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WY Dept of Health
AUG 08 2012
Healthcare Licensing and Surveys

PRINTED: 07/20/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535028	A. _____ B. WING _____	C 07/03/2012

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 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 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.	F 225	F225 All bruises of unknown origin will be documented on an incident report and will be investigated according to the facilities updated policies. The bruise identified on 5/21/12 on resident #2 was documented and investigated on 7/20/12. This will be evidenced by: The Abuse and Neglect investigation reporting policy and the Incident Report policy being updated to reflect current regulation, appropriate agencies, and the chain of command to be utilized when reporting abuse and neglect, skin tears, bruises of unknown origin, and unwitnessed falls. A quality indicator has been developed for weekly tracking of bruises and skin tears by the MDS coordinator for monthly monitoring and quarterly reporting to the QI committee. 8/8/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dan VanBeek — TITLE: Administrator — (X6) DATE: 08-07-12

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

Accepted the changes discussed on 8/8/12 w/ DON Connie Clouse have been incorporated DOC = 8/8/12

8-8-12

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and review of facility logs and investigation reports, the facility failed to ensure one injury of unknown origin was investigated for 1 of 1 sample resident (#2) who had an injury of unknown origin. The findings were: 1. Review of the 5/23/12 social service care conference notes timed at 2:30 PM revealed resident #2 had a bruise on the left hand. According to these notes, the resident was asked about the bruise "several x's [times]" but s/he provided no explanation of how or when the bruise happened. Review of the 5/23/12 social service notes timed at 1:55 PM showed the social worker had noted the bruise on the resident's left hand on the morning of 5/22/12 while she was placing curlers in the resident's hair. The following concerns were identified: a. Review of the medical record and incident reports showed no evidence the cause of the bruise (unknown injury) was investigated b. Interview with the administrator on 6/29/12 at 4:20 PM revealed the bruise was not reported or investigated as to the cause. c. Review of facility documentation revealed the bruise of uknown etiology was not reported to the required state agency	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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F 226	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on staff interview and review of policies and procedures, the facility failed to ensure abuse and neglect training was provided for employees in accordance with policy and procedure requirements for 2 of 5 employees whose files were reviewed. The findings were. According to the facility's policy on Abuse: Seven Key Points, revised July 11, 2008, "... the following components should be included in the training. The definition of abuse, The seven key points of abuse, Dealing with difficult behaviors, and Dealing with personal stress." Interview with CNA #1 on 6/28/12 at 1:15 AM revealed s/he had worked at the facility since April 2012. She stated her training on abuse and neglect consisted of being handed something to read then answering one question. The CNA said she was then asked to sign her name to a form and that was the training. Interview with CNA #2 on 6/28/12 at 1:30 AM revealed she had been given a handout as well and was quickly asked three questions. This CNA was also asked to sign a form indicating she had received training on abuse and neglect. This CNA said she had worked in the facility since March 2012. While interview with the administrator on 6/28/12 at 4:20 PM revealed staff had been educated on how to work with this resident after 5/22/12, she said the education provided prior to 5/22/12 had proven to be ineffective.	F 226	**F226** The staff has been inserviced on the updated abuse and neglect policy. Abuse and Neglect education will be provided yearly and on an as needed basis by the Director of Nursing and the Administrator or their appointed designee. The abuse and neglect policy has been updated to include the definition of abuse, seven key points of abuse and dealing with personal stress. Education by a LCSW on Dealing with Difficult Behaviors and Dealing with Personal Stress will be completed by all Nurses and Certified Nurse Aides on 8/6/12 and 8/7/12 and will be provided on a yearly and as needed basis. A quality indicator has been developed for monthly tracking for new employees receiving abuse and neglect training. The Director of Nursing will monitor for quarterly reporting to the QI committee.	8/8/12
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by,
Based on staff interview, and medical record review, the facility failed to ensure the care plan was updated to reflect the current needs for 1 of 5 sample residents (#2). The findings were.

