

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNF AND NFs		PROVIDER # 535038	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE 3/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY		
UP PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
F 160	483.10(c)(6) CONVEYANCE UPON DEATH Upon the death of a resident with a personal fund deposited with the facility the facility must convey within 30 days the resident's funds, and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, one (#46) of two residents who had trust accounts and were deceased did not have the funds in their accounts conveyed within 30 days. Findings were: Interview with a front office staff member #36 on 3/15/06 at 1:45 PM revealed that resident #46 had a balance of \$10.01 in his/her trust account on the date of the resident's death, which was 12/15/05. Review of a photocopy of the check revealed the actual date of the check disbursing the residents funds was 1/18/06. F160 The facility will ensure upon the death of a resident that funds will be refunded appropriately by: 1. Balances on all residents that leave the facility or pass away will be sent to the appropriate person within 30 days. 2. Discharges will be reviewed daily in the morning meeting from there the Payroll Manager and the Business Office Manager will meet and proceed with the closing of accounts. 3. All accounts will be closed within 30 days. If a Holiday falls at the end of this 30 days it will be done prior to the Holiday. 4. Account activity will be reviewed twice a month by the Payroll Manager and Business Office Manager to ensure all accounts are closed that need to be. 5. This will be monitored by Administrator on a monthly basis. To ensure the proper steps are taken to get all funds back to the appropriate person in the proper time frame. This will be reported to QA committee monthly for feed back and any improvements that could be added. 03/31/06			

Any deficiency statement ending with an asterisk(*) denotes a deficiency which the institution may be exempted from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for marking boxes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided or pending hearing the above findings and plans of correction are disclosable 12 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 478 YELLOW CREEK ROAD EVANSTON, WY 82830		
(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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(I)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting	F 156	F156 The facility will ensure that the rights and services of each resident is met. This will be accomplished by: 1. The Advocacy Information posted in the corridor on 03/13/06 with the correct information of the State Licensing & Survey Agency has been updated to include the correct Name, Address & Phone number for the Office of HealthCare Licensing & Survey Agency. 2. Resident admission information has been updated with correct name, address, & phone number for the Office of HealthCare Licensing & Survey. 3. Future corrections of this information will be updated by the Payroll Manager or Social Service Designer. 4. A quality monitoring tool will be implemented to ensure this information is current. The monitor will be completed quarterly and reported quarterly at the Quality Assurance Meeting. 5. The QA Committee will be responsible	04/03/06 WYoming	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Sharon K. Leeper HHA-537
TITLE
for Compliance
DATE
4/10/06

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 156	Continued From page 1 personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's	F 156			

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F 156	Continued From page 2 policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure the name of the state survey and certification agency was accurately posted. Findings were: Observation of advocacy information posted in the corridor on 3/13/06 at 7:30 PM revealed the name of the state licensure/survey and certification agency was listed as the "Office of Health Quality." The correct name of the agency, The Office of Healthcare Licensing & Surveys, was not indicated. Furthermore, record review revealed the information provided directly to residents and families upon admission, not only had the same incorrect name of the agency, but lacked a phone number.	F 156			

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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE

475 YELLOW CREEK ROAD
EVANSTON, WY 82930

SA 5/9/06

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F 157 SS=E	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of incident reports, policy review, and staff and family interviews, the facility failed to notify the physician and/or family of a change in	F 157	F157 The facility will ensure the notification of changes requirement is met. This will be accomplished by: 1. The family of resident #15 has been notified of the re-opened skin tear to the upper right arm. 2. The Director of Nursing spoke with Hospice and the physician regarding resident #28. Orders were changed on 03/22/06 to weigh resident every other week. Findings were reported to Hospice. 3. Resident #18's physician was notified of stage I pressure sore on 03/20/06. Orders were obtained and treatments started. Resident's family was notified of orders & condition of resident and documented. 4. Families or Legal Representatives and the resident's physician will be contacted immediately for all future changes in residents status.	

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F 157	Continued From page 4 resident health status for three of ten (#15, #18, #28) sample residents. The findings were: 1. Review of nursing notes showed on 1/19/06 resident #15 re-opened a skin tear to the upper right arm while being assisted off the toilet. Review of the 1/26/06 skin meeting notes showed the resident received a skin tear to the right upper arm during a transfer on 1/19/06. Review of physician orders showed on 1/20/06 the physician signed new orders for the treatment of the skin tear. Review of nursing notes failed to show the family was notified. Review of the incident report showed the skin tear occurred on 1/19/06, but the family was not notified until 1/23/06. During an interview on 3/16/06 at 4:15 PM, a family member stated they were not notified of the skin tear until they asked staff about it. During an interview on 3/16/06 at 9:57 AM, the director of nursing (DON) stated the day shift staff should have notified the family the day after the skin tear occurred. 2. Review of the 8/26/05 history and physical revealed resident #28 had congestive heart failure (CHF) and had an ongoing problem with edema. The H&P documented the resident had 3+ edema in the lower extremities. The admission physician orders dated 8/26/05 and the March 2006 orders showed an order for weights every other day, and call [the physician] if less than 75 kilograms (kg) [165 pounds] or more than 85 kg [187 pounds]. Physician orders showed that on 2/10/06, the Lasix was increased to 40 milligrams every day, instead of every other day. There lacked evidence in the medical record the physician was notified when the resident's weight dropped below 165 pounds. The resident's weight had been below 165 pounds since 12/19/05. The	F 157	5. All nursing staff RN's, LPN's & C.N.A's participated in an in-service on 03/31/06 topic was proper notification to physicians and resident's families immediately upon any change of resident's condition.. 6. A quality monitoring tool will be implemented to ensure proper notification of a residents change in status immediately. This monitor will be completed monthly, minimally and reported monthly at the Quality Assurance meeting. <i>7. The QA Committee will be responsible for overall monitoring of this practice.</i>	03/31/06	

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 476 YELLOW CREEK ROAD EVANSTON, WY 82930		
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F 157	Continued From page 5 resident's most recent weight on 3/9/06 was 156.6 pounds. During an interview on 3/15/06 at 5:10 PM, the DON confirmed there was no evidence the physician was notified. 3. Observation on 3/13/06 at 9:15 PM revealed resident #18 had a stage I pressure sore on both sides of his/her buttocks. Interview with registered nurse (RN) #2 at this time confirmed the resident had a stage I pressure sore on both sides of the resident's buttocks. Review of the medical record on 3/16/06 (three days later) revealed the physician and the family were not notified of the newly identified pressure sore. Interview with the director of nursing on 3/16/06 at 10:10 AM confirmed the physician and family had not been notified and that she was also unaware of the newly identified pressure sore. 4. Review of the facility's undated policy on physician notification revealed the following instructions: "Purpose: To ensure that resident's physician is notified within 24 hours of the following. B. Changes in resident's condition...F. Any skin breakdown." Review of the facility's undated policy on family notification revealed the following instructions: "Purpose: To ensure families are notified within 24 hours of any change in resident's condition....B. Change in resident's condition...D. Development of pressure ulcers	F 157			

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F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, the facility failed to ensure privacy was maintained for one (#38) of ten sample residents. The findings were: Observation on 3/13/06 at 8:55 PM revealed	F 164	F164 The facility will ensure personal privacy will be maintained for each resident. This will be accomplished by: 1. The charge nurse or a nurse assigned to ensure quality care is provided will observe nurse aides #25 & 20 while providing cares to resident #38. 2. An all nursing staff in-service was conducted on 03/31/06 instructing nursing staff on proper procedures to ensure privacy & confidentiality for all residents. An additional in-service scheduled for 04/14/06 will require each nurse aide to demonstrate skills in resident cares while ensuring privacy. Each C.N.A. will then be signed off on and or receive additional training if necessary. As part of the monitoring this in-service will be conducted every 6 months or as needed.		

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ROCKY MOUNTAIN CARE EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE

476 YELLOW CREEK ROAD
EVANSTON, WY 82930

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F 164	Continued From page 7 resident #38 received bedtime care by certified nurse aides (CNAs) #25 and #20. Continued observation revealed CNA #25 left the room to obtain supplies while CNA #20 remained with the resident. The CNAs left the resident uncovered exposing his/her buttocks and upper thighs, and the privacy curtain was not pulled. A non staff member opened the door without knocking and was able to observe the resident's exposed buttocks and upper thighs. Interview with the director of nursing on 3/16/06 at 8:08 AM confirmed the resident should not have been left exposed. Review of the facility's undated policy on privacy revealed the following instructions: "Purpose: To ensure the privacy of residents in our facility...2. Privacy curtains will always be pulled around resident when performing any resident care."	F 164	3. The Director Of Nursing or designee will randomly observe nurse aides as they perform personal cares on resident's to ensure resident privacy and if resident privacy is being violated immediate in-servicing & corrective action will be taken. 4. A quality monitoring tool will be implemented to ensure resident's personal privacy. This monitor will be completed by Don - C62 monthly and reported quarterly at the QA meeting.	03/31/06
F 169 SS=E	483.10(h) WORK The resident has the right to refuse to perform services for the facility; or perform services for the facility, if he or she chooses, when the facility has documented the need or desire for work in the plan of care; the plan specifies the nature of the services performed and whether the services are voluntary or paid; compensation for paid services is at or above prevailing rates; and the resident agrees to the work arrangement described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility	F 169	5. Overall compliance will be ensured by the QA committee.	

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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE

476 YELLOW CREEK ROAD
EVANSTON, WY 82930

34 5/1/06

(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 164	Continued From page 7 resident #38 received bedtime care by certified nurse aides (CNAs) #25 and #20. Continued observation revealed CNA #25 left the room to obtain supplies while CNA #20 remained with the resident. The CNAs left the resident uncovered exposing his/her buttocks and upper thighs, and the privacy curtain was not pulled. A non staff member opened the door without knocking and was able to observe the resident's exposed buttocks and upper thighs. Interview with the director of nursing on 3/16/06 at 8:08 AM confirmed the resident should not have been left exposed. Review of the facility's undated policy on privacy revealed the following instructions: "Purpose: To ensure the privacy of residents in our facility...2. Privacy curtains will always be pulled around resident when performing any resident care."	F 164		
F 169 SS=E	483.10(h) WORK The resident has the right to refuse to perform services for the facility; or perform services for the facility, if he or she chooses, when the facility has documented the need or desire for work in the plan of care; the plan specifies the nature of the services performed and whether the services are voluntary or paid; compensation for paid services is at or above prevailing rates; and the resident agrees to the work arrangement described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility	F 169	F169 The facility will ensure the resident's have the right to refuse to perform services for the facility. This will be accomplished by: 1. The practice of residents being required to sack their own clothing & place the soiled clothing in hampers has been discontinued. All soiled laundry is being handled by the nursing staff daily. 2. The scheduled hours for laundry personnel have been modified to adequately meet the demand for laundry services depending on resident census & acuity. 3. A method of continuous monitoring will be implemented to ensure residents have the right to refuse to perform services for the facility. This monitor will be completed quarterly by the DON & reported at the Quality Assurance meeting.	03/31/06 by the DON & Social Services

4. Overall monitoring will be accomplished by the QA Committee.

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F 169	Continued From page 8 did not ensure residents did not perform services for the facility without documentation of the residents' desire to work. Findings were: Group interview with residents on 3/14/06 at 9:30 AM revealed they were required to sack their own clothing and put the soiled clothing in the yellow hampers in the hallways in order for the laundry to be done by the facility. One resident stated that when she/he was new her/his laundry was not done for nearly a week. The resident stated s/he did not know why until s/he was told s/he needed to bag her/his own personal laundry and put it in the hamper. Residents said not all had to bag their own laundry, but those who were able were expected to do so. Interview with the laundry aide on 3/14/06 at 11 AM verified some of the residents bagged their own soiled personal laundry because she did not have time to go to each individual's room and collect laundry due to a restriction to her work hours. She indicated a chart on the bulletin board in the laundry that showed how many hours a laundry aide was allotted each day depending upon the resident census. On that particular day the laundry aide was limited to less than 5 hours to independently complete all laundry-related tasks.	F 169			
F 221 SS=0	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by:	F 221	F221 The facility will ensure resident's have the right to be free from any physical restraints imposed for the purposes of discipline or convenience, and not required to treat the residents medical symptoms. This will be accomplished by:		

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON <i>SA 5/4/06</i>			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 221	Continued From page 9 Based on record review and staff interview, the facility failed to ensure one of four sample residents (#45) with restraints was not unnecessarily restrained. Findings were: Closed medical record review revealed resident #45 had an order for two full side rails to "prevent independent transfers" and for bed mobility, every day, every shift. The following concerns were noted regarding the use of the side rail restraints for this resident: a. The bed entrapment assessment completed on 1/9/06 did not show there was a medical reason for the use of a side rail. The assessment indicated the purpose of the side rail was for turning and repositioning and to prevent unassisted transfer and ambulation. b. There lacked evidence in the record that an alternative to full side rails had been attempted. c. Documentation in the nurses' notes on 1/15/06 at 4:50 AM revealed the resident was found on the floor by certified nurse aides (CNAs). That same entry indicated the resident may have been ambulating back from the bathroom. The resident complained that day of discomfort to the left shoulder and arm. d. Nurses' notes on 2/7/06 at 10:15 PM revealed the resident fell. The note revealed the resident stated, "I crawled out the end of my bed to go to the bathroom and fell in the bathroom on my right knee." The resident had used the toilet and crawled back into bed. Side rails were noted to be up on both sides of the bed at the time of the accident. e. The bed entrapment assessment completed on 2/23/06 did not identify behaviors	F 221	1. Resident #45 bed entrapment assessment was reviewed & revised by the Director of Nursing on 03/17/06 with corrected purpose for side rail usage based on the residents assessment & behaviors with specific symptoms to identify the need for restraints. <i>the least restrictive</i> 2. Updated orders for resident #45 continued with side rail usage due to medicine diagnosis of left side weakness caused by a stroke. Resident #45 had bed alarm in place also due to confusion. 3. A quality monitoring tool has been implemented to ensure resident's rights to be free from any physical restraints except when required to treat resident's medical symptoms. This monitor will be ongoing with a fall/restraint committee reviewing residents throughout the month with a report provided at the monthly committee meeting then reported at the monthly Quality Assurance meeting.	03/30/06	

Overall monitoring for compliance will be accomplished by the QA committee.

4. The QIO has been contacted to assist the facility with physical restraints.

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930		
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F 221	Continued From page 10 such as "attempts to climb over/around side rails" or attempts transfers/ambulation without assistance recommended for safety" despite the previously noted falls. The only behavior related to side rail use was "uses side rails/restraints appropriately." f. The side rail need/approval form revealed the reason for the behavior was to prevent unassisted transfers from bed to treat the following medical symptoms: CVA with left sided weakness, atrial fibrillation, COPD, increased weakness. The specific symptoms the resident may have exhibited related to these diagnoses and the associated need for a physical restraint were not identified. The plan continued to be to use the side rails whenever the resident was in bed. g. The restraint review completed 2/23/06 revealed the resident had had one fall involving the restraint in the past 30 days, yet the recommendation of the review committee was to continue the restraint for the next 90 days. There was no evidence the facility had attempted alternative, less-restrictive methods for this resident. h. Interview with the social services director on 3/15/06 at 3 PM revealed she did not believe the resident could feel the edge of the bed with the side of his/her body affected by the stroke and needed the side rail for that reason. She was unaware if alternatives to side rails had been attempted or evaluated. i. The physician's order did not identify the specific medical symptoms for the use of the full side rails for this resident.	F 221			

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 476 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
F 226 SS=F	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on policy review, review of new employee personnel records, and staff interview, the facility did not consistently implement policies related to misappropriation of property in 1 of 5 reviewed personnel records and did not ensure their policies provided accurate information required to reporting abuse allegations to the State Survey Agency (SSA). Findings were: 1. Review of personnel record information for staff member #37, who was employed as a housekeeper, revealed the individual's employment application had the following concerns: a. Blank spaces were noted for dates of employment at two previous jobs noted on the application. The individual at the facility who had checked the references documented "verified dates of service," yet not dates of service were indicated. There was no indication as to why the individual left his/her last employer. Interview on 3/16/06 at 2:45 PM with staff member #36 revealed the staff member (#37) had worked at their facility at some prior time, yet that was not indicated on the application. b. The applicant indicated s/he had been convicted of delivery of a controlled substance and conspiracy to deliver a controlled substance. The local criminal background check also revealed the staff person had been arrested for	F 226	F226 The facility will ensure that written policies & procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident's property are reviewed, revised, developed & implemented. This will be accomplished by: 1. Staff #37 was terminated on 3/15/06 2. The process & procedures for accepting all applications will be reviewed, revised & implemented by a work committee consisting of the HR Manager, Administrator, and department managers from each department and monitored in QA. Initial revisions to the hiring process have already been implemented such as follows.		

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930		
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F 226	Continued From page 12 shoplifting, which was not noted by the employee on his/her application. c. Review of the facility's policy #2029, Abuse Prevention, revealed if the screening process indicates any history of abuse or misappropriation of property, the individual will not be hired. In this instance, the facility did not follow their own policy. d. Interview with a resident in the dining room on 3/14/06 at 6 PM revealed the resident had a gold cross stolen by a staff member who currently worked in the facility. The resident stated this was reported to the facility, and no one believed her. 2. Review of policy #2001 regarding Abuse-Prohibiting, Investigating, and Reporting, last revised on 11/10/03, the following concerns were noted: a. Under the heading Screening of Staff, number 6 indicated a yearly criminal background investigation would be completed on all staff at the time the facility applied for its annual license renewal, where applicable by state law. In longhand someone had added: "-Not Wyoming." b. Another heading was: Regulation for Reporting Pursuant to Utah Code Annotated 62A-3-303. The information was not specific to Wyoming, where the facility is located and licensed. c. Under the heading entitled Investigation and Reporting Procedures the policy indicated only "severe" cases of sexual or physical abuse need be reported. d. Section 3 under this heading indicated the State Survey and Certification Agency at 801-538-6168 or the Office of Health Quality at 307-777-7121 would be notified of significant incidents between residents or abuse and	F 226	A. All applications & accompanying background checks will be received and reviewed by the HR Manager prior to any position being offered to an applicant. B. Applications missing required information will be returned to the applicant for completion or the department manager designee or HR Manager will call the applicant to obtain missing information.		

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 226	Continued From page 13 misappropriation of property. However the number listed first in the policy is the Utah agency SSA, which has no authority to investigate in Wyoming, and is not the Wyoming agency. In addition, the name of the Wyoming Agency is incorrect and the Wyoming phone number requires updating. e. Section 4 identifies what the administrator will do to initiate the investigative process. According to this policy the facility will use the "State's Investigation Form," which Wyoming does not have. Part 9 under this section says that after the investigation is complete if notification was made to the Utah State Survey and Certification Agency, the written report will be faxed within five days of the incident to the Utah State Agency attention: Complaint Team Manager, fax number 801-536-0948. None of this information is applicable to a facility operating in Wyoming. 3. Review of the facility's incident reports revealed an incident of resident to resident abuse was reported to the Wyoming Long Term Care Ombudsman, however it was not reported to the Wyoming SSA. Interview with the Social services director on 3/15/08 at 3 PM verified this was not reported. The director stated she was not certain at the time of the report to the Ombudsman whether or not this was a reportable incident.	F 226	C. Background checks which return with a negative result will be reviewed by the Administrator & HR Manager to ensure privacy of the applicant. Applicant will not be hired when criminal history is present. D. A minimum of two employer references will be completed by the HR Manager. If there are not two employment references available the HR Manager will obtain three personal references that are verifiable.		

