JUL. 26. 2007 3:59PM   NO. 1278 P. 1

TO: JANELLE CONLIN

POC accepted 7/27/07 Janelle Conlin, OPRM

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

PRINTED: 07/06/2007
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
	535013	A. BUILDING ______ B. WING ______	C 06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3133 BOXELDER DRIVE CHEYENNE, WY 82001

(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 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and policy and procedure review, the facility failed to promptly notify the physician for one (#122) of one sample resident who verbalized	F 157	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it. F157-Plan of Correction This plan of correction is the facility's credible allegation of compliance. Resident #122 is no longer in the facility. Other residents at risk will be identified by the Director of Nurses or designee who will conduct a facility record audit to identify residents who have made statements of suicide ideation and to confirm physician notification. The Director of Nurses or designee will educate licensed nurses on the need to immediately notify physicians when suicide ideation is identified and note such on the 24-hour report. The Director of Nurses or designee will conduct random monthly audits X 3 to confirm that statements of suicide ideation are communicated to the physician. Results of the audits will be reviewed by the QA&A Committee for recommendation and continued compliance. Data will be reviewed monthly X 3 months. Date of compliance is August 5, 2007.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] (AMENDED COPY)   TITLE: NHA   (X6) DATE: 7-26-07

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

POC accepted - message left for Dan Sto... 7/27/07 @ 10:15Am.

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Wyoming Dept of Health
Licensing and Surveys

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MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 157	Continued From page 1	F 157		

suicidal ideation. The findings were:

Review of the admission face sheet showed resident #122 was admitted to the facility on 1/3/07 with diagnoses including chronic obstructive pulmonary disease, chronic back pain, depression, and dysphagia (difficulty swallowing). A nursing progress note dated 2/21/07 and timed at 9 PM documented, "Resident A&OX3 [alert and oriented times three] however quite depressed this evening. States therapy stated that I won't ever go home & my medicare is running out. I just as well put a gun to my head, or divorce my wife so Medicaid won't get everything of ours. Resident placed on q15 [every 15] min [minute] checks for safety. MD notified by clipboard" The following concerns were identified:

a. There was no evidence the physician was promptly notified of the resident's suicidal ideation.

b. Interview with LPN #2 on 6/20/07 at 1:19 PM revealed the clipboard was used for issues that can wait until the next time the physician makes a visit.

c. Review of the facility "Guidelines for Physician Notification of Condition/Clinical Problems in Center Resident" dated 4/28/05, revealed the physician should be notified immediately of the potential of suicide if the resident makes a suicidal gesture or discusses a detailed plan for carrying out suicide.

d. Interview with the director of nursing on 6/20/07 at 1:45 PM confirmed there was no evidence the physician was promptly notified.

e. Interview on 6/21/07 at 4:12 PM with the medical director (who was also the resident's attending physician) confirmed this situation warranted immediate physician notification.

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MOUNTAIN TOWERS HEALTHCARE	3129 GOXELDER DRIVE CHEYENNE, WY 82001

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F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident, family and staff interview, the facility failed to provide care in an individualized manner that promoted each resident's dignity for two (#28, #83) of 12 sample residents. The findings were: 1. According to the 4/20/07 quarterly Minimum Data Set (MDS) assessment, resident #98 required extensive assistance with transfers and dressing. Observation on 6/19/07 at 9 AM revealed the resident was in his/her room seated in a wheelchair wearing a hospital gown and t-shirt. Interview with a family member at that time revealed she came to the facility that morning to bring the resident clean laundry. The following concerns were identified in regard to promoting dignity for this resident: a. Observation in the resident's room on 6/19/07 at 10:45 AM showed the resident remained seated in a wheelchair wearing the t-shirt and hospital gown. At 11:10 AM, wearing the same clothing, the resident exited his/her room and independently propelled the wheelchair past the third floor nurses' station and into the elevator. The resident exited the elevator on the first floor. At 11:29 AM maintenance worker #1 accompanied the resident back to the third floor hallway adjacent to the nurses' station and dining room. The maintenance worker said he brought	F 241	F241-Plan of Correction This plan of correction is the facility's credible allegation of compliance. Resident #98 was dressed within a short time after clothing was brought in by the family. Resident #83 was provided a commode to accommodate toileting needs. Other residents at-risk will be identified by the Social Services Director or designee who will conduct a facility audit to confirm that other residents are dressed appropriately for the time of day to promote dignity. The Director of Nurses or designee will conduct a facility audit to identify residents who require the use of bedside commode to promote a dignified toileting plan. Nursing staff will be educated regarding the appropriate dressing of residents and keeping commodes accessible for their use. The Social Services Director or designee will conduct random monthly audits X 3 to confirm that residents are dressed appropriately and in a dignified manner for the time of day.	

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	535013	A. BUILDING _____ B. WING _____	C 06/21/2007

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MOUNTAIN TOWERS HEALTHCARE	3179 BOKELDER DRIVE CHEYENNE, WY 82001

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F 241	Continued From page 3	F 241		

the resident back because the resident was wearing "no underclothes."

b. Continuous observation on 6/19/07 from 11:29 AM - 11:52 AM showed the resident continued to wear the hospital gown and t-shirt while seated in the high-traffic hallway adjacent to the dining room and the nurses' station. On two occasions the resident leaned forward in the wheelchair exposing his/her incontinence brief.

c. Interview with the resident on 6/19/07 at 11:32 AM confirmed a family member brought clean laundry to the facility earlier that morning. At 11:52 AM the resident was assisted to his/her room. At that time the resident said, "I get to put my pants on. Yeah!"

2. According to the 11/14/06 5 day Medicare, and the 2/23/07 and 5/18/07 quarterly MDS assessments, resident #83 was totally dependent upon staff and required a mechanical lift for transfers. The following concerns were identified:

a. Observation on 6/18/07 at 12:35 PM revealed the hoyer lift would not fit in the resident's bathroom and there was no bedside commode available for the resident's use. Interview with certified nurse aide (CNA) #4 and CNA #8 at the time confirmed the resident was required to urinate and move his/her bowels in his/her incontinence briefs.

b. Interview with CNA #7 on 6/18/07 at 2 PM confirmed the resident was incontinent of bowel and bladder and was dependent on staff for transfers. The CNA further stated the resident was "checked and changed" because the Hoyer lift did not fit in the toilet room and the resident did not have a commode.

c. Interview with licensed practical nurse (LPN) # 4 on 6/20/07 at 1:30 PM revealed she was unaware of why the resident did not have a

The Director of Nurses or designee will conduct random monthly audits X 3 to confirm that commodes are accessible and utilized for identified residents.

Results of the audits will be reviewed by the QA & A Committee for recommendation and continued compliance. Data will be reviewed monthly x3 months.

