POC accepted 8/27/12
Janelle Cordell, OHLS

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WY Dept of Health

AUG 1 6 2012

Healthcare Licensing

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

PRINTED: 08/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING B. WING	07/26/2012

NAME OF PROVIDER OR SUPPLIER: CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE

STREET ADDRESS, CITY, STATE, ZIP CODE: 713 OAK STREET, SUNDANCE, WY 82729

(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=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES 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:	F 156	F 156 The facility will ensure accurate information regarding the State survey agency by updating all contact information and posting it in a public area. A quality indicator has been developed for monthly monitoring by SSD of all necessary Medicare and Medicaid information to ensure its accuracy. This will be reported quarterly to the QI committee.	7/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan Van Beek
TITLE: Administrator
(X6) DATE: 08-16-12

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.

POC accepted. Msg left for Jan Van Beek on 8/27/12 @ 11:25 am.
JC

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CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET SUNDANCE, WY 82729

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F 166	Continued From page 1 A description of the manner of protecting 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 166		

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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 and staff interview, the facility failed to ensure accurate information regarding the State survey agency was provided for residents during 2 of 2 random observations. The findings were: Observation of posted information on 7/23/12 at 6:30 PM and on 7/26/12 at 12 noon showed the State survey agency address was incorrect. Interview with the DON on 7/26/12 at 12:15 PM verified the address was incorrect.	F 156		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	719 OAK STREET SUNDANCE, WY 82729

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F 225	Continued From page 3 of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility information, staff interview, and review of policy and procedure, the facility failed to ensure 1 of 4 allegations of abuse/neglect were investigated. The findings were:	F 226	F225 The facility will make every effort to prevent further abuse or neglect by immediately suspending any individual with an allegation of abuse or neglect pending further investigation of the incident. This includes the incident with resident #3 and #24 in which the CNA was terminated on 7/24/12. A quality indicator has been developed to monitor all incidents and allegations immediately by the DON and Administrator, and take necessary steps to ensure residents are free from abuse and neglect. This will be monitored monthly and reported quarterly to the QI committee. 7/30/12 08-16-12	

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F 225	Continued From page 4	F 225		

Review of the facilities alleged allegations of abuse and neglect, revealed an incident that occurred on 7/20/12 that involved CNA #3 failing to provide acceptable incontinence care to a resident (non-sample #19). Interview with the DON on 7/26/12 at 11:15 AM revealed there was not an investigation done related to that allegation. The DON explained the following Monday, 7/23/12, when she began to review that allegation, another allegation was brought to her attention that happened the early morning of 7/23/12 concerning the same CNA and a different resident. In this instance CNA #3 failed to provide timely and adequate care related to incontinence for resident #24. Review of this 7/23/12 investigation and continued interview with the DON revealed the CNA was terminated based on the results of the investigation. However, the DON verified an investigation should have been conducted on 7/20/12 and the CNA should have been suspended pending that investigation. Review of the schedule for 7/21/12 and 7/22/12 showed CNA #3 worked the night shifts from 6 PM to 6 AM on those dates. Interview with the DON on 7/26/12 at 12:15 PM verified the CNA worked those scheduled shifts. Review of the facility policy and procedure for prevention and reporting abuse last reviewed in May 2012, showed, "Administration will take necessary steps to prevent further potential abuse while the investigation is in process."

F 241 SS=D 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY — F 241

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

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F 241	Continued From page 5 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interviews, the facility failed to ensure dignity was maintained for 2 of 9 sample residents (#4, #6). The findings were: 1. Observation on 7/24/12 at 9:35 AM revealed CNA #1 assisted resident #4 to the bathroom. During the observation, the resident was observed to have swollen feet, legs, and knees and cried out in pain upon standing or movement. The CNA first attempted to assist the resident to a standing position in order to use the walker to walk from the wheelchair to the bathroom. Next, the CNA wheeled the resident into the bathroom in his/her wheelchair and insisted the resident stand, hold onto the grab bar, and then pivot to the toilet seat which the resident had difficulty doing and again, cried out in pain saying s/he was afraid of falling. The resident stated several times that s/he could not do the transfer. The transfer from the toilet back into the wheelchair showed the same concerns. During the entire observation, which took thirty minutes, the CNA was obviously frustrated and impatient with the resident. The CNA made comments such as "you're all right, you won't fall" in an irritated tone of voice. During the observation the resident responded to the CNA's frustration by becoming frustrated him/herself and said s/he "was trying but [his/her] feet hurt" and by crying. The resident complained of his/her feet "not moving right." Interview with the DON on 7/26/12 at 12:15 PM verified the CNA had talked with her about her	F 241	F 241 Resident dignity will be maintained at all times, including the dignity of residents' #4 and #6. This will be evidenced by all staff being trained on dignity and respect of the residents. This includes the DON instructing the CNA's on listening to residents needs, asking for assistance when needed in completing resident cares to help decrease pain and anxiety as expressed by resident #4. This also includes resident #6 who requested to take a shower at a later time and the CNA being in a hurry to do so. The resident also requested to wear her oxygen and the CNA did not allow her to and she did not notify the nurse to check her oxygen saturation level. A quality indicator has been developed for monitoring by the charge nurse and DON to ensure the dignity and respect of the residents. This will be monitored monthly and reported quarterly by the DON to the QI committee.	9/1/12 08-16-12