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F 228	Continued From page 13 misappropriation of property. However the number listed first in the policy is the Utah agency SSA, which has no authority to investigate in Wyoming, and is not the Wyoming agency. In addition, the name of the Wyoming Agency is incorrect and the Wyoming phone number requires updating. e. Section 4 identifies what the administrator will do to initiate the investigative process. According to this policy the facility will use the "State's Investigation Form," which Wyoming does not have. Part 9 under this section says that after the investigation is complete if notification was made to the Utah State Survey and Certification Agency, the written report will be faxed within five days of the incident to the Utah State Agency attention: Complaint Team Manager, fax number 801-536-0948. None of this information is applicable to a facility operating in Wyoming. 3. Review of the facility's incident reports revealed an incident of resident to resident abuse was reported to the Wyoming Long Term Care Ombudsman, however it was not reported to the Wyoming SSA. Interview with the Social services director on 3/16/06 at 3 PM verified this was not reported. The director stated she was not certain at the time of the report to the Ombudsman whether or not this was a reportable incident.	F 228	E. All reference checks will be documented with the date, time and name of the individual providing the information. Any additional information will be documented as well. F. Following completion of reference checks, background checks & licensing/registry verification the application will be returned to the appropriate department manager to determine if an offer of employment is in order.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 635038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2008
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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE

475 YELLOW CREEK ROAD
EVANSTON, WY 82930

3/14/08

(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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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930		
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F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure dignity was maintained for three (#11, #18, #38) of ten sample residents. The findings were: 1. Observation on 3/13/06 at 9:15 PM revealed certified nurse aide (CNA) # 25 tilted the wheelchair of resident #18 on its back two wheels and pushed the resident rapidly down the hallway into his/her room. Interview with the CNA at the time revealed s/he tilted the wheelchair back because the resident dragged his/her feet on the floor. Interview with the director of nursing (DON) on 3/16/06 at 8:08 AM confirmed tilting the wheelchair back was not appropriate. 2. Observation on 3/13/06 at 9:17 PM, at 9:20 PM, and at 9:25 PM revealed registered nurse #2 entered the room of resident #18 without knocking. Review of the undated facility policy on privacy revealed the following instructions: "Purpose: To ensure the privacy of residents in our facility. ...1. Employees will always knock on the resident's door and announce their names before going into resident's room..." Interview with the DON on 3/16/06 at 8:08 AM confirmed staff should knock prior to entering a resident's room. 3. Observation on 3/14/06 at 8:40 AM revealed resident #18 had hot cereal dripping down the left	F 241	F241 The facility will promote care for resident in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This will be accomplished by: 1. An In-Service was conducted on 03/31/06. Although the in-service was geared towards nursing staff, staff members from all departments were in attendance. Director of Nursing addressed the importance of staff's attention to resident's dignity, & respect for their rights at all times by all staff. 2. Resident #25 has been reassessed for the need for foot rests. All resident's utilizing wheelchairs will be assessed for foot rests. A monitoring tool will be established and the charge nurse on each shift along with the Director of Nursing and restorative staff will monitor this continually and report to QA monthly.	#18	

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F 241	Continued From page 15 side of his/her mouth onto the clothing protector. Continued observation revealed the resident's mouth was not cleaned until 9 AM (20 minutes later). During the observation, a staff member was seated at the table next to the resident. 4. Observation on 3/13/06 at 6 PM revealed resident #11 had an indwelling catheter and the catheter bag was uncovered while the resident was in the dining room. Interview with the DON on 3/16/06 at 8:08 AM confirmed the catheter bag should have been covered while the resident was in a public area. 5. Observation on 3/13/06 at 6 PM revealed resident #38 had an indwelling catheter and the catheter bag was uncovered while the resident was in the dining room. Interview with the DON on 3/16/06 at 8:08 AM confirmed the catheter bag should have been covered while the resident was in a public area. 6. Observation during the breakfast meal on 3/14/06 at 8:32 AM revealed CNA #13 referred to the clothing protector as a "bib" in front of sample resident #38.	F 241	3. Nursing staff were instructed at In-service on 03/31/06 and reminded to always knock and announce their name before entering the room of resident #18 and all resident rooms. 4. Nursing staff were instructed and reminded at an in-service on 03/31/06 that allowing food dripping from any residents mouth, as with resident #18, is not appropriate care and compromises the resident's dignity. 5. Nursing staff were instructed and reminded at an in-service on 03/31/06 that any resident including #11 & 38 who must utilize a catheter bag have the right to have the bag covered at all times to protect the privacy & dignity. 6. Nursing staff were instructed & reminded that all residents, including #38, may need to use clothing protectors. In order to protect the resident's dignity all staff will use dignified terminology when addressing residents or speaking to other staff.		

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON	STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930
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F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to accommodate the individual needs of one of one (#38) sample residents, in a total sample of 10, who had individualized needs regarding laundry and availability of a method to alert staff while confined to bed. The findings were: Observation on 3/13/06 at 7:29 PM and on 3/14/06 at 10:35 AM revealed a sign posted above the bed of resident #38. The sign reminded staff that the resident's laundry was to be washed with a special detergent. The sign instructed staff to only use the clean linen in the closet. Review of the 3/8/06 care plan showed there were special linen precautions due to allergies to chlorine. Interview with certified nurse aide (CNA) #25 on 3/13/06 at 8:55 PM revealed the resident had an allergy to the facility's laundry soap. The CNA stated the resident's linens and hospital gowns were washed in a special detergent and kept in a bedside table located in the resident's bathroom; away from the facility's linen supply. However, observation on 3/13/06 at 8:55 PM revealed there was no linen in the bedside table located in the resident's bathroom and the CNA left the room to obtain the incontinence pad that was placed next to the resident's skin.	F 246	F 246 The facility will ensure the resident's have the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other resident's would be endangered. This will be accomplished by: 1. Resident #38 continues to require laundry being washed in a special detergent to alleviate allergic reaction. Laundry staff hours have been adjusted to adequately meet the laundry needs of the resident and the facility. 2. Resident #38, who continues to be on complete bedrest, also continues to be transported to the TV area in her bed so that she can be out of her room and be able to socialize with other residents. Resident #38 is always provided with a call bell so that she can alert staff if she is requiring assistance.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 246	Continued From page 17 Interview with the laundry aide on 3/14/06 at 11 AM revealed her hours were limited and based on actual resident census. She stated she was not able to get all of the laundry done and distributed each day due to the limited time allotted. Furthermore, she stated she usually worked a little longer each day on her own time to do the best she could to get as much as possible done. Observation on 3/13/06 at 7:25 PM revealed clean clothes that had not yet been removed from the dryers. Review of a falls meeting note dated 2/23/06 showed the resident was on complete bedrest due to a fracture in the lower extremity. During an interview on 3/13/06 at 7:55 PM, CNA #25 stated the resident was on bedrest, so the resident was brought to the TV area (adjacent to the dining room) in the hospital bed. The CNA stated the resident was usually there from about 3:30 PM until 7:30 PM each night. Observation on 3/13/06 from 7:30 PM until 8:45 PM revealed the resident was confined to the hospital bed in the TV area (adjacent to the dining room). The resident did not have a call light, or other method to alert staff, and staff were not present in the room. During an interview on 3/16/06 at 9:57 AM, the director of nursing (DON) stated the resident had the ability to use the call light. The DON further stated she did not know how the resident could alert staff of his/her needs, if there was not a call light available.	F 246	3. Quality monitoring tools are being developed to ensure that resident #38 and any resident who may require special laundry services receive the required services, and to ensure that resident #38 and all residents who are transported away from their room and call light and left unattended in an area such as the TV room will have a call bell or another method to alert staff if assistance is required. The charge nurse on each shift and the DON will monitor both of these residents' concerns on a daily basis and report results monthly in the QA Committee. <i>4. Over all compliance will be monitored by the QA Committee.</i>	04/28/06 5/9/06	

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 248 SS=ID	403.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide activities to meet the needs of one of one (#38) sample resident who was on bedrest. The findings were: Observation of resident #38 at the following times revealed the resident was awake in bed in his/her room, without any stimulation (no TV or radio) or activity: on 3/14/06 from 8:55 AM until 12 noon (at 11:32 AM, the resident was calling out "...hey, hey!" to staff members as they walked by the room.), on 3/14/06 from 2:25 PM until 4:10 PM (bingo was at 3:45 PM), on 3/15/06 at 10:20 AM (while a story time activity was going on in the lounge), on 3/15/06 from 2:28 PM until 3:15 PM, and on 3/15/06 from 4:05 PM until 4:50 PM (while a social was going on in the lounge/dining room). Review of a falls meeting note dated 2/23/06 showed the resident was on complete bedrest due to a fracture in the lower extremity. During an interview on 3/15/06 at 9:50 AM, the director of nursing (DON) stated the resident was on complete bedrest. Review of a 3/1/06 activity note showed the resident was supposed to attend activities in bed (staff could wheel the bed to the activity) due to a fractured leg. The 2/8/06 data collection tool for activities revealed the resident	F 248	F 248 The facility will ensure that , ongoing programs of activities designed to meet, in accordance with the comprehensive assessment, the interest and the physical, mental, and psychosocial well-being of each resident. This will be accomplished by: 1. Actively assisting to and involving resident #38 or any resident who is on bed rest or restricted mobility in daily scheduled activities and also schedule them for one on one activity 3-5 times per week. 2. Activity Department staff will assist residents with in room leisure needs/requirements as they request or when care planned for the individual resident. 3. The activity director and staff will review, revise and/or develop a quality monitoring tool to ensure that provisions of ongoing activity programs meet each residents needs		

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 476 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	
F 248	Continued From page 19 had interests in painting, visiting, crafts, music, watching TV, and coloring. During an interview on 3/16/06 at 8 AM, the activity director stated even though the resident was on bedrest, the resident did not receive one-to-one activities. The activity director agreed the resident was at higher risk, and required more attention with regard to activities, because the resident was on bedrest. She further stated staff should be bringing the resident to activities in the bed. In addition, she stated the resident enjoyed working on painting and coloring in his/her room. Furthermore, she stated the resident should be attending sensory group four times per week. However, review of the sensory group documentation revealed the resident only attended on 3/8/06 and 3/10/06.	F 248	according to their comprehensive assessment. This monitor will then be reported quarterly at the QA Committee. <i>4. Over all compliance will be monitored by the QA committee.</i>	04/28/06 5/19/06	
F 253 SS=F	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation on four of four halls, and staff, resident, and family interviews, the facility failed to ensure a clean, comfortable interior or furnishings. Findings were: 1. Observation on 3/13/06 between 7:25 PM and 8 PM revealed the following housekeeping or maintenance concerns in areas of the facility frequented by residents:	F 253			

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON <i>SH 5/4/06</i>			STREET ADDRESS, CITY, STATE, ZIP CODE 479 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	
F 248	Continued From page 19 had interests in painting, visiting, crafts, music, watching TV, and coloring. During an interview on 3/16/06 at 8 AM, the activity director stated even though the resident was on bedrest, the resident did not receive one-to-one activities. The activity director agreed the resident was at higher risk, and required more attention with regard to activities, because the resident was on bedrest. She further stated staff should be bringing the resident to activities in the bed. In addition, she stated the resident enjoyed working on painting and coloring in his/her room. Furthermore, she stated the resident should be attending sensory group four times per week. However, review of the sensory group documentation revealed the resident only attended on 3/8/06 and 3/10/06.	F 248	F253 The facility will ensure the provision of housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior. This will be accomplished by: 1. Developing a comprehensive plan to correct each of the listed deficiencies impacting the maintenance department. Items to be included in the immediate corrective plan for maintenance: A. All tiled floors in the building including hallways, resident rooms, closets etc will be repaired with replacement tiles where broken or cracked, stripped & waxed and put on a buffing schedule to adequately keep accumulations of wax and dirt building up from happening. B. Cracks in the walls, specifically in the resident dining room will be repaired and the wall's painted.		
F 253 SS=F	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation on four of four halls, and staff, resident, and family interviews, the facility failed to ensure a clean, comfortable interior or furnishings. Findings were: 1. Observation on 3/13/06 between 7:25 PM and 8 PM revealed the following housekeeping or maintenance concerns in areas of the facility frequented by residents:	F 253			

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON <i>SA 5/4/06</i>			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 253	Continued From page 20 a. On all four hallways and in the central nursing station area, a heavy accumulation of blackened wax and dirt was evident on the floors along the baseboards. Damaged or missing sections of baseboards were also noted throughout the building. Unprotected corners that projected outward into living and traffic areas were noted to be scraped and damaged throughout the building. b. In the main dining room there was a crack in the wall beneath the window near the horseshoe-shaped tables. Table legs and pedestals were scraped and scratched throughout the dining room. c. One corridor door to a clean utility room had a knob that was coming off of the door. Another door to the kitchen on the main hall had damaged veneer, and an attempt to repair it with strips of masking tape was apparent. Ceiling tiles near room 211 had been removed, exposing water pipes. d. A 3/4 inch crack in the floor tile in hall one was seen. e. In the secure unit in the space where an old linen closet had formerly been located, the collar was missing from the sprinkler pipe, leaving a gap in the ceiling. f. There was a broken cupboard door in the dining area of the secure unit. g. Four light fixtures in the dining room of the secure unit had noticeable accumulations of dead insects. h. The Arjo tub in the 1st Avenue Hall had gouges along its upper sloped interior surface. i. In the same tub room two shower stalls were noted to have chipped and cracked tile flooring around the floor drains, thereby preventing effective cleaning and sanitization.	F 253	Unprotected corners will be repaired and painted or covered with commercial corner guards when budgeted. C. Doors throughout the building will be looked at for missing veneer or rough uncleanable surfaces and repaired. Door knobs will be adjusted for proper usage or replaced if worn beyond ability to clean the surface adequately. D. Ceiling tiles throughout the building will be inspected and repaired or replaced as necessary especially in the 200 hall. E. All fire sprinklers will be brought up to code with collars and appropriate spacing relative to the ceiling, especially the one noted in the secure unit. F. The central nurses station will be repaired where missing veneer is exposing the wooden substructure. Cupboard doors will be looked at throughout the building and repaired or replaced as necessary, especially in the secure unit.		<i>5/11/06</i> <i>CE</i> <i>5/19/06</i> <i>15/06</i> <i>James</i> <i>file</i>

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 02930	
(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 253	Continued From page 21 j. The central nurses' station exhibited large areas of damaged or missing veneer, exposing its wooden substructure. 2. Two residents interviewed on 3/14/06 at 9:30 AM commented on odors in the facility. One resident stated he/she had noticed odors coming from the laundry. Another resident stated it smelled in the hallway. The residents stated they had addressed this issue with the facility and were led to believe it was illegal to cover up odors with sprays or foggers. The residents stated they did not believe anything could be done about the odors. Residents also stated they had noticed damage to the doors and walls in various locations around the building and black marks on the walls. 3. Observation in the dining room on 3/16/06 at 8 AM revealed ten residents in wheelchairs with drips, dried spills, and food accumulations on wheelchair surfaces. One of these residents had a wheelchair with a large splattering of what appeared to be white paint on the wheels and other outer surfaces of the chair. Interview with the housekeeping supervisor on 3/16/06 at 8:30 AM evidenced there was not currently an employee assigned to the task of cleaning wheelchairs. The supervisor said there had been an employee who was supposed to wash soiled wheelchairs, but that individual had quit the week before. 4. Interview with the supervisor of the housekeeping department on 3/13/06 at 5 PM revealed the housekeeping staff's hours were based on the resident census. Observation at the time revealed the housekeeping carts were	F 253	G. Chipped or cracked tiles in the shower stalls of the tub room will be repaired or replaced. H. Gouges in the Arjo tub on 1st avenue will be repaired as soon as a specialist for tub repair can be arranged. The tub will be reviewed for possible replacement as a budget item. I. Table legs & pedestals will be repaired from scrapes and scratches and painted or varnished as necessary. 2. Simultaneous to the maintenance issues being corrected there will be a detailed preventative maintenance program developed and initiated by the maintenance department and directed by the administrator & owner. The preventative maintenance program will be tied to a Quality Monitoring tool to ensure that routine repairs of the basic interior of the building are dealt with as soon as possible upon discovery. This monitor	FILED CB 5/11/06 CB

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE ZIP CODE 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
F 253	Continued From page 22 parked on the soiled side of the laundry area and the supervisor stated the housekeeping aides had gone home that day at approximately 2 PM, due to census. 5. During a family interview on 3/15/08 at 4:15 PM, a family member stated the facility was not clean and had odors. The family member stated the environment had "...gone downhill since Fall."	F 253	will be completed by the Administrator or designee in cooperation with the maintenance director and reported monthly at the QA meeting.		
F 254 SS=E	483.15(h)(3) ENVIRONMENT- LINENS The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview, the facility failed to ensure residents had enough clean bed and bath linens. Findings were: Observation on 3/13/06 at 7:25 PM in the laundry department revealed the department was closed for the day, no laundry staff were present, and each of two dryers contained clothing that had not been removed and hung up or folded. Interview with the supervisor of the laundry/housekeeping/maintenance departments on 3/13/06 at 5 PM evidenced that laundry staff hours were limited based on census. The supervisor reviewed the laundry schedule with the surveyor and stated that on that particular day the laundry aide was scheduled to come in at about 8 AM and left for the day at approximately 2 PM. Interview with a group of cognitive residents on	F 254	3. Housekeeping services will develop a comprehensive plan to correct each deficiency and simultaneously developing a quality monitoring tool to ensure that all housekeeping services are performed adequately to meet resident's needs. The monitoring tool will be developed by the Director or housekeeping services in conjunction with the housekeeping staff, the director of nursing and the Administrator or their designees. The monitor will be completed on an ongoing basis and reported at the quality assurance meeting monthly for at least 6 months then quarterly. Items to be included in the immediate corrective plan for housekeeping		by the Administrator

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON	STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930
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F 253	Continued From page 22 parked on the soiled side of the laundry area and the supervisor stated the housekeeping aides had gone home that day at approximately 2 PM, due to census. 5. During a family interview on 3/15/06 at 4:15 PM, a family member stated the facility was not clean and had odors. The family member stated the environment had "...gone downhill since Fall."	F 253	including but not limited to: A. Light fixtures throughout the building will be cleaned and noticeable accommodations of dead insects will be eliminated, especially in the secure unit dining room. B. Housekeeping hours will be adjusted as needed to adequately meet the needs & services of the residents and to ensure cleanliness of the building. To ensure 100% elimination of odors housekeeping staff will be in serviced on proper technique and correct chemical usage when cleaning following resident incontinence of bowel or bladder.	
F 264 SS=E	483.15(h)(3) ENVIRONMENT- LINENS The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview, the facility failed to ensure residents had enough clean bed and bath linens. Findings were: Observation on 3/13/06 at 7:26 PM in the laundry department revealed the department was closed for the day, no laundry staff were present, and each of two dryers contained clothing that had not been removed and hung up or folded. Interview with the supervisor of the laundry/housekeeping/maintenance departments on 3/13/06 at 5 PM evidenced that laundry staff hours were limited based on census. The supervisor reviewed the laundry schedule with the surveyor and stated that on that particular day the laundry aide was scheduled to come in at about 8 AM and left for the day at approximately 2 PM. Interview with a group of cognitive residents on	F 254	4. A quality monitoring tool will be reviewed, revised or developed to ensure that nursing staff are	