Date of compliance is August 1, 2007.

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	528015	A. BUILDING _____ B. WING _____	C 06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 241	Continued From page 4 bedside commode. Interview with LPN #5 on 6/20/07 at 3 PM revealed the resident had a bedside commode when s/he was on another floor and was unsure why it was not transferred with him/her or where it was currently located.	F 241		
F 246 SS=D	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff provided the necessary equipment to meet the needs of one (#83) of twelve sample residents. The findings were: According to the 11/14/06 5 day Medicare, and the 2/23/07 and 5/16/07 quarterly MDS assessments, resident #83 was totally dependent upon staff and required a mechanical lift for transfers. The following concerns were identified: a. Observation on 6/18/07 at 12:35 PM revealed the hoyer lift would not fit in the resident's bathroom and there was no bedside commode available for the resident's use. Interview with certified nurse aide (CNA) #4 and CNA #8 at the time confirmed the resident was required to urinate and move his/her bowels in his/her incontinence briefs. b. Interview with CNA #7 on 6/18/07 at 2 PM confirmed the resident was incontinent of bowel and bladder and was dependent on staff for	F 246	F246-Plan of Correction This plan of correction is the facility's credible allegation of compliance Resident #83 was provided a commode to accommodate toileting needs. The Director of Nurses or designee will conduct a facility record audit to identify other residents who require the use of a bedside commode. The Director of Nurses or designee will educate staff on the necessity to obtain and utilize needed equipment for each resident. The Director of Nurses or designee will conduct random monthly observations X 3 to confirm that commodes are accessible for the accommodation of needs for the residents. Results of the audits will be reviewed by the QA & A Committee for recommendation and continued compliance. Data will be reviewed monthly x3 months. Date of compliance is August 3, 2007.	

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F 246	Continued From page 6 transfers. The CNA further stated the resident was "checked and changed" because the Hoyer lift did not fit in the toilet room and the resident did not have a commode. e. Interview with licensed practical nurse (LPN) # 4 on 6/20/07 at 1:30 PM revealed she was unaware of why the resident did not have a bedside commode. Interview with LPN #5 on 6/20/07 at 2 PM revealed the resident had a bedside commode when s/he was on another floor and was unsure why it was not transferred with him/her or where it was currently located.	F 246		
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide social service interventions for one (#122) of one sample resident who verbalized suicidal ideations related to concerns about being discharged from the facility and the potential for financial difficulties. The findings were: Review of the admission face sheet showed resident #122 was admitted to the facility on 1/3/07 with diagnoses including chronic obstructive pulmonary disease, chronic back pain, depression, and dysphagia (difficulty swallowing). A nursing progress note dated 2/21/07 and timed at 9 PM documented "Resident A&OX3 [alert and oriented times three]	F 250	F250-Plan of Correction This plan of correction is the facility's credible allegation of compliance. Resident #122 is no longer in the facility. The Director of Nurses or designee will conduct a facility audit to identify residents with suicide ideation. The Director of Nurses or designee will educate licensed nurses of the need to notify the Social Services Department when a resident has a suicide ideation. The Social Services Director or designee will follow-up on the suicide ideation, arrange mental health counseling as appropriate, and document follow-up	

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F 250	Continued From page 6 however quite depressed this evening. States therapy stated that I won't ever go home & my medicare is running out. I just as well put a gun to my head, or divorce my wife so Medicaid won't get everything of ours. Resident placed on q15 (every 15) min [minute] checks for safety. MD notified by clipboard". The following concerns were identified: a. Review of the medical record showed no evidence social service staff was aware of the suicidal ideation. The next social services note was on 2/26/07 (5 days later) and addressed plans for discharge planning. b. Interview with the director of nursing on 6/20/07 at 1:45 PM confirmed the lack of social service intervention for the suicidal ideation. c. Further interview with the administrator on 6/20/07 at 1:35 PM revealed that when a resident verbalized suicidal ideation, the expectation was to promptly notify social services and attain mental health counseling	F 250	The Director of Nurse or designee will conduct random monthly audits to confirm that residents with suicide ideation are reported to the Social Services Department and that follow-up is documented. Results of the audits will be reviewed by the QA & A Committee for recommendation and continued compliance. Data will be reviewed monthly x3 months. Date of compliance is August 5, 2007.	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns;	F 272	272-Plan of Correction This plan of correction is the facility's credible allegation of compliance. Resident #31 is no longer in the facility. The Director of Nurses or designee will conduct a facility record audit to identify other residents who are in need of a bowel and bladder assessment.	

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F 272	Continued From page 7 Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure a comprehensive assessment was completed in regard to incontinence for one (#31) of one sample resident who needed an incontinence assessment. The findings were: Review of the 1/23/07 significant change and the 4/13/07 quarterly Minimum Data Set (MDS) assessments for resident #31 revealed s/he was frequently incontinent of urine (daily with some control) and of bowel (2 to 3 times per week). Review of the 4/14/06 care plan revealed incontinence was identified as a problem. Review of the medical record revealed there was a bowel and bladder monitor performed in 1/07 however, no evaluation or assessment was completed utilizing the information collected. In addition, review of the full nursing assessment completed on 1/16/07 revealed the resident was incontinent but there was no comprehensive assessment to	F 272	The Director of Nurses or designee will conduct random monthly audits X 3 to confirm that bowel and bladder assessments are completed. Results of the audits will be reviewed by the QA & A Committee for recommendation and continued compliance. Data will be reviewed monthly x3 months. Date of compliance is August 5, 2007.	

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F 272	Continued From page 8 determine the causative factors. During an interview with the unit manager on 6/20/07 at 3 PM, she confirmed there was no other assessment than what was in the current medical record.	F 272		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, physician interview,	F 278	F278-Plan of Correction This plan of correction is the facility's credible allegation of compliance. Resident #102 was not negatively affected by the deficient practice. Documentation is now current and accurate regarding this resident's skin condition. The Director of Nurses or designee will conduct a facility audit to identify other residents and confirm that skin conditions are accurately reflected in documentation. The Director of Nurses or designee will conduct an in-service training with licensed nurses on how to accurately document a resident's skin condition. The Director of Nurses or designee will conduct random monthly audits to confirm accuracy of skin documentation. Results of the audits will be reviewed by the QA & A Committee for recommendation and continued compliance. Data will be reviewed monthly X 3 months. Date of compliance is August 5, 2007.	