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F 241	Continued From page 6 frustration with the resident and was aware the situation was not performed properly and in a dignified and respectful manner. 2. Observation on 7/24/12 at 10:10 AM revealed CNA #2 told resident #6 it was time for his/her shower. At the time, the resident asked to shower at a later time because s/he was visiting with one of the surveyors. The CNA continued to tell the resident it was time for a shower and that she (the CNA) was busy and did not know if it could be worked in at a later time. Finally, the CNA did allow the resident to wait five minutes before assisting him/her to the shower. In addition, during this observation the resident was wearing his/her oxygen due to having felt s/he needed it at 10:09 AM. When the resident asked if s/he could wear the oxygen into the shower room, the CNA said "no." The CNA did not ask how the resident felt or if s/he was short of breath or notify the nurse to have his/her oxygen saturation checked. The CNA just said "no." Interview with the DON on 7/26/12 at 12:15 PM revealed residents should always be treated with dignity and respect. Interview with the resident on 7/25/12 at 12:30 PM revealed sometimes s/he feels better with the oxygen on even if his/her oxygen saturation level was alright. The resident said s/he would have been more comfortable with the oxygen on during the walk to the shower but that s/he did alright without it.	F 241		
F 243 SS=E	483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the	F 243		

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F 243	Continued From page 7 facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview and review of the resident council meeting minutes, the facility failed to ensure the resident council could meet privately and have input into meeting rules and bylaws development. The resident council normally had 14 to 17 residents who attended the meetings. The findings were: 1. Review of the resident council meeting minutes from October 2011 through June 2012 showed between three to five staff always attended the resident council meeting. During the confidential resident council meeting with seven residents held on 7/24/12 at 1:30 PM, residents said staff was too involved in their meetings. The following concerns were identified; a. Residents were especially upset over the election of council officers held in November 2011. Residents felt they did not have input into the nominees or voting. b Residents verbalized they were frustrated that they were not allowed input into the resident council bylaws being drafted. Interview with the social worker on 7/26/12 at 11:30 AM verified she had drafted the bylaws and given them to the administrator for input and then planned to have the residents provide their input. However, the	F 243	F 243 The facility will ensure the resident council can meet privately and have input into meeting rules and bylaws development. This will be evidenced by: Staff attending resident council meetings only when invited by the council president. Residents will develop their own council bylaws including a section on election of officers. A quality indicator has been developed for SSD to monitor monthly staff invitation and attendance at resident council meetings. The results will be reported quarterly to the QI committee.	9/21/12

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F 243	Continued From page 8 residents were told by the social worker that they would get to read the bylaws after the administrator approved them. Their interpretation was they would have no input because the bylaws would be approved and signed off by the administrator prior to their reviewing them. c. Interview with the social worker on 7/26/12 at 11:30 AM also revealed she had the understanding having the social worker and/or activity director at the resident council meetings was required. She further said staff used to attend only when invited by the residents but that lately staff just attended routinely without asking residents for permission.	F 243		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES 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, staff interview and medical record review, the facility failed to ensure 6 of 9 sample residents (#4, #6, #9, #10, #18, #24) received an ongoing individualized activity program. The findings were: 1. Review of the 12/1/11 admission MDS assessment for resident #4 showed family, pets, personal belongings, choosing his/her own clothing, and friends were very important to him/her. Review of this same MDS assessment showed the resident triggered for activities and	F 248		

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F 248	Continued From page 9	F 248		

required further assessment. The following concerns were identified with the resident's activity plan:

a. Review of the most recent assessment which was performed on 11/18/11 showed the resident enjoyed being in a large group, cooking/baking, bingo/trivia brain games, music, and socializing. However, review of the July 2012 participation record showed the resident participated in a music activity only twice and in games five times. Cooking/baking activities were not offered. Although group activities were on the schedule, review revealed no evidence the resident was offered any opportunities to participate in group activities.

b. Review of the 5/30/12 activities care plan showed some goals were not measurable. Goals included s/he "...will experience a sense of security/satisfaction, belonging through tailored activity plan; [S/he] will initiate pleasurable activity on own or with verbal prompt."

c. Review of the activity flow sheet for July 2012 revealed the resident received one to one activities which included a visit by staff three to five times per week. However, there was no evidence the effectiveness of the visit was evaluated. Review of activity records showed the resident's response to the visit was not documented.

2. Review of the 4/22/12 significant change MDS assessment for resident #24 showed family, personal belongings, going outside in good weather, religious practices, friends, and having books, newspapers and magazines available to read and keeping up with the news were very important to him/her. The following concerns were identified with the resident's activity plan:

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F 248	Continued From page 10 a. Review of the most recent activity assessment performed on 3/30/12 showed the resident enjoyed cooking/baking, card games, watching sports, music, plants and sometimes socializing. However, review of the July 2012 participation record showed the resident participated in no music activity, went outside once, read independently one day, participated in one religious activity, and cooking/baking activities were not offered. b. Review of the activities care plan showed some goals were not measurable. Goals included his/her "... activity needs will be met." Review of the 7/18/12 care plan showed no activity needs were identified. c. Review of the activity flow sheet for July 2012 revealed the resident received one to one activities which included a visit by staff. However, there was no evidence the effectiveness of the visit was evaluated. Review of activity records showed the resident's response to the visit was not documented. 3. Review of the 7/20/12 admission MDS assessment for resident #6 showed family, personal belongings, friends, music, going outside in good weather, religious practices and group activities were very important to him/her. The following concerns were identified with the resident's activity plan: a. Review of the 7/2/12 admission activity assessment showed the resident enjoyed cooking/baking, bingo/trivia brain games, cards and other games, exercises, shopping trips, outdoor activities, gardening, socializing and music. However, review of the July 2012 participation record showed the resident participated in a music activity three times, trivia	F 248	F 248 The facility will provide an individualized ongoing activity program for all residents including residents #4,#6,#9, #10, #18, #24. This will be evidenced by: All residents including residents #4, #6, #9, #10, #18 #24 will be asked to participate in group activities and the results of the response will be documented in the activities flow sheet. The resident care plans will have measurable goals to be coordinated with the residents activity assessment and flow sheet. Activities will be planned according to the individualized plan of care on all residents. All charting will reflect what activities the resident participated in for the day. The documentation of one on one visits will list what the activity is and what the residents response to the activity is. Any resident that wanders and has difficult behaviors the activity director will work with the social service director to develop a meaningful activity plan for that resident including resident #18. All activity assessments will be completed on admission to include family and resident input and yearly thereafter.The activity assessments and careplans on residents #4,#6,#9,#10,#18,#24 will be updated immediately and quarterly updates on each residents activity plan and response to the plan will be completed with the MDS process. A quality indicator has been developed for the activities director to monitor if all	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	710 OAK STREET SUNDANCE, WY 82729