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 253	Continued From page 22 parked on the soiled side of the laundry area and the supervisor stated the housekeeping aides had gone home that day at approximately 2 PM, due to census. 5. During a family interview on 3/15/06 at 4:15 PM, a family member stated the facility was not clean and had odors. The family member stated the environment had "...gone downhill since Fall."	F 253	properly trained to adequately clean behind residents. This monitor will be developed by the director of nursing in cooperation with the Director of Staff Development/In-service director and reported to QA monthly. Items to be included in the immediate corrective plan include:	
F 254 SS=E	483.15(h)(3) ENVIRONMENT- LINENS The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview, the facility failed to ensure residents had enough clean bed and bath linens. Findings were: Observation on 3/13/06 at 7:25 PM in the laundry department revealed the department was closed for the day, no laundry staff were present, and each of two dryers contained clothing that had not been removed and hung up or folded. Interview with the supervisor of the laundry/housekeeping/maintenance departments on 3/13/06 at 5 PM evidenced that laundry staff hours were limited based on census. The supervisor reviewed the laundry schedule with the surveyor and stated that on that particular day the laundry aide was scheduled to come in at about 8 AM and left for the day at approximately 2 PM. Interview with a group of cognitive residents on	F 254	A. Nursing staff will be trained/retrained on correct procedures for handling soiled linen or soiled resident clothing to ensure odors are not present or lingering. This training will include proper/adequate cleaning of the surrounding environment following incontinence including beds, chairs, floors, walls, toilets, etc. The In-service director will personally monitor Nursing staff on a regular basis to ensure	

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F 253	Continued From page 22 parked on the soiled side of the laundry area and the supervisor stated the housekeeping aides had gone home that day at approximately 2 PM, due to census. 5. During a family interview on 3/15/06 at 4:15 PM, a family member stated the facility was not clean and had odors. The family member stated the environment had "...gone downhill since Fall."	F 253	compliance with correct procedure involving incontinence.	04/28/06
F 254 SS-E	483.15(h)(3) ENVIRONMENT- LINENS The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview, the facility failed to ensure residents had enough clean bed and bath linens. Findings were: Observation on 3/13/06 at 7:25 PM in the laundry department revealed the department was closed for the day, no laundry staff were present, and each of two dryers contained clothing that had not been removed and hung up or folded. Interview with the supervisor of the laundry/housekeeping/maintenance departments on 3/13/06 at 5 PM evidenced that laundry staff hours were limited based on census. The supervisor reviewed the laundry schedule with the surveyor and stated that on that particular day the laundry aide was scheduled to come in at about 8 AM and left for the day at approximately 2 PM. Interview with a group of cognitive residents on	F 254	B. All resident's wheelchairs will be immediately cleaned as necessary then placed on a regular cleaning schedule by the night shift staff. The In-service Director will conduct an In-service on proper cleaning of wheelchairs for nursing staff and will also include all staff from all departments as any staff member observing a soiled wheelchair should perform initial cleaning duties to eliminate drips, spills and food accumulations. <i>5. The QA Committee will monitor over all compliance.</i>	

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 476 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
F 253	Continued From page 22 parked on the soiled side of the laundry area and the supervisor stated the housekeeping aides had gone home that day at approximately 2 PM, due to census. 5. During a family interview on 3/15/06 at 4:15 PM, a family member stated the facility was not clean and had odors. The family member stated the environment had "...gone downhill since Fall."	F 253			
F 254 SS=E	483.15(h)(3) ENVIRONMENT- LINENS The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview, the facility failed to ensure residents had enough clean bed and bath linens. Findings were: Observation on 3/13/06 at 7:25 PM in the laundry department revealed the department was closed for the day, no laundry staff were present, and each of two dryers contained clothing that had not been removed and hung up or folded. Interview with the supervisor of the laundry/housekeeping/maintenance departments on 3/13/06 at 5 PM evidenced that laundry staff hours were limited based on census. The supervisor reviewed the laundry schedule with the surveyor and stated that on that particular day the laundry aide was scheduled to come in at about 8 AM and left for the day at approximately 2 PM. Interview with a group of cognitive residents on	F 254	F254 The facility will ensure provisions of clean bed & bath lines that are in good condition. This will be accomplished by: 1. The Director of Laundry services, director of Nursing and Administrator will conduct a complete review of laundry services to ensure an adequate inventory of bed and bath linens and clothing protectors that are in good condition. That they are stocked and		

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 476 YELLOW CREEK ROAD EVANSTON, WY 82830		
(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 254	Continued From page 23 3/14/06 at 9:30 AM revealed they did not always have enough towels or washcloths. One resident stated s/he routinely hid extra washcloths in a dresser drawer to ensure s/he would have clean ones to use. Another resident stated s/he frequently had to go four or more days without getting a clean washcloth or towel. Yet another resident stated s/he was sometimes out of towels or washcloths for three to four days. Interview with the laundry aide on 3/14/06 at 11 AM revealed she was aware of the problem with the inadequate supply of bath linens. She said when linens became badly stained she would not send them back out. She stated she was not responsible for ordering new linens, did not know how the process worked, but thought the supervisor periodically ordered linens. She wasn't sure when her department last received a supply of new linens. Interview with the social services director on 3/15/06 at 3 PM revealed she was also aware residents had a problem with the quantity of clean linens available. One resident at the group meeting on 3/14/06 also commented that the night before at dinner there were not enough clean clothing protectors for residents in the dining room and some residents had received "damp" ones to wear.	F 254	available for residents use as needed. In addition, laundry aide hours will be adjusted to adequately meet resident's needs on a daily basis. A quality monitoring tool will be reviewed, revised or developed to ensure residents always have clean bed & bath linens and clothing protectors that are not stained and in good condition. The Director of Laundry services and the Director of Nursing or designee will monitor this service and report to the QA Meeting monthly for 6 months and then quarterly. Items to be		

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON	STREET ADDRESS, CITY, STATE, ZIP CODE 476 YELLOW CREEK ROAD EVANSTON, WY 82830
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F 254	Continued From page 23 3/14/06 at 9:30 AM revealed they did not always have enough towels or washcloths. One resident stated s/he routinely hid extra washcloths in a dresser drawer to ensure s/he would have clean ones to use. Another resident stated s/he frequently had to go four or more days without getting a clean washcloth or towel. Yet another resident stated s/he was sometimes out of towels or washcloths for three to four days. Interview with the laundry aide on 3/14/06 at 11 AM revealed she was aware of the problem with the inadequate supply of bath linens. She said when linens became badly stained she would not send them back out. She stated she was not responsible for ordering new linens, did not know how the process worked, but thought the supervisor periodically ordered linens. She wasn't sure when her department last received a supply of new linens. Interview with the social services director on 3/15/06 at 3 PM revealed she was also aware residents had a problem with the quantity of clean linens available. One resident at the group meeting on 3/14/06 also commented that the night before at dinner there were not enough clean clothing protectors for residents in the dining room and some residents had received "damp" ones to wear.	F 264	included in immediate corrective action include: A. Inventory of linens completed on 02/27/06 and replacement stock ordered and put into use on 03/13/06. Inventory will be monitored monthly. B. Laundry aide hours have been adjusted to meet resident needs on a daily basis. C. Social Service designee will monitor resident concerns regarding bed & bath linens and clothing protectors during monthly resident council meetings. <i>any concerns will be reported to the administrator.</i> <i>The QA Committee will be responsible for over all monitoring to ensure compliance.</i>	5/19/06 04/28/06
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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 257 SS=E	483.15(h)(6) ENVIRONMENT- TEMPERATURE The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on resident interview and observation, the facility did not ensure comfortable, safe temperature levels in the main dining room. Findings were: Interview with a group of cognitive residents on 3/14/06 at 9:30 AM revealed they felt it was "too warm" in the dining room. The residents stated this issue had been raised at resident council but nothing ever changed. Residents stated they were told by the staff that some residents wanted the temperature turned up. Observation in the main dining room on 3/14/06 at 6 PM revealed the electronic thermostat in the main dining room was set at 84 degrees. On 3/14/06 at 5:40 PM interview with licensed practical nurse (LPN) #3 revealed the temperature in the resident dining room was too warm and she was "hot."	F 257	F257 The facility will ensure the provisions of comfortable and safe temperature levels. Facility initially certified after Oct. 1, 1990 must maintain a temperature range of 71-81 degrees. This will be accomplished by: 1. Thermostats throughout the building will be set to fall within the parameters of the Oct. 1, 1990 certification levels. Individual thermostats may need to be adjusted to meet the temperature desires of the majority of residents in a given location. 2. Following inspection of the zone valve in the dining room it was replaced as it was found to be defective.		

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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE

475 YELLOW CREEK ROAD
EVANSTON, WY 82930

3/15/06

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F 257 SS=IE	483.15(h)(6) ENVIRONMENT- TEMPERATURE The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on resident interview and observation, the facility did not ensure comfortable, safe temperature levels in the main dining room. Findings were: Interview with a group of cognitive residents on 3/14/06 at 9:30 AM revealed they felt it was "too warm" in the dining room. The residents stated this issue had been raised at resident council but nothing ever changed. Residents stated they were told by the staff that some residents wanted the temperature turned up. Observation in the main dining room on 3/14/06 at 6 PM revealed the electronic thermostat in the main dining room was set at 84 degrees. On 3/14/06 at 5:40 PM interview with licensed practical nurse (LPN) #3 revealed the temperature in the resident dining room was too warm and she was "hot."	F 257	3. Director of Maintenance will develop a monitoring tool for quality assessment regarding building temperatures and will report to QA quarterly or seasonally as outside temperature fluctuate. 4. Complaints will be monitored by the QA Committee.	04/28/06 5/19/06

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930		
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F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; 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 staff interview and medical record review, the facility failed to ensure a comprehensive assessment was completed for two (#24, #45) of eleven sample residents in a	F 272	F272 The facility will ensure that on initial and periodic comprehensive, accurate, standardized, reproducible assessments of each resident's functional capability is conducted. This will be accomplished by: 1. Reviewing, revising, or developing a quality monitor plan to ensure that each residents comprehensive assessment is complete with all of each resident needs being identified during the assessment. Once the assessment is complete the facility will ensure that each aspect of the residents needs assessment is actually dealt with in resident cares on a daily basis. In addition as the residents condition changes the assessment will be updated and adhered to immediately in the resident's daily cares. The daily monitoring of each resident assessment will be completed by the charge nurse on each shift.		

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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE

475 YELLOW CREEK ROAD
EVANSTON, WY 82930

SA 5/4/06

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F 272	Continued From page 26 variety of areas. The findings were: 1. Review of the 3/25/05 Initial Minimum Data Set (MDS) assessment and the 9/19/05 and 12/17/05 quarterly MDS assessments for resident #24 revealed s/he had a history of falls. Review of the entire medical record revealed the following concerns: a. The resident had a fall on 10/20/05 and sustained a one to two inch jagged laceration on the head which required transfer to the emergency room for treatment. b. The resident had a fall on 11/9/05 in which s/he sustained a deep star shaped head wound. c. The resident was found on the floor on 12/14/05 d. The resident was found on the floor on 12/20/05. e. The resident had a fall on 1/1/06. While the resident was assessed for risk of falls on a quarterly basis, no comprehensive assessment to determine the cause of the falls was completed. Interview with the director of nursing on 3/16/06 at 8:08 AM confirmed no comprehensive assessment was completed. 2. Closed record review revealed resident #45 had an order for two side rails up to prevent independent transfers and for bed mobility every day, every shift. Nurses' notes on 2/7/06 at 10:16 PM revealed the resident had experienced a fall while ambulating independently and had sustained an injury to the right knee. The resident was quoted in the note as stating, "I crawled out the end of my bed to go to the bathroom and fell in the bathroom on my right knee. I got back up and crawled into bed." The nurses' note indicated the side rails had been up on both sides of the	F 272	~~ensure that each aspect of the residents mds assessment is actually dealt with in resident cares on a daily basis. In addition as the residents condition changes the assessment will be updated and adhered to immediately in the resident's daily cares. The daily monitoring of each resident assessment will be completed by the charge nurse on each shift. To specifically ensure this is being completed daily the DON will conduct routine spot checks to ensure compliance, but will minimally monitor compliance on a weekly basis with reporting to the QA committee monthly.~~ 2. Resident #24 was re-assessed for falls with appropriate interventions put in place to safeguard the resident from continued falls.	

*last
reassess*

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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE

475 YELLOW CREEK ROAD
EVANSTON, WY 82930

3/5/06

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F 272	Continued From page 26 variety of areas. The findings were: 1. Review of the 3/25/05 Initial Minimum Data Set (MDS) assessment and the 9/18/05 and 12/17/05 quarterly MDS assessments for resident #24 revealed s/he had a history of falls. Review of the entire medical record revealed the following concerns: a. The resident had a fall on 10/20/05 and sustained a one to two inch jagged laceration on the head which required transfer to the emergency room for treatment. b. The resident had a fall on 11/9/05 in which s/he sustained a deep star shaped head wound. c. The resident was found on the floor on 12/14/05 d. The resident was found on the floor on 12/28/05. e. The resident had a fall on 1/1/06. While the resident was assessed for risk of falls on a quarterly basis, no comprehensive assessment to determine the cause of the falls was completed. Interview with the director of nursing on 3/18/06 at 8:08 AM confirmed no comprehensive assessment was completed. 2. Closed record review revealed resident #45 had an order for two side rails up to prevent independent transfers and for bed mobility every day, every shift. Nurses' notes on 2/7/06 at 10:15 PM revealed the resident had experienced a fall while ambulating independently and had sustained an injury to the right knee. The resident was quoted in the note as stating, "I crawled out the end of my bed to go to the bathroom and fell in the bathroom on my right knee. I got back up and crawled into bed." The nurses' note indicated the side rails had been up on both sides of the	F 272	3. Closed record #45 has been reviewed and corrected interventions have been put in place to ensure inappropriate be entrapment ever occurring in this facility again. 4. Nursing staff received additional training in regards to comprehensive assessment on 03/31/06. In addition specific training was provided for C.N.A's regarding fall interventions and appropriate use of restraints if ever utilized or ordered for a resident in the future. <i>5. Each resident at risk for falls will be comprehensively assessed by an interdisciplinary team to assure interventions are appropriate & the least restrictive.</i>	

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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE

475 YELLOW CREEK ROAD
EVANSTON, WY 82030

84 5/4/06

(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	Continued From page 26 variety of areas. The findings were: 1. Review of the 3/25/05 Initial Minimum Data Set (MDS) assessment and the 9/19/05 and 12/17/05 quarterly MDS assessments for resident #24 revealed s/he had a history of falls. Review of the entire medical record revealed the following concerns: a. The resident had a fall on 10/20/05 and sustained a one to two inch jagged laceration on the head which required transfer to the emergency room for treatment. b. The resident had a fall on 11/9/05 in which s/he sustained a deep star shaped head wound. c. The resident was found on the floor on 12/14/05 d. The resident was found on the floor on 12/28/05. e. The resident had a fall on 1/1/06. While the resident was assessed for risk of falls on a quarterly basis, no comprehensive assessment to determine the cause of the falls was completed. Interview with the director of nursing on 3/16/06 at 8:08 AM confirmed no comprehensive assessment was completed. 2. Closed record review revealed resident #45 had an order for two side rails up to prevent independent transfers and for bed mobility every day, every shift. Nurses' notes on 2/7/06 at 10:15 PM revealed the resident had experienced a fall while ambulating independently and had sustained an injury to the right knee. The resident was quoted in the note as stating, "I crawled out the end of my bed to go to the bathroom and fell in the bathroom on my right knee. I got back up and crawled into bed." The nurses' note indicated the side rails had been up on both sides of the	F 272	6. This quality monitor will be implemented to ensure that comprehensive assessments will be conducted on each resident on admission, at specific required review dates and upon recognition of change in the resident's condition. This monitor will be ongoing on a daily basis per the charge nurse on each shift with routine monitoring by the DON with reporting completed at the monthly QA meetings. <i>7. Over all, Compliance will be monitored by the QA Committee.</i>	04/28/06 5/19/06

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON				STREET ADDRESS, CITY, STATE, ZIP CODE 476 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)		
F 272	Continued From page 27 bed and the call light had been within reach. The bed entrapment assessment completed on 2/23/06 had a section headed as "Behaviors." Under that section the document inaccurately showed the resident used side rails/restraints appropriately. The assessment had two places where the evaluators could indicate by a check mark of the resident "attempts to climb over/around side rails" or "attempts transfers/ambulation without assistance recommended for safety." Despite the documented incident on 2/7, neither of these areas was checked. The restraint review progress note also written by the same committee on 2/23/06 recommended continued restraint use for 90 days with a reassessment at that time. There was no evidence this recommendation was based on an accurate restraint assessment.			F 272	F276 The facility will ensure that each resident will be assessed using the quarterly review instrument specified by the state and approved by CMS not less frequently than once every three months. This will be accomplished by: 1. The quarterly assessment on resident #11 and all other residents have been revised to fall within the quarterly assessment guidelines. The MDS Coordinator and the DON recalculated the correct dates to ensure the past, current and future dates all fall within the specified quarterly review dates. 2. The quality monitor on the quality assessment is in place as the MDS Coordinator currently tracks the dates to know when each resident's quarterly assessment is due and schedules the quarterly care planning team meeting to		
F 276 SS=D	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 staff interview and medical record review, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment for one (#11) of seven sample residents who required a quarterly MDS assessment. The findings were: According to the Centers for Medicare and Medicaid Services Long-Term Care Facility			F 276			

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON	STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930
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F 276	Continued From page 28 Resident Assessment Instrument User's Manual Revised August 2005, page 2-15, a Quarterly assessment must be conducted "not less frequently than once every three months." "Timing edits in the MDS standard system count 92-day intervals because there are never more than 92 days in any consecutive three-month intervals." To calculate the 92 day intervals compare the R2b date from one OBRA assessment to the next. Review of the MDS assessments for resident #11 revealed an initial assessment was completed on 9/11/05 and a quarterly was completed on 12/25/05 (105 days since the initial). Interview with the director of nursing and MDS coordinator on 3/16/06 at 8:08 AM revealed the problem was the computer calculation.	F 276	coordinate with the quarterly assessment dates. 3. To ensure all quarterly assessments are completed within the specified guidelines the MDS Coordinator and the DON will track the MDS assessment dates for each resident on a weekly basis reporting their monitor on the correct dates at the monthly QA meeting. <i>4. Over all monitoring to ensure compliance will be done by the QA Committee.</i>	04/28/06 5/19/06

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 635038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2006
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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE

476 YELLOW CREEK ROAD
EVANSTON, WY 82930

8/15/06

(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 278 SS=D	483.20(g) - (j) 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. 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 an individual who willfully and knowingly causes another individual 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. 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 assure assessments were accurate for two of eleven (#8, #15) sample residents. The findings were: 1. Review of the 2/22/06 admission Minimum Data Set (MDS) assessment showed resident #8	F 278	F278 The facility will ensure that each resident's assessment will accurately reflect the resident's status. This will be accomplished by: 1. The MDS Coordinator will ensure that all information on the admission assessment for each resident is complete, and accurate by utilizing all the information available regarding the resident at admission. Available information may include the physician's admission order, the resident history and physical from other providers and information obtained from the resident's family or legal representative. Further to ensure the admission assessment is complete and accurate along with	

Each member of the IDT will assure the assessment is

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 278	Continued From page 30 did not have any fractures in the past 180 days. However, review of the 1/16/06 history and physical revealed the resident had a fracture to the left femur. In addition, the admission physician orders dated 2/9/06 showed the resident had a fractured left hip. During an interview on 3/16/06 at 9:50 AM, the director of nursing (DON) stated the assessment was inaccurate. 2. Closed record review revealed resident #45 had two full side rails up while in bed. The bed entrapment assessment completed on 2/23/06 failed to identify the the resident attempted to climb around the side rails. Nurses' notes dated 2/7/06 at 10:15 PM revealed the resident had crawled out the end of the bed to go to the bathroom and fell and injured the right knee. In addition, the medical symptoms that justified the use of full side rails were not identified by the assessment team.	F 278	each consequent quarterly assessment, other members of the resident care planning team will review update/correct the information on the assessment to accurately reflect the resident's status. 2. The assessment for resident #8 has been review and revised to accurately reflect the resident's history of fractures. 3. The closed record of resident #45 can not be changed or modified, however the MDS Coordinator, the care plan assessment team, the fall committee and the DON will closely review resident's with restraint orders and those resident's who maybe considered candidates for restraints to ensure justification of the <i>least restrictive</i> restraint. Use of restraints by any resident will be reviewed monthly by the fall committee to		

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F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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 services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to complete a comprehensive care plan for one (#24) of eleven sample residents. The findings were: Review of the 5/1/05 Resident Assessment Protocol (RAP) Summary for resident #24 revealed s/he required a care plan for pressure sores. Review of the entire medical record revealed there was no care plan for pressure sores. Interview with the director of nursing on 3/16/06 at 2 PM confirmed there was no care plan for pressure sores.	F 279	F279 The facility will ensure the results of each resident's assessment will be utilized to develop, review & revise the resident's comprehensive plan of care. This will be accomplished by: 1. The DON provided specific training to the RAI process and completion of care plans for all residents following the in-service the MDS Coordinator, and the care plan team and the DON reviewed and revised resident #24's assessment to include a skin integrity care plan and include this in the medical record addressing possible pressure ulcers. 2. The quality monitoring and the resident's assessment is utilized in developing the residents comprehensive care plan will be audited and presented to the QA Committee on a monthly basis for 6 months and then quarterly thereafter.		04/28/06 5/19/06 by the DON

3. Over all compliance will be monitored by the QA committee.

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F 281 SSE	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure professional standards were followed. The findings were: 1. Observation of medication administration on 3/14/06 revealed the following concerns: a. From 8:25 AM until 8:29 AM (4 minutes) the medication cart was left unlocked. During this time licensed practical nurse (LPN) #1 had her back to the medication cart. b. From 8:33 AM to 8:42 AM (9 minutes) the medication cart was left unlocked. During this time LPN #1 was across the dining room and did not have the medication cart within her sight. c. From 5:50 PM until 5:52 (2 minutes) the medication cart was left unlocked. During this time LPN #3 had her back to the medication cart. d. From 6:15 PM until 6:18 PM (3 minutes) the medication cart was left unlocked and the bottom drawer was left pulled out while LPN #3 crossed the dining room to administer medications to a resident. The following medications were accessible to residents in the open bottom drawer: Lexapro (antidepressant), Lipitor (for high cholesterol), Candesartan cilexetil (antihypertensive), Synthroid (for hypothyroidism), Toprol XL (antihypertensive), Terazosin (antihypertensive), Omeprazole (for acid reflux), Flagyl (anti-infective), Pantasa CR	F 281	F281 The facility will ensure that services provided or arranged for the resident by the facility will meet professional standards of quality. This will be accomplished by: 1. A quality monitoring tool will be implemented to ensure medication carts are locked at all times when not in use and attended by a med nurse. This monitor will be completed on an ongoing basis with frequent audits conducted by the charge nurse and or DON and reported at the monthly QA meetings. 2. All medication nurses received additional training on 03/31/06 regarding the rules & regulations on medication administration and keeping the medication carts locked when not attended.		

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F 281	Continued From page 33 (for ulcerative colitis), Fosamax (for prevention or treatment of osteoporosis), Cymbalta (antidepressant), Digitek (cardiac drug), Pericolace (stool softener/laxative), Nexium (for acid reflux and erosive esophagitis), Plavix (antiplatelet drug), Tramadol (analgesic), Zyrtec (antihistamine), Celebrex (for arthritis), Plendil (antihypertensive), Avandia (antidiabetic), Levothyroxide (for hypothyroidism), Lasix (diuretic), Zyprexa (antipsychotic) disintegrating tablets 27 5 milligram (mg) tablets and 15 20 mg tablets, Acetaminophen (analgesic), Docusate Sodium liquid (laxative), Miralax powder (laxative) 9 containers, ASA (Aspirin-analgesic), Vitamin E, Gafatuss DM syrup (expectorant/cough syrup), Lactulose (laxative), 13 syringes, and Medicated chest rub with a warning "Keep out of reach of children. If swallowed get medical help or contact a Poison Control Center right away." According to the "Medication Guide for the Long-Term Care Nurse", sixth edition, 2003, page 67, medication carts should be kept locked when unattended. 2. Observation on 3/14/06 from 8:05 AM until 8:15 AM, LPN #1 did not cleanse her hands between administration of medications to non-sample resident #9 and non-sample resident #42. Observation on 3/14/06 from 5:40 PM until 6 PM revealed LPN #3 did not cleanse her hands after she administered medications to non-sample residents #19, #21, #39, #32, and #16. Interview with the DON on 3/15/06 at 8:08 AM confirmed hands should be cleansed between residents when medications were administered. 3. Review of the 3/06 physician's orders for resident #11 revealed an order dated 8/29/05 for	F 281	3. A quality monitoring tool will be implemented to ensure that all nursing staff, including c.n.a's, LPN's, med nurses & Rn's clean their hands between administering medications or providing routine care to all resident's including resident's #9,4,19,21,39,32 & 16. This monitor will be completed by In-service director and/or the DON and reported to the QA meeting monthly. 4. A quality monitoring tool will be implemented to ensure that residents are weighed as specified on their comprehensive care plan or as ordered by the physician. The monitor will be completed by the MDS Coordinator and or the DON on ongoing basis and reported at the QA meeting monthly. The weekly weight orders for resident #11 has been revised on the vital signs flow sheet and resident is		

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F 281	Continued From page 33 (for ulcerative colitis), Fosamax (for prevention or treatment of osteoporosis), Cymbalta (antidepressant), Digitek (cardiac drug), Pericolace (stool softener/laxative), Nexlum (for acid reflux and erosive esophagitis), Plavix (antiplatelet drug), Tramadol (analgesic), Zyrtec (antihistamine), Celebrex (for arthritis), Plavix (antihypertensive), Avandia (antidiabetic), Levothyroxide (for hypothyroidism), Lasix (diuretic), Zyprexa (antipsychotic) disintegrating tablets 27 5 milligram (mg) tablets and 15 20 mg tablets, Acetaminophen (analgesic), Docusate Sodium liquid (laxative), Miralax powder (laxative) 9 containers, ASA (Aspirin-analgesic), Vitamin E, Guaiacum DM syrup (expectorant/cough syrup), Laculose (laxative), 13 syringes, and Medicated chest rub with a warning "Keep out of reach of children. If swallowed get medical help or contact a Poison Control Center right away." According to the "Medication Guide for the Long-Term Care Nurse", sixth edition, 2003, page 67, medication carts should be kept locked when unattended. 2. Observation on 3/14/06 from 8:05 AM until 8:15 AM, LPN #1 did not cleanse her hands between administration of medications to non-sample resident #9 and non-sample resident #42. Observation on 3/14/06 from 5:40 PM until 6 PM revealed LPN #3 did not cleanse her hands after she administered medications to non-sample residents #19, #21, #39, #32, and #16. Interview with the DON on 3/16/06 at 8:08 AM confirmed hands should be cleansed between residents when medications were administered. 3. Review of the 3/05 physician's orders for resident #11 revealed an order dated 8/29/05 for	F 281	being weighed weekly as ordered by the physician. 5. A quality monitoring tool will be implemented to ensure that all medications for all residents, including resident #28, as ordered by the physician and recorded in the medication administration record (mar) are the same. This monitor will be completed by the charge nurses and the DON on an ongoing basis and reported at the QA meeting monthly. 6. The QA committee will ensure and monitor overall compliance.	04/28/06 5/19/06	

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F 281	Continued From page 34 weekly weights. Review of the vital signs flow sheet revealed the resident was not weighed from 8/24/05 until 2/21/06 (almost 26 weeks). Interview with the DON revealed the resident was not weighed because the Hoyer scale was broken. According to the Wyoming Nursing Practice Act and Administrative Rules and Regulations dated July 2005 nurses must follow physicians orders. 4. Review of the March 2006 recapitulation physician orders and medication administration record (MAR) for resident #28 showed an order for Digoxin 0.25 milligrams (mg) every other day, and skip the third day (however, the resident received the medication every two days, and skipped the third). Review of the previous recapitulation orders and MARs revealed the order was for Digoxin 0.25 mg everyday, and skip the third day. There was not a physician's order to change the order to every other day. During an interview on 3/15/06 at 5:10 PM, the DON stated she did not know where the every other day came from, because there was not an order for that. She stated the order was typed in wrong on the recapitulation, and the nursing staff should have caught the mistake.	F 281	F282 The facility will ensure that 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: 1. A quality monitoring tool will be implemented to assure that residents are weighed as specified on their comprehensive care plans or as ordered by the physician. The monitor will be completed by the MDS coordinator and or the Don on an ongoing basis and reported at the QA meeting monthly. The weekly weight order for resident #11 has been revised on the vital signs flow sheets and resident is being weighed weekly as ordered by the physician.		
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. This REQUIREMENT is not met as evidenced by:	F 282	2. A quality monitoring tool will be implemented to ensure that interventions are identified/certified on the comprehensive care plans to prevent pressure sores on a		04/28/06 5/19/06

3. Each resident's care plan will be followed. This will be monitored by the DON.

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F 282	Continued From page 35 Based on observation, staff interview and medical record review, the facility failed to ensure the care plan was followed for two (#11, #18) of ten sample residents. The findings were: 1. Review of the 3/06 physician's orders for resident #11 revealed an order dated 8/29/05 for weekly weights. Review of the vital signs flow sheet revealed the resident was not weighed from 8/24/05 until 2/21/06 (almost 26 weeks). Interview with the director of nursing (DON) revealed the resident was not weighed because the Hoyer scale was broken. 2. Review of the 4/9/05 annual and 12/21/05 quarterly Minimum Data Set (MDS) assessments for resident #18 revealed s/he had a history of pressure sores. Review of the current care plan revealed on 4/19/05 a pressure relieving device on the bed and in the wheelchair was identified as an intervention to prevent pressure sores. Observations from 4 PM until 10 PM, on 3/13/06, from 8 AM until 6:45 PM, on 3/14/06 from 8 AM until 6 PM on 3/15/06, and from 8 AM until 1 PM on 3/16/06 revealed there was no pressure relieving device on the resident's wheelchair. Interview with certified nurse aide (CNA) #25 at 9:20 PM on 3/13/06 revealed the cushion in the resident's wheelchair was "hard as a rock." Interview with registered nurse #2 at the same time revealed she too thought the cushion was hard. Interview with the restorative aide on 3/16/06 at 9:50 AM revealed the cushion in the resident's wheelchair was not a pressure relieving device; she stated the purpose of the cushion was to prevent the resident from sliding out of the wheelchair, not to prevent pressure.	F 282	resident will be completed as planned or ordered by the physician. The charge nurse and or DON will be responsible for monitoring to ensure that all residents identified at risk for pressure sores will have their needs met appropriately. The monitor will be completed on an ongoing basis and reported to QA monthly. A pressure relieving cushion has been obtained for resident #18 and is in place in the wheelchair. Continued usage of this cushion will be monitored by the charge nurse on a daily basis. <i>A. Compliance will be monitored by the QA Committee.</i>		

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 478 YELLOW CREEK ROAD EVANSTON, WY 82930		
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F 309 SS=D	483.25 QUALITY OF CARE 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 REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure resident weights were completed as ordered to meet the needs of two (#11, #28) of ten sample residents. The findings were: 1. Review of the 9/11/05 initial and 12/25/05 quarterly Minimum Data Set (MDS) assessments revealed resident #11 had edema (fluid retention). Review of the the 12/19/05 (6 PM), 12/23/05 (6 PM), 12/25/05, 12/26/05 (6 PM), and 12/29/05 (6 PM), nurse's notes revealed the resident's left leg and foot had 4 plus pitting edema. Review of the 12/31/05 (11 AM and 8 PM), 1/1/06 (1:50 PM), 1/2/06 (8 PM), 1/4/06 (6 PM), 1/9/06 (6 PM), and 1/11/06 (6 PM), nurse's notes revealed the resident's left leg had 3 plus pitting edema. According to "Nursing Interventions & Clinical Skills" by Elkin, Perry, and Potter, 3rd edition, 2004, page 730 "...weight is the most effective way to evaluate fluid balance [retention or loss]." Additionally, the authors instructed the "Presence of edema indicates fluid excess." The following concerns were identified: a. Review of the 3/06 physician's orders revealed an order dated 8/29/05 for weekly weights. However, review of the vital signs flow sheet revealed the resident was not weighed from	F 309	F309 The facility will ensure that each resident receives 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: 1. A quality monitoring tool will be implemented to ensure that residents are weighed as specified on their comprehensive care plan or as ordered by the physician. The monitor will be completed by the MDS Coordinator and/or DON on an ongoing basis and reported at the QA meeting monthly. The weekly weight orders for Resident #11 and the every other day weight orders for resident #28 have been revised on the vital signs flow sheet and the residents are being weighed weekly and every other week respectively. 2. At 03/31/06 Nursing in-service, the DON stressed the importance and need for	04/28/06	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 309	Continued From page 37 8/24/06 until 2/21/06 (almost 26 weeks). b. Interview with the director of nursing (DON) on 3/16/06 at 8:08 AM revealed the resident was not weighed because the Hoyer scale was broken. c. Review of the 2/14/06 physician's order revealed an order to "Get Hoyer fixed so pt [patient/resident] can get weighed." d. Review of the 3/8/06 nutrition progress notes revealed the resident had lost 23.4 pounds since August. 2. Review of the 8/25/06 history and physical (H&P) revealed resident #28 had congestive heart failure (CHF) and had an ongoing problem with edema. The H&P documented the resident had 3+ edema in the lower extremities. The admission physician orders dated 8/25/05 and the March 2006 orders showed an order for weights every other day, and call [the physician] if less than 75 kilograms (kg) [165 pounds] or more than 85 kg [187 pounds]. Physician orders showed on 2/10/06, the Lasix was increased to 40 milligrams every day, instead of every other day. Review of the vital signs flow sheet from 8/30/05 through 3/13/06, and the medication administration records for January, February, and March 2006 revealed weights were not done as ordered every other day. In addition, there lacked evidence in the medical record the physician was notified when the resident's weight dropped below 165 pounds. The resident's weight had been below 165 pounds since 12/19/05. The resident's most recent weight on 3/9/06 was 158.8 pounds. During an interview on 3/15/06 at 5:10 PM, the DON stated there was no additional weight information. In addition, the DON confirmed there was no evidence the physician was notified.	F 309	watching resident's weights as a mean of monitoring for edema and other changes in the resident's health status. <i>4. Overall monitor for compliance will be the QA Committee.</i> <i>3. Physician will be notified of weight fluctuations per orders or facility policy.</i>		

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F 312 SSHE	483.25(a)(3) ACTIVITIES OF DAILY LIVING 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, and medical record review, the facility failed to ensure staff provided the necessary care to maintain good personal hygiene and/or nutrition for three (#11, #18, #38) of 10 sample residents. The findings were: PERSONAL HYGIENE: 1. Review of the 9/11/05 initial and the 12/25/05 quarterly Minimum Data Set (MDS) assessments for resident #11 revealed s/he was incontinent of bowel all (or almost all) of the time. Review of the 9/11/05 initial assessment revealed the resident was totally dependent on staff for toileting and personal hygiene. Review of the 12/25/05 quarterly MDS assessment revealed s/he required extensive assistance with toileting and personal hygiene. Observation on 3/13/06 at 8 PM revealed the resident was incontinent of bowel. Observation of perineal care provided at that time revealed certified nurse aide (CNA) #25 used back to front wipes four times, and used the same area of the cleansing wipe three times. Continued observation revealed the CNA then wiped the back of the upper thighs. The CNA used upward motions towards the perineal area three times when the CNA cleansed the right	F 312	F312 The facility will ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This will be accomplished by: 1. A quality monitoring tool will be reviewed, revised or implemented to ensure that all residents are treated with dignity and receive appropriate pericare as specified in the facility policy, which has been reviewed and revised to include the most appropriate procedures known for pericare. Charge nurses and the DON are conducting daily spot checks. This monitor will be completed by the staff developer and overseen by the DON. Nursing staff responsible for daily resident pericare received in-service training on 03/31/06. Residents #11, #18 and 38 are now receiving appropriate pericare.		

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F 312	Continued From page 39 thigh, and four times when the CNA cleansed the left thigh. 2. Review of the 4/9/05 annual MDS assessment for resident #18 revealed s/he was incontinent of bowel frequently (2-3 times per week) and incontinent of bladder all (or almost all) of the time. Review of the 12/21/05 quarterly MDS assessment revealed the resident was incontinent of bowel and bladder all (or almost all) of the time. Review of the 4/9/05 annual MDS assessment revealed the resident required total assistance of staff for toileting and personal hygiene. Review of the 12/21/05 quarterly MDS assessment revealed s/he required extensive assistance of staff for toileting and personal hygiene. Observation on 3/13/06 at 9:15 PM revealed the resident was incontinent of bowel and bladder. Continued observation revealed CNA #25 provided perineal care for the resident. The CNA used the same area of the cleansing wipe twice then folded it and used that same area three times. 3. Review of the 3/9/06 annual MDS assessment for resident #38 revealed s/he was incontinent of bowel two to three times per week. Observation on 3/13/06 at 8:55 PM revealed the resident was incontinent of bowel. Observation at that time revealed CNA #25 provided perineal care for the resident. Continued observation of the perineal care revealed the CNA did not cleanse the perineal area, only the buttocks and anal area, nor did the CNA cleanse the anterior perineal area. 4. Review of the facility policy and procedure on perineal care, undated, instructed "Cleaning the	F 312	2. A quality monitor will be reviewed, revised or implemented to ensure that ~~all~~ <i>all</i> residents requiring assistance including resident #38 receive assistance with meals immediately after their meal tray is served. Staff involved in assisting residents with the meals received in-service training on proper process and procedures in assisting residents on 03/31/06. This monitor will be completed by director of food services, the charge nurse and the DON by conducting routing spot checks and reporting the monitor at monthly QA meetings. <i>3. Overall monitor for compliance will be the QA committee.</i>	04/28/06 <i>5/19/06</i>	

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F 312	Continued From page 40 perineum-the area between the thighs, including the genitals and anus-is a must after episodes of bowel/bladder incontinence. Besides making the person more comfortable, cleaning removes excretions that can cause irritation, skin breakdown, infection, and odor." The policy further instructed "...use gentle downward strokes to wash from front to back..." "Use a clean section of the washcloth for each stroke." Interview with the director of nursing and infection control nurse on 3/13/06 at 8:08 AM confirmed this was the proper procedure for perineal care. NUTRITION 1. Review of the 3/9/06 annual Minimum Data Set (MDS) assessment revealed resident #38 required extensive staff assistance for eating. Review of the Resident Assessment Protocol (RAP) for nutrition for the 3/9/06 MDS assessment showed the resident required set-up assistance and assistance with feeding. Observation on 3/14/06 at 8:10 AM revealed the resident was in a hospital bed in the lounge adjacent to the dining room. The resident's food tray was placed on a bedside table next to the resident. At 8:30 AM (20 minutes later), licensed practical nurse (LPN) #1 asked staff "...who is supposed to feed [the resident]?" Finally, at 8:32 AM (22 minutes after the tray was placed beside the resident), certified nurse aide (CNA) #13 assisted the resident with eating. On 3/16/06 at 9:57 AM, the director of nursing (DON) stated she did not know if 22 minutes was reasonable to have a resident wait for assistance, because she had not even thought of that. Review of the weight record showed the resident weighed 136 pounds on 3/9/06 (previously, the resident weighed 143# on 2/13/06, and 143# on 9/12/05).	F 312			

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON <i>St 6/1/00</i>			STREET ADDRESS, CITY, STATE, ZIP CODE 476 YELLOW CREEK ROAD EVANSTON, WY 82930		
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F 314 SS*Q	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to provide services to prevent a pressure sore for one (#18) of six sample residents at risk for pressure sores. The findings were: Review of the 4/9/05 initial and the 12/21/05 quarterly Minimum Data Set (MDS) assessments for resident #18 revealed s/he had a stage II pressure sore. Review of the skin assessments dated 3/5/06 and 3/12/06 revealed the resident was at risk for pressure sores due to impaired chair mobility, incontinence of bowel and bladder, very limited sensory perception, and medications. Preventive measures identified on these skin assessments included a wheelchair cushion to relieve pressure and to keep the resident clean and dry. Review of the care plan revealed an intervention written on 4/19/05 that included placing a pressure relieving device in the wheelchair and to keep the resident clean and dry. Observation on 3/13/06 at 9:16 PM revealed the resident was incontinent of bowel and	F 314	F314 The facility will ensure, based on the comprehensive assessment of a resident who enters the facility without pressure sores does not develop pressure sores unless the resident's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This will be accomplished by: 1. A quality monitor has been implemented to ensure that appropriate care is provide to <u>all</u> residents to protect against development of pressure sores and that residents with pressure sores receive appropriate cares to promote healing, prevent infection and prevent new sores from developing, including ✓ resident #18. This monitor will be completed on an ongoing basis by the charge nurses and Infection Control Nurse and overseen by the DON. This monitor will be reported monthly to at QA meetings.		

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F 314	Continued From page 42 bladder. Observation also revealed the resident had a stage I pressure sore on both sides of his/her buttocks. Interview with registered nurse (RN) #2 at this time confirmed the resident had a stage I pressure sore on both sides of the resident's buttocks. Certified nurse aide (CNA) #25 stated he/she thought incontinence and the cushion in the resident's wheelchair was part of the cause of the pressure sore. The CNA further stated the cushion was "hard as a rock." RN #2 agreed with the CNA's statement and further stated an evaluation of the cushion should be done. Review of the medical record on 3/16/06 (three days later) revealed the following concerns: a. There was no documentation of the newly identified pressure sore. b. There was no evidence the physician and family were notified of the newly identified pressure sore. c. There was no assessment of the newly identified pressure sore. d. There was no evidence treatment was identified or provided. e. There was no evidence the care plan for preventive treatment was followed in regard to providing a pressure relieving cushion for the wheelchair. f. Interview with the restorative aide on 3/16/06 at 9:50 AM revealed the cushion in the resident's wheelchair was not a pressure relieving device; she stated the purpose of the cushion was to prevent the resident from sliding out of the wheelchair not to prevent pressure. g. There was no evidence an assessment of the appropriateness of the wheelchair cushion was completed. h. Interview with the director of nursing on 3/16/06 at 10:10 AM confirmed the physician and	F 314	2. Staff involved in providing cares to residents received in-service training on March 31, 2006 to update them on proper pressure sore protocols. 3. Appropriate corrective steps have been taken to ensure resident #18 is receiving proper pressure sore cares. The "hard as a rock" wheel chair cushion has been replaced with a new cushion for pressure relief. Documentation to match resident #18's comprehensive plan of care has been completed regarding the care. The family and physician have been notified and brought up to date on the resident's condition. The physician ordered a revised treatment plan and the plan is being followed. 4. The over all monitor will be the QA Committee.		5/19/06 04/28/06

3. Each resident who has, or is at risk for a pressure ulcer, will receive timely & proper incontinence care (if indicated), timely documentation & notification of the family & physician (if appropriate), timely assessment, care planning & intervention. The QIO has been contacted to assist the facility with pressure ulcers.

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 476 YELLOW CREEK ROAD EVANSTON, WY 82930		
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F 314	Continued From page 43 family were not notified, no assessment was completed and no treatment was implemented. She further stated she was unaware of the newly identified pressure sore.	F 314	F315 The facility will ensure based on the resident's comprehensive assessment, that all residents who enter the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization is 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 accomplished by: 1. A quality monitor will be reviewed, revised or established to ensure that all residents experiencing urinary incontinence receive appropriate cares at all times. Corrective action for resident #11 include: the physician was notified of the leaking suprapubic catheter and possible need for replacement. All staff providing peri care to incontinent residents received in-service on 03/31/06 to update on proper protocols for providing peri care to all		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of facility policies and procedures, the facility failed to ensure one (#11) of one sample residents with a suprapubic catheter received adequate hygiene to prevent urinary tract infections. The findings were: Observation on 3/13/06 at 8 PM revealed resident #11 had a suprapubic catheter (a tube that permits direct urinary drainage from the bladder through the lower abdominal wall from a surgical opening) in place. Review of the 9/11/05 Initial Minimum Data Set (MDS) assessment for resident #11 revealed the resident required total dependence on staff for catheter care. Review of the 12/25/05 quarterly MDS assessment revealed	F 315			04/28/06 5/19/06

including proper handwash
& changing gloves,

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 315	Continued From page 44 the resident required extensive assistance of staff for catheter care. Review of facility data updated on 3/13/06 revealed the resident had a history of urinary tract infections. Observation revealed the suprapubic catheter was leaking at the insertion site providing an entrance for bacteria directly into the bladder. Interview with CNAs #20 and #26 at that time confirmed the suprapubic catheter was leaking and had been for several weeks. Observation on 3/13/06 at 8 PM revealed the resident was incontinent of bowel. Continued observation revealed certified nurse aide (CNA) #25 provided perineal care, and without changing gloves, then provided suprapubic catheter care for the resident. Review of the undated facility policy on caring for indwelling catheters did not address cleansing around the insertion site of a suprapubic catheter, however, interview with the director of nursing on 3/13/06 at 8:30 AM confirmed the procedure utilized by the CNA was not correct.	F 315	residents. Resident #11 is now receiving appropriate peri care. The charge nurse and the DSD will routinely oversee staff providing peri care. The quality monitor will be completed by the DSD and overseen by the DON. This monitor will be reported at QA meetings monthly. <i>for all incontinent residents</i> <i>2. Responsibility for monitoring over all compliance with this requirement resides with the QA committee.</i>		
F 323 SS=E	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, staff interview, and review of facility documents, the facility failed to ensure a safe environment for residents, visitors, and staff. The findings were: 1. Observation of medication administration on	F 323			

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 476 YELLOW CREEK ROAD EVANSTON, WY 82930		
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F 315	Continued From page 44 the resident required extensive assistance of staff for catheter care. Review of facility data updated on 3/13/06 revealed the resident had a history of urinary tract infections. Observation revealed the suprapubic catheter was leaking at the insertion site providing an entrance for bacteria directly into the bladder. Interview with CNAs #20 and #25 at that time confirmed the suprapubic catheter was leaking and had been for several weeks. Observation on 3/13/06 at 8 PM revealed the resident was incontinent of bowel. Continued observation revealed certified nurse aide (CNA) #25 provided perineal care, and without changing gloves, then provided suprapubic catheter care for the resident. Review of the undated facility policy on caring for indwelling catheters did not address cleansing around the insertion site of a suprapubic catheter, however, interview with the director of nursing on 3/13/06 at 9:30 AM confirmed the procedure utilized by the CNA was not correct	F 315	F323 The facility will ensure that the resident environment remains free from accident hazards as is possible. This will be accomplished by: 1. A quality monitoring tool will be implemented to ensure the medication carts are not left unlocked or unattended when medication nurse is out of the line of vision of the cart. The DON conducted an in-service on 03/31/06 for all nursing staff responsible for medication administration updating them on the standards and requirements involved the safety of residents relevant to the hazards of having the medication cart unattended. The Charge Nurses, DSD and the DON will complete the monitor by conducting routine checks/ensuring medication administration time frames. This monitor will be reported monthly at the QA meeting.		
F 323 SS=	483.26(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, staff interview, and review of facility documents, the facility failed to ensure a safe environment for residents, visitors, and staff. The findings were: 1. Observation of medication administration on	F 323	2. A quality monitoring tool will be implemented to protect residents from the hazardous items throughout		the medication cart to ensure it is properly attended or locked.

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 323	Continued From page 45 3/14/06 revealed the following concerns: a. From 8:25 AM until 8:29 AM (4 minutes) the medication cart was left unlocked. During this time the licensed practical nurse (LPN) #1 had her back to the medication cart. b. From 8:33 AM to 8:42 AM (9 minutes) the medication cart was left unlocked. During this time LPN #1 was across the dining room and did not have the medication cart within her sight. c. From 5:50 PM until 5:52 (2 minutes) the medication cart was left unlocked. During this time LPN #3 had her back to the medication cart. d. From 6:15 PM until 6:18 PM (3 minutes) the medication care was left unlocked and the bottom drawer was left pulled out while LPN #3 crossed the dining room to administer medications to a resident. The following medication were accessible to residents in the open bottom drawer: Lexapro (antidepressant), Lipitor (for high cholesterol), Candesartan colexetil (antihypertensive), Synthroid (for hypothyroidism), Toprol XL (antihypertensive), Terazosin (antihypertensive), Omeprazole (for acid reflux), Flaygl (anti-infective), Pentasa CR (for ulcerative colitis), Fosamax (for prevention or treatment of osteoporosis), Cymbalta (antidepressant), Digitek (cardiac drug), Pericolace (stool softener/laxative), Nexlun (for acid reflux and erosive esophagitis), Plavix (antiplatelet drug), Tramadol (analgesic), Zyrtec (antihistamine), Celebrex (for arthritis), Plendil (antihypertensive), Avandia (antidiabetic), Levothyroxide (for hypothyroidism), Lasix (diuretic), Zyprexa (antipsychotic) disintegrating tablets 27 5 milligram (mg) tablets and 15 20 mg tablets, Acetaminophen (analgesic), Docusate Sodium liquid (laxative), Miralax powder (laxative) 9 containers, ASA (Aspirin-analgesic), Vitamin E,	F 323	the building. Included in the monitor for routine observation will be the following possible hazards: A. All storage units, closets or utility rooms throughout the facility with hazardous products or chemicals will be locked at all times when not in use. B. Any public area or service areas that residents can access will be cleared of any and all hazardous items and maintained hazard free at all times. C. Managers of each department will be responsible to routinely spot check and instruct their staff to keep hazardous items out of resident's reach. This monitor will be completed and reported monthly at QA by the environmental director (maintenance, laundry and		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 635038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 323	Continued From page 46 Gulatus DM syrup (expectorant/cough syrup), Laculose (laxative), 13 syringes, and Medicated chest rub with a warning "Keep out of reach of children. If swallowed get medical help or contact a Poison Control Center right away." Interview with the director of nursing (DON) on 3/16/06 at 9:30 AM confirmed medication carts should be locked when out of the line of vision of the nurse. 2. On 3/13/06 at 5:30 PM, observation in the special care unit revealed room 106 was unlocked and contained the following hazardous items that were accessible to residents: a. One container of Spray A Fell with the warning that it was an eye irritant and "Keep out of reach of children." b. One container of Glassy Glass and Hard Surface cleaner with the warning "May be harmful if ingested," and can cause eye and skin irritation. c. One container of Attack Val U Chem with the warning "Precautions: avoid contact with eyes and skin. Keep out of reach of children." d. One gallon jug of Neutral 64 with "Danger. Keep out of reach of children." e. One bottle of Dispatch disinfectant with the warning "Keep out of reach of children." f. One sharps container which was approximately one-third full. g. One Phillips screwdriver. h. One dirty dustpan, 2 mop heads and a mop bucket. Interview with the DON on 3/16/06 at 9:30 AM confirmed these materials were hazardous and should be in a locked area inaccessible to residents.	F 323	housekeeping supervisor), the DON and the Administrator, 3. A monitoring tool will be reviewed, revised or implemented to ensure that ✓ dryer lint traps are cleaned out at the end of each shift per facility policy. Laundry staff received an in-service on proper cleaning of lint traps on 04/07/06. The maintenance director and the Administrator will complete this monitor and report monthly at the QA meeting. 4. Over all monitoring will be done by the QA Committee to ensure compliance.	04/28/06 5/19/06	

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON <i>SH 5/4/06</i>			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 323	Continued From page 47 3. Observation on 3/13/06 at 7:45 PM in the activities room revealed two needles in one of the drawers below the counter top. There was one resident in the room at the time of the observation, the door was open and the room was accessible to other residents. No staff members were in the room. 4. Observation in the laundry area on 3/13/06 at 5 PM, after the laundry aide had left for the day, revealed the lint traps in the dryers were not cleaned out and contained a quantity of lint. Interview with the supervisor of the maintenance/housekeeping/laundry departments at the time of the observation revealed the laundry aide cleaned out the lint trap at the beginning of each shift. Review of the laundry policy for cleaning the laundry department documented the lint screens were to be cleaned out at the end of each shift.	F 323	F329 The facility will ensure each resident's drug regimen is free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (included duplicate therapy); or for excessive duration; or without adequate monitoring for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the above reasons. This will be accomplished by: 1. A quality monitoring tool will be implemented to ensure unnecessary drugs are not included in any resident's drug regimen, including resident #30. All nursing staff responsible for medication orders or medication administration received an in-service by the DON on 03/31/06 covering the appropriate use of medications and proper documentation on behavior tracking sheets. This monitor will be completed by the DON and reported monthly at the QA meeting. 2. Appropriate use of Ativan for		
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 329			04/28/06

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON <i>SA 5/4/06</i>			STREET ADDRESS, CITY, STATE, ZIP CODE 476 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
F 329	Continued From page 48 Interview, the facility failed to assure the drug regimen was free of unnecessary drugs for one (#30) of seven sample residents who received psychoactive medications. The findings were: Review of the 3/06 physician's orders for resident #30 revealed Ativan (anti-anxiety) 1-2 mg (milligrams) every 6 hours as needed for anxiety. Review of the 3/06 Medication Administration Record revealed the resident received Ativan on 3/3/06 at noon, 3/7/06 at 11 AM, and 3/10/06 at 11:30 AM. Review of the behavior monitoring form revealed the resident had no behaviors of aggression, agitation, or restlessness on these dates or at any time during the month of March. Interview with LPN #2 on 3/14/06 at 2:30 PM revealed the resident was sometimes given Ativan prior to his/her bath to prevent possible anxiety.	F 329	residents #30 was assessed at a psychotropic meeting on 03/30/06. Resident #30 will not receive Ativan prior to bathing. The resident will be administered Ativan as ordered by the physician for appropriate behaviors and will be documented accordingly on the behavior tracking sheet.		
F 331 SS=E	483.25(I)(2)(II) ANTIPSYCHOTIC DRUGS Based on a comprehensive assessment of a resident, the facility must ensure that residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure three (#17, #18, #38) of six sample residents using antipsychotic medication received gradual dose reductions. The findings were:	F 331	3. Overall Monitoring will be done by the QA Committee to ensure compliance.		

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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

SA 5/1/06

STREET ADDRESS, CITY, STATE, ZIP CODE

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
F 329	Continued From page 48 Interview, the facility failed to assure the drug regimen was free of unnecessary drugs for one (#30) of seven sample residents who received psychoactive medications. The findings were: Review of the 3/06 physician's orders for resident #30 revealed Ativan (anti-anxiety) 1-2 mg (milligrams) every 6 hours as needed for anxiety. Review of the 3/06 Medication Administration Record revealed the resident received Ativan on 3/3/06 at noon, 3/7/06 at 11 AM, and 3/10/06 at 11:30 AM. Review of the behavior monitoring form revealed the resident had no behaviors of aggression, agitation, or restlessness on these dates or at any time during the month of March. Interview with LPN #2 on 3/14/06 at 2:30 PM revealed the resident was sometimes given Ativan prior to his/her bath to prevent possible anxiety.	F 329	F331 The facility will ensure, based on the comprehensive assessment of all residents, that all residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This will be accomplished by: 1. A quality monitoring tool will be implemented to ensure that an effort to reduce or eliminate the use of antipsychotic drugs for each resident receiving these drugs. This monitor will be completed by the psychotropic drug review committee, monthly or as indicated. Dosage reductions will be requested for residents and recommended to the physician. The physician will be requested to provide documentation if the dose reduction is not approved. Which will include rationale for not ordering dosage reduction. This monitor will be reported at QA monthly.	
F 331 SS=E	483.26(l)(2)(ii) ANTIPSYCHOTIC DRUGS Based on a comprehensive assessment of a resident, the facility must ensure that residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure three (#17, #18, #38) of six sample residents using antipsychotic medication received gradual dose reductions. The findings were:	F 331		

alternatives attempted and risks versus benefits.

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON <i>SA 5/4/06</i>			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 331	Continued From page 49 1. Review of the 3/06 physician's orders for resident #17 revealed an order for Haldol (antipsychotic) 1 milligram (mg) twice daily. Review of the 8/8/05, 10/6/05, and 2/23/06 psychotropic medication review forms revealed the resident had received Haldol 1 mg twice daily since 4/22/05 without an attempt at a dose reduction. Further review of the medical record revealed there was a statement that a dose reduction was contraindicated but there was no rationale as to why a dose reduction was contraindicated. Interview with the director of nursing (DON) on 3/16/06 at 2:30 PM confirmed there was no other documentation regarding the rationale for not attempting a dose reduction. In addition, review of the 2/06 and 3/06 behavior monitoring forms revealed the resident had no episodes of increased aggression, hallucinations, or delusions which were the targeted behaviors for the use of Haldol. 2. Review of the 3/06 physician's orders for resident #18 revealed an order dated 2/8/05 for Haldol 2 mg daily. Review of the 3/23/05 and 10/5/05 psychotropic medication review forms revealed the resident had not had a dose reduction attempted since it was ordered 2/8/05 (11 months) and there was no rationale as to why a dose reduction was contraindicated. Furthermore, review of the 12/05, 1/06, 2/06, and 3/06 behavior monitoring forms revealed there were no episodes of the targeted behaviors. Interview with the DON on 3/16/06 at 2:30 PM confirmed there was no other documentation regarding the rationale for not attempting a dose reduction.	F 331	Psychotropic drug review committee includes DON, Medical Director, Pharmacy Consultant, MDS Coordinator, DSD, Administrator and other doctor's with residents showing necessary reductions. 2. The following corrective actions were implemented for sample residents #17, 18 and 38: A. During the psychotropic drug review for residents #38 the physician increased the order for Zyprexa due to increased behaviors and documented the reason for not reducing the medication including <i>attempted risks versus benefits</i> . B. The physician reduced the psychotropic medication order for resident #18 due to documented minimal to no recent behaviors. C. The physician <i>then</i> discontinued the <i>medication</i> <i>04/28/06</i> <i>5/19/06</i>		

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON <i>SH 5/4/06</i>			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 331	Continued From page 50 3. Review of physician orders showed resident #38 received Zyprexa (antipsychotic) 7.5 milligrams (mg) twice per day since 6/10/05. There lacked evidence a dose reduction had been attempted since then. Review of the most recent quarterly psychotropic medication review (dated 10/5/05) showed the resident was on Zyprexa 5 mg, which was inaccurate. There lacked documentation from the physician stating why a dose reduction would be contraindicated, nor a discussion of the risks versus benefits. Review of the February and March 2006 behavior monitoring forms showed the resident did not exhibit any behaviors (agitation and aggression) for which the Zyprexa was used. Review of the pharmacist's drug regimen book (under the June 2005 tab) revealed a Food and Drug Administration (FDA) public health advisory dated 4/11/05. The advisory stated the FDA had determined that the treatment of behavioral disorders in elderly patients with dementia with atypical antipsychotic medications (including Zyprexa) was associated with increased mortality. During an interview on 3/16/06 at 9:40 AM, the DON stated a dose reduction had not been attempted because the psychotropic medication committee last discussed the resident in October, and the resident wasn't due to be discussed until later in March. The DON stated there was no physician statement on why a dose reduction would be contraindicated.	F 331	psychotropic drug order for residents #17 due to documented recent behaviors. <i>3. Overall monitoring will be done by the QA Committee to ensure compliance.</i>		

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON <i>SA 5/4/06</i>			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure medication errors were not greater than five percent. The medication error rate was 6.5 percent. The findings were: 1. Observation of medication administration for resident #20 on 3/14/06 at 9:32 AM revealed licensed practical nurse (LPN) #2 administered Combivent inhaler two puffs but waited only 40 seconds between puffs. Review of the facility's protocol on spacing and proper sequence of inhaled medications revealed there should be a one minute wait between puffs to allow additional puffs to penetrate the lungs more effectively. Interview with the director of nursing on 3/16/06 at 9:30 AM confirmed there should be a wait of one minute between puffs. 2. Observation of medication administration on 3/14/06 at 6 PM revealed LPN #3 administered vitamin C 500 mg (one tablet) to resident #7 and review of the physician's orders revealed the order was for vitamin C extended release (two tablets). 3. Observation of medication administration on 3/14/06 at 5:58 PM revealed LPN #3 administered Oyster Calcium 500 mg (one tablet) to resident #32. Review of the physician's orders revealed the order was for Ocal with vitamin D.	F 332	F332 The facility will ensure that it is free of medication error rates of 5% or greater. This will be accomplished by: 1. A quality monitoring tool will be implemented to ensure that all residents receiving a medication regimen receive all prescribed medications appropriately and as ordered by the physician. All staff involved in receiving physician's orders for resident medications, receiving medications from the pharmacy or administering resident medication were updated on proper medication administration protocol on 03/31/06. Each charge nurse will spot check medication nurses to ensure proper medication administration. ✓ Each medication nurse will double check for proper medication and dosage upon receipt of medication from pharmacy and prior to each prescribed administration time. The DON will conduct random audits to ensure		

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON <i>Est 5/4/06</i>			STREET ADDRESS, CITY, STATE, ZIP CODE 476 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	
F 332	Continued From page 62 Review of the label on Oyster Caldurn revealed there was no vitamin D. 4. Interview with LPN #3 on 3/15/06 at 3:45 PM confirmed the aforementioned were medication errors.	F 332	medication administration is following the "5" rights medication administration. This monitor will be reported at the QA meeting monthly. 2. The following corrective actions have been processed for residents #20, 7 and 32.	04/28/06 5/19/06	
F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF 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. 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: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and family interview, the facility failed to ensure adequate	F 353	A. Resident #20 is receiving 2 puffs of inhaler per facility protocol with 1 minute between puffs. B. Resident #7 is now receiving two tablets of extended release vitamin C as ordered per physician. C. Resident #32 is now receiving Oscal with vitamin D per physician orders.		

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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

SH 5/4/06

STREET ADDRESS, CITY, STATE, ZIP CODE

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
F 332	Continued From page 52 Review of the label on Oyster Calcium revealed there was no Vitamin D. 4. Interview with LPN #3 on 3/15/06 at 3:45 PM confirmed the aforementioned were medication errors.	F 332	F353 The facility will ensure the provision of 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 accomplished by:	
F 353 SS-E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF 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. 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: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and family interview, the facility failed to ensure adequate	F 353	1. Staffing on the special care unit has been increased to appropriately meet or exceed resident care needs. The DON and Administrator will monitor to ensure that staffing is always appropriate in SCU. Scheduling has been modified to ensure adequate staff in the SCU, including staff breaks, etc, whenever the DON, MDS Coordinator, DSD, or R/T Director may temporarily cover while scheduled staff have breaks allowing the other scheduled staff on 1 st and 2 nd Avenue to remain on their units. 2. Staffing for the entire facility will meet residents needs based on activity. 3. This will be monitored	5/19/06 04/28/06 <i>based on activity</i>

by the BSD.

1. The QA committee will be responsible for compliance.

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 353	Continued From page 53 staffing was provided for residents who resided in the special care unit (SCU). The census in the SCU was eight. The findings were: Interview with certified nurse aide (CNA) #7 on 3/13/06 at 4:15 PM revealed there was only one CNA staffed in the SCU on a regular basis. She stated the floor nurse administered medications, otherwise the CNA worked alone. She further stated the population in the SCU were difficult to care for due to their dementia and/or severe behavior problems. Finally, she stated there was not enough staff to take good care of residents in the SCU. Interview with a family member on 3/15/06 at 8 PM revealed he/she believed the SCU was short-staffed and that was why altercations occurred between residents from time to time which occasionally resulted in a resident getting hurt. Observation on 3/14/06 from 9:40 AM through 11:50 AM, and from 2:15 PM until 5 PM revealed the one certified nurse aide (CNA) in the SCU was occupied in individual resident rooms and not where she could observe residents in the general areas such as the hallway and dining room. Observations revealed from one to four residents were in the dining room area unsupervised by staff during the observation period. Observation on 3/16/06 at 10:20 AM revealed resident #17 was unsupervised in the SCU dining room. The resident had the left knee on the floor and his/her right hand on a chair and was getting up from the floor. Observation also revealed at that same time resident #30, also unsupervised by staff, was in the SCU dining room and shouted "Get out of the way" to resident #17. In addition, a third resident was unsupervised in the SCU dining	F 353			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53503B	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 476 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
F 353	Continued From page 54 room at that same time. On 3/16/06 at 8:08 AM, the director of nursing stated she was supposed to staff according to census only, and not according to acuity.	F 353	F371 The facility will ensure that storage, preparation, distribution and service of food will be provided under sanitary conditions. This will be accomplished by:		
F 371 SS=F	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility did not ensure food was prepared and served under clean and sanitary conditions. Findings were: 1. Observation in the main kitchen on 3/13/06 at 4:10 PM revealed the following cleanliness and sanitation concerns: a. The interior of the ice machine had numerous cracks in the plastic interior liner of the lid's surface. In addition, rust and pitted areas were noted on the upper interior of the wall used for holding ice. Ice was in contact with these surfaces. b. All ceiling vents, with the exception of two, throughout the kitchen were coated with heavy dust and blackened dust particles were visible on the ceiling near the vents in a spray pattern. These vents were located directly over areas where food and clean dishware were handled on a daily basis. c. A heavy dust build up was present on the juice machine motor.	F 371	1. A quality monitoring will be implemented to ensure sanitary conditions. Conditions are always maintained in food preparation and service area including the kitchen, dining rooms and activity area where food and snack are occasionally prepared for residents and visitors. This monitor will be completed on an ongoing basis by the dietary manager, infection control nurse, DON and or administrator and reported at QA meetings monthly. 2. Specific corrective actions to listed findings: A. A replacement ice machine was installed 04/19/06. B. Ceiling vents and surrounding area that showed blackened dust particles, dust particles in a spray		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 371	Continued From page 55 d. Grease and dust coated the hood filters located directly over the food preparation equipment. Strands of dust were apparent. e. A strand of dust was noted to be suspended from the sprinkler head located between the dining room door and the handwashing sink. f. The clean dish lowerator had greasy, dirty plastic supports that contacted the edges of clean dishes. g. The microwave oven's upper surface was dusty. h. The steamtable wells contained a large quantity of hard water deposits. i. The floor in the dry storage room was dirty and cereal was spilled on the floor. j. The water conditioner equipment mounted on the wall in the food preparation area was coated with dust. 2. All of the above were again noted during an observation in the kitchen on 3/14/06 between 5PM and 5:15 PM. In addition the following was noted: a. The range ovens were encrusted with baked on grease and food. b. A sponge mop was located in the kitchen janitor's closet. 3. Observation in the activities room on 3/13/06 at 7:10 PM revealed a "clean" Oster blender with dried food residue on the blade. 4. On 3/15/06 at 3:35 PM the dietary manager stated a staff member had unsuccessfully attempted to clean the hood filters (after the surveyor had pointed out the condition of the filters to the consulting dietitian) by running them	F 371	pattern have been cleaned and put on a routine cleaning schedule. C. Exterior of juice machine has been placed on a daily cleaning schedule by dietary staff. The interior of the machine including the motor will be maintained and cleaned by the juice product company representative on a routine basis. D. The hood and filters located over the food prep area will be cleaned weekly by staff and professionally cleaned and inspected annually for fire safety. E. The sprinkler head located between the dining room door and the hand washing sink has been cleaned and all sprinkler heads will be monitored by the dietary manger		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 371	Continued From page 58 through the dish machine the night before. The build up was such that a professional cleaning service would have to be hired. Review of the policy and procedure for cleaning the hood revealed it was to be done every two weeks and maintained free of dust and grease. The policy also noted the filters were a potential fire hazard and were to be washed weekly. 5. Observation on 3/13/06 at 7:45 PM revealed a microwave oven was located in the soiled utility room. Dried food was splattered on the upper interior surfaces of the microwave. Interview during the exit conference with the director of nursing on 3/16/06 at 2:40 PM revealed she did not know the microwave was used for food. She was unable to explain why food preparation equipment was located and being used in the soiled utility room.	F 371	and maintenance director for cleanliness. F. The clean dish lowerator has been cleaned and added to the daily cleaning list. G. Microwave has been cleaned and added to the daily cleaning list. H. The steam table wells have been delimed 03/23/06 and added to the weekly cleaning schedule. I. All floors have been cleaned appropriately and will be swept and/or mopped daily or as needed to eliminate any dirt or spills. J. The wall mounted water conditioner equipment in the food preparation area has been cleaned and added to the weekly cleaning schedule or as need. K. The range ovens have been cleaned 03/29/06 and added to the weekly cleaning		
F 430 SS=D	483.60(c)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the physician responded to the pharmacist's recommendation regarding consideration of a dose reduction for two of (#17, #24) six sample residents receiving antipsychotic medications. The findings were: 1. Review of the 5/26/05 pharmacy quality assurance (drug regimen) review for resident #17	F 430			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2006
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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE

475 YELLOW CREEK ROAD
EVANSTON, WY 82930

JA 5/19/06

(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 371	Continued From page 56 through the dish machine the night before. The build up was such that a professional cleaning service would have to be hired. Review of the policy and procedure for cleaning the hood revealed it was to be done every two weeks and maintained free of dust and grease. The policy also noted the filters were a potential fire hazard and were to be washed weekly. 6. Observation on 3/13/06 at 7:45 PM revealed a microwave oven was located in the soiled utility room. Dried food was splattered on the upper interior surfaces of the microwave. Interview during the exit conference with the director of nursing on 3/16/06 at 2:40 PM revealed she did not know the microwave was used for food. She was unable to explain why food preparation equipment was located and being used in the soiled utility room.	F 371	schedule areas needed to eliminate encrusted baked on grease or food from spills. 1. The sponge mop has been disposed of. 3. The Oster blender in the activity room is used for mulching paper for resident projects. A sign has been placed on the blender "for paper mulching only" and put away in the activity room cupboard. 4. The hood and filters have been put on a weekly cleaning schedule with a professional cleaning conducted annually during annual fire safety inspection.	
F 430 SS=D	483.60(c)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the physician responded to the pharmacist's recommendation regarding consideration of a dose reduction for two of (#17, #24) six sample residents receiving antipsychotic medications. The findings were: 1. Review of the 5/26/06 pharmacy quality assurance (drug regimen) review for resident #17	F 430	5. The microwave in the soiled utility room has been removed. The unit was used to heat personal warm towels for a resident that has been discharged. <i>6. A cleaning schedule has been developed & will be implemented. This will be monitored by the DM & the dietary consultant.</i>	5/19/06 04/28/06

7. Overall compliance will be monitored by the QA committee.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 476 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
F 371	Continued From page 58 through the dish machine the night before. The build-up was such that a professional cleaning service would have to be hired. Review of the policy and procedure for cleaning the hood revealed it was to be done every two weeks and maintained free of dust and grease. The policy also noted the filters were a potential fire hazard and were to be washed weekly. 5. Observation on 3/13/06 at 7:45 PM revealed a microwave oven was located in the soiled utility room. Dried food was splattered on the upper interior surfaces of the microwave. Interview during the exit conference with the director of nursing on 3/16/06 at 2:40 PM revealed she did not know the microwave was used for food. She was unable to explain why food preparation equipment was located and being used in the soiled utility room.	F 371	F430 The facility will ensure that the pharmacist reports any irregularities on residents' drug regimens and acts upon the pharmacist reports. This will be accomplished by: 1. A quality monitor will be implemented to ensure the pharmacist and/or psychotropic drug review committee recommendations for drug reduction, or discontinuance, to physicians receive feed back from the physician. If recommendation to physician is accepted drugs ordered will be changed accordingly. If recommendation to physician is not accepted appropriate documentation from the physician will be added to the medical record. This monitor will be completed by MDS coordinator and/or the DON and reported to QA monthly.		5/19/06 04/28/06
F 430 SS=D	483.00(c)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the physician responded to the pharmacist's recommendation regarding consideration of a dose reduction for two of (#17, #24) six sample residents receiving antipsychotic medications. The findings were: 1. Review of the 5/26/05 pharmacy quality assurance (drug regimen) review for resident #17	F 430	2. Corrective actions for residents #17 and 24; follow-up physicians were contacted for both residents and the physicians followed the pharmacist recommendations		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2008
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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON	STREET ADDRESS, CITY, STATE ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82030
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(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 430	Continued From page 57 revealed the pharmacist made the following recommendation: "...Dilantin level has been low for some time now. I would suspect increased seizure activity now from use of Haldol, which lowers the seizure threshold, along with the low Phenytoin levels. DO [discontinue] the Haldol!" Review of the 3/06 physician's orders revealed and order for Haldol 1 milligram (mg) twice daily for psychotic disorder. Review of the entire medical record revealed no evidence the physician responded to the recommendations. Interview with the director of nursing (DON) on 3/16/06 at 2:30 PM confirmed there was no evidence the physician responded to the recommendation. 2. Review of the pharmacy quality assurance (drug regimen) review for resident #24 revealed it was recommended that Risperdal (antipsychotic) be discontinued on 6/25/05, 9/24/05, and 12/27/05. Review of the 3/06 physician's orders revealed there was still an order for Risperdal 0.5 milligrams every 8-10 hours as needed for psychotic disorder. Review of the entire medical record revealed no evidence the physician responded to the recommendations. Interview with the DON on 3/16/06 at 2:30 PM confirmed there was no evidence the physician responded to the recommendation.	F 430	and discontinued the Haldol for resident #17 and discontinued Risperdal for resident #24. <i>3. Overall compliance will be monitored by the QA committee.</i>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/18/2006
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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

5/1/06

STREET ADDRESS, CITY, STATE, ZIP CODE

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)	(X6) COMPLETION DATE
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to ensure the infection control program was fully implemented to prevent infection in the facility. The census was 43. The findings were: Observations of staff infection control practices, review of the infection control program manual, and interview with the infection control nurse revealed the infection control program was not formally implemented or followed. The following concerns were identified: a. On 3/13/06 at 8 PM observation revealed certified nurse aides (CNAs) #20 and #25 provided bedtime care for resident #11. Observation revealed CNA #20 dropped the container of cleansing wipes on the floor. Already gloved CNA #25 picked the container up and began to provide perineal care for the resident without changing his/her gloves. After perineal care was completed CNA #25 repositioned the resident touching his/her shoulders, without removing or changing gloves or washing his/her	F 441	F441 The facility will ensure establishment & continued maintenance of an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility will establish an infection control program under which it investigates, controls and prevents infections in the facility; determine what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This will be accomplished by: 1. The overall Infection Control program will be reviewed and revised, as necessary, to appropriately minimize the potential for infection for all residents, visitors and staff. 2. Immediate corrective actions have included.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 478 YELLOW CREEK ROAD EVANSTON, WY 82920		
(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 441	Continued From page 59 hands. After CNA #25 repositioned the resident, he/she provided care of the suprapubic catheter insertion site and the catheter itself without changing gloves. Interview with the infection control nurse on 3/16/06 at 9 AM revealed compliance with proper handwashing techniques and utilization of gloves by staff was not monitored officially or on a regular basis. b. Review of the 9/11/05 Initial and the 12/25/05 quarterly Minimum Data Set (MDS) assessments for resident #11 revealed s/he was incontinent of bowel all (or almost all) of the time. Review of the 9/11/05 Initial assessment revealed the resident was totally dependent on staff for toileting and personal hygiene. Review of the 12/25/05 quarterly MDS assessment revealed s/he required extensive assistance with toileting and personal hygiene. Observation on 3/13/06 at 3 PM revealed the resident was incontinent of bowel. Observation of perineal care provided at that time revealed certified nurse aide (CNA) #26 used back to front wipes four times, and used the same area of the cleansing wipe three times. Continued observation revealed the CNA then wiped the back of the upper thighs. The CNA used upward motions towards the perineal area three times when the CNA cleansed the right thigh and four times when the CNA cleansed the left thigh. c. Review of the 4/9/05 annual MDS assessment for resident #18 revealed s/he was incontinent of bowel frequently (two to three times per week) and incontinent of bladder all (or almost all) of the time. Review of the 12/21/05 quarterly MDS assessment revealed the resident was incontinent of bowel and bladder all (or almost all) of the time. Review of the 4/9/05 annual MDS assessment revealed the resident	F 441	A. An In-service was presented to all staff on 03/31/06 regarding proper hand washing technique including the proper procedure and the appropriate/necess any occasions when to wash hands. This In-service was repeated for all C.N.A.'s, including #20 & #25, on 04/14/06. Each C.N.A. demonstrated competencies and has been signed off by the instructor.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 441	Continued From page 60 required total assistance of staff for toileting and personal hygiene. Review of the 12/21/05 quarterly MDS assessment revealed s/he required extensive assistance of staff for toileting and personal hygiene. Observation on 3/13/06 at 9:15 PM revealed the resident was incontinent of bowel and bladder. Continued observation revealed CNA #25 provided perineal care for the resident. The CNA used the same area of the cleansing wipe twice then folded it and used that same area three times. d. Review of the 3/9/06 annual MDS assessment for resident #38 revealed s/he was incontinent of bowel two to three times per week. Observation on 3/13/06 at 8:55 PM revealed the resident was incontinent of bowel. Observation at that time revealed CNA #25 provided perineal care for the resident. Continued observation of the perineal care revealed the CNA did not cleanse the perineal area, only the buttocks and anal area, nor did the CNA cleanse the anterior perineal area. e. Observation on 3/13/06 at 8 PM revealed resident #11 had a suprapubic catheter (a tube that permits direct urinary drainage from the bladder through the lower abdominal wall from a surgical opening) in place. Review of the 8/11/05 Initial Minimum Data Set (MDS) assessment for resident #11 revealed the resident required total dependence on staff for catheter care. Review of the 12/25/05 quarterly MDS assessment revealed the resident required extensive assistance of staff for catheter care. Review of facility data updated on 3/13/06 revealed the resident had a history of urinary tract infections. Observation revealed the suprapubic catheter was leaking at the insertion site providing an entrance for bacteria directly into the bladder. Interview with CNAs #20 and #25 at	F 441	B. All C.N.A.'s, including CNA's #20 and #25, were also required to demonstrate their skills / competencies in providing perineal and personal hygiene cares, supra-pubic catheter care and the total cleansing process/procedure following the incontinence of bowel and bladder of any resident. All demonstrated competencies were documented by the nurse instructor. C. A Director of Staff Development (DSD) /In-Service coordinator has been hired to continually	

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 441	Continued From page 61 that time confirmed the suprapubic catheter was leaking and had been for several weeks. Observation on 3/13/06 at 6 PM revealed the resident was incontinent of bowel. Continued observation revealed certified nurse aides (CNAs) #25 provided perineal care and without changing gloves then provided suprapubic catheter care for the resident. f. While there was regular monitoring of residents on antibiotics, there was no formal and regular monitoring of other potential infections such as elevated temperatures, wound drainage, signs and symptoms of respiratory or gastrointestinal illness. Interview with the infection control nurse on 3/16/06 at 9 AM revealed she "just hears and knows about infections because she is out on the floor." g. Observation on 3/13/06 at 6 PM and on 3/14/06 at 8 AM revealed resident #44, who stated on 3/14/06 at 8:45 AM that s/he had diarrhea, nausea and vomiting, was seated at the table in the dining room. Interview with certified nurse aide (CNA) #7 on 3/13/06 at 4:15 PM revealed resident #17 had just been ill with vomiting and diarrhea. Observation at that time revealed the resident was in the special care unit dining room along with two other residents. During an interview on 3/16/06 at 9 AM, the infection control nurse stated "she was aware a few residents were currently sick with flu like symptoms but had not formally investigated any of the cases." Interview further revealed she had not documented the name, date of onset, causative agent, or origin of infection for each resident who had flu like symptoms. In addition, no precautionary measures to prevent the spread of infection were implemented. h. There was a log of employees who called	F 441	monitor and educate nursing staff, including C.N.A.'s, to ensure proper perineal and personal hygiene cares and proper hand washing techniques are used by all staff for all residents, all the time. 3. An infection control program will be developed and implemented referencing CDC policies and procedures. The program will maintain records that identify each resident with symptoms of or a confirmed infection, the date of infection, the site of origin, what precautionary measures were taken to prevent the spread of infection, and the date of resolution. The program will also analyze clusters, changes in prevalent organisms, or increases in the rate of infection.		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 093030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLET DATE
F 441	Continued From page 61 that time confirmed the suprapubic catheter was leaking and had been for several weeks. Observation on 3/13/06 at 8 PM revealed the resident was incontinent of bowel. Continued observation revealed certified nurse aides (CNAs) #25 provided perineal care and without changing gloves then provided suprapubic catheter care for the resident. f. While there was regular monitoring of residents on antibiotics, there was no formal and regular monitoring of other potential infections such as elevated temperatures, wound drainage, signs and symptoms of respiratory or gastrointestinal illness. Interview with the infection control nurse on 3/16/06 at 9 AM revealed she "just hears and knows about infections because she is out on the floor." g. Observation on 3/13/06 at 6 PM and on 3/14/06 at 8 AM revealed resident #44, who stated on 3/14/06 at 8:45 AM that s/he had diarrhea, nausea and vomiting, was seated at the table in the dining room. Interview with certified nurse aide (CNA) #7 on 3/13/06 at 4:15 PM revealed resident #17 had just been ill with vomiting and diarrhea. Observation at that time revealed the resident was in the special care unit dining room along with two other residents. During an interview on 3/16/06 at 9 AM, the infection control nurse stated "she was aware a few residents were currently sick with flu like symptoms but had not formally investigated any of the cases." Interview further revealed she had not documented the name, date of onset, causative agent, or origin of infection for each resident who had flu like symptoms. In addition, no precautionary measures to prevent the spread of infection were implemented. h. There was a log of employees who called	F 441	4. The infection control program will include policies and procedures for employees or volunteers who exhibit symptoms, or are ill with a communicable disease. 5. The current Infection Control Nurse will ensure appropriate infection control measures are in place as her responsibilities transition to the Director of Staff Development over the next several months. 6. As the I.C. program is reviewed and revised quality monitors will be implemented to ensure ; A. All nursing staff providing personal cares to all residents will provide the cares utilizing appropriate techniques.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 476 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
F 441	Continued From page 61 that time confirmed the suprapubic catheter was leaking and had been for several weeks. Observation on 3/13/06 at 8 PM revealed the resident was incontinent of bowel. Continued observation revealed certified nurse aides (CNAs) #25 provided perineal care and without changing gloves then provided suprapubic catheter care for the resident. f. While there was regular monitoring of residents on antibiotics, there was no formal and regular monitoring of other potential infections such as elevated temperatures, wound drainage, signs and symptoms of respiratory or gastrointestinal illness. Interview with the infection control nurse on 3/16/06 at 9 AM revealed she "just hears and knows about infections because she is out on the floor." g. Observation on 3/13/06 at 6 PM and on 3/14/06 at 8 AM revealed resident #44, who stated on 3/14/06 at 8:45 AM that s/he had diarrhea, nausea and vomiting, was seated at the table in the dining room. Interview with certified nurse aide (CNA) #7 on 3/13/06 at 4:15 PM revealed resident #17 had just been ill with vomiting and diarrhea. Observation at that time revealed the resident was in the special care unit dining room along with two other residents. During an interview on 3/16/06 at 9 AM, the infection control nurse stated "she was aware a few residents were currently sick with flu like symptoms but had not formally investigated any of the cases." Interview further revealed she had not documented the name, date of onset, causative agent, or origin of infection for each resident who had flu like symptoms. In addition, no precautionary measures to prevent the spread of infection were implemented. h. There was a log of employees who called	F 441	B. All residents receive proper care and monitoring relative to communicable disease. C. Methods of identifying documenting and investigating high risk residents such as those who have invasive devices, pressure sores, decreased mental status, altered immune systems, or may be immobile, nutritionally compromised or recently discharged from the hospital. 7. Policies and procedures will be developed and implemented to outline utilization of outside resources and experts in the field of Infection Control such as:	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 441	Continued From page 02 in sick, however, monitoring of employee illness was not performed in a manner to identify trends or potential spread of infection to residents or others. I. There was no risk assessment of communicable diseases of staff or residents performed. J. There was no methodology for identifying, documenting, and investigating high risk residents such as those who had invasive devices, pressure sores, decreased mental status, altered immune systems, were immobile, were nutritionally compromised, or were recently discharged from the hospital. K. There was no plan to involve local state epidemiologists for non-sporadic facility wide infections.	F 441	A. Wyoming state epidemiologists, B. Center for Disease Control, C. Staff of the QIO contracted to RMC, D. Pressure sore consultants / specialists, E. Other entities as they may be required or become available. 8. Review and revision of the Infection Control program will be ongoing based on referenced CDC guidelines. The Director Of Nursing and the Director of Staff Development will have primary oversight responsibilities of the program with the administrator and quality assurance team having overall responsibility of monitoring the program and ensuring compliance with this requirement.		05/19/06
F 444 SS=D	~~483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure adequate handwashing to prevent spread of infection during care for one (#11) of ten sample residents. The findings were: On 3/13/06 at 8 PM observation revealed certified nurse aides (CNAs) #20 and #25 provided bedtime care for resident #11. Observation~~				

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2006
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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE

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
F 441	Continued From page 62 in elck, however, monitoring of employee illness was not performed in a manner to identify trends or potential spread of infection to residents or others. i. There was no risk assessment of communicable diseases of staff or residents performed. j. There was no methodology for identifying, documenting, and investigating high risk residents such as those who had invasive devices, pressure sores, decreased mental status, altered immune systems, were immobile, were nutritionally compromised, or were recently discharged from the hospital. k. There was no plan to involve local state epidemiologists for non-sporadic facility wide infections.	F 441	F444 The facility will require all staff to wash their hands that will meet and try to exceed professional practices. This requirement will be accomplished by: 1. All staff was in-serviced and trained by DON on when hands are to be washed. CNA #20 and 25 were instructed one on one for proper hand washing and proper glove changing. They were instructed on Resident #11 and all other residents on when to change gloves, after every task and the proper use of wipes.	
F 444 SS=D	483.05(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure adequate handwashing to prevent spread of infection during care for one (#11) of ten sample residents. The findings were: On 3/13/06 at 8 PM observation revealed certified nurse aides (CNAs) #20 and #25 provided bedtime care for resident #11. Observation	F 444	2. This will be monitored by infection control nurse and DON. They will train every CNA on proper hand washing and when hand washing will take place. This will be after each direct resident contact. They will train all CNAs for proper glove changing which is for each task on different parts of their anatomy. This will be monitored by QA for proper training and the effectiveness of cutting down	daily 04/28/06 5/19/06

3, over all monitor
= QA Committee

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2008
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 444	Continued From page 63 revealed CNA #20 dropped the container of cleansing wipes on the floor. Already gloved CNA #25 picked the container up and began to provide perineal care for the resident without changing his/her gloves. After perineal care was completed CNA #25 repositioned the resident touching his/her shoulders, without removing or changing gloves or washing his/her hands. After CNA #25 repositioned the resident, he/she provided care of the suprapubic catheter insertion site and the catheter itself, again without changing gloves. Interview with the infection control nurse and director of nursing on 3/13/08 at 8:08 AM confirmed the CNA should have changed gloves after contamination and prior to performing other care for the resident.	F 444	on all diseases throughout the facility for greater care of residents and staff.		
F 454 SS=L	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policies, and staff interviews, the facility failed to notify the local fire authority and the survey and certification agency when the fire sprinkler system was down for more than four hours. In addition, the facility did not implement a fire watch system to detect fires or hazards while the system was down. Furthermore, the facility failed to assure the fire alarm system was still operational, and that the local fire department would receive fire alarm signals from the facility, which resulted in an	F 454			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 635038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2006
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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON <i>Set 5/9/06</i>	STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930
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(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 444	Continued From page 63 revealed CNA #20 dropped the container of cleansing wipes on the floor. Already gloved CNA #25 picked the container up and began to provide perineal care for the resident without changing his/her gloves. After perineal care was completed CNA #25 repositioned the resident touching his/her shoulders, without removing or changing gloves or washing his/her hands. After CNA #25 repositioned the resident, he/she provided care of the suprapubic catheter insertion site and the catheter itself, again without changing gloves. Interview with the infection control nurse and director of nursing on 3/13/06 at 8:08 AM confirmed the CNA should have changed gloves after contamination and prior to performing other care for the resident.	F 444	F454 The facility will ensure the safety of residents, personnel and the public in maintaining the health by: 1. The personnel will ensure that the fire department, Office of Healthy Licensing and Survey and the certification agency will be notified when the sprinkler system is down for 4 hours. The facility will implement a fire watch in 15 minutes of the alarm system going down. The fire watch will stay in place until the sprinkler system is 100% back in compliance to ensure the safety of all residents and staff.	
F 454 SS=L	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policies, and staff interviews, the facility failed to notify the local fire authority and the survey and certification agency when the fire sprinkler system was down for more than four hours. In addition, the facility did not implement a fire watch system to detect fires or hazards while the system was down. Furthermore, the facility failed to assure the fire alarm system was still operational, and that the local fire department would receive fire alarm signals from the facility, which resulted in an	F 454	2. A new policy was written and approved by the survey team for fire watch. It contains 8 steps to follow with complete instructions on how to check each room and to look for fire or potential hazards that may cause fires while the alarm system is down. To ensure the alarm system is working we had an outside contractor put in a new dialer with a	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2006
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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE

476 YELLOW CREEK ROAD
EVANSTON, WY 82930

Set 5/1/06

(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)	(X6) COMPLETION DATE
F 454	Continued From page 64 Immediate jeopardy situation. The census was 43. The findings were: During the initial tour of the facility on 3/13/06 at 4:55 PM, the maintenance director stated the fire system was down. He stated the sprinkler system had been down for approximately six hours that day. He also stated he had not notified the survey and certification agency. At that time, he showed the surveyors a blank fire walk sheet. He stated he did not have any documentation fire watch procedures had been implemented. On 3/13/06 at 5:45 PM, the facility provided a fire walk policy. The policy only listed three procedures: 1) notify fire department that alarms are down, 2) initiate fifteen minute checks within two hours on all halls including utility rooms, and 3) notify Administrator and/or Director of Nursing. The policy did not describe the purpose of the fire walk, or describe the duties of the person assigned the fire walk task. During an interview on 3/14/06 at 2:55 PM, the maintenance director stated there were two individuals who would be doing the fire watch procedures. He stated they were not given written procedures, and were only told to look for fire, and smell for smoke. They were not instructed to look for potential hazards, and were not instructed to physically go into each room. Observation on 3/14/06 at 9:50 AM, 10:38 AM, 11:22 AM, and 11:50 AM revealed the individuals performing the fire watch did not open all doors, and did not go into all rooms. Another observation on 3/14/06 at 3:15 PM revealed the person who was performing the fire watch in the special care unit did not touch or open the door to room 108 which contained hazardous and flammable materials.	F 454	dedicated line from facility. This will send a signal to the Sheriff's Dispatcher and a central station. Both of these entities will place a call to the fire department giving us dual coverage from this point forward on the alarm system going off. 3. This will be monitored by running mock fire drills quarterly one on each shift to ensure all employees know the proper procedures are being followed and recorded with staff instructed on all points of the fire drill being carried out in a proper and timely manner. The ~~Administrator will~~ <i>maintenence director will</i> monitor ~~these with the~~ Administrator. These reports will be reviewed by QA monthly to evaluate if drills are needed more often and will make recommendations to the Administrator for more drills. 4. The QA Committee will be responsible for compliance.	<i>4/25/06</i> ~~04/28/06~~ <i>5/19/06</i>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 476 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)	(X6) COMPLETION DATE	
F 454	Continued From page 65 During an interview on 3/13/06 at 5:45 PM, the administrator and general manager stated they were not aware a fire watch should have been implemented; they were under the impression the fire system would be fixed soon. The general manager stated there was no excuse for not contacting the survey and certification agency. On 3/14/06 at 1:43 PM, the maintenance director stated he called the fire department the day before, but did not actually tell them the fire system was down. The maintenance director stated only the sprinkler system was down, but the alarm system was working, and the fire department would receive a signal if the alarms went off. On 3/14/06 at 2:30 PM, a fire drill was done at the request of the surveyors. At 2:37 PM, after the fire drill, the maintenance director called the fire department (via the sheriff's dispatch, who received the signals). The maintenance director was told they did not receive the alarm from the facility. On 3/14/06 at 3 PM, the maintenance director stated they had a fire drill a couple of weeks ago, but had not checked to assure the fire alarm system was functioning, and that the fire department was receiving the alarm from the facility. On 3/16/06 at 1:50 PM, the maintenance director stated they discovered a problem with the module at the sheriff's office, and they discovered they no longer had a dedicated line through the phone company for the fire alarm system. The maintenance director stated the facility had not been checking to assure the fire department was receiving alarms, so they were unaware how long the alarm system had not been functioning. On 3/14/06 at 3 PM, immediate jeopardy was	F 454			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 536038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2006
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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
F 454	Continued From page 68 called. On 3/16/06 at 9:15 AM, the immediate jeopardy was removed on-site. The facility had written and implemented new policies regarding the fire alarm system and fire watch procedures. REFERENCES: NFPA 101 Life Safety Code Standard A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4. If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5. Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24 hour	F 454		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2006
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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON	STREET ADDRESS, CITY, STATE, ZIP CODE 476 YELLOW CREEK ROAD EVANSTON, WY 82930
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(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 454	Continued From page 67 period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1. Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8.	F 454	F465 The facility will provide a safe functional sanitary and comfortable environment for residents, staff and the public by: 1. A new spray head will be installed in the dish room. This will stop the water from running all the time and the spray head will come with a new rubber gasket in place. 2. The floor sink, floors and base boards in the janitors sink in the kitchen will be cleaned with all dirt and grime scrubbed completely away and added to a weekly cleaning list to ensure proper cleanliness at all times. 3. The lower portion of the wall in the dishroom will be repaired properly with a water proof covering added that will be 12" in to protect against future water damage. 4. The bathroom for kitchen employees had a loose pipe running down the wall, this pipe has been fastened back to a stud in the wall stopping the vibrating and loud noise when the water is turned on. 5. The floors in the dry storage	
F 465 SS=E	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation of environmental areas primarily frequented by public and/or staff, the facility did not ensure the areas were maintained in a clean, functional, and sanitary manner. Findings were: Observation on 3/13/06 at 4:10PM revealed the following environmental concerns: a. The spray hose in the dish room had a hot water leak that ran continuously during the observation. The rubber gasket on the sprayer was stretched and loose.	F 465		5/19/06

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2006
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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE

475 YELLOW CREEK ROAD
EVANSTON, WY 82930

3/15/06

(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 465	Continued From page 68 b. The floor sink, floors, and baseboards in the janitor's sink in the kitchen were black with accumulated grime. c. The lower portion of the wall in the dishroom was damaged, exposing a mesh-like material used as part of the substructure. d. The bathroom for kitchen employees had a hot water valve for the hand washing sink that vibrated and made a loud noise when the hot water tap was turned on. e. The floors were dirty next to baseboards in the kitchen and dry storage areas. Observation on 3/13/06 at 7:25 PM revealed the following additional environmental concerns: a. The door to a clean linen room was damaged. b. Soil and blackened wax accumulation was seen in all four hallways, along baseboards and round the perimeters of electrical access covers, which were located in the middle of hallways. The laundry room perimeter was soiled and dirt and dust was evident behind the washers and dryers.	F 465	area will be cleaned appropriately along with the baseboards and will be added to the cleaning list for in depth cleaning weekly. 6. The door to the clean linen room will be repaired properly and restored to an appropriate looking décor of the facility. 7. All hallways will be stripped and waxed on a timely basis with added attention to the soiled and blackened areas of accumulation to maintain overall appearance of the facility. The electrical access covers in the middle of the hall will be cleaned of any buildup to enhance the overall cleanliness of the building. The laundry room will be cleaned daily with special attention given to the perimeter to have the entire room bright finished floor. Behind the washer and dryer will be cleaned daily to remove all dirt, soil and dust. 8. All these items will be checked by the appropriate department head in dietary and maintenance to ensure all cleaning is being done on a	04/28/06 <i>5/19/06</i>

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82030		
(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 466	Continued From page 68 b. The floor sink, floors, and baseboards in the janitor's sink in the kitchen were black with accumulated grime. c. The lower portion of the wall in the dishroom was damaged, exposing a mesh-like material used as part of the substructure. d. The bathroom for kitchen employees had a hot water valve for the hand washing sink that vibrated and made a loud noise when the hot water tap was turned on. e. The floors were dirty next to baseboards in the kitchen and dry storage areas. Observation on 3/13/06 at 7:25 PM revealed the following additional environmental concerns: a. The door to a clean linen room was damaged. b. Soil and blackened wax accumulation was seen in all four hallways, along baseboards and round the perimeters of electrical access covers, which were located in the middle of hallways. The laundry room perimeter was soiled and dirt and dust was evident behind the washers and dryers.	F 465	daily basis and that the cleaning listed are being signed as the tasks are completed. This will be monitored by the Administrator. The Administrator will report in the monthly QA meeting and the committee will look for added opportunities to continue improvements on the overall cleaning of these areas along with the rest of the facility. 9. The Administrator will be responsible for compliance.		

