administered during the eleven days without a bowel movement. Interview with a registered nurse on 3/1/05 at 5:10 PM confirmed there was no indication the resident had a bowel movement since 2/18/05 and that no PRN laxative had been given from 2/19/05 through 3/1/05. Review of the 9/22/04 significant change Minimum Data Set (MDS) assessment and the quarterly 12/21/04 MDS assessment revealed the resident was continent of bowel. Interview with a registered nurse (RN) on 3/2/05 at 2 PM revealed the resident toileted him/herself independently and exhibited no signs or symptoms of constipation. 2. Review of the facility's bowel tracking report for February and March 2005 revealed resident #3 had not had a bowel movement from 2/23/05 to 3/1/05 (7 days). Review of the February 2005	(F 281)	2. D.O.N. held an in-service with all nursing staff to instruct on use of Care Tracker System and how to attain information from the system. 3. Residents #2, #3, #11 and #33 were questioned and had BM's without staff knowledge to due their independence prior to surveyor's departure. Independent residents will be given a tool to help retain independence and allow proper charting in regards to BM's. 4. Aides were in-serviced on questioning independent residents on bowel and bladder daily and documenting on Care Tracker System. 5. Charge nurses will daily check compliance of bowel and bladder and follow up with appropriate interventions. BM's will be audited for compliance by Q.A. Committee. By the DON or administrator if trends will be reported to 6. The D.O.N. held a mandatory in-service with all nursing staff, regarding documentation of BM's in the care tracker system and nurse's documentation of PRN laxatives.	

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{F 281}	Continued From page 6 physician's orders revealed an order dated 8/30/02 for medications according to standing orders. Review of the standing orders for constipation included Milk of Magnesia (laxative) 30 cubic centimeters (cc) PRN (as needed) if no bowel movement for three days, bisacodyl (laxative) suppository one daily PRN if no bowel movement for three days, tap water enema (solution to stimulate bowel activity) or Fleets enema PRN if no results from the suppository, and notify the physician for chronic constipation. Review of the Medication Administration Record (MAR) for February and March 2005 revealed no PRN laxatives were administered during the seven days without a bowel movement. Interview with a registered nurse on 3/1/05 at 5:10 PM confirmed there was no indication the resident had a bowel movement since 2/22/05 and that no PRN laxative had been given from 2/23/05 through 3/1/05. Review of the 11/28/04 quarterly MDS assessment revealed the resident was continent of bowel. Interview with an RN on 3/2/05 at 2 PM revealed the resident toileted him/herself independently and exhibited no signs or symptoms of constipation. 3. Review of the facility's bowel tracking report for February and March 2005 revealed resident #11 went from 2/23/05 through 3/1/05 (7 days) without a bowel movement. Review of the February 2005 care plan revealed elimination had been identified as a problem with a goal for the resident to have a bowel movement every two to three days. Further review of the care plan revealed approaches included administering a laxative according to standing orders for no bowel movement in three days. Review of the February 2005 physician's orders revealed an order dated	{F 281}		

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{F 281}	Continued From page 7 11/2/03 for medications according to standing orders. Review of the standing orders for constipation included Milk of Magnesia (laxative) 30 cubic centimeters (cc) PRN (as needed) if no bowel movement for three days, bisacodyl (laxative) suppository one daily PRN if no bowel movement for three days, tap water enema (solution to stimulate bowel activity) or Fleets enema PRN if no results from the suppository, and notify the physician for chronic constipation. Review of the Medication Administration Record (MAR) for February and March 2005 revealed no PRN laxatives were administered during the seven days without a bowel movement. Interview with a registered nurse on 3/1/05 at 5:10 PM confirmed there was no indication the resident had a bowel movement since 2/22/05 and that no PRN laxative had been given from 2/23/05 through 3/1/05. Review of the 11/24/04 annual MDS assessment revealed the resident was continent of bowel. Interview with an RN on 3/2/05 at 2 PM revealed the resident toileted him/herself independently and exhibited no signs or symptoms of constipation. 4. Review of the facility's bowel tracking report for February and March 2005 revealed resident #33 went from 2/24/05 through 3/1/05 (6 days) without a bowel movement. Review of the February 2005 physician's orders revealed an order dated 6/22/04 for medications according to standing orders. Review of the standing orders for constipation included Milk of Magnesia (laxative) 30 cubic centimeters (cc) PRN (as needed) if no bowel movement for three days, bisacodyl (laxative) suppository one daily PRN if no bowel movement for three days, tap water enema (solution to stimulate bowel activity) or Fleets	{F 281}		

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{F 281}	Continued From page 8 enema PRN if no results from the suppository, and notify the physician for chronic constipation. Review of the Medication Administration Record (MAR) for February and March 2005 revealed no PRN laxatives were administered between 2/23/05 and 3/1/05. Interview with a registered nurse on 3/1/05 at 5:10 PM confirmed there was no indication the resident had a bowel movement since 2/23/05 and that no PRN laxative had been given from 2/23/05 through 3/1/05. Review of the 9/22/04 significant change and the 12/21/04 quarterly MDS assessments revealed the resident was continent of bowel. Interview with an RN on 3/2/05 at 2 PM revealed the resident toileted him/herself independently and exhibited no signs or symptoms of constipation.	{F 281}		

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535038	A. Building B. Wing	5/6/2005

Name of Facility	Street Address, City, State, Zip Code
ROCKY MOUNTAIN CARE EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0164 Reg. # 483.10(d)(3) LSC	03/28/2005	ID Prefix F0254 Reg. # 483.15(h)(3) LSC	03/28/2005	ID Prefix F0492 Reg. # 483.75(b) LSC	04/04/2005
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/2/2005

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO