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

PRINTED: 10/03/200
FORM APPROVEI
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	R-C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 272} SS=B	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete resident assessment protocols (RAPs) on annual assessments for two (#1, #36) of two residents	{F 272}	**F-272 COMPREHENSIVE ASSESSMENTS** 1) RAPS will be completed for Resident #1 and #36; 2) The "Assessment Due Schedule Report" will be reviewed and compared to Resident charts to ascertain that all "Resident Assessment Protocols" are completed for all Residents who required annual assessments; 3) The MDS data collector and DON will meet monthly to audit the RAI calendar to ascertain appropriate documentation is complete; 4) The DON will meet with the Administrator monthly to review the RAI audit and the DON will report to QA Committee quarterly. 5) Overall compliance will be monitored by the QA Committee. POC approved with changes/additions as indicated for overall monitor. Administrator informed on 10/9/07 at 1350.	10/09/2007

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia Ann Mills — TITLE: NHA — (X6) DATE: 10/9/07

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

OCT 09 2007

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{F 272}	Continued From page 1 who required annual assessments. The findings were: 1. Medical record review on 9/18/07 revealed resident #1 had an annual Minimum Data Set (MDS) assessment completed on 8/28/07. There were no completed RAPs found in the medical record. 2. Medical record review on 9/18/07 revealed for resident #36 had an annual MDS assessment completed on 8/24/07 and there were no completed RAPs found for this MDS assessment. 3. Interview on 9/18/07 at 11:30 AM with the administrator, the director of nursing, and the MDS data collector confirmed the RAPs for these assessments had not been completed.	{F 272}	**F-273 RESIDENT ASSESSMENT – WHEN REQUIRED** 1) The Minimum Data Set (MDS) assessment for Resident #27 will be completed; 2) All New Resident Admissions assessments will be completed in accordance with the "Long-term Care Facility Resident Assessment Instrument User's Manual" Version 2;	
F 273 SS=D	483.20(b)(2)(i) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete an admission Minimum Data Set (MDS) assessment in the required 14 days from admission for one (#27) of one resident who required an admission assessment. The findings were:	F 273	3) The DON will be notified of all new Resident admits and the MDS process will begin; 4) Medical Records personnel will audit new admit charts report to the DON and the Administrator of findings and the DON will report to QA Committee quarterly. 5) Overall compliance will be monitored by the QA Committee.	10/09/2007

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F 273	Continued From page 2 Review of the medical record face sheet on 9/18/07 at 10 AM revealed resident #27 was admitted to the facility on 7/23/07. Further review revealed a comprehensive admission assessment was not in the record. Interview on 9/18/07 at 11:30 AM with the administrator, the director of nursing, and the MDS data collector confirmed the comprehensive admission assessment was not completed for this resident, who had been admitted 53 days earlier. According to the the "Long-Term Care Facility Resident Assessment Instrument User's Manual," Version 2.0, the admission assessment is a comprehensive assessment for a new resident that must be completed within 14 calendar days of admission to the facility. According to this manual, the admission day is counted as Day "1", and the 14 day calculation includes weekends.	F 273	**F-275 RESIDENT ASSESSMENT – WHEN REQUIRED:** 1) Resident #11 and #16 MDS's will be completed; 2) The "Assessment Due Schedule Report" will be reviewed and compared to Resident charts to ascertain that all annual comprehensive assessments will be completed within 366 days of the most recent comprehensive assessment; 3) The MDS data collector and DON will meet monthly to audit the RAI calendar to ascertain appropriate annual comprehensive assessments are complete; 4) The DON will meet with the Administrator monthly to review the RAI audit and the DON will report to QA committee quarterly. 5) Overall compliance will be monitored by the QA Committee.	10/09/2007
F 275 SS=D	483.20(b)(2)(iii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete an annual minimum data set (MDS) assessments in the required 12 month period for two (#11, #16) of two supplemental residents who required an annual assessments. The findings were: 1. Medical record review revealed the last	F 275		

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F 275	Continued From page 3 comprehensive assessment for resident #11 was an annual assessment, dated 7/21/06. 2. Medical record review for resident #16 revealed the last comprehensive assessment was dated 8/21/06. 3. Interview on 9/18/07 at 11:30 AM with the administrator, the director of nursing, and the MDS data collector confirmed the current annual assessments for these two residents were late. The interview revealed an annual assessment for resident #11 was started on 9/17/07 (approximately 8 weeks late), and the annual MDS assessment for resident #16 was started on 9/13/07 (approximately 4 weeks late). According to the the "Long-Term Care Facility Resident Assessment Instrument User's Manual," Version 2.0, an annual comprehensive reassessment must be completed within 366 days of the most recent comprehensive assessment.	F 275		
{F 276} SS=E	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to implement a system to maintain and/or complete quarterly minimum data set (MDS) assessments in the required 92 day period for 18 (#4, #5, #6, #8, #13, #15, #18, #19, #20, #21, #22, #32, #34, #35, #37, # 38,	{F 276}	**F-276 Continued on next page.**	

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{F 276}	Continued From page 4 #39, #40) of 18 sample residents who needed to have current quarterly assessments completed. The facility census was 42. The findings were: Interview with the nursing home administrator on 9/18/07 at 10:15 AM revealed the director of nursing and the MDS assessment data collector were focused on completing MDS assessments for the specific resident's sited on the 7/19/07 survey and new resident admissions. She stated while these residents' assessments were completed, others were falling behind schedule. She confirmed there were no audits conducted by the facility to identify additional residents' who's MDS assessments were past due. The interview further revealed there was no facility system to maintain and/or complete the quarterly minimum data set assessments within the required 92 day period. The following concerns were found related to late quarterly assessments and lack of a system to identify quarterly assessments which were due: 1. Medical record review on revealed the following 18 residents did not have quarterly MDS assessments completed within 92 days of their previous assessment: a .Resident #4 - last assessment completed on 4/27/07. b. Resident #5 - last assessment completed on 4/26/07. c. Resident #6 - last assessment completed on 4/19/07. d. Resident #8 - last assessment completed on 3/23/07. e. Resident #13 - last assessment completed on 5/31/07. f. Resident #15 - last assessment completed on 3/29/07.	{F 276}	**F-276 QUARTERLY REVIEW ASSESSMENT** 1) The quarterly minimum data set (MDS) assessments for Residents #4, #5, #6, #8, #13, #15, #18, #19, #20, #21, #22, #32, #34, #35, #37, #38, #39, and #40 will be completed according to MDS version 2.0; 2) The "Assessment Due Schedule Report" will be reviewed and compared to Resident charts to ascertain that all quarterly assessments will be completed within 92 days of the most recent quarterly assessment; 3) The MDS data collector and the DON will meet monthly to audit the RAI calendar to ascertain appropriate quarterly assessments will be and are completed in the required time frames; **F-276 Continued next page.**	

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{F 276}	Continued From page 5 g. Resident #18 - last assessment completed on 5/10/07. h. Resident #19 - last assessment completed on 5/10/07. i. Resident #20 - last assessment completed on 5/31/07. j. Resident #21 - last assessment completed on 4/19/07. k. Resident #22 - last assessment completed on 5/03/07. l. Resident #32 - last assessment completed on 3/22/07. m. Resident #34 - last assessment completed on 5/24/07. n. Resident #35 - last assessment completed on 5/17/07. o. Resident #37 - last assessment completed on 4/12/07. p. Resident #38 - last assessment completed on 5/10/07. q. Resident #39 - last assessment completed on 5/09/07. r. Resident #40 - last assessment completed on 5/03/07. 2. Interview on 9/18/07 at 11:30 AM with the administrator, the DON, and the MDS data collector confirmed these residents did not have quarterly MDS assessments completed when they were due. According to the the "Long-Term Care Facility Resident Assessment Instrument User's Manual," Version 2.0, a quarterly assessment must be completed every 92 days and a comprehensive assessment completed every 366 days from the most recent comprehensive assessment.	{F 276}	**F-276 – Continued** 4) The DON will meet with the Administrator monthly to review the RAI audit and the DON will report to QA Committee quarterly. 5) Overall compliance will be monitored by the QA Committee.	10/09/2007
{F 520}	483.75(o)(1) QUALITY ASSESSMENT AND	{F 520}	**F-520 Continued on next page.**	

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{F 520} SS=E	Continued From page 6 ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to develop a quality assurance (QA) plan of action to correct previous cited resident assessment deficiencies at F272, and F276. The lack of action resulted in a systems failure to identify quarterly resident assessments due. The resident census was 42. The findings were: Interview with the nursing home administrator	{F 520}	**F-520 QUALITY ASSESSMENT AND ASSURANCE:** 1) A new Quality Assurance program was implemented on August 1, 2007 and includes a section on MDS review. The MDS review will be the focus for the October QA Committee; 2) An audit will be completed on all Residents including #1, #4, #5, #6, #8, #11, #13, #15, #16, #18, #19, #20, #21, #22, #27, #32, #34, #35, #36, #37, #38, #39, and #40 by the DON and will be reviewed at the October 2007 QA Committee meeting; **F-520 Continued next page.**	

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{F 520}	Continued From page 7 on 9/18/07 at 10:15 AM revealed the director of nursing and the Minimum Data Set (MDS) assessment data collector were focused on completing MDS assessments for the specific residents' cited on the 7/19/07 survey and new admissions. She stated while these residents' assessments were completed, others were falling behind schedule. She confirmed there were no audits conducted by the facility to identify additional residents' who's MDS assessments were past due. Additionally there was no evidence the QA committee had developed a plan to correct the resident assessment deficiencies. She explained a master schedule had been developed for QA projects. However, the area of resident assessments was not scheduled to be focused on until May 2008. Review of all open resident records on 9/18/07 showed 18 (#4, #5, #6, #8, #13, #15, #18, #19, #20, #21, #22, #32, #34, #35, #37, #38, #39, #40) residents had past due quarterly MDS assessments that were not completed. In addition, annual MDS assessment for two residents (#11, #16) were lacking, and overdue. The current annual assessments for resident's #1 and #36 did not include the resident assessment protocols (RAPs). One admission MDS assessment for resident #27 was overdue and not completed. For additional details on the specific MDS assessments please refer to tags F 272, F 273, F 275, and F 276.	{F 520}	**F-520 - Continued** 3) The DON will monitor all new admission assessments, comprehensive assessments, quarterly assessments, as well as RAPs, and meet with the MDS data collector to audit the RAI calendar and the "Assessment Due Schedule Report for appropriate documentation; 4) The DON will report MDS findings to QA Committee quarterly and the Administrator and Corporate will monitor for compliance. 5) overall compliance will be monitored by the QA Committee.	10/09/2007

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

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Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535040	A. Building B. Wing	09/18/2007

Name of Facility	Street Address, City, State, Zip Code
DOUGLAS CARE CENTER	1108 BIRCH STREET DOUGLAS, WY 82633

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).

uploaded 10/12/07
53 — 155391

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 08/31/2007	ID Prefix F0164 Reg. # 483.10(e), 483.75(l)(4) LSC	Correction Completed 08/31/2007	ID Prefix F0174 Reg. # 483.10(k) LSC	Correction Completed 08/31/2007
ID Prefix F0176 Reg. # 483.10(n) LSC	Correction Completed 08/31/2007	ID Prefix F0221 Reg. # 483.13(a) LSC	Correction Completed 08/31/2007	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 08/31/2007
ID Prefix F0242 Reg. # 483.15(b) LSC	Correction Completed 08/31/2007	ID Prefix F0254 Reg. # 483.15(h)(3) LSC	Correction Completed 08/31/2007	ID Prefix F0274 Reg. # 483.20(b)(2)(ii) LSC	Correction Completed 08/31/2007
ID Prefix F0278 Reg. # 483.20(g) - (i) LSC	Correction Completed 08/31/2007	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 08/31/2007	ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC	Correction Completed 08/31/2007
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 08/31/2007	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 08/31/2007	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 08/31/2007

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
07/19/2007	X			

272, 276, 520

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Name of Facility	Street Address, City, State, Zip Code
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ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 08/31/2007	ID Prefix F0318 Reg. # 483.25(e)(2) LSC	Correction Completed 08/31/2007	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 08/31/2007
ID Prefix F0353 Reg. # 483.30(a) LSC	Correction Completed 08/31/2007	ID Prefix F0356 Reg. # 483.30(e) LSC	Correction Completed 08/31/2007	ID Prefix F0386 Reg. # 483.40(b) LSC	Correction Completed 09/14/2007
ID Prefix F0387 Reg. # 483.40(c)(1)-(2) LSC	Correction Completed 09/14/2007	ID Prefix F0425 Reg. # 483.60(a),(b) LSC	Correction Completed 08/31/2007	ID Prefix F0428 Reg. # 483.60(c) LSC	Correction Completed 08/31/2007
ID Prefix F0441 Reg. # 483.65(a) LSC	Correction Completed 08/31/2007	ID Prefix F0444 Reg. # 483.65(b)(3) LSC	Correction Completed 08/31/2007	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 08/31/2007
ID Prefix F0492 Reg. # 483.75(b) LSC	Correction Completed 08/31/2007	ID Prefix F0502 Reg. # 483.75(j)(1) LSC	Correction Completed 08/31/2007	ID Prefix F0507 Reg. # 483.75(j)(2)(iv) LSC	Correction Completed 08/31/2007

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
07/19/2007	X			

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ID Prefix F0514 Reg. # 483.75(l)(1) LSC	Correction Completed 08/31/2007				
Reviewed By State Agency	**Reviewed By** RS	**Date:** 10/12/07	**Signature of Surveyor:** Karen R Thomas RN Health Surveyor		**Date:** 9/19/07
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**		

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
07/19/2007	X			