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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE

475 YELLOW CREEK ROAD
EVANSTON, WY 82930

Sub 5/4/06

(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)	(X6) COMPLETION DATE
F 493 SS=F	483.75(d)(1)-(2) GOVERNING BODY The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on resident, staff, and family interview, and record review, the person functioning in the facility as the administrator was not a licensed nursing home administrator as required by the State of Wyoming. Findings were: Interview with the General Manager on 3/13/06 at 4 PM revealed he was not a licensed nursing home administrator. The person holding the administrator's license was revealed to live in Utah and was called into the facility by the General Manager. Interview with a group of eight cognitive residents on 3/14/06 at 9:30 AM revealed they believed that the individual introduced to the surveyors as the "General Manager" was the nursing home administrator. Interview on 3/14/06 at 10:30 AM with the person licensed by the facility as the administrator established he was a Certified Public Accountant and had delegated the duties of the administrator to the unlicensed person who had the title of General Manager. On 3/14/06 at 11:40 AM,	F 493	F493 The facility will have the governing body to oversee all the responsibility for policies operations and appointing the administrator to ensure compliance of all rules and regulations by: 1. The Governing body will hire a full time administrator to be full time on site to administer all the day to day responsibility pertaining to the rules and regulation. The Administrator will be the only one to sign items for administrators signature. 2. The General Manager will not sign anything that requires the Administrators signature. All residents have been informed of the new Administrator and his role as the Administrator in the facility. 3. The General Manager will carry out all duties and responsibilities as directed by the administrator after decisions have been made as to issues at hand. 4. This will be monitored by QA in the facility by getting a monthly report from the	<i>licensed</i>

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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE

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
F 493 SS=F	483.75(d)(1)-(2) GOVERNING BODY The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on resident, staff, and family interview, and record review, the person functioning in the facility as the administrator was not a licensed nursing home administrator as required by the State of Wyoming. Findings were: Interview with the General Manager on 3/13/06 at 4 PM revealed he was not a licensed nursing home administrator. The person holding the administrator's license was revealed to live in Utah and was called into the facility by the General Manager. Interview with a group of eight cognitive residents on 3/14/06 at 9:30 AM revealed they believed that the individual introduced to the surveyors as the "General Manager" was the nursing home administrator. Interview on 3/14/06 at 10:30 AM with the person licensed by the facility as the administrator established he was a Certified Public Accountant and had delegated the duties of the administrator to the unlicensed person who had the title of General Manager. On 3/14/06 at 11:40 AM,	F 493	Administrator on the ongoing day to day operations of the Administrators position. With his monthly goals for improving resident quality of care, and overall improvement of the facility. 5. The governing body will monitor this monthly and will be responsible for compliance.	04/30/06 7/12/06

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 493	Continued From page 70 interview with the licensed administrator revealed he delegated all the daily operations and nursing home functions to the general manager. He further stated he, as the licensed administrator of the facility, only worked on the financial issues. On 3/15/06 at 4:15 PM, when asked who the administrator was, a family member identified the general manager. The family member stated the general manager did not have a Wyoming license, but must have one now because he/she just received a letter in the mail which was signed by the general manager, with the title "administrator". Review of investigative data sheets (incident reports) dated 2/11/06, 2/12/06 and 2/17/06 revealed the general manager signed his name next to the line "administrator". Review of the 1/4/06 interdisciplinary meeting notes for resident #15 revealed the "administrator" was the general manager.	F 493	F507 The facility will ensure that each resident's clinical laboratory test results are filed and contain dates of testing and the name and address of the testing laboratory. This will be accomplished by: 1. A quality monitor will be implemented to ensure that all residents, including resident #18, clinical lab tests are completed as ordered and the results are appropriately placed in the residents medical record in a timely manner. This monitor will be completed by the charge nurses, MDS coordinator and/or the DON on an ongoing basis and reported at QA meetings monthly.		5/9/06 04/28/06 <i>in the medical record</i>
F 507 SS=0	483.76(j)(2)(iv) LABORATORY SERVICES The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure laboratory results were in the medical record for one (#18) of ten sample residents. The findings were:	F 507	2. The DON will be responsible for overall compliance.		

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON <i>Set 5/4/06</i>			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 507	Continued From page 71 Review of the 3/06 physician's orders for resident #18 revealed blood tests TSH (thyroid stimulating hormone test), T4 free (thyroid test), and PSA (prostate test for cancer) were ordered for 3/7/06. Review of the entire medical record revealed the results of these tests were not in the medical record. Interview with the director of nursing on 3/16/06 at 2:30 PM revealed the tests were completed but the results were not in the facility.	F 507	F513 The facility will ensure that each residents reports of x-ray and other diagnostic services be signed, dated and placed in the medical record. This will be accomplished by: 1. A quality monitoring tool will be implemented to ensure that all residents, including resident #11, x-rays or other diagnostic services are completed as ordered and the requests are placed in the resident's medical record in a timely manner. This monitor will be completed by the charge nurses, MDS coordinator and/or the DON on an ongoing basis and reported at QA meetings monthly.	04/28/06 5/19/06	
F 513 SS=D	483.75(k)(2)(iv) RADIOLOGY AND OTHER DIAGNOSTIC SERVICES The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure radiology results were in the medical record for one (#11) of ten sample residents. The findings were: Review of the 3/06 physician's orders for resident #11 revealed an order for x-rays of both femurs. Review of the entire medical record revealed the results of these x-rays were not in the medical record. Interview with the director of nursing on 3/16/06 at 2:30 PM revealed the tests were completed but the results were not in the facility.	F 513	2. The DON will be responsible for overall compliance.		

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

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 517 SS=F	483.75(m)(1) DISASTER AND EMERGENCY PREPAREDNESS The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policies, and staff interviews, the facility failed to have detailed procedures for when the fire alarm system was not functioning, including fire watch procedures and assuring the fire department was notified. In addition, the facility failed to have a detailed plan to ensure rapid staff response in the event of a fire. The census was 43. The findings were: 1. During the initial tour of the facility on 3/13/06 at 4:55 PM, the maintenance director stated the fire system was down. He stated the sprinkler system had been down for approximately six hours that day. At that time, he showed the surveyors a blank fire walk sheet. He stated he did not have any documentation fire watch procedures had been implemented. On 3/13/06 at 5:45 PM, the facility provided a fire walk policy. The policy only listed three procedures: 1) notify fire department that alarms are down; 2) initial fifteen minute checks within two hours on all halls including utility rooms, and 3) notify Administrator and/or Director of Nursing. The policy did not describe the purpose of the fire walk, or describe the duties of the person assigned the fire walk task. During an interview on 3/14/06 at 2:55 PM, the maintenance director stated there were two individuals who would be	F 517	1517 The facility will ensure disaster and emergency preparedness is met by: 1. If at anytime the alarm system goes down a fire watch will be implemented within 15 minutes by the administrator, charge nurse, or on call person, depending on the time the alarm system goes down or off. 2. The policy for the fire sprinkler system when set off has to be rewritten to include all the proper steps to meet all needs of residents and staff. 15 steps in all. 3. The maintenance director will call the fire department every time the alarm goes down to let them know that the system is being worked on. He will call the fire department to let them know the system is back on line. A. All staff will be in-serviced and trained on the proper procedures when the alarm goes off and the responsibility for residents and all staff safety to be placed at the highest priority.		

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NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82930		
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F 517	Continued From: page 73 doing the fire watch procedures. He stated they were not given written procedures, and were only told to look for fire, and smell for smoke. Observation on 3/14/06 at 9:50 AM, 10:38 AM, 11:22 AM, and 11:50 AM revealed the individuals performing the fire watch did not open all doors, and did not go into all rooms. During an interview on 3/13/06 at 5:45 PM, the administrator and general manager stated they were not aware a fire watch should have been implemented; they were under the impression the fire system would be fixed soon. On 3/14/06 at 1:43 PM, the maintenance director stated he called the fire department the day before, but did not tell them the fire system was down; he told them he was working on the system. The maintenance director stated only the sprinkler system was down, but the alarm system was working, and the fire department would receive a signal if the alarms went off. 2. On 3/14/06 between 9:30 AM and 10:15 AM the fire alarm sounded two times. Each time all eight cognitive residents in the group meeting did not react to the alarm. When asked by the surveyor if we needed to leave our location, the residents indicated these were probably false alarms, and there was no reason to do anything. 3. Observations during the remainder of the morning of 3/14/06, revealed the alarms continued to sound periodically with no reaction from the residents or staff. 4. The fire drill policy indicated the fire drill flag would be placed in a room or area desired for the drill. A fire drill was conducted on 3/14/06 at 2:30 PM, at the request of the surveyors, with the	F 517	B. Every alarm will be addressed in the proper manner with all procedures followed. (A code red for fire or an all clear for no fire.) Residents will be instructed by staff that a drill was performed to ensure their safety or fire was found is under control with evacuation of the facility under way. 4. A. All staff was in-serviced and trained on fire drill procedures. CNA #8 was instructed in a one on one to ensure proper training was conveyed. All staff was shown the strobe light with a red lens that will imitate a fire and was given a hand out outlining proper protocol to follow when a fire is found. B. All staff was in-serviced/trained as to the importance of		

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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

SA 5/4/06

STREET ADDRESS, CITY, STATE, ZIP CODE

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
F 517	Continued From page 74 following concerns noted: a. The red fire flag was placed in a vacant resident room. A staff member (CNA #8), identified by the maintenance manager as a new staff member, entered the room, and seeing no residents, left the room. The resident call light was initiated a second time. The same staff member went into the resident room and in a moment came out of the room again and did not initiate the alarm. b. The maintenance manager asked a more experienced staff member (the activity director) to go to that particular room and check around. In a few minutes the staff person exited the resident room and pulled the manual alarm. A staff member at the nurses' station hesitated, looked at the maintenance manager, and asked, "Is this real?" When the maintenance manager cued the staff member with a nod, the staff began to check rooms and residents according to the facility's fire plan. c. One nurse aide (CNA #34) was charting on a wall mounted electronic monitor in the hall where the drill was occurring. The aide, who was also a new hire per review of personnel records, did not respond at any time to the fire drill. d. Following the drill, the staff met to discuss the identified concerns. Several of the staff indicated they would not necessarily recognize the fire drill flag and could mistake it for a blanket or an afghan. Interview with the maintenance manager at this time revealed new employees had been told about the fire drill flag during orientation, but had not seen it. e. A telephone call to the dispatcher at the sheriff's department following the drill at 2:37 PM revealed the signal from the facility's alarm	F 517	reacting to every alarm as a real threat to the safety of all residents and personnel in the facility. They are to go into proper procedure and complete all details of the drill with all steps followed. C. All staff was trained that they stop all activities they are doing when the alarm goes off and proceed to drill procedures until the all clear is called out. CNA #34 was instructed one on one to ensure complete compliance. All new hires are instructed at orientation the proper procedures to follow when the alarm goes off. D. All staff was in-serviced and shown the strobe light that will represent a fire so there is not a misunderstanding of	

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F 517	Continued From page 75 system was not received by the sheriff's department. f. Interview with the maintenance director at 2:37 PM revealed no evidence a fire plan had been developed that took the current status of the facility's sprinkler system into consideration.	F 517	what the strobe light represents. The new hires will also be shown the strobe light during orientation.		
F 518 SS=F	483.75(m)(2) DISASTER AND EMERGENCY PREPAREDNESS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that two of two new employees assigned to the hallway where a fire drill was conducted were adequately trained in emergency fire procedures. Findings were: Observations on 3/14/06 at 2:30 PM revealed an employee entered the room where a red fire flag had been placed on a chair. The call light was activated twice and the same certified nurse aide (CNA #8) responded to the call system both times, and turned off the nurse call light without ever initiating the fire alarm for a drill. The maintenance manager observed the certified nurse aide and then commented that this was a "new" employee. He indicated he would attempt to get a more experienced staff member to go to the room where the fire drill blanket was located.	F 518	B. A new system was put into place that ensures that the Sheriff's Department will receive a signal. Also the fire department will receive a call from the company we now contract with on the system we had to replace the old system. This gives us dual coverage for the protection of our residents. F. A plan will be written and placed in the fire and disaster manual that will detail the procedures for the protection of the residents and staff. 5. All these issues will be monitored by Administrator and the QA committee will on a monthly basis and will work up a plan of action to give direction to staff and QA committee for improvement		04/28/06

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 517	Continued From page 75 system was not received by the sheriffs department. f. Interview with the maintenance director at 2:37 PM revealed no evidence a fire plan had been developed that took the current status of the facility's sprinkler system into consideration.	F 517	in all areas and provide feed back for the next months improvements.		
F 518 SS=F	403.75(m)(2) DISASTER AND EMERGENCY PREPAREDNESS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that two of two new employees assigned to the hallway where a fire drill was conducted were adequately trained in emergency fire procedures. Findings were: Observations on 3/14/06 at 2:30 PM revealed an employee entered the room where a red fire flag had been placed on a chair. The call light was activated twice and the same certified nurse aide (CNA #8) responded to the call system both times, and turned off the nurse call light without ever initiating the fire alarm for a drill. The maintenance manager observed the certified nurse aide and then commented that this was a "new" employee. He indicated he would attempt to get a more experienced staff member to go to the room where the fire drill blanket was located.	F 518	6. The administrator will be responsible for compliance.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 475 YELLOW CREEK ROAD EVANSTON, WY 82030	
(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 517	Continued From page 75 system was not received by the sheriff's department. f. Interview with the maintenance director at 2:37 PM revealed no evidence a fire plan had been developed that took the current status of the facility's sprinkler system into consideration.	F 517	F518 The facility will train employees in emergency by: 1. All staff was in-serviced on the newly purchased strobe light that will represent a fire. CNA #34 was trained one on one. All employees were given a handout with step by step procedures to be followed when a fire drill is run or when the fire alarm goes off. All new hires are orientated on fire drills. All staff was instructed that all activities are to be stopped when the alarm sounds and follow the hand out of instruction to ensure resident and staff safety. CNA #34 was trained one on one then ask if he/she had any questions. The fire flag has been replaced by a strobe light with a red lens.	
F 518 SS=F	463.75(m)(2) DISASTER AND EMERGENCY PREPAREDNESS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that two of two new employees assigned to the hallway where a fire drill was conducted were adequately trained in emergency fire procedures. Findings were: Observations on 3/14/06 at 2:30 PM revealed an employee entered the room where a red fire flag had been placed on a chair. The call light was activated twice and the same certified nurse aide (CNA #8) responded to the call system both times, and turned off the nurse call light without ever initiating the fire alarm for a drill. The maintenance manager observed the certified nurse aide and then commented that this was a "new" employee. He indicated he would attempt to get a more experienced staff member to go to the room where the fire drill blanket was located.	F 518	2. This will be monitored by the administrator. QA committee will assess the response of fire drills on a monthly basis. Each shift will be evaluated the level of staff knowledge during fire drill participation will determine how many	04/28/06

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NAME OF PROVIDER OR SUPPLIER

ROCKY MOUNTAIN CARE EVANSTON

STREET ADDRESS, CITY, STATE, ZIP CODE

475 YELLOW CREEK ROAD
EVANSTON, WY 82030

(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 518	Continued From page 76 He then notified a more experienced staff person (the activity director) to go into that same resident room. That staff person immediately reacted to the fire drill flag and initiated the fire alarm. During the drill, another certified nurse aide (CNA #34) was observed on the hallway actively engaged in using the electronic charting screen mounted on a wall. During the entire drill, this CNA did not respond to the alarm or participate in the drill in any way, even though she was in the hall where the "fire" was discovered. Instead, the CNA continued charting throughout the drill. Following the drill, the staff met to discuss the identified concerns. Several of the staff indicated they would not necessarily recognize the fire drill flag and could mistake it for a blanket or an afghan. Interview with the maintenance manager at this time revealed new employees had been told about the fire drill flag during orientation, but had not seen it. Review of personnel records revealed CNA #34, who was charting in the hallway, was also a new employee, having been hired on 2/15/06.	F 518	drills will be run until the QA committee feels all staff is proficient in fire drills. Then each shift will be drilled at least once per quarter. 3. The administrator will be responsible for compliance.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 521 SS=F	483.75(o)(2)-(4) QUALITY ASSESSMENT AND ASSURANCE 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 review of quality assurance committee minutes and staff interview, the facility failed to develop and implement plans of action to address concerns identified through the quality assurance (QA) process. The findings were: Review of the QA committee minutes for the last two meetings along with interview of the general manager and the director of nursing (DON) on 3/16/06 at 10:45 AM revealed the facility gathered data, such as the number of falls or number of pressure ulcers, but did not develop a plan to address the concerns, including setting goals, timeframes, or approaches. The DON stated the front-line staff (certified nurse aides, nurses, housekeepers, etc) were not involved in the QA process. The DON further stated there were no	F 521	F521 The facility will ensure that 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. This will be accomplished by: 1. The overall Quality Assurance program will be reviewed and revised, as necessary, to appropriately identify root cause quality issues and collect and analyze data, pertaining to all residents rights & services, including but not limited to: A. Privacy and confidentiality B. Appropriate staff treatment of residents C. Dignity of residents D. Accommodation of needs E. Activities & Social Services		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 635038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
F 621	Continued From page 78 special committees to look at processes (how to do things better, different, etc.). The DON stated the facility was not far enough along in their QA to look at developing plans of action, because they were just now gathering data. The general manager stated the facility had not done an annual review of the QA program to see how effective it was.	F 521	2. As a result of the state survey completed 03/16/06 the facility will review, revise and or implement quality monitors in areas of care or services provided to all residents that were identified to be deficient practices or substandard quality of care. Action plans to correct identified quality deficiencies, will be developed, implemented, assessed for effectiveness, and revised as appropriate. In addition, monitors will be implemented in areas that were not identified during the survey, but need a monitor to ensure the best care for all residents. Mechanisms will be developed to attain input regarding quality issues from all residents, staff, families and visitors. Each monitor implemented will have an assigned staff member or members who will be		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 478 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) COMPLE DATE
F 521	Continued From page 78 special committees to look at processes (how to do things better, different, etc.). The DON stated the facility was not far enough along in their QA to look at developing plans of action, because they were just now gathering data. The general manager stated the facility had not done an annual review of the QA program to see how effective it was.	F 521	responsible for overseeing and completing the monitor, including monitoring the effect of implemented changes and making revision to the action plan as needed. Each monitor will be reported to the QA team monthly or at least quarterly, depending on the severity / acuity of area being monitored. The Administrator and Quality Assurance Team will have overall responsibility for accuracy and completion of all monitors and corrective remedies.		05/19/06 5/19/06

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 476 YELLOW CREEK ROAD EVANSTON, WY 82030	
(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) COMPL DATE
F 521	Continued From page 78. special committees to look at processes (how to do things better, different, etc.). The DON stated the facility was not far enough along in their QA to look at developing plans of action, because they were just now gathering data. The general manager stated the facility had not done an annual review of the QA program to see how effective it was.	F 521	F. Right to be free of restraints or least restrictive restraints G. Accurate comprehensive assessment & comprehensive care plans H. Comfortable, clean and sanitary physical environment free of infectious diseases I. Free from pressure sores J. Minimal unnecessary drugs or antipsychotic drugs administered free of errors K. Sufficient staff in all areas of service to meet each resident's needs L. Right to appetizing meals & nutrition served under proper sanitary conditions M. Staff trained to respond to disaster and emergency situations that ensure all resident's safety N. A quality assessment and assurance process that will ensure all residents receive the best overall care and services available	