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 09/22/2005

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 281} SS=F	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: failed to ensure medications were administered as ordered for five sample (#25, #32, #34, #35, #43) residents and seven (#10, #12, #20, #37, #42, #45, #46) non-sample residents. The census was 47. The findings were: Review of September Medication Administration records (MARs) revealed medications were not documented as given as noted below for 11 residents. Interview with licensed practical nurse (LPN) #1 on 9/22/05 at 2 PM revealed she could not verify if the medications were or were not administered. 1. Review of the September 2005 MAR for resident #12 revealed the following medications were not documented as being given: a. Coumadin (blood thinner)1 mg at 6 PM on 9/18/05. b. Digoxin (regulates the heart rate) 0.25 mg at 8 AM on 9/18/05. 2. Review of the September 2005 MAR for resident #35 revealed the following medications were not documented as being given: a. Coreg (for congestive heart failure) 6.25 mg at 8 AM on 9/7/05. b. Prevacid 30 mg at 8 AM on 9/6/05 c. Effexor (antidepressant) 75 mg at 8 AM on 9/6/05 d. Coumadin (blood thinner) 5 mg at 6 PM on	{F 281}	F281 The service provided or arranged by the facility must meet professional standards of quality. This will be accomplished by: 1) Residents #25, #32, #34, #35, #43, #10, #12, #20, #37, #42, #45 & #46 were checked to ensure medications were given appropriately. — 10/14/2005 2) The nurse will administer medications as ordered & the procedure for signing off medications will be followed at each medication pass. DON will monitor randomly. — 10/14/2005 3) Nurse will administer medications as ordered & document according to the Standards of the nursing practice Act for medication administration at each medication pass. — 10/14/2005 4) An In-service was presented on 10/14/2055 to all nursing staff by Don to address aspects of a medication pass according to Standards of Nursing Practice Act for medication administration. — 10/14/2005 5) Random audits for all nurses at least quarterly by DON will occur to insure compliance. — 10/14/2005 6) Medication administration audits will be reviewed quarterly at the QA Committee meeting for ongoing compliance. — 10/14/2005	9/15/05

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

Roland Parks — General Manager — 10-14-05

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.

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 09/22/2005

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{F 281}	Continued From page 1 9/6/05. 3. Review of the September 2005 MAR for resident #25 revealed the following medications were not documented as being given: a. Clonidine (antihypertensive) 0.01 mg at 6 PM on 9/15/05. 4. Review of the September 2005 MAR for resident #32 revealed the following medications were not documented as being given: a. Toprol ER (antihypertensive and antianginal) 25 mg at 8 AM on 9/15/05. 5. Review of the September 2005 MAR for resident #34 reviewed the following medications were not documented as being given: a. Ecotrin (analgesic) 81 mg at 12 noon on 9/8/05. b. Lorazepam (antianxiety) 0.5 mg at 12 noon on 9/8/05. 6. Review of the September 2005 MAR for resident #20 revealed the following medications were not documented as being given: a. Atenolol (antihypertensive, antianginal) 25 mg at 8 AM on 9/20/05. 7. Review of the September 2005 MAR for resident #37 revealed the following medications were not documented as being given: a. Effexor (antidepressant) 75 mg at 8 AM on 9/4/05. b. Depakote (anticonvulsant) 500 mg at 8 AM on 9/4/05 8. Review of the September 2005 MAR for resident #42 revealed the following medications were not documented as being given:	{F 281}		

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{F 281}	Continued From page 2 a. Dyazide (diuretic) at 8 AM on 9/17/05. 9. Review of the September 2005 MAR for resident #43 revealed the following medications were not documented as being given: a. Flomax 0.4 mg at 8 PM on 9/15/05. b. Remeron (antidepressant) 15 mg at 8 PM on 9/15/05. 10. Review of the September 2005 MAR for resident #45 revealed the following medications were not documented as being given: a. Trazadone (antidepressant) 150 mg at 9 PM on 9/7/05 11. Review of the September 2005 MAR for resident #46 revealed the following medications were not documented as being given: a. Sinemet (antiparkinson agent) 25/100 mg at 12 noon on 9/8/05. b. ASA (aspirin) 325 mg at 8 AM on 9/13/05. 12. Review of the September 2005 MAR for resident #10 revealed there was no documentation the resident received the following medications: a. Colace (laxative) 100 milligrams (mg) at 8 AM on 9/13/05.	{F 281}		
{F 282} SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	{F 282}	F282 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:	9/15/05

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{F 282}	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on staff interview, and medical record review, the facility failed to ensure the plan of care was updated for one (#36) non-sample resident. The findings were: Review of the 8/5/05 special interdisciplinary treatment meeting notes for resident #36 revealed a recommendation to discontinue the two hour behavior care plan as previously implemented. Review of the 7/12/05 care plan on ineffective individual coping revealed the care plan was not updated to reflect this change. Interview with LPN #1 on 9/22/05 at 1 PM confirmed the care plan was changed and the care plan should have been updated.	{F 282}	1) Resident #36 has her written plan of care updated to the special interdisciplinary notes. 2) The DON In-serviced all nursing staff on updating the resident's careplans to reflect appropriate care provided as needed. 3) The DON In-serviced all department heads at the morning meeting on updating careplans quarterly & with each family meeting as needed. 4) Random audits or resident's careplans will be done by DON or MDS Coordinator for updating careplans. 5) DON will present audits to QA committee quarterly to ensure ongoing compliance.	10/14/2005 10/14/2005 10/14/2005 10/14/2005 10/14/2005
{F 323} SS=D	483.25(h)(1) ACCIDENTS 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 and staff interview, the facility failed to ensure the residents' environment remained free of hazards. The findings were: 1. On 9/20/05 at 11:45 AM, on 9/21/05 at 2 PM and on 9/22/05 at 9:30 AM, observation showed the treatment cart on the 300 hall was unlocked and accessible to residents. Further observation showed the following items were accessible to residents: five tubes of zinc oxide in the cart	{F 323}	F323 The facility must ensure that the residents environment remains free of accident hazards. This will be accomplished by: 1) Treatment & medication carts will be locked by nurses when left unattended. DON will monitor.	10/14/2005

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{F 323}	Continued From page 4 drawers and two tubes on top of the cart, lapril cream 0.77% that said keep out of the reach of children, one bottle of broncosaline aerosol, 4 pair scissors, 1 bottle of cosopt eye drops, two albuterol (bronchodilator) inhalers, one bottle of tobradex eye drops, one tube of bacitracin ointment for the eye, three tubes of allergy cream that carried the warning to get immediate help or call the poison control center if swallowed, 1 tube of Mometasone furoate cream (steroid), 1 bottle of Ciproflaxacin (antibiotic) 0.3% eye drops, 1 bottle of Flonase (bronchodilator), 22 tubes of Atrovent (bronchodilator), 2 pair nail clippers, 1 box of DuoNeb (bronchodilator) aerosol inhalers, numerous ointments, creams, and eye drops, and 3 bottles of Epi-clenz hand sanitizer with the warning "For external use only. Do not use in eyes. If swallowed, call a doctor. Keep out of reach of children. Flammable. Keep away from fire or flame" was located on the top of the treatment cart. Interview with LPN #2 on 9/20/05 at 11:50 AM confirmed the treatment cart should be kept locked. 2. On 9/20/05 at 10:20 AM observation revealed the shower room door was unlocked. Observation further revealed five straight edge razors were placed in a bucket within residents' reach. Interview with CNA #1 on 9/20/05 at 10:30 AM confirmed the door should have been locked. 3. On 9/20/05 at 7:10 AM observation of the tub room revealed approximately three quarters of an inch of standing water on the floor. Observation further revealed a flexible wand shower head was continually leaking water onto the floor. Interview with CNA #4 at this time revealed the shower head had been this way for approximately two weeks.	{F 323}	1A) The DON in-serviced all nursing staff that addressed locking of treatment & medication carts as well as removal of potential hazards off the top if the carts. 2) The shower room will be locked at all times to ensure safety of residents. 2A) All supplies will be disposed of after a resident is discharged from the facility by C.N.A. working in shower room. 2B) The DON In-serviced all nursing staff on the importance of keeping the shower room locked at all times to prevent harm of a resident. 2C) Audits will be reviewed quarterly by QA Committee for ongoing compliance. 3) Shower head will be replaced 10/22/05. Will In-service Bath Aids on the procedure for placing requests fro repairs on the maintenance log. And will inspect tub/shower room monthly. Will be monitored by QA Committee quarterly. 4) Two new fixtures ordered and will be installed immediately. Snaps will be replaced on the other covers to ensure that all covers are securely attached.	10/14/2005 10/14/2005 10/14/2005

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{F 323}	Continued From page 5 4. On 9/20/05 at 7:15 AM, observation of the tub room revealed three overhead light fixtures. Two of the covers were not securely attached, and two had large cracks in them. Interview with the director of maintenance on 9/22/05 at 8:15 AM revealed he was not aware of this problem. 5. Observation of the oxygen storage closet on 9/20/05 at 10:45 AM revealed two oxygen canisters sitting on the floor just inside the door; neither was in a holder. Interview with the director of central supply at 10:50 on 9/20/05 revealed the cylinders should always be restrained in a way that would prevent them from falling over	{F 323}	5) The DON In-Serviced all nursing staff on safe placement & securing of oxygen canisters when not in use in the oxygen room. 6) The above will be monitored quarterly by the QA Committee.	10/14/2005 10/14/2005
{F 514} SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	{F 514}	F514 The facility must maintain clinical records on each resident in accordance with accepted professional standards & practice that are complete & accurately documented, readily accessible and systematically organized. This will be accomplished by: 1) Resident #12 will have both medications passed and signed off properly on Mar's sheets. 2) Resident #35 will have all four medications passed and signed off properly on Mar's sheet. 3) Resident #25 will have medications passed and signed off properly on Mar's sheet. 4) Resident #32 will have medication passed and signed off properly on Mar's sheet.	10/14/2005 10/14/2005 10/14/2005 10/14/2005

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{F 514}	Continued From page 6 by: Based on resident and family interview, staff interview and medical record review, the facility failed to ensure medications were administered as ordered for five sample (#25, #32, #34, #35, #43) residents and seven (#10, #12, #20, #37, #42, #45, #46) non-sample residents. The census was 47. The findings were: Review of September Medication Administration records (MARs) revealed medications were not documented as noted below for 11 residents. Interview with licensed practical nurse (LPN) #1 on 9/22/05 at 2 PM revealed she could not verify if the medications were or were not administered. 1. Review of the September 2005 MAR for resident #12 revealed the following medications were not documented as being given: a. Coumadin (blood thinner)1 mg at 6 PM on 9/18/05. b. Digoxin (regulates the heart rate) 0.25 mg at 8 AM on 9/18/05. 2. Review of the September 2005 MAR for resident #35 revealed the following medications were not documented as being given: a. Coreg (for congestive heart failure) 6.25 mg at 8 AM on 9/7/05. b. Prevacid 30 mg at 8 AM on 9/6/05 c. Effexor (antidepressant) 75 mg at 8 AM on 9/6/05 d. Coumadin (blood thinner) 5 mg at 6 PM on 9/6/05. 3. Review of the September 2005 MAR for resident #25 revealed the following medications were not documented as being given: a. Clonidine (antihypertensive) 0.01 mg at 6	{F 514}	5) Resident #34 will have both medications passed and signed off properly on Mar's sheet. 6) Resident #20 will receive medication and Mar's will be signed off properly . 7) Resident #37 will receive both medications and Mar's sheet will be signed off properly. 8) Resident #42 will receive medication and Mar's will be signed off properly. 9) Resident #43 will have medications passed and signed off properly on Mar's. 10) Resident #45 will be given medication and Mar's will be signed off properly. 11) Resident #46 will have medications passed and Mar's will be signed off properly. 12) Resident #10 will have documentation stating medication was given and Mar's will be properly signed off. 13) All items will be monitored by QA quarterly. 14) Residents #25, #32, #34, #35, #43, #10, #12, #20, 337, #42, #45 & #46 were checked with staff to ensure medications were given appropriately. 15) The nurse will pass medications & the procedure for signing off medications will be followed at each medication pass.	10/14/2005 10/14/2005 10/14/2005 10/14/2005 10/14/2005 10/14/2005 10/14/2005 10/14/2005 10/14/2005 10/14/2005 10/14/2005

