Reviewed and approved 3 changes on page 3 w/in after discussion c Tani upon DOO

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

PRINTED: 08/16/2006
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 08/03/2006

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 PRECEEDED 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 medical record review, staff interview, and policy and procedure review, the facility failed to assure a physician was immediately notified upon a significant change in medical condition for	F 157	Disclaimer "This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." F157 1. Resident #8's physician will be notified of any significant change of condition per facility policy and procedure. 2. All residents have the potential to be affected by this practice. Guidelines will be put into place for notification of change of condition. 3. All nursing staff will be inserviced on guidelines and proper assessment techniques. Per 24 hour report and Nurse to Unit Manager report in a.m. Unit Managers will monitor for appropriate assessments and followup daily or 5 x a week on any significant change of condition for compliance. 4. Results of inservices and monitoring will be brought to the monthly Performance Improvement Committee meeting for review, comments, and recommendations. 5. Compliance Date: 09/15/06	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynda Patterson, NHA [signature]
TITLE: Executive Director
(X6) DATE: 8/28/06

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

RECEIVED
AUG 3 0 2006
WYOMING DEPT OF HEALTH
HEALTH FACILITIES

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F 157	Continued From page 1	F 157		

1 (#8) of 21 sample residents. The findings were:

Review of the July 2006 physician's orders for resident #8 revealed diagnoses including emphysema and chronic obstructive pulmonary disease (COPD). In addition, the orders included titrating (adjusting) the resident's oxygen to keep the saturation levels greater than 90 percent, and duo nebulizer treatments (inhaled medications for breathing) every 4 hours as necessary. Further medical record review showed a form titled "Change in Medical Condition Assessment" dated 7/28/06 that documented the following problem: "Res [resident] cont [continues] to be decreased L [left] lobes O2 sats [oxygen saturation levels] cont to fluctuate between 62% et [and] 88%. Res currently on 3.5 L [liter] O2/NC [oxygen per nasal cannula]. Sats @ [at] 88%. When res moves O2 sats drop into low 70's. PRN [as necessary] neb tx [nebulizer treatment] given, little improvement noted." The following suggestion to the physician was noted: "schedule neb tx [schedule routine nebulizer treatment]?" The following concerns were identified:

A handwritten note on the 7/28/06 "Change in Medical Condition Assessment" documented the form was sent to the physician via facsimile on 7/29/06 at 2 AM; however, there was no evidence the physician was ever contacted in regard to the resident's change in condition.

No documented response from the physician was on the aforementioned form, or in the medical record.

Interview with the restorative nurse on 8/2/06 at 9:10 AM confirmed a physician was never contacted. The restorative nurse further confirmed the physician should have been notified, and if the resident's physician was not

f23

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F 157	Continued From page 2 available, the nurse should contact either the physician on call, or the facility's medical director. According to the facility policy, "Condition Change of a Resident" revised on 4/28/06, the definition of immediate notification is "the physician should be informed at the time the event occurs directly or by pager."	F 157	**F226** 1. **There was no individual resident identified in this deficiency therefore no individual plan of correction can be addressed.** 2. **All residents have the potential to be affected by this practice.** 3. **All current Housekeeping staff will be inserviced on Facility Abuse Policy and Procedure. Any new Housekeeping staff hired will go through this training prior to working on floors. All Housekeeping employees will be inserviced annually on abuse policy and procedures. Staff Development Coordinator and Housekeeping Supervisor will monitor monthly for compliance.** 4. **Results of inservicing and monitoring will be brought to the monthly Performance Improvement Committee for review, comments, and recommendations.** 5. **Compliance Date: 09/15/06** added per phone request of Toni Wynn on 9/6/06 1pm LB 6. Housekeeper #1 and #2 were inserviced on 8/3/06 regarding abuse & neglect. LB	
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of facility policy, the facility failed to ensure 2 of 5 direct care staff who were interviewed, were adequately trained on prohibiting mistreatment and abuse of residents. The findings were: Interview on 8/3/06 at 10 AM with the executive director, director of nursing services, social service director, and the healthcare group district manager revealed housekeeping, laundry and janitorial staff were employed under a separate group of the corporate company. It was further revealed that the supervisor position responsible for directing these staff at this facility was vacant and had been for about two weeks. A support supervisor from another facility was filling in about three days a week. Interview with the support housekeeping supervisor on 8/1/06 at 9:52 AM revealed all staff employed by this health care	F 226		