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F 278	Continued From page 6 medical record review, and staff interview, the facility failed to accurately document skin assessments for one (#102) of five sample residents identified as having pressure ulcers. The findings were: Review of the 6/7/07 and the 6/13/07 weekly pressure ulcer condition report for resident #102 revealed s/he had a 0.6 centimeter (cm) x [by] 0.6 cm stage II pressure ulcer on his/her left heel. Review of the "Resident Weekly Skin Check Sheet", however, revealed the resident had a head to toe skin assessment completed on 6/7/07 and on 6/14/07 and the skin was clear, dry, and intact. Observation on 6/21/07 at 8:10 AM revealed there was a pressure ulcer on the left heel. Interview with the resident's physician on 6/21/07 at 4:10 PM revealed the resident had a stage II pressure ulcer on his/her left heel.	F 278		
F 281	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to follow standards of clinical practice in regard to following physician's orders for 4 (#55, #83, #102, #116) of 12 sample residents. The findings were: 1. Review of the 5/07 and 6/07 Medication Administration Records (MARs) for resident #102 revealed an order dated 2/25/07 for a fentanyl (narcotic pain medication) patch. Further review revealed the order included instructions to check	F 281	F281 - Plan of Correction This plan of correction is the facility's credible allegation of compliance. Resident #102 was not negatively affected by the deficient practice. This resident now has accurate documentation indicating patch placement is monitored. Resident #55 was not negatively affected by the deficient practice. This resident is no longer in the facility. Resident #116 was not negatively affected by the deficient practice. Vital signs for this resident are being documented as ordered. Resident #83 was not negatively affected by the deficient practice. Vital signs for this resident are being documented as ordered.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(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 281	Continued From page 10	F 281		

the placement of the patch every shift. Review of both MARs, however, revealed no evidence the patch was ever checked for placement.

2. Review of the physician's orders for resident #58 revealed an order dated 8/27/2000 for a weekly blood pressure (B/P) check because of vasotec (antihypertensive) therapy. Review of the vital sign flow sheet and the nursing notes revealed there was no evidence the resident's B/P was checked for three of the four weeks in 5/07. Review of the 5/07 MAR revealed a B/P check was initialed as being done on 5/14, 5/21, and 5/28, however, there were no B/P results documented in the record for these dates.

3. Review of the physician's orders for resident #116 revealed an order dated 8/4/06 for daily vital signs. Review of the vital sign flow sheet, the nursing notes, and the 5/07 and 6/07 MARs revealed vital signs were not taken 16 of 31 days in 5/07 and 10 of 20 days reviewed in 6/07.

4. Review of the physician's orders for resident #83 revealed an order dated 11/6/07 for vital signs daily. Review of the vital sign flow sheet and the 5/07 and 6/07 treatment records and MARs revealed there was no evidence vital signs were taken daily as ordered.

5. Interview with the director of nursing and the unit managers on 6/20/07 at 3 PM revealed physician orders should be followed.

6. According to the State of Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, pages 3-6, nursing must function under the direction of a licensed physician.

The Director of Nurses or designee will conduct a facility audit to identify that other residents with orders for fentanyl patch placement and vital signs are documented as indicated.

The Director of Nurses or designee will educate nursing staff on the following of physician orders for fentanyl patch placement and the documentation of vital signs.

The Director of Nurses or designee will conduct random monthly audits X 3 to confirm that ordered fentanyl patch placement checks and vital signs are documented as ordered.

Results of the audits will be reviewed by the QA & A Committee for recommendation and continued compliance. Data will be reviewed monthly x3 months.

Date of compliance is August 5, 2007.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	533015	A. BUILDING _____ B. WING _____	C 06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3129 BOXELDER DRIVE CHEYENNE, WY 82001

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F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to assure staff followed care plans as written for 2 (#31, #98) of 12 sample residents. Interventions not implemented included those for toileting and repositioning. The findings were: 1. According to the 5/14/07 quarterly Minimum Data Set assessment (MDS), resident #31 was assessed as totally dependent for transfers, frequently incontinent of bowel (2 - 3 times per week), and frequently incontinent of bladder (tends to be incontinent daily with some control present). Review of the care plan showed the resident was to be toileted every morning, before and after meals, at bedtime and PRN (as needed). Review of the physician's orders revealed an order dated 3/8/06 to toilet the resident and provide pericare every two hours. The following concerns were identified: a. Interview with certified nurse aide (CNA) #9 on 6/19/07 at 11:43 AM revealed the resident requires a sit-to-stand lift for transfers. The CNA also said the resident was last toileted after breakfast, and would be toileted again after lunch. b. Observation on 6/19/07 at 1:50 PM showed the resident was taken to his/her room to be toileted by CNAs #9 and #2. Interview with	F 282	F282-Plan of Correction This plan of correction is the facility's credible allegation of compliance. Resident #31 is no longer in the facility. Resident #98 has shown great progress in his wound healing. The resident was re-evaluated for repositioning requirements and was care planned accordingly. The Director of Nurses or designee will conduct a facility audit to confirm that residents are receiving toileting and repositioning in accordance with the care plan. The Director of Nurses or designee will educate nursing staff on the need to toilet residents according to the care plan and on the need to reposition residents with skin at risk according to the care plan. The Director of Nurses or designee will conduct random monthly audits to confirm that residents are toileted according to the care plan. The Director of Nurses will conduct random monthly audits to confirm that residents are repositioned according to the care plan. Results of the audits will be reviewed by the QA & A Committee for recommendation and continued compliance. Data will be reviewed monthly x3 months. Date of compliance is August 5, 2007.	

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	535013	A. BUILDING _____ B. WING _____	C 06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	2128 BOXELDER DRIVE CHEYENNE, WY 82001

(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 282	Continued From page 12	F 282		

CNA #2 at 2:03 PM revealed that when the resident was toileted, s/he was incontinent of urine. Further interview with CNA #2 at that time revealed she thought the resident should be toileted every two hours; however, she was told by CNA #9 the resident's toileting schedule was "after breakfast and after lunch."

2. Review of the current care plan for resident #88 revealed s/he had impaired skin integrity identified as a problem. Further review of the care plan revealed approaches for prevention of pressure sores or skin breakdown included "when resident is out of bed, change position Q [every] 2 hrs [hours] by toileting, boosting, shifting of weight, ambulating, or return to bed for rest." and to "turn & [and] reposition Q 2 hrs and PRN (as needed)." The following concerns were identified:

a. Observation on 6/19/07 at 9 AM revealed the resident was in his/her room seated in a wheelchair. Interview with a family member at that time revealed the sores on the resident's "bottom" were "a problem." Further interview with the resident at that time revealed his/her "bottom" was "very painful" and s/he was waiting to be laid down.

b. Interview with CNA #3 at 10:20 AM revealed she assisted the resident out of bed that morning at 7:45 AM. Observation on 6/19/07 at 10:45 AM showed the resident remained in his/her room seated in a wheelchair. Interview with the resident at that time revealed s/he was "still" waiting to be laid down.