Review of the 1/16/12 admission MDS assessment for resident #2 showed s/he had the ability to understand and be understood. Further review showed the resident required limited assistance of one staff member for all ADLs (activities of daily living) except eating and personal hygiene. Review showed for personal hygiene the resident required supervision of one person. Review of the MDS assessment also

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F 280	Continued From page 4 showed the resident's balance was unsteady and s/he required assistance with moving from a seated to standing position, moving on and off the toilet, and for transfers. Review of the 4/16/12 quarterly MDS assessment showed the resident's ADLs were unchanged except s/he required limited assistance with personal hygiene instead of supervision only. Review of the following nursing notes showed the resident required assistance of one staff for ADLs. 1/25/12 timed at 10 AM, 4/3/12 timed at 7 PM, 4/4/12 timed at 11.55 PM and 4/18/12 at 10:30 AM. Additionally, review of the 4/17/12 nursing notes, not timed, showed the resident had a ".. visibly unsteady gait when ambulating." Review of the nursing notes dated 4/6/12 and timed at 2:30 PM showed the resident was "demanding." Review of the 4/21/12 nursing notes timed at 5:45 AM revealed the resident was "rude" to staff and was refusing to take medications because s/he thought staff was trying to poison him/her. Review of the 4/21/12 nursing notes written at 9:05 AM revealed the resident was "yelling at staff," using the call light frequently, and had increased confusion. Because of these increased behaviors, the physician was notified and ordered a mental health evaluation. Review of the record showed a mental health evaluation was performed on 4/27/12. Review of this document showed the therapist "Completed assessment and recommended some behavior interventions." Further review of the medical record however, showed no written evidence of the recommended behavior interventions at that time. Review of an additional mental health assessment performed by the same licensed practitioner was performed on 5/17/12 and recommendations were included	F 280	**F280** The resident plan of care will be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in the disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment. This will be evidenced by: The resident, residents family or residents legal representative, and appropriate disciplines working together to develop the plan of care appropriate for all residents. The care plan for resident #2 was updated and developed on 5/31/12. All recommendations will be addressed with the resident and added to the resident plan of care in a timely manner to ensure the residents current level of functioning. A quality indicator has been developed for weekly monitoring by the IDT that all care plans are being updated and personalized on each resident. This will be monitored monthly for quarterly reporting to the QI committee.	8/8/12

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F 280	Continued From page 6 One of the recommendations was for the social service staff member to work with the resident to develop a written contract of expectations and responsibilities for both the staff and the resident. This contract was developed on 5/21/12 and was to be used when problematic behaviors arose. Also in the contract was the resident would do all personal care s/he was capable of doing. However, interview with the DON on 7/2/12 at 3 PM and the administrator on 8/29/12 at 4:20 PM verified the care plan had not been updated with the recommendations or conditions in the written contract.	F 280		
F 309 SS=D	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, 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 review of facility documents and the medical records, the facility failed to ensure a comprehensive nursing assessment was performed to determine the current level of functioning for 1 of 5 sample residents (#2). In addition, the facility failed to ensure staff received sufficient education and accurate communication to provide the necessary care for this resident. The findings were: Review of the 1/16/12 admission MDS	F 309		

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F 309	Continued From page 6 assessment for resident #2 showed s/he had the ability to understand and be understood. Further review showed the resident required limited assistance of one staff member for all ADLs (activities of daily living) except eating and personal hygiene. Review showed for personal hygiene the resident required supervision of one person. Review of the MDS assessment also showed the resident's balance was unsteady and s/he required assistance with moving from a seated to standing position, moving on and off the toilet, and for transfers. Review of the 4/16/12 quarterly MDS assessment showed the resident's ADLs were unchanged except s/he required limited assistance with personal hygiene instead of supervision only. Review of the following nursing notes showed the resident required assistance of one staff for ADLs: 1/26/12 timed at 10 AM, 4/3/12 timed at 7 PM, 4/4/12 timed at 11.55 PM and 4/18/12 at 10.30 AM. Additionally, review of the 4/17/12 nursing notes, not timed, showed the resident had a "...visibly unsteady gait when ambulating." Review of the nursing notes dated 4/6/12 and timed at 2:30 PM showed the resident was "demanding." Review of the 4/21/12 nursing notes timed at 5:45 AM revealed the resident was "rude" to staff and was refusing to take medications because s/he thought staff was trying to poison him/her. Review of the 4/21/12 nursing notes written at 9:05 AM revealed the resident was "yelling at staff," using the call light frequently, and had increased confusion. Because of these increased behaviors, the physician was notified and ordered a mental health evaluation. Review of the record showed a mental health evaluation was performed on 4/27/12 Review of this document showed the	F 309	**F309** Each resident will receive and the facility will 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 will be evidenced by: Resident #2 has had a functional assessment and mental health evaluation completed to determine her current status. All residents will have mental health evaluations, functional assessments, physical therapy evaluations as needed to assist in measuring, monitoring and documenting the residents current level of functioning. The plan of care will be updated accordingly, and staff instructed on any changes necessary. The staff have been educated on the current status of resident #2. A weekly quality indicator has been developed to monitor for changes in resident functional status by the IDT committee. This will be monitored monthly for quarterly reporting to the QI committee.	8/8/12