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{F 514}	Continued From page 7 PM on 9/15/05. 4. Review of the September 2005 MAR for resident #32 revealed the following medications were not documented as being given: a. Toprol ER (antihypertensive and antianginal) 25 mg at 8 AM on 9/15/05. 5. Review of the September 2005 MAR for resident #34 reviewed the following medications were not documented as being given: a. Ecotrin (analgesic) 81 mg at 12 noon on 9/8/05. b. Lorazepam (antianxiety) 0.5 mg at 12 noon on 9/8/05. 6. Review of the September 2005 MAR for resident #20 revealed the following medications were not documented as being given: a. Atenolol (antihypertensive, antianginal) 25 mg at 8 AM on 9/20/05. 7. Review of the September 2005 MAR for resident #37 revealed the following medications were not documented as being given: a. Effexor (antidepressant) 75 mg at 8 AM on 9/4/05. b. Depakote (anticonvulsant) 500 mg at 8 AM on 9/4/05 8. Review of the September 2005 MAR for resident #42 revealed the following medications were not documented as being given: a. Dyazide (diuretic) at 8 AM on 9/17/05. 9. Review of the September 2005 MAR for resident #43 revealed the following medications were not documented as being given: a. Flomax 0.4 mg at 8 PM on 9/15/05.	{F 514}	16) The nurse will document medication administration according to standards for nursing practice medication administration at each medication pass. 17) An In-Service was presented on 10/14/2005 to all nursing staff by DON to address appropriate documentation of medication pass. 18) DON will present results of audit to QA meeting quarterly to ensure compliance. 19) Random chart audits will be done by Don at least quarterly to ensure on going compliance	10/14/2005 10/14/2005 10/14/2005 10/14/2005

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{F 514}	Continued From page 8 b. Remeron (antidepressant) 15 mg at 8 PM on 9/15/05. 10. Review of the September 2005 MAR for resident #45 revealed the following medications were not documented as being given: a. Trazadone (antidepressant) 150 mg at 9 PM on 9/7/05 11. Review of the September 2005 MAR for resident #46 revealed the following medications were not documented as being given: a. Sinemet (antiparkinson agent) 25/100 mg at 12 noon on 9/8/05. b. ASA (aspirin) 325 mg at 8 AM on 9/13/05. 12. Review of the September 2005 MAR for resident #10 revealed there was no documentation the resident received the following medications: a. Colace (laxative) 100 milligrams (mg) at 8 AM on 9/13/05.	{F 514}		

Department of Health and Human Services
Centers For Medicare & Medicaid Services

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	09/22/2005

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 **F0273**	**09/15/2005**	ID Prefix **F0278**	**09/15/2005**	ID Prefix **F0279**	**09/15/2005**
Reg. # **483.20(b)(2)(i)**		Reg. # **483.20(g) - (i)**		Reg. # **483.20(d), 483.20(k)(1)**	
LSC		LSC		LSC	
ID Prefix **F0312**	**09/15/2005**	ID Prefix **F0314**	**09/15/2005**	ID Prefix **F0329**	**09/15/2005**
Reg. # **483.25(a)(3)**		Reg. # **483.25(c)**		Reg. # **483.25(l)(1)**	
LSC		LSC		LSC	
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:		Date:
			Linda Brown	RN	10/3/05
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**		

Followup to Survey Completed on: 08/15/2005

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