c. Observation on 6/19/07 at 11:18 AM showed the resident exited his/her room and independently propelled the wheelchair into the third floor elevator. The resident exited the elevator on the first floor. Further observation at

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	535613	A. BUILDING _____ B. WING _____	C 06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3125 BOXELDER DRIVE CHEYENNE, WY 82001

(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 282	Continued From page 13 11:29 AM revealed maintenance worker #1 accompanied the resident back to the third floor. g. Continuous observation on 6/19/07 from 11:29 AM - 11:52 AM showed the resident remained seated in the wheelchair in the hallway adjacent to the dining room and the nurses' station. At 11:53 AM observation revealed the resident was briefly (approximately 10 minutes) lifted utilizing the sit to stand lift while staff placed clean sweat pants on him/her. The resident was then taken back to the dining area to await and to eat lunch. h. Observation on 6/19/07 at 1:20 PM and 1:41 PM showed the resident was in his/her room seated in the wheelchair. At 1:41 PM the resident said, "I'm still waiting for my people to lay me down." Further observation on 6/19/07 at 2:19 PM showed the resident remained in the wheelchair in his/her room. At 2:19 PM CNA #4 and CNA #5 entered the resident's room, assisted the resident with his/her oxygen tubing, then left the room. At 2:35 PM the resident said, "They came in and left. I want to lay down and take some pressure off this butt. Oh, boy! " i. With the exception of approximately 10 minutes (from 11:53 AM until 12:03 PM) on 6/19/07, the resident remained in his/her wheelchair without being repositioned from 7:45 AM until 3 PM (7 hours and 15 minutes) at which time staff transferred the resident to bed.	F 282		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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	535013	A. BUILDING _____ B. WING _____	C 06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	123 BOXELDER DRIVE CHEYENNE, WY 82001

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F 309	Continued From page 14	F 309	F309 Plan of Correction	

This REQUIREMENT is not met as evidenced by:
Based on observation, resident, family and staff interview, and medical record and policy and procedure review, the facility failed to assure appropriate care and treatment of pain to prevent harm for one (#99) of five sample residents with identified pressure ulcers. In addition, prolonged symptoms of respiratory problems were not assessed and treated for one (#33) of one sample resident who exhibited an ongoing cough. The findings were:

1. Medical record review showed resident #98 was re-admitted to the facility on 3/2/07 with diagnoses including diabetes. According to the 3/15/07 Minimum Data Set (MDS) assessment, the resident had one stage I and one stage II pressure sores and pain daily. Review of the 4/20/07 quarterly MDS assessment revealed the resident continued to have one stage I and one stage II pressure sores and moderate pain. Review of the "Weekly Pressure Ulcer Condition Report" from 5/30 through 6/18/07 revealed there was a stage II pressure ulcer on the left coccyx area and another stage II pressure ulcer on the right buttock. The following concerns were identified:

a. Observation on 6/19/07 at 9 AM revealed the resident was in his/her room seated in a wheelchair. Interview with a family member at that time revealed the sores on the resident's "bottom" were a "problem." Interview with the resident at that time revealed his/her "bottom" was "very painful" and s/he was waiting to be laid down. Interview with certified nurse aide (CNA) #3 at 10:00 AM on 6/19/07 revealed she assisted

This plan of correction is the facility's credible allegation of compliance

Resident #98 has an updated Pain Assessment to reflect his current level of pain. His pain appears to be well controlled based on a pain assessment, medications will be administered as indicated. Resident #33 had no negative effect from the deficient practice. The resident was assessed by a physician and received new orders to treat the respiratory condition.

The Director of Nurses or designee will perform pain assessments of residents with wounds to identify those who are at-risk for pain. In addition, residents who exhibit coughs will be assessed and treated for as appropriate for respiratory issues.

The Director of Nurses or designee will educate nursing staff on the need to assess, treat, and document pain and abnormal respiratory findings.

The Director of Nurses or designee will conduct random monthly audits X 3 to confirm that residents with wounds are adequately assessed and treated for pain and that abnormal findings on respiratory assessments are addressed and documented.

Results of the audits will be reviewed by the QA & A Committee for recommendation and continued compliance. Data will be reviewed monthly x3 months.

Date of completion is August 5, 2007.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 309	Continued From page 15	F 309		

the resident out of bed that morning at 7:45 AM. Observation on 6/19/07 at 10:45 AM showed the resident remained in his/her room seated in a wheelchair. Interview with the resident at that time revealed s/he was "still" waiting to be laid down. Observation on 6/19/07 at 11:16 AM showed the resident exited his/her room and independently propelled the wheelchair into the third floor elevator. The resident exited the elevator on the first floor. Further observation at 11:29 AM revealed maintenance worker #1 accompanied the resident back to the third floor. Continuous observation on 6/19/07 from 11:29 AM - 11:52 AM showed the resident remained seated in the wheelchair in the hallway adjacent to the dining room and the nurses' station. Observation on 6/19/07 at 1:20 PM and 1:41 PM showed the resident remained in his/her room seated in the wheelchair. At 1:41 PM the resident said, "I'm still waiting for my people to lay me down." Further observation at 2:10 PM showed the resident remained in the wheelchair in his/her room. At 2:19 PM CNAs #4 and #5 entered the resident's room, assisted the resident with his/her oxygen tubing, then left. At 2:35 PM the resident said, "They came in and left. I want to lay down and take some pressure off this butt. Oh, boy!"

b. With the exception of approximately 10 minutes (from 11:53 AM until 12:03 PM) on 6/19/07, the resident remained in his/her wheelchair without being repositioned from 7:45 AM until 3 PM (7 hours and 15 minutes) at which time staff transferred the resident to bed. Observation on 6/19/07 at 3 PM revealed one stage II pressure sore on each buttock near the coccyx area.

c. Observation on 6/20/07 at 3:15 PM revealed CNA #5 and registered nurse (RN) #1 transferred the resident from the wheelchair to

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F 309	Continued From page 16	F 309		

the bed utilizing the sit to stand lift. While the resident was being transferred, s/he cried out in pain. Continued observation revealed the resident had one Stage II pressure sore on each buttock near the coccyx area. During the observation the resident stated s/he had "terrible" pain and would like some medication to provide relief. CNA #6 and RN #1 stated they would see that s/he received something for the pain. However, review of the 6/07 Medication Administration Record (MAR) on 6/21/07 revealed the last pain medication the resident received was on 6/16/07 at 3 PM.

d. Interview with CNA #6 on 6/20/07 at 5 PM revealed he had been taking care of the resident for the past three to four months. The CNA further stated the resident was capable of making his/her needs known. Interview on 6/20/07 at 5:12 PM with LPN #3 confirmed the resident was capable of making his/her needs known.

e. Review of the facility policy POL 619, dated 10/31/06, on pain management revealed the following instructions: "Residents will be screened for pain upon admission/readmission, quarterly, with any new complaints, or with significant status change resulting in pain thereafter. Residents complaining of pain and/or exhibiting signs of pain (i.e., Repetitive behaviors, physical behaviors, crying, fidgeting, angry outbursts, etc.) are assessed with attention to identify the underlying causes and circumstances." Review of the medical record revealed the most recent pain assessment was completed on 3/2/07 upon admission where it indicated s/he had none. However, there was no evidence the resident was assessed or monitored for pain when s/he complained of "terrible" pain in his/her buttocks repeatedly during observations on 6/19/07 and 6/20/07.

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2. Interview with CNA #7 on 6/19/07 at 1:42 PM revealed resident #93 had a "bad" cough. The CNA further commented the resident started coughing "about one month ago" and the cough "was getting worse."

Observation on 6/18/07 at 6:15 PM revealed the resident was in his/her room. The resident could be heard coughing from the hallway. Interview of the resident on 6/19/07 at 9 AM revealed s/he did not "feel well" and observation revealed s/he was coughing. Review of the physician's orders revealed an order dated 12/31/06 for Robitussin 1-2 teaspoons every four hours as needed for cough. Review of the 6/07 MAR revealed the resident did not receive anything for his/her cough. Review of the nursing notes revealed there was no assessment or documentation of any kind that addressed the resident's cough and that s/he did not feel well. During an interview with licensed practical nurse (LPN) #4 on 6/21/07 at 8 AM, she confirmed she had not administered the resident any medication or assessed the resident for his/her cough.

F 314	483.25(c) PRESSURE SORES	F 314	F-314-Plan of Correction
SS=G	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.		This plan of correction is the facility's credible allegation of compliance. Resident #93 has showed great progress in his wound healing. This resident's pain appears to be well controlled. The Wound Nurse has consulted with the Director of Nurses to facility and have agreed on wound measurements and documentation. Resident #93 is able to independently shift body weight in wheelchair and this is reflected on the care plan. There was no negative effect from the delay in occupational therapy assessment.

This REQUIREMENT is not met as evidenced by:

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F 314	Continued From page 18 Based on observation, resident, family, and staff interview, medical record review, and policy and procedure review, the facility failed to ensure appropriate care and treatment to prevent harm for one (#38) of five sample residents with identified pressure ulcers. The findings were: Medical record review showed resident #38 was re-admitted to the facility on 3/2/07 with diagnoses including diabetes. According to the 3/15/07 Minimum Data Set (MDS) assessment, the resident had one stage I and one stage II pressure sores and pain daily. Review of the 4/20/07 quarterly MDS assessment revealed the resident continued to have one stage I and one stage II pressure sores and moderate pain. Review of the "Weekly Pressure Ulcer Condition Report" from 5/30 through 6/18/07 revealed there was a stage II pressure ulcer on the left coccyx area and another stage II pressure ulcer on the right buttock. The following concerns were identified: a. Observation on 6/19/07 at 9 AM revealed the resident was in his/her room seated in a wheelchair. Interview with a family member at that time revealed the sores on the resident's "bottom" were "a problem." Further interview with the resident at that time revealed his/her "bottom" was "very painful" and s/he was waiting to be laid down. Interview with CNA #3 at 10:00 AM revealed she assisted the resident out of bed that morning at 7:45 AM. Observation on 6/19/07 at 10:45 AM showed the resident remained in his/her room seated in a wheelchair. Interview with the resident at that time revealed s/he was "still" waiting to be laid down. Observation on 6/19/07 at 11:15 AM showed the resident exited his/her room and independently propelled the wheelchair into the third floor elevator. The	F 314	The Director of Nurses or designee will conduct a facility audit to confirm that residents with pressure ulcers have an appropriate treatment protocol listed in their individualized care plans. The Director of Nurses or designee will conduct a facility audit to confirm that resident's with pressure ulcers are treated accordingly and documented accurately. The Rehabilitation Manager or designee will conduct an audit to confirm that other residents have received therapy assessments timely. The Director of Nurses or designee will educate nursing staff on the need to reposition residents with skin at- risk according to the care plan. Nursing staff will be educated on the need to assess for and administer pain medications as ordered and per nursing judgement. The Rehabilitation Manager or designee will educate therapy staff regarding the system that will be utilized to confirm that therapy assessments are completed timely. The Director of Nurses or designee will conduct random monthly audits X 3 to confirm that residents are repositioned according to the care plan. The Director of Nurses or designee will conduct random audits to confirm that residents that complain of discomfort are assessed and medicated as ordered per nursing judgement.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3135 BOXELDER DRIVE CHEYENNE, WY 82001

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F 314	Continued From page 19 resident exited the elevator on the first floor. Further observation 11:29 AM revealed maintenance worker #1 accompanied the resident back to the third floor. Continuous observation on 6/19/07 from 11:29 AM - 11:52 AM showed the resident remained seated in the wheelchair in the hallway adjacent to the dining room and the nurses' station. Observation on 6/19/07 at 1:20 PM and 1:41 PM showed the resident was in his/her room seated in the wheelchair. At 1:41 PM the resident said, "I'm still waiting for my people to lay me down." Further observation on 6/19/07 at 2:10 PM showed the resident remained in the wheelchair in his/her room. At 2:19 PM CNA #4 and CNA#5 entered the resident's room, assisted the resident with his/her oxygen tubing, then left the room. At 2:35 PM the resident said, "They came in and left. I want to lay down and take some pressure off this butt. Oh, boy!" b. With the exception of approximately 10 minutes (from 11:53 AM until 12:03 PM) on 6/19/07, the resident remained in his/her wheelchair without being repositioned from 7:45 AM until 3 PM (7 hours and 15 minutes) at which time staff transferred the resident to bed. Observation on 6/19/07 at 3 PM revealed one stage II pressure sore on each buttock near the coccyx area. c. Observation on 6/20/07 at 3:15 PM revealed CNA #5 and registered nurse (RN) #1 transferred the resident from the wheelchair to the bed utilizing the sit to stand lift. While the resident was being transferred, s/he cried out in pain. Continued observation revealed the resident had one stage II pressure sore on each buttock near the coccyx area. During the observation the resident stated s/he had "terrible" pain.	F 314	The Rehabilitation Manager will conduct random audits to confirm that new orders for therapy evaluations are completed timely. Results of the audits will be reviewed by the QA & A Committee for recommendation and continued compliance. Data will be reviewed monthly x3 months. Date of compliance is August 5, 2007.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(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 314	Continued From page 20	F 314		

d. Observation on 6/21/07 at 7:44 AM with the wound care nurse revealed there were four open areas on the right buttock instead of just one. The wound measurements taken by the wound care nurse at this time were as follows: the right buttock overall wound measurement was 6.0 cm x 3.0 cm which was larger than the measurements taken on 6/18/07 which were 2.4 cm x 1.3 cm x 0.1 cm and those taken on 6/20/07 which were 4.0 cm x 3.0 cm, overall. Interview with the wound care nurse at this time confirmed these measurements were accurate.

e. Record review on 6/21/07 at 2:33 PM revealed no documentation of the skin assessments performed by the wound care nurse in front of the surveyor on 6/21/07 at 7:44 AM. In addition, there was no documentation of the pressure ulcer measurements from 6/20/07 which were taken by the wound nurse and were written on a yellow notepad which she showed the surveyor on 6/21/07 at 7:44 AM. Interview with the wound care nurse on 6/21/07 at 2:33 PM revealed she was not going to document the assessments until the director of nursing also observed the resident's wounds. The wound care nurse further stated she did not want "different measurements for the two observations." However, on 6/21/07 at 7:44 AM, the director of nursing (DON) came into the room and saw the wound care nurse taking the measurements. The DON did not stay to assist nor did she question the wound nurse's ability to do accurate measurements at that time). Interview with the administrator on 6/25/07 at 1:35 PM revealed the wound care nurse should document her assessments in the medical record at the time they are performed.

f. Review of the physician's orders revealed an order dated 6/6/07 at 8:30 AM for

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	535013	A. BUILDING _____ B. WING _____	C 06/21/2007

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MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 314	Continued From page 21 occupational therapy to perform a seating evaluation due to the resident's sores on his/her buttocks. Review of the medical record on 6/19/07 revealed there was no evidence the evaluation was performed. Interview with the director of nursing on 6/20/07 at 3 PM revealed there was no evaluation report in the medical record. On 6/21/07 at 10 AM, the director of nursing provided a copy of the evaluation which was performed on 6/20/07 (14 days after it was ordered). g. Review of the facility policy on pressure ulcer prevention and care, POL 314, revised 10/31/06, revealed instructions to evaluate and individualize use of various devices to reduce or relieve pressure and/or reduce skin injuries that may result in pressure ulcers..."For example, residents at higher risk for pressure ulcers may need repositioning more than every hour when sitting in a chair (especially if they show evidence of stage I pressure ulcers with less frequent repositioning)." Review of the facility policy PRO 61008-01, revised 4/28/07, on pressure ulcer/non-pressure ulcer assessment revealed instructions to monitor daily progress of the pressure ulcer/non-pressure ulcer. Finally, review of the facility policy PRO 68107, revised 4/28/03, on positioning a resident with pressure ulcers revealed instructions "Reposition resident at least every two hours whether the resident is in bed or in chair. Some residents may require repositioning more frequently depending on location of the ulcer and nutritional and hydration status."	F 314		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315		

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F 315	Continued From page 22 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review the facility failed to ensure staff properly handled the catheter bag for one (#98) of three sample residents with urinary catheters. In addition, the facility failed to provide care to promote dryness for one (#31) of six sample residents assessed as being incontinent. The findings were: 1. Review of the 3/15/07 significant change and the 4/20/07 quarterly Minimum Data Set (MDS) assessments for resident #98 revealed s/he had a catheter in place for urination. Observation on 6/18/07 at 2:30 PM revealed the resident was transferred from the wheelchair to the bed utilizing a sit to stand mechanical lift. Continued observation revealed registered nurse (RN) #1 held the catheter bag at the armpit level of the resident during the transfer and urine was observed flowing back up the catheter tubing towards the bladder. Interview with the director of nursing on 6/20/07 at 3 PM revealed the catheter bag should not be held above the level of the bladder. Review of the facility policy #PRO 68201-08, revised 4/28/06, on urine drainage bags revealed instructions that the drainage bag should be hung below the bladder level to reduce the incidence of reverse flow of urine.	F 315	F315-Plan of Correction This plan of correction is the facility's credible allegation of compliance. Resident #98 has no evidence of negative effects from the deficient practice. Resident #98's foley catheter will not be held above the level of his bladder. Resident #31 is no longer in the facility. The Director of Nurses or designee will identify residents currently utilizing a foley catheter and confirm that resident's catheter bags are handled appropriately. The Director of Nurses or designee will identify residents on a toileting plan and confirm that the resident is toileted according to that plan. The Director of Nurses or designee will educate the nursing staff on proper handling of foley catheter bags to maintain bags below the level of the bladder and on toileting residents according to the toileting plan.	

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MOUNTAIN TOWERS HEALTHCARE	3120 BOXELDER DRIVE CHEYENNE, WY 82001

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F 315	Continued From page 23 2. 1. According to the 6/14/07 quarterly minimum data set assessment, resident #31 was assessed as totally dependent for transfers, frequently incontinent of bowel (2 - 3 times per week), and frequently incontinent of bladder (tends to be incontinent daily with some control present). Review of the care plan showed the resident was to be toilated every morning, before and after meals, at bedtime and PRN as needed). Review of the physician's orders revealed an order dated 3/8/06 to toilet the resident and provide pericare every two hours. The following concerns were identified: a. Interview with CNA #7 on 6/19/07 at 11:43 AM revealed the resident required a sit-to-stand lift for transfers and was last toileted after breakfast. The CNA further stated the resident would be toileted again after lunch. b. Observation on 6/19/07 at 1:50 PM showed the resident was taken to his/her room to be toileted by CNAs # 9 and #2. Interview with CNA #2 at 2:03 PM revealed that when the resident was toileted, s/he was incontinent of urine. Further interview with CNA #2 at that time revealed she thought the resident should be toileted every two hours; however, she was told by CNA #9 the resident's toileting schedule was "after breakfast and after lunch."	F 315	The Director of Nurses or designee will conduct random observations to confirm that Foley catheter bags are not held above the level of the bladder. The Director of Nurses or designee will conduct random monthly audits X 3 to confirm that residents are toileted according to the toileting plan. Results of the audits will be reviewed by the QA & A Committee for recommendation and continued compliance. Data will be reviewed monthly x3 months. Date of compliance is August 5, 2007.	
F 324 S8=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and	F 324	F324-Plan of Correction This plan of correction is the facility's credible allegation of compliance. Resident #122 is no longer in the facility. There was no evidence of adverse effects for resident #56 from the deficient practice. Resident #98 is being safely transferred with the mechanical lift.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3126 BOXELDER DRIVE CHEYENNE, WY 82001

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F 324	Continued From page 24 medical record review, the facility failed to provide appropriate supervision for one (#122) of one sample resident who verbalized suicidal ideation. In addition, safety procedures were not followed while utilizing a lift for one (#98) of five sample residents who required a mechanical lift during transfers. The findings were: 1. Review of the admission face sheet showed resident #122 was admitted to the facility on 1/9/07 with diagnoses including chronic obstructive pulmonary disease, chronic back pain, depression and dysphagia (difficulty swallowing). A nursing progress note dated 2/21/07 and timed at 9 PM documented, "Resident A&OX3 [alert and oriented times three] however quite depressed this evening. States therapy stated that I won't ever go home & my medicare is running out. I just as well put a gun to my head, or divorce my wife so Medicaid won't get everything of ours. Resident placed on q15 [every 15] min [minute] checks for safety. MD notified by clipboard". The following problems were noted with determining the level of safety and supervision measures that needed to be in place once the resident verbalized the suicidal ideation: a. There was no evidence the facility evaluated the resident's intent on suicide, and if the resident had a plan and the means to carry out the ideation. b. There was no evidence the 15-minute supervisory checks were implemented. c. Interview with the director of nursing (DON) on 6/21/07 at 1:45 PM confirmed no safety assessment was performed, nor was there evidence staff conducted the 15-minute supervisory checks. The DON further confirmed the expectation was for these interventions to be	F 324	Other residents at risk will be identified by the Director of Nurses or designee who will conduct a facility record audit to identify residents who have made statements of suicide ideation and to confirm physician notification. The Director of Nurses or designee will identify residents utilizing a mechanical lift and confirm that proper lifting procedures are followed. The Director of Nurses or designee will educate licensed nurses regarding evaluation of resident's expressing suicide ideation and the implementation of safety checks. The Director of Nurses or designee will educate CNA's regarding the proper utilization of the mechanical lift. The Director of Nurses or designee will conduct a facility audit to confirm that residents with suicide ideation are evaluated and safely monitored. The Director of Nurses or designee will conduct a facility audit to confirm that CNA's are correctly utilizing the mechanical lift. Results of the audits will be reviewed by the QA & A Committee for recommendation and continued compliance. Data will be reviewed monthly x3 months. Date of compliance is August 6, 2007.	

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F 324	Continued From page 25 done. 2. Observation on 6/19/07 at 11:50 AM revealed certified nurse aide (CNA) #4 assisted by a second CNA (name unknown) transferred resident #98 using the sit to stand mechanical lift. Observation during the transfer revealed the CNAs did not attach the upper straps of the sling to the lift prior to raising the resident up with the mechanical lift. Interview with the education director on 6/21/07 at 3:32 PM revealed all CNAs were oriented and instructed on how to use the lifts properly. He confirmed the straps should be checked for placement prior to operating the mechanical lift.	F 324		
F 385 SS=D	483.40(a) PHYSICIAN SERVICES A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the physician provided timely supervision of resident care for one (#106) of 12 sample residents. The findings were: Review of the admission face sheet showed resident #106 was admitted to the facility on	F 385	F385 Plan of Correction This plan of correction is the facility's credible allegation of compliance. Resident #106 had no negative effect from the deficient practice. The order was subsequently received to discontinue the fluid restriction. The Director of Nurses or designee will conduct a facility audit to confirm that outstanding faxes have a response. The Director of Nurses or designee will educate licensed nurses on the process for follow-up when requesting orders via fax.	

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	530013	A. BUILDING _____ B. WING _____	C 06/21/2007

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F 385	Continued From page 26 3/2/07. According to the 4/19/07 history and physical the resident's diagnoses included hyponatremia and alcohol abuse. A physician diet order dated 5/9/07 documented the resident's fluid intake was to be restricted to 1800 cc per day. On 5/10/07 a "Change in Medical Condition Assessment" was faxed to the physician requesting the fluid restriction to be discontinued. The request also documented the resident "does not eat/drink much anyway & is probably at more risk for dehydration." The following concerns were noted: a. Interview with the Registered Dietitian on 6/20/07 at 3 PM revealed the resident's physician was asked to discontinue the fluid restriction because the hyponatremia was resolved. The RD stated the request was refaxed to the physician on 5/17/07 due to a lack of response. The RD further confirmed that as of 6/20/07 at 3 PM, the physician had not responded to the request. b. On 6/20/07 at 3:04 PM, licensed practical nurse (LPN) #4 telephoned the physician's office and spoke to the office nurse. LPN #4 reported the office nurse told her the physician had signed the request to discontinue the fluid restriction on 5/11/07; however, the physician's office had not responded to the facility.	F 385	The Director of Nurses or designee will conduct random monthly audits X 3 to confirm that faxes to physicians have a response. Results of the audits will be reviewed by the QA & A Committee for recommendation and continued compliance. Data will be reviewed monthly x3 months. Date of compliance is August 5, 2007.	
F 406 SS=D	483.45(a) SPECIALIZED REHABILITATIVE SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a	F 406	F406-Plan of Correction This plan of correction is the facility's credible allegation of compliance. There was no negative effect on resident #98 based on this deficient practice. The occupational therapy evaluation was subsequently completed.	

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F 406	Continued From page 27 provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide timely occupational therapy services for one (#98) of three sample residents receiving occupational therapy. The findings were: Review of the physician's orders for resident #98 revealed an order dated 6/6/07 at 8:30 AM for occupational therapy to perform a seating evaluation due to the resident's sores on his/her buttocks. Review of the medical record on 6/19/07 revealed there was no evidence the evaluation was performed. Interview with the director of nursing on 6/20/07 at 3 PM revealed there was no evaluation report in the medical record. On 6/21/07 at 10 AM, the director of nursing provided a copy of the evaluation which was performed on 6/20/07 (14 days after it was ordered).	F 406	The Rehabilitation Manager or designee will conduct an audit to confirm that other residents have received therapy assessments timely. The Rehabilitation Manager or designee will educate the therapy staff on the need for timely assessments once orders are received. The Rehabilitation Manager or designee will conduct random chart audits to confirm that orders for therapy assessments/evaluations are completed timely. The Rehabilitation Manager or designee will utilize a system to confirm that therapy assessments are completed timely Results of the audits will be reviewed by the QA & A Committee for recommendation and continued compliance. Data will be reviewed monthly X 3 months Date of compliance is August 6, 2007.	
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.	F 441	F441-Plan of Correction This plan of correction is the facility's credible allegation of compliance. There were no apparent negative effects on any residents in the facility based on the deficient practice. Employee #1 communicated that she believed that her symptoms were allergy related.	