(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 11 type games three times, and church once. Review of the July 2012 activity calendar showed no cooking/baking activities were offered. b. Review of the 7/12/12 activities care plan showed some goals were not measurable. Goals included s/he "will actively participate in selected activities." Further review of the care plan showed no selected activities were identified in the goals. c. Review of the activity flow sheet for July 2012 revealed the resident received one to one activities which included a visit by staff. However, there was no evidence the effectiveness of the visit was evaluated. Review of activity records showed the resident's response to the visit was not documented. 4. Review of the 5/1/12 significant change MDS assessment for resident #10 showed music and keeping up with the news was important to him/her. The following concerns were identified with the resident's activity plan: a. Review of the most recent assessment which was performed on 3/30/11 showed the resident enjoyed gardening/plants and music. Further review showed the resident sometimes enjoyed games, exercises, outdoor activities, and socializing. However, review of the July 2012 participation record showed the resident participated in no current events (news) and no outdoor activities. The resident participated in games only three times. b. Review of the 5/1/12 activities care plan showed some goals were not measurable. Goals included "Activities to engage [resident] will be found, based on [his/her] past interests and current capability." c. Review of the activity flow sheet for July 2012 revealed the resident received one to one	F 248	appropriate residents have been asked to attend group activities and all those residents with one on one scheduled activity visits are completed to include documentation of attendance, and the residents response to the activity. The activity director will also have a quality indicator to ensure resident activity assessments are completed on admission and yearly thereafter, with individualized care plans to include measurable goals. The social service director will have a quality indicator to monitor wandering or difficult behavior residents to ensure their activity and psychosocial needs are being met. This will be monitored monthly by the activities director and social service director as noted above for quarterly reporting to the QI committee.	9/1/12

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activities which included staff visits. However, there was no evidence the effectiveness of the visit was evaluated. Review of activity records showed the resident's response to the visit was not documented.

5. Review of medical record for resident #9 revealed a physician note dated 6/25/12. Included in the list of his findings were: "Boredom. This is a significant problem for the (resident). I will talk to the activities director and see if there is anything we can pull together to give (the resident) some sort of daily activity that might be more stimulating than essentially puzzles and word games." Additional review of the record revealed the most recent activities assessment was dated 6/15/11. Interview with the activities director on 7/26/12 at 8:30 AM revealed she was unaware of the June 2012 physician note. She also verified the June 2011 assessment was the most recent.

6. Review of the 10/22/11 annual MDS assessment showed activity preferences were assessed by staff for resident #18 because the resident was unable to answer the questions. The activities that were shown to be important to the resident included: caring for personal belongings, listening to music, spending time away from the nursing home, and spending time outdoors. Review of section V of this MDS showed the area for activities triggered and required additional assessment. Review of the most current activity assessment dated 3/30/11 showed the resident liked small and large groups, and one to one activities. The assessment then showed the activities the resident liked were: Arts/crafts, music/dancing, outdoor activities, and gardening. The assessment showed the resident rarely or

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never made themselves understood, and the assessment failed to include how the information was obtained. Review of a 10/14/09 document found in the medical record showed details of the resident's history. Attached to this document was a letter written by the resident's daughter describing things the resident liked. Some of the activities that were specific to this resident included "[S/he likes to keep crackers in [his/her] pocket...also loves pens and pencils and usually carries several around all day...will color or doodle little funny pictures." "[S/he] was a hard worker...and needs something to do...loves to sweep...loves stuffed animals, especially bears, also baby dolls." The following concerns were identified related to the activity plan for this resident:

a. Periodic observations of the resident on 7/24/12, 7/25/12, and 7/26/12 showed the resident wandered around the dining area and halls carrying a pink purse, slept in a chair near the chapel, and frequently tried to elope out the nursing home entrance.

b. Review of the 7/20/12 care plan for activities showed many of the goals were not measurable or well developed such as: "[The resident] will experience a sense of security/satisfaction/belonging through tailored activity plan" and "Activities to engage [the resident] will be found, based on her past interests and current capability." A note on the care plan was added on 7/25/12 showing some of the specific activities the resident enjoyed such as activities involving music, dancing, coloring and folding material. However, the care plan failed to include activities that were described by the daughter such as sweeping, and having stuffed animals and baby dolls.

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c. Interview with the activity director on 7/26/12 at 8:30 AM revealed she was not aware of the letter in the record from the daughter. She then stated they had tried some things in the past such as dolls and sweeping; however, she did not know when or what the resident's response to these activities were.

b. Review of the July 2012 one to one activity log showed general categories of activities with just an 'x' or a check mark. On the log the resident was marked under the area of "family" for 8 days, had one "visit" and one "sensory" activity. The log failed to show what these activities consisted of, how long they lasted, and what the residents reaction or response was. Interview with the activity director on 7/26/12 at 8:30 AM verified no goals or responses were documented during the one to one visits.

7. Interview with the activity director on 7/26/12 at 8:30 AM verified no goals or responses were documented during the one to one visits. Activity staff documented only that the visit occurred.