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F 226	Continued From page 3	F 226		

group were to have abuse education prior to resident contact. To ensure this, abuse education was completed on their first day of orientation. Staff were to read the information, sign the handbook, and discuss the information with their supervisor. Interview with the healthcare group district manager on 8/3/06 at 10:35 AM confirmed the training process was for the employee to read the handbook that contained the abuse policy, then the employee signed the handbook receipt that acknowledged they understood the policies. The following concerns were noted:

a. Interview with housekeeper #1 on 8/1/06 at 9:38 AM revealed she had been working at the facility for approximately one month. The housekeeper denied being provided any abuse education and asked what abuse education was. She was able to give an example of abuse; however, she stated she would not intervene, and did not know of any timeline for reporting the abuse. At 4:35 PM on 8/1/06 the support supervisor stated he found the signed form for housekeeper #1. He further stated she must have signed it without reading it.

b. Interview with housekeeper #2 on 8/1/06 at 10:50 AM revealed she had been working at the facility for approximately one month. When asked if she had received any training on what to do if she witnessed an abuse situation, she stated she was not taught anything about abuse. She further said she did not remember reading anything concerning abuse. During an interview with the healthcare group district manager on 8/3/06 at 10:35 AM, he provided the signed handbook receipt for both housekeepers #1 and #2.

Review of the 1/1/00 resident abuse/neglect policy that was included in the employee

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F 226	Continued From page 4 handbook showed definitions of abuse and neglect, described the need to report and gave a timeline of "within twenty-four hours." The policy further stated "the new employee must understand the serious nature of this topic...the account manager must review with the new employee: what is abuse, what is neglect, what are they to do if they witness either, what may happen if they are guilty of either." The policy failed to provide any information on appropriate interventions to deal with resident abuse and neglect situations.	F 226		

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F 272 SS=F	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure completion of comprehensive assessments in various areas for 6 (#7, #8, #9, #13, #104, #124) of 12 sample	F 272	F272 1. Residents #'s 7, 8, 9, 13, 104, and 124 will have corrected comprehensive assessments completed. 2. All residents have the potential to be affected by this practice. a new log for audits will be completed. 3. All staff that complete MDS's and RAP's will be retrained on completing them comprehensively by District Director of Utilization Services. Director of Nursing will randomly monitor MDS's Quarterly for compliance. 4. Results of training and monitoring will be brought to the monthly Performance Improvement Committee for review, comments, and recommendations. 5. Compliance Date: 09/15/06	

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F 272	Continued From page 6 residents for whom comprehensive assessments were required since 6/1/06. The findings were: 1. According to the 7/14/06 significant change Minimum Data Set (MDS) assessment, resident #104 triggered for comprehensive assessments in the areas of delirium, cognitive loss, mood state, behavioral symptoms, psychosocial well-being, activities, falls, and dehydration/fluid maintenance. According to Section V of that MDS assessment, all comprehensive assessment information was located in the 7/14/06 Resident Assessment Protocol (RAP) summary. Review of those RAP summaries revealed comprehensive assessments identifying causative and contributing factors were not completed. Interview with the MDS coordinator on 8/2/06 at 2:30 PM confirmed there was no further information identified as part of the comprehensive assessments. 2. According to the 6/19/06 admission MDS assessment, resident #7 triggered in the areas of psychosocial well-being and mood state. According to Section V of that MDS assessment, all comprehensive information was located in the 6/19/06 RAP Summary. Review of the RAP summaries revealed no comprehensive assessment of those triggered areas. 3. According to the 6/1/06 admission MDS assessment, resident #13 triggered in the areas of cognitive loss and behavioral symptoms. According to Section V of that MDS assessment, all comprehensive information was located in the 5/31/06 RAP Summary. Review of the RAP summaries revealed there were no comprehensive assessments of those triggered	F 272		