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F 441	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed during three of four days of survey to assure an employee who exhibited symptoms of communicable illness did not report to work and perform job duties, including direct resident care. The findings were: Observation on 6/18/07 at 6 PM revealed licensed practical nurse (LPN) #1 was coughing, sneezing and blowing her nose while in the third floor dining area with residents present awaiting their evening meal. Observation on 6/21/07 at 9:20 AM showed LPN #1 answered the call light for resident #17. Interview with the LPN at that time revealed she did not feel well and had difficulty sleeping the previous night due to "sweats" and "chills." Interview with the infection control nurse on 6/21/07 at 3:32 PM confirmed staff who exhibited symptoms of a cold, the flu, or signs and symptoms of other illness should not come to work or should be sent home if they do report for duty. Interview with the director of nursing on 6/21/07 at 4:32 PM confirmed she was aware LPN #1 was not feeling well.	F 441	The Director of Nurses of designee will perform random observations of staff to identify others who may be experiencing symptoms of illness. The Director of Nurses or designee will educate staff on not reporting to work when exhibiting symptoms of communicable illness. The Director of Nurses or designee will conduct random observations to confirm that staff are not on duty with potentially communicable illnesses. Results of the audits will be reviewed by the QA & A Committee for recommendation and continued compliance. Data will be reviewed monthly x3 months. Date of compliance is August 5, 2007.	
F 492 SS=E	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.	F 492		

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F 492	Continued From page 29	F 492		

This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review and staff interview, the facility failed to assure the appropriate level of nursing staff performed skin assessments and administered medications. The findings were:

1. Review of the physician's orders for resident #2 showed s/he was readmitted to the facility on 6/2/07 with diagnoses of cerbrovascular accident, anemia, and decubitus ulcer. Review of the "Weekly Pressure Condition Reports" showed late entries dated 6/20/07. The entries documented assessments of the resident's left ischial tuberosity and left heel. Interview with licensed practical nurse (LPN) #1 on 6/20/07 at 10:40 AM confirmed she performed the assessments on 6/7/07 and documented the late entries on 6/20/07.

According to the November 2003 Wyoming Board of Nursing, Nursing Practice Act and Administrative Rules and Regulations, a licensed practical nurse (LPN) may not perform assessments independently. LPNs must practice under the direction and supervision of a registered nurse.

2. Observation on 6/20/07 at 3:15 PM revealed certified nurse aide (CNA) #6 and registered nurse (RN) #1 transferred the resident from the wheelchair to the bed utilizing the sit to stand lift. Observation also revealed the resident had one stage II pressure sore on each buttock near the coccyx area. Continued observation revealed CNA #6 applied Baza (medicated cream) to the

F492-Plan of Correction

This plan of correction is the facility's credible allegation of compliance.

Resident #2 had no negative effects from the deficient practice and has been assessed by a Registered Nurse.

LPN #1 was educated on the Nurse Practice Act.

CNA's have been educated that their license does not allow them to apply anti-fungal creams.

The Director of Nurses or designee will perform random observations of nursing staff to confirm they are practicing within the scope of their license.

The Director of Nurses will educate the nursing staff on the Nurse Practice Act that prevents LPN's from performing assessments independently and CNA's from applying anti-fungal creams.

The Director of Nurses or designee will conduct random audits to confirm that LPN's and CNA's are performing within their scope of practice according to the regulations.

Results of the audits will be reviewed by the QA & A Committee for recommendation and continued compliance. Data will be reviewed monthly x3 months.

Date of compliance is August 5, 2007.

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MOUNTAIN TOWERS HEALTHCARE	3123 BOXELDER DRIVE CHEYENNE, WY 82001

(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 492	Continued From page 30 pressure sores on each buttock. According to the November 2003 Wyoming Nursing Practice Act and Administrative Rules and Regulations, a CNA may not administer medications.	F 492		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure skin assessments were documented in a timely manner for three (#2, #17, #98) of five sample residents identified as having pressure ulcers. The findings were: 1. Review of the physician's orders for resident #2 showed s/he was readmitted to the facility on 6/2/07 with diagnoses of cerbrovascular accident, anemia, and decubitus ulcer. Review of the "Weekly Pressure Condition Reports" showed late entries dated 6/20/07. The entries documented assessments of the resident's left ischial tuberosity and left heel. Interview with the	F 514	F514-Plan of Correction This plan of correction is the facility s credible allegation of compliance. Residents #2, #17, and #98 were not negatively affected by the deficient practice. Assessments for cited residents were documented as late entries per professional standards. The Director of Nurses or designee will conduct audits to identify timely documentation of skin assessments for residents with pressure ulcers. The Director of Nurses or designee will educate nursing staff on the timely documentation of skin assessments for residents with pressure ulcers. The Director of Nurses or designee will conduct random monthly audits to confirm that skin assessments for residents with pressure ulcers are documented timely. Results of the audits will be reviewed by the QA & A Committee for recommendation and continued compliance. Data will be reviewed monthly x3 months. Date of compliance is August 3, 2007.	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535018	A. BUILDING _____ B. WING _____	C 06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3120 BOXELDER DRIVE CHEYENNE, WY 82001

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F 514	Continued From page 31	F 514		

LPN on 6/20/07 at 10:40 AM confirmed she performed the assessments on 6/7/07 and documented the late entries on 6/20/07.

2. Review of the face sheet for resident #17 showed s/he was admitted to the facility on 5/17/07 with diagnoses including failure to thrive and malnutrition. Review of the 5/27/07 "Pressure Ulcer Risk Assessment Tool" documented the resident was admitted with a pressure ulcer. On 5/27/07 the physician ordered, "Wound care nurse to follow pt [patient] wounds." The following concerns were identified:

Review of the medical record showed no comprehensive skin assessment between 5/27/07 and 6/13/07. Interview with the director of nursing (DON) on 6/20/07 at 2:25 PM revealed the wound care nurse was on vacation during that time and the assessments were performed, but not documented.

3. Observation on 6/21/07 at 7:44 AM with the wound care nurse revealed resident #98 had four open areas on the right buttock and one on the left. The wound measurements taken by the wound care nurse at this time were as follows: the right buttock overall wound measurement was 6.0 cm x 3.0 cm which was larger than the measurements taken on 6/18/07 which were 2.4 cm x 1.3 cm x 0.1 cm, and those taken on 6/20/07 which were 4.0 cm x 3.0 cm, overall. Interview with the wound care nurse at this time confirmed these measurements were accurate.

Record review on 6/21/07 at 2:33 PM revealed no documentation of the skin assessments performed on 6/21/07 at 7:44 AM and on 6/20/07 by the wound nurse. Interview with the wound care nurse at that time revealed she was not going to document the assessments until the

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	560018	A. BUILDING _____ B. WING _____	C 06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(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 514	Continued From page 32 director of nursing also observed the resident's wounds. The wound care nurse further stated she did not want "different measurements for the two observations." Interview with the administrator on 6/25/07 at 1:35 PM revealed the wound care nurse should document her assessments in the medical record at the time they are performed.	F 514		