F 272 SS=F | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS — F 272

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 resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
Identification and demographic information;
Customary routine;

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F 272	Continued From page 16 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 on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide comprehensive assessments in a variety of areas for 9 of 9 sample residents (#1, #4, #5, #6, #9, #10, #18, #24, #25). The findings were: According to the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, April 2012, "Review a triggered CAA by doing	F 272		

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an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions...This is also an opportunity to consider any issues and/or conditions that may contribute to the triggered condition, but are not necessarily captured in the MDS data...Use the information gathered thus far to make a clear issue or problem statement." Failure to complete comprehensive assessments of triggered areas was identified as follows:

1. Review of the 5/1/12 annual MDS assessment showed resident #10 triggered for a problem in cognitive loss, communication, urinary incontinence, behavioral symptoms, falls, nutritional status, pressure ulcer and psychotropic drug use. Review of the CAAs for these areas showed no evidence the decision to care plan or not to care plan each specific care area was based on the analysis of the causes and contributing factors. The decision making rationale was not evident.

2. Review of the 7/12/12 admission MDS assessment for resident #6 showed the following areas triggered for comprehensive assessment: ADL (activities of daily living) functional/rehabilitation potential, urinary incontinence, falls, nutritional status, pressure ulcer, psychotropic drug use and pain. Review of the CAAs showed the areas were not comprehensively assessed utilizing the causes and contributing factors to determine the rationale for care planning.

3. Review of the 4/22/12 significant change MDS assessment for resident #24 showed s/he triggered for further review in the following areas:

F 272

F 272

The facility will complete a comprehensive assessment of triggered areas to include the potential need for care plan interventions by making a clear issue or problem statement on all resident CAA's including residents #1, #4, #5, #6, #9, #10, #18, #24, #25. This will be evidenced by: the MDS coordinator ensuring there is decision making rational which includes summarizing the data that is collected on the MDS and noting any other information not captured on the MDS and the reason for or for not care planning the triggered area for all resident CAA's including residents #1, #4, #5, #6, #9, #10, #18, #24, #25.
A quality indicator has been developed for the MDS coordinator to monitor the completion of CAA's for accuracy monthly for quarterly reporting to the QI committee. 9/01/12

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ADL functional/rehabilitation potential, urinary incontinence, mood state, falls, nutritional status, pressure ulcer, and pain. Review of the care area triggers showed the areas were not comprehensively assessed utilizing the causes and contributing factors to determine the rationale for care planning.

4. Review of the 12/1/11 admission MDS assessment for resident #4 showed the following areas triggered for comprehensive assessment: cognitive loss, visual function, communication, ADL functional/rehabilitation potential, urinary incontinence, psychosocial well-being, activities, falls, nutritional status and pressure ulcers. Review of the care area triggers showed the areas were not comprehensively assessed utilizing the causes and contributing factors to determine the rationale for care planning.

5. Review of the 6/26/12 annual MDS assessment for resident #9 showed nutritional status, rehab potential, urinary incontinence and falls triggered for comprehensive assessment. Review of these individual CAAs showed they failed to summarize the collected data used for the care planning decision.

6. Review of the unsigned January 2012 annual MDS assessment for resident #1 showed delirium, nutritional status, rehab potential, urinary incontinence, falls, pressure ulcer, pain and psychological well being triggered for comprehensive assessment. Review of these individual CAAs showed they failed to summarize the collected data used for the care planning decision.

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7. Review of the 10/22/11 annual MDS assessment for resident #18 showed several areas were triggered for additional assessment. Review of these individual CAAs showed they failed to summarize the data that was collected to demonstrate the need for the care planning decision. These areas that triggered and had non-comprehensive CAAs were as follows: cognitive loss/dementia, communication, urinary incontinence, psychosocial well-being, behavioral symptoms, activities, falls, nutritional status, and psychotropic drug use.

8. Review of the 2/10/12 annual MDS assessment for resident #5 showed several areas were triggered for additional assessment. Review of these individual CAAs showed they failed to summarize the data that was collected to demonstrate the need for the care planning decision. These areas that triggered and had non-comprehensive CAAs were as follows: visual function, ADL function/rehab potential, urinary incontinence, mood state, falls, nutritional status, pressure ulcers, psychotropic drug use, and pain.

9. Review of the 6/30/12 admission MDS assessment for resident #25 showed several areas were triggered for additional assessment. Review of these individual CAAs showed they failed to summarize the data that was collected to demonstrate the need for the care planning decision. These areas that triggered and had non-comprehensive CAAs were as follows: cognitive loss, ADL function/rehab potential, urinary incontinence, falls, nutritional status, pressure ulcers, and psychotropic drug use.

10. During an interview on 7/26/12 at 10:40 AM

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with the MDS coordinator, she verified the decision making rationale was not evident in the CAAs.

F 279 483.20(d), 483.20(k)(1) DEVELOP
SS=D 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 medical record review, staff interview and family interview, the facility failed to ensure a care plan was developed for one non-sample resident (#20) who was identified with a specific hydration need. The findings were:

Review of the 6/21/12 quarterly MDS assessment for resident #20 showed s/he required extensive

F 272

F 279

F 279 The facility will 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. This will be evidenced by: the care plan on all residents being updated to reflect the residents current level of care this includes resident #20 care plan being updated to include hydration and providing fluids in a manner she could accept.
A quality indicator has been developed for weekly monitoring by the IDT of all resident care plans to ensure changes are added in a timely manner. This will be monitored monthly by the DON for quarterly reporting to the QI committee. 9/01/12

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F 279	Continued From page 20 assistance with eating. In addition, the previous 3/24/12 annual MDS assessment showed the resident had triggered for the area of hydration status and fluid intake. Interview with the resident's family member on 7/26/12 at 5:10 PM revealed s/he had concerns that had not been adequately handled by the facility regarding hydration. The family stated the resident could not communicate well due to dementia. S/he further explained the resident could not drink from a straw. However, the facility usually provided the water in the resident's room in a container that had a straw attached to the lid, and no pour spout. The family member then stated the DON had responded to these concerns and provided a note to the CNAs to provide an additional drinking glass so the resident could be offered to drink from the glass, not the straw. The following concerns were identified: a. Review of the medical record showed there was not a care plan developed related to the resident's fluid intake needs or limitations. b. Interview with the DON on 7/26/12 at 11:15 AM verified the information on the posted note should be incorporated into the resident's care plan, and staff needed to ensure the resident was provided adequate fluids in a manner s/he could accept.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 281		

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F 281	Continued From page 21 interview, the facility failed to ensure physician orders were followed for 1 of 9 sample residents (#5). The findings were: Review of the nursing note dated 5/26/12 timed at 2:50 PM showed resident #5 was complaining about a lump on the right side of his/her head. The nurse described in the note, the lump was golf ball sized and tender to the touch. The note also showed the resident complained the lump gave him/her headaches. The note concluded with the decision to relay a message to have an appointment made "...on Tuesday when the clinic is open to be evaluated by a physician." The following concerns were identified related to timing of a physician visit and following orders: a. Review of physician progress notes showed the physician visited the resident on 6/27/12. At that time, the physician wrote orders which showed a 6/27/12 timed at 10:30 AM order for a skull x-ray series, and also a 6/27/12 at 6 PM order for a CT (computerized tomography) scan of the head, the right parietal region. Both orders were noted; however, review of the medical record failed to show any results or evidence the CT scan had been done. b. Interview with the DON on 7/25/12 at 8:45 AM verified the 6/27/12 order was not done at that time, it was re-ordered on 7/9/12 at 9:50 AM. Review of the 7/9/12 physician order verified this, and the DON stated it should have been done when first ordered, she was uncertain why it had not been performed. Review of the nursing notes showed the CT scan was completed on 7/10/12.	F 281	**F281** All services provided or arranged by the facility will meet professional standards of quality. This will be evidenced by: physician appointments will be made in a timely manner and all ordered tests and procedures will be performed at the earliest possible time including those for resident #5. All nurses will be inserviced by the DON on the procedure for scheduling tests and procedures. A quality indicator has been developed for the charge nurses to track Doctor visits, tests, and procedures. This will be monitored daily for monthly tracking and quarterly reporting by the DON to the QI committee.	9/01/12
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282	08-16-12	

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F 282	Continued From page 22 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure staff followed the care plan for 1 of 9 sample residents (#4). The findings were: Review of the nursing notes dated 7/24/12 and timed at 6:35 AM revealed resident #4 was found on the floor, having fallen out of bed. Review of the care plan showed it was updated on 7/24/12 to include a sit to stand lift for transfers. Interview with RN #1 on 7/26/12 at 10:40 AM revealed she was the person who had updated the care plan and she had done so immediately after the fall at 6:35 AM. This RN further stated the fall was discussed during shift report with staff. However, observation on 7/24/12 at 9:35 AM showed CNA #1 did not use the sit to stand lift for transferring the resident from the wheelchair to the toilet. During the transfer the resident cried and expressed a fear of falling. Interview with the DON on 7/26/12 at 12:15 PM revealed the CNA had reported the incident to her and was aware she had placed the resident in a potentially unsafe situation during the transfer by not following the care plan.	F 282	F 282 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 evidenced by: All staff will follow the written plan of care on all residents including resident #4 who is care planned for a mechanical lift and the CNA failed to utilize it. All staff will be in serviced by the DON on utilizing and following each residents plan of care. A quality indicator has been developed for weekly tracking by the charge nurses to ensure the plan of care is being followed. The DON will monitor monthly for quarterly reporting to the QI committee.	9/01/12
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		

gmb 08-16-12

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536029	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET SUNDANCE, WY 82729

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F 309	Continued From page 23 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 medical record review and staff and resident interview, the facility failed to ensure all necessary assessments, monitoring, and nursing measures were implemented for pain menagement for 3 of 4 sample patients (#4, #5, #6) who experienced pain. In addition, the facility failed to ensure a physician visit was scheduled and a diagnostic procedure was carried out in a timely manner for the care needs of 1 of 9 sample residents (#5). The findings were: 1. Review of the admission face sheet for resident #6 showed s/he was admitted with diagnoses including status post hip fracture, gout, and obesity. Review of the 7/12/12 admission MDS assessment showed the resident had frequent pain that limited his/her day to day activities. The resident rated the pain as 8 out of 10 (8/10) with 10 being the worst. Review of the medical record for the resident showed a physician's order dated 6/29/12 for Hydrocodone 5/325 milligrams (mg) one tablet four times per day. Review of the MAR and the PRN tracking sheets for June and July 2012 revealed the following concerns with pain management: a. Review of the June 2012 MAR showed on 6/29/12 at 8 PM the resident received Hydrocodone one tablet for pain rated 8/10. Review of the medical record showed no evidence the resident's pain was re-assessed to	F 309	F 309 The facility must provide the necessary care and services to attain and maintain the highest practicable physical, mental, psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This will be evidenced by: All residents including residents #4, #5, #6 will have their pain re-assessed within 1hour after oral administration of pain medication with alternative measures utilized if necessary and pain is unrelieved. And adequate reassessment of pain until pain is stated tolerable by the resident. All residents including resident #5 will have MD appointments and procedures scheduled in a timely manner. The nurses will be in serviced on the procedure for pain follow up and scheduling procedures and appointments when requested by the resident or ordered by the physician. A quality indicator has been developed for daily tracking for follow up on pain medication effectiveness and physician, procedure appointments scheduled in a timely manner. The DON will monitor monthly for quarterly reporting to the QI committee.	9/01/12

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	530029	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET SUNDANCE, WY 82729

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F 309	Continued From page 24	F 309		

determine the effectiveness of the Hydrocodone in relieving the resident's pain. The next pain assessment was performed on 6/30/12 at 5:30 AM (11 and 1/2 hours later) and the resident rated the pain at 8/10. Additionally, there was no evidence non-pharmacological interventions were attempted to address the resident's pain.

b. Review of the July 2012 MAR showed the resident had a pain level of 7/10 at 10:30 PM on 7/8/12. The resident was administered Hydrocodone, however, upon re-assessment at 1 AM on 7/9/12, two and one-half hours later, showed the medication was not effective. At the time of re-assessment the resident rated the pain as increased to 8/10. The resident then received Indocin 25 mg (anti-inflammatory) as an additional measure to address his/her pain. However, there was no evidence a re-assessment was performed after administration of the additional medication to determine whether or not the resident's pain level of 8/10 was relieved. The next assessment was on 7/9/12 at 9:15 AM, 8 hours later.

c. Review of the July 2012 MAR showed the resident had pain rated 8/10 on 7/12/12 at 5:50 PM. The resident was administered Hydrocodone one tablet at that time. Review of the medical record showed no evidence the resident was re-assessed to determine the effectiveness of the medication in relieving his/her pain. The next assessment of pain was performed the following day 7/13/12 at 11:32 AM (17 hours later).

d. Review of the July 2012 MAR showed the resident's pain level was 6/10 on 7/18/12 at 5:55 PM and was administered Hydrocodone. Review of the medical record showed no evidence the resident's pain was re-assessed until the following day, 7/19/12, at 5 PM, nearly 24 hours

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	535029	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET BUNDANCE, WY 82729

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F 309	Continued From page 26	F 309		

later, at which time the pain level remained at 6/10.

e. Review of the July 2012 MAR showed on 7/20/12 at 7:30 PM the resident received Hydrocodone for pain. Continued review showed there was no description, location, or intensity of the pain documented. In addition there was no evidence a re-assessment of the pain was performed. The next pain assessment was on 7/21/12 at 3 AM at which time the resident again received Hydrocodone without a description, location, or intensity of pain being assessed.

f. Interview with the resident on 7/24/12 at 10:05 AM and on 7/25/12 at 12:30 PM revealed pain was a big problem for him/her. The resident said the pain was severe and impacted the quality of his/her life by limiting day to day activities.

g. Interview with the DON on 7/26/12 at 12:15 PM verified the expectation of pain management was to re-assess the resident's level of pain one to two hours after administration of a pain medication to determine the effectiveness.

2. Review of the 5/30/12 quarterly MDS assessment for resident #4 showed s/he had occasional pain. Review of the medical record for the resident showed a physician's order dated 12/30/11 for a Fentanyl Patch 25 mcg (micrograms) for pain management. Review of the physician's standing orders for this resident showed an order for Tylenol 325 mg one to two tablets every four to six hours as needed for pain. Review of the MAR and the PRN tracking sheets for June and July 2012 revealed the following concerns with pain management:

a. Review of the June 2012 PRN tracking flow sheet showed the resident had pain rated 4/10 and received two tablets of Tylenol 325 mg

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	535020	A. BUILDING _____ B. WING _____	07/26/2012

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F 309	Continued From page 26	F 309		

for the pain on 6/3/12 at 6 PM. Continued review revealed no evidence a re-assessment of the resident's pain level was performed to determine the effectiveness of the medication in relieving the pain. The next pain assessment was 6/7/12 at 4:05 PM, four days later.

b. Review of the June 2012 PRN tracking flow sheet showed the resident had pain rated 7/10 and was administered two tablets of Tylenol 325 mg for pain on 6/11/12 at 7:30 PM. Further review of the flow sheet showed no evidence a re-assessment was performed to determine the effectiveness of the medication in relieving the resident's pain. The next pain assessment was performed 25 hours later on 7/12/12 at 10:30 PM.

3. Review of the nursing note dated 5/26/12 timed at 2:50 PM showed resident #5 was complaining about a lump on the right side of his/her head. The nurse described in the note, the lump was golf ball sized and tender to the touch. The note also showed the resident complained the lump gave him/her headaches. The note concluded with the decision to relay a message to have an appointment made "...on Tuesday when the clinic is open to be evaluated by a physician." The following concerns were identified related to delay of the physician visit and following orders:

a. Review of the nurses' notes failed to show the appointment was scheduled or any communication was made to the physician. Interview with the DON on 7/26/12 at 8:45 AM verified there was not a physician appointment made, she checked with the clinic and it was perhaps due to the physician being on vacation at that time.

b. Review of the 6/27/12 physician progress notes showed the physician visited the resident

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F 309	Continued From page 27 as part of a 60 day visit. The physician addressed the residents lump on the head, and the note showed "...[s/he] remains concerned that the bump on [his/her] head is present and perhaps even enlarging. With this [s/he] associates having headaches and feels as though frequently that the staff does not take [him/her] seriously and that [s/he] is often chided and told that [s/he] should have nothing wrong." The physician noted the lump would be "looked into more...and is probably consistent with a bony growth..." c. Review of physician orders showed a 6/27/12 timed at 10:30 AM order for a skull x-ray series, and also ordered on 6/27/12 at 6 PM was an order for a CT (computerized tomography) scan of the head, the right parietal region. Both orders were noted, however, review of the medical record failed to show any results or evidence the CT scan was done. d. Interview with the DON on 7/25/12 at 8:45 AM verified the 6/27/12 order was not done at that time, it was re-ordered on 7/9/12 at 9:50 AM. Review of the 7/9/12 physician order verified this, and the DON stated it should have been done when first ordered. Review of the 7/10/12 nursing notes showed the CT scan was completed on 7/10/12. e. Observation and interview with the resident on 7/25/12 at 11:46 AM revealed s/he had a visible lump on the right side of her head. At that time, the resident stated, s/he had an appointment the previous day with a neurosurgeon who was going to remove the lump. The resident stated the lump caused him/her to have headaches and although s/he was worried about surgery, was happy something was being done.	F 309		
F 312	483.25(n)(3) ADL CARE PROVIDED FOR	F 312		