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F 309	Continued From page 7	F 309		

therapist "Completed assessment and recommended some behavior interventions." Further review of the medical record however, showed no written evidence of the recommended behavior interventions at that time. Review of an additional mental health assessment performed by the same licensed practitioner was performed on 5/17/12 and recommendations were included. One of the recommendations was for the social service staff member to work with the resident to develop a written contract of expectations and responsibilities for both the staff and the resident. This contract was to be used when problematic behaviors arose. Also in the contract was the resident would do all personal care s/he was capable of doing. The following concerns were identified:

a Review of the medical record showed no evidence a re-assessment of the resident's capability for self care was performed since the 4/16/12 quarterly MDS assessment was completed. The 4/16/12 MDS assessment showed the resident required the assistance of staff for all ADL,s except eating. There was no evidence in the medical record that showed a change in staff assistance was indicated. Interview with the DON on 7/2/12 at 3 PM revealed she had discussed the resident's capabilities for self care with the resident's physician and the physician agreed staff should evaluate the resident's status. However, this same physician wrote in the progress notes dated 5/23/12 the following: " there appears to have been some misunderstandings about the level of independence and capabilities that [s/he] has. [S/he] does require assistance with hair brushing as [s/he] is unable to raise the arms to a considerable extent, though can brush [his/her]

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F 309	Continued From page 8 teeth (needs help retrieving the materials to do such), and given the safety bars on the toilet, [s/he] cannot reach herself to wipe appropriately and also requires assistance with standing up to an upright posture and also requires assistance with transitioning in and out of bed." Review of the medical record revealed no evidence the resident's level of independence had increased or that s/he required less assistance with ADLs. b. Interview with the DON on 7/2/12 at 3 PM revealed an interdisciplinary meeting was set for 5/23/12 with the resident and family to discuss the mental health therapist's recommendations and the written contract developed on 5/21/12. The therapist was asked to attend this meeting but was unable to do so. The therapist did provide a copy of her recommendations to the DON prior to the meeting. However, the care plan was not updated with the recommendations or conditions in the written contract at this time. Communication of the new recommendations was verbal and rushed between the DON and CNAs #1 and #2 because the DON was called to assist with an emergency in the hospital. According to interviews with CNA #1 on 6/28/12 at 1:15 AM, CNA #2 on 6/28/12 at 1:30 AM, and CNA #3 on 6/29/12 at 6:08 PM, as well as the LPN on 6/28/12 at 1:52 AM, and the DON on 7/2/12 at 3 PM, there was a misunderstanding and/or misinterpretation regarding the level of assistance the staff should have provided for the resident on the evening and night shifts of 5/22-5/23/12. The DON, according to these CNA interviews, asked CNA #1 and #2 to pass along the information to other CNAs because she did not have time to do so. c. While interview with the administrator on 6/29/12 at 4:20 PM revealed staff had been	F 309		

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educated on how to work with this resident after 5/22/12, she said the education provided prior to 5/22/12 had proven to be ineffective.

d. Review of the 5/23/12 physician's progress notes showed the resident "...has had ongoing concerns regarding the provision of [his/her] care, particularly overnight and by night staff members. [S/he] has been consistently and easily upset regarding the attitude and provision of cares and assistance and has voiced these concerns particularly as [s/he] appeared to be developing some depressive symptoms as well and concern was raised regarding some sleep disruption related to a potential mood disorder."

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