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F 272	Continued From page 7 areas. 4. According to the 6/13/06 admission MDS assessment, resident #8 triggered in the areas of delirium, cognitive loss, psychosocial well-being, mood state, and behavioral symptoms. According to Section V of that MDS assessment, all comprehensive information was located in the 6/13/06 RAP Summary. Review of the RAP summaries revealed no comprehensive assessment of those triggered areas. 5. According to the 6/15/06 admission MDS assessment, resident #9 triggered in the areas of cognitive loss, psychosocial well-being, mood state and urinary incontinence and indwelling catheter. According to Section V of that MDS assessment, all comprehensive information was located in the 6/14/06 RAP Summary. Review of the RAP summaries revealed no comprehensive assessment of those triggered areas. Interview with the restorative nurse on 8/3/06 at 8:35 AM confirmed she completed the RAP for the resident's indwelling catheter. The restorative nurse confirmed the assessment of the catheter was not complete. 6. Review of the 7/24/06 annual MDS assessment for resident #124 revealed s/he required comprehensive assessments including communication, cognitive loss, psychosocial well-being, mood state, and behavioral symptoms. According to Section V of that MDS assessment, all comprehensive information was located in the 7/24/06 RAP summary. Review of the 7/24/06 RAP summaries revealed there was not a comprehensive assessment completed for these areas.	F 272		

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F 272	Continued From page 8 Interview with the social service assistant (SSA) on 8/3/06 at 5 PM confirmed she completed all RAP assessments for the triggered areas of delirium, cognitive loss, psychosocial well-being, mood state, and behavior symptoms. Further interview revealed the SSA thought the RAP assessments were "What we can do for them, a care plan." When questioned at that time in regard to training, both the SSA and the social services director (SSD) commented they received no formal training on the RAP process. The SSD further commented the training was, "by trial and error."	F 272		

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F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the Minimum Data Set (MDS) assessments were completed accurately for 3 (#87, #101, #122) of 21 sample residents. The findings were: According to the Centers for Medicare & Medicaid	F 278	F278 1. MDS corrections will be completed and submitted for residents #87, 101, and 122, according to the CMS RAI manual effective 10/03 as revised 3/06 2. All residents have the potential to be affected by this practice. 3. An audit of all previously completed significant changes of condition assessments will be done to identify other MDS's that need to be corrected and resubmitted. UC and MDS Coordinator will be re-trained on sections G9 and Q2 for Significant Change of Condition MDS's by District Director of Utilization Services. Director of Nursing will monitor Significant Change of Condition assessments quarterly for compliance. 4. Results of training and monitoring will be brought to the monthly Performance Improvement Committee meeting for review, comments, and recommendations. 5. Compliance Date: 09/15/06	

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F 278	Continued From page 10 Services Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Version 2.0, revised August 2005, Section G9 is used "To document any changes occurring in the resident's overall ADL [activities of daily living] self-performance, as compared to status of 90 days ago." Section Q2 is used "To monitor the resident's overall progress at the facility over time...as compared to...status of 90 days ago." Concerns with documentation in either one or both sections were identified for the following residents: a. Review of the MDS assessments showed a significant change assessment was completed on 4/28/06 for resident #87. According to the assessment, the resident declined in self-performance (from limited to total assistance, 3 to 4, in all areas) for the following ADLs: bed mobility, transfers, dressing, eating, hygiene, and toilet use. However, the assessment was coded as "No change" at Sections G9 and Q2. b. Review of a significant change MDS assessment completed on 4/14/06 showed resident #101 declined in self-performance for transfers, bathing, and toilet use (from 3 to 4 in all areas). Further review showed the facility coded Section Q2 as "No change." c. Review of the MDS assessments showed the most recent assessment for resident #122 was a significant change assessment dated 7/14/06. However, further review showed both Sections G9 and Q2 were coded as "No change." Interview with the MDS coordinator on 8/3/06 at 7:20 AM confirmed the aforementioned MDS assessments were miscoded.	F 278		