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F 312 SS=D	Continued From page 28 DEPENDENT RESIDENTS 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 and staff interview,medical record review, and review of policies and procedures, the facility failed to ensure staff provided appropriate perineal (incontinence) care for 1 of 6 residents (#4) who required staff assistance with personal hygiene. The findings were: Review of the 12/1/11 admission, and the 2/29/12 and 5/30/12 MDS assessments for resident #4 showed s/he required staff assistance with perineal care and personal hygiene. Observation on 7/24/12 at 9:35 AM showed CNA #1 transferred the resident to the toilet where the resident had a bowel movement. During observation of the perineal care provided by the CNA, it was noted the last wipe used was soiled with feces indicating the resident was not thoroughly cleaned. Interview with the DON on 7/26/12 at 12:15 PM revealed the CNA had reported her error to the DON and the CNA knew she should have continued perineal care until the resident was totally clean. Review of the facility policy on Incontinence care, reviewed 10/26/10 showed instructions to "Wash the anal area with another clean wipe using gentle front-to-back strokes, if soiled with feces, use a clean wipe to	F 312	F 312 A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This will be evidenced by: All residents including resident #4 receiving incontinence care per the facility policy. All nursing staff will be educated by the DON on performing proper incontinence cares on all residents. A quality indicator has been developed to monitor incontinence cares weekly by the charge nurses and DON for monthly monitoring and quarterly reporting by the DON to the QI committee.	8/8/12

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F 312	Continued From page 29 complete the task."	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: ~~Based on observation, medical record review,~~ and staff interview, the facility failed to assure a safe transfer for 1 of 9 sample residents (#4). The findings were: Review of the nursing notes dated 7/24/12 and timed at 6:35 AM revealed resident #4 was found on the floor, having fallen out of bed. Review of the care plan showed it was updated on 7/24/12 to include a sit to stand lift for transfers. Interview with RN #1 on 7/26/12 at 10:40 AM revealed she was the person who had updated the care plan and she had done so immediately after the fall at 6:35 AM. This RN further stated the fall was discussed during shift report with staff. The following concerns were identified: a. Observation on 7/24/12 at 9:35 AM showed CNA #1 attempted to transfer the resident from the wheelchair to the walker. The resident complained that s/he was unable to stand to use the walker because his/her feet were swollen and painful. Observation at this time showed the resident's feet and legs were swollen. Continued	F 323	The facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This will be evidenced by: All residents will be transferred according the plan of care including resident #4. The nursing staff will be educated by the DON on following the plan of care and safety measures for each resident. A quality indicator has been developed to ensure all residents are being transferred per their plan of care for daily monitoring by the CNA's and nurses. The DON will monitor monthly for quarterly reporting to the QI committee.	9/01/12

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F 323	Continued From page 30	F 323		

observation showed the CNA spent approximately five more minutes trying to get the resident to stand to use the walker. When the CNA was unable to get the resident to use the walker, she then transferred the resident to toilet using the wheelchair.

b. Observation revealed while transferring from the wheelchair to the toilet, the CNA had the resident stand and hold onto the grab bar located next to the toilet. Observation showed the resident was unable to move his/her feet to transfer and the CNA placed the resident's hands on the bar to hold him/herself up while the CNA pivoted the resident towards the toilet seat. Observation showed the resident was placed on the toilet seat at an angle. During this transfer the resident cried and said s/he could not stand and the pain was terrible. The resident also expressed fear of falling during this transfer.

c. After the resident used the toilet, the CNA again attempted to have the resident assist with his/her transfer back to the wheelchair by pivoting and hanging on to the grab bar. Observation showed the resident was unable to put his/her hands on the grab bar so the CNA placed them on the bar for him/her. The resident then complained of severe pain in the hands and again began to cry.

d. Observation of both transfers showed they were difficult for the resident and s/he verbalized a fear of falling. However, the CNA, at no time, asked for assistance, nor did she use the sit to stand lift as indicated on the care plan. Interview with the DON on 7/26/12 at 12:15 PM revealed the CNA had reported the incident to her and was aware she had placed the resident in a potentially unsafe situation during the transfer.

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F 371 483.35(i) FOOD PROCURE, F 371

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F 371 SS=F	Continued From page 31 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) 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 failed to ensure food sanitation requirements were met in the kitchen related to equipment and cleaning. The findings were: 1. Observation on 7/23/12 at 3:20 PM showed the ice and water dispenser in the facility kitchen had a build up of a white and brownish substance on the interior of the plastic dispenser shield. Interview with the dietary manager on 7/26/12 at 8:55 AM verified cleaning of the dispenser shield was not included on a cleaning schedule, and when looking at it, she agreed it needed to be cleaned more frequently. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch." In addition, the ice and water dispenser was mounted on a counter partially over a sink. The dispenser drain hose came out from the bottom of the machine and into the sink. The drain hose laid on the bottom of the sink and there was no prevention of back flow should the sink fill up.	F 371	The facility will store, prepare, distribute and serve food under sanitary conditions. This will be evidenced by: The dietary staff will receive education by the Certified Dietary Manager with assistance from the Registered Dietitian through an in-service on sanitation. This education will include appropriate procedure on ice machine cleaning and proper storage of soiled dish towels. 8/30/12 The Ice machine "Shield" will be included on Policy and Procedure #DT 043, steps for Care and Cleaning of Dietary Equipment. 8/16/12 "T" was replaced on ice machine hose to prevent back flow per maintenance. 7/26/12 Dish towels will be stored in quaternary solution when in use and lying flat to dry when not in use as stated in Policy and Procedure # DT 052. 8/16/12 The proper storage of soiled dish towels and cleaning of the dietary equipment will be monitored for compliance by a daily checklist. The will be monitored monthly and reported quarterly by the Certified Dietary Manager through the QAPI process to assure ongoing compliance. 8/30/12	

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	535020	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 32 Interview with the maintenance director on 7/26/12 at 8:20 AM verified there was no back flow prevention on the dispenser with the way it was set up. The director reviewed the instruction manual for the dispenser machine and stated another configuration of the drain hose was needed to incorporate appropriate back flow prevention. According to Food Code 2009, U.S. Public Health Service: 5-202.13 "An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch)." 2. Observation on 7/25/12 at 3:20 PM in the dish room off the facility kitchen showed a bucket on a self that contained a damp dirty towel. The bucket was located on the "dirty" side of the dish room and did not contain any sanitizer solution. Interview with the dietary manager at that time stated the dirty towel should be placed into the dirty linen container and not left in the bucket. When the towel was removed from the bucket, there were what appeared to be small maggots both alive and dead in the bottom. The dietary manager discarded the bucket and towel. According to Food Code 2009, U.S. Public Health Service: 4-803.11 "Soiled linens shall be kept in clean, nonabsorbent receptacles or clean, washable laundry bags and stored and transported to prevent contamination of food, clean equipment, clean utensils, and single-service and single-use articles."	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be	F 428		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET SUNDANCE, WY 82729

(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 428	Continued From page 33 reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to conduct a drug regimen review (DRR) monthly for 2 of 9 sample residents (#4, #10). The findings were: 1. Review of the monthly drug regimen review forms for resident #10 showed no drug regimen review was performed during the month of April 2012. Interview with the DON on 7/26/12 at 12:15 PM revealed she was unsure why the review was missed. 2. Review of the monthly drug regimen review form for resident #4 showed no evidence a review of medications was performed by the pharmacist during the month of June 2012. Interview with the DON on 7/26/12 at 12:15 PM revealed she had discussed the lacking DRR with the pharmacist and she said it was an oversight.	F 428	F 428 The facility will ensure the pharmacist reports any irregularities to the attending physician and the director of nursing and these reports are acted upon. This will be evidenced by: The pharmacist and the DON will ensure all monthly drug regime reviews are completed on every resident including resident #4 and #10, and any irregularities reported to the physician. A quality indicator has been developed for monthly monitoring by the DON to ensure all drug regime reviews are completed, for quarterly reporting to the QI committee.	8/05/12
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		

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F 441	Continued From page 34 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policy and procedures, the facility failed to	F 441		

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F 441	Continued From page 35 ensure infection control protocols were followed in regard to hand washing/hygiene during the care of 1 (#4) of 9 sample residents. The findings were: Observation on 7/24/12 at 9:35 AM showed CNA #1 provided perineal care to resident #4. Observation showed the CNA did not remove the soiled gloves used during perineal care prior to assisting the resident from the toilet to the wheelchair. Observation showed the CNA touched the resident's skin, clothing and wheelchair with the soiled gloves. Once the resident was in the wheelchair, the CNA removed her soiled gloves but did not wash or cleanse her hands. Review of the facility policy on hand washing and hygiene, reviewed 8/8/10, showed instructions to "Change gloves during patient and resident care if moving from one contaminated body site to another contaminated site. Also, change after one contaminated site to clean and vice versa." Interview with the DON on 7/26/12 at 12:15 PM revealed the CNA should have removed her gloves between perineal care and assisting the resident to the wheelchair. The DON also said the CNA was aware she should have removed her gloves but feared the resident was going to fall. Observation at the time, however, showed the CNA had time to remove her gloves prior to assisting the resident back to the wheelchair.	F 441	F 441 The facility will ensure that its current infection control protocols are followed in regard to hand washing/hygiene during the care of all residents including resident #4. This will be evidenced by: All nursing staff will be in serviced by the DON and infection control nurse on proper hand hygiene and incontinence cares to ensure infection control protocols followed. A quality indicator has been developed for weekly monitoring by the nursing staff. The DON will monitor monthly and report quarterly at the QI committee.	9/1/12
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of	F 520		

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F 620	Continued From page 36 nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of the CMS-2567 (Centers for Medicare and Medicaid Statement of Deficiencies) and review of facility documents, the facility failed to ensure the quality assurance and performance improvement (QAPI) program was effective in resolving identified concerns. The findings were: Interview with the quality assurance coordinator on 7/26/12 at 12:15 PM revealed data was collected and analyzed. However, review of the CMS-2567 for last year's survey, dated 7/14/11 revealed the following deficiencies were written: a. F225 related to allegation of abuse	F 620	F 520 The facility will meet this requirement by the DON, a physician and three other staff members attending quarterly QI meetings. The Long Term Care Unit will be conducting daily tracking for weekly review of QI at the IDT meeting to assure the appropriate implementation and monitoring is being done for Tags F241, F272, F279, F281, F309, F312, F371, F428, F441. The plan will be revised as needed with continued monitoring by the IDT members. The committee will consist of the DON, Social Services Director, Dietary Manager, Activities Director, MDS RN, and Restorative Aide when available. All QI will be monitored monthly for quarterly reporting to the QI committee. To be forwarded to the Board of Directors quarterly. The Physician has attended the August 14, 2012 meeting.	8/14/12

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F 520	Continued From page 37 investigations; b. F241 dignity; c. F272 related to lack of comprehensive assessments; d. F279 related to lack of care plan development; e. F281 related to professional standards; f. F309 related to not providing the necessary care and services; g. F312 related to inadequate personal hygiene; h. F371 pertaining to clean and sanitary conditions; and i. F428 related to drug regimen reviews; and j. F 441 pertaining to infection control. These same issues were identified as concerns during the current survey conducted 7/23/12 through 7/26/12.	F 520		

8-16-12