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F 281 SS=D	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, staff interview, and policy and procedure review, the facility failed to assure care was accurately documented for 1 (#137) of 1 sample resident with a peripherally inserted central catheter (PICC) line. In addition, the facility failed to clarify physician orders for monitoring blood glucose levels for 1 (#40) of 5 sample residents with a diagnosis of insulin-dependent diabetes mellitus. The findings were: 1. Closed record review for resident #137 revealed physician's orders that documented the resident was admitted to the facility on 6/20/06 with diagnoses including cellulitis, diabetes, and morbid obesity. The 6/20/06 physician's orders also documented an order for 2 grams of Vancomycin (an antibiotic) 24 hours a day per IV (intravenous) for two weeks to treat the cellulitis. Review of the IV medication sheet documented the resident received the medication via a PICC line. The IV medication sheet also showed the line should be flushed with normal saline and Heparin every 12 hours. Further review of the IV medication sheet showed the following problems: There was no documentation the resident received the Vancomycin on 6/24/06, 6/25/06, 6/28/06, 6/29/06, 6/30/06, or 7/30/06. There was no documentation the PICC line was flushed with normal saline on 6/24/06, 6/25/06, 6/26/06, 6/27/06, 6/28/06, 7/2/06, 7/3/06, and 7/4/06.	F 281	F281 1. Resident #40's blood glucose level physician order will be clarified. Resident #137 was a closed record review therefore this individual resident cannot be addressed due to no longer in facility. 2. All residents have the potential to be affected by this practice. All physician orders from previous day will be reviewed in morning meeting for accuracy and any orders needing clarification will be corrected within 24 hours. Guidelines for IV therapy catheter care will be implemented. 3. An inservice will be conducted to nursing staff on IV documentation guidelines. Unit Managers will audit daily or 5 x a week IV documentation for compliance. 4. Results of clarification orders, inservicing, and audits will be brought to the monthly Performance Improvement Committee for review, comments, and recommendations. 5. Compliance Date: 09/15/06	

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F 281	Continued From page 12	F 281		

There was no documentation the PICC line was flushed with Heparin on 6/21/06, 6/22/06, 6/24/06, 6/25/06, 6/28/06, 6/29/06, 6/30/06, and 7/3/06.

Interview with the director of nursing services (DNS) on 8/3/06 at 9:30 AM confirmed the resident received the Vancomycin via the PICC line from 6/21/06 through 7/4/06. The DNS further commented it was a standard of practice for the PICC line to be flushed with normal saline before and after the administration of the Vancomycin. Then, following the second flush with saline, the PICC line should be flushed with Heparin. The DNS stated the saline and Heparin flushes should be documented on the IV medication sheet; she did not know why they were not documented.

Review of the facility policy and procedure "Catheter Care Guidelines" dated 1/06, revealed PICC catheters should be flushed with 5 milliliters (ml) of normal saline before and after each use, then flushed with 3 ml of Heparin after saline use, or at least every 24 hours.

2. Review of the medical record showed resident #40 had diagnoses including diabetes. Review of the July 2006 recapitulation of physician orders revealed it was signed by the physician and a registered nurse for accuracy. However, an order dated 4/14/05 showed "FSBS [finger stick blood sugar] at 0700 and @ 2000 Q [every] week call MD if BS [blood sugar] is < [less than] 600 or > [greater than] 350." Interview with licensed practical nurse (LPN) #23 on 8/2/06 at 8:50 AM confirmed the order was confusing, and should be clarified. According to the 2004 sixth edition of "Clinical Nursing Skills Basic to Advanced Skills," by Smith, Duell, and Martin, "If a written order...is questionable for any reason, the physician must

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 08/03/2006

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 PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET ON DATE
F 281	Continued From page 13 be notified for clarification."	F 281	F282 1. Care Plans will be followed as written for resident #'s 33, 35, 40, 42, 59, 87, 101, and 122. 2. All residents have the potential to be affected by this practice. Residents will receive 2 baths per week unless otherwise ordered. All residents will be toileted per care plan of AC, PC, AM, PM, HS, and PRN and/or check and change. Residents on a restorative program will receive their program as ordered. 3. C.N.A's will be inserviced on bath documentation and refusals, and toileting schedules per care plans. Restorative aides will be inserviced on completing all programs and documentation of refusals. Unit managers will audit bath documentation daily or 5 x week for compliance. Restorative Nurse will audit restorative documentation daily or 5 x week to ensure all programs are completed for compliance. 4. Results of inservicing and audits will be brought to the monthly Performance Improvement Committee for review, comments, and recommendations. 5. Compliance Date: 09/15/06	
F 282 SS=E	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 8 (#33, #35, #40, #42, #59, #87, #101, #122) of 21 sample residents. Interventions not implemented included those for bathing, the restorative program, and individual toileting plans. The findings were: 1. Review of medical records revealed residents #33, #42, and #59 were currently care planned to received baths or showers at least twice a week. Review of Activities of Daily Living (ADL) Flow Records for these residents raised the following concerns: a. The 2006 ADL Flow Records for resident #33 documented baths were given on June 2, 13, 16, 23, and 30; indicating baths were not given for periods of 11 days (2-13 June), 6 days (16-23 June), and 6 days (23-30 June). These records failed to document any instance in which the resident refused a bath or a bath was contraindicated based on medical conditions. Similarly, the April and May ADL Flow Records	F 282		

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 08/03/2006

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F 282	Continued From page 14	F 282		

revealed 4 periods in which only one bath was documented in a week 's time; 3-10 April (6 days), 13-19 April (6 days), 9-16 May (6 days), and 24-30 May (6 days).

b. Resident #42 received baths on June 5, 8, 15, 19, 22, and 29; a 7-day period elapsed between 8-15 June with only a single bath given in a week's time. In addition, review of the May 2006 ADL Flow Record revealed this resident received only one bath in a 15-day period (16-31 May); this being annotated as "B/B" on 29 May. Interview with licensed practical nurse (LPN) #23 on 8/3/06 at 8:50 AM confirmed the "B /B" notation stood for "bed bath." No further documentation existed to explain why resident #42 was not bathed as care planned.

c. Review of the 2006 ADL Flow Record for resident #59 revealed s/he repeatedly failed to receive a bath for periods of at least 6 days (15-22 May, 3-10 April, 6-13 March, 16-23 March, and 23-30 March. The resident 's medical record failed to document any condition or refusal to indicate a necessity for not implementing the resident's care plan.

2. Review of the 6/16/06 quarterly Minimum Data Set (MDS) assessment showed resident #40 was totally dependent on staff for ADLs including toileting. Review of the updated 9/20/06 care plan for incontinence showed a scheduling regime of "AC [before meals], PC [after meals], AM, PM, HS [bedtime], and PRN [as needed] and/or check and change." Interview on 8/3/06 at 4:48 PM with the director of nursing (DNS) clarified the timeline for AC was directly before the resident was taken into the dining room, PC is after the meal when the resident was taken away from the dining room.

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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 08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 15	F 282		

Observation on 8/1/06 at 7 AM until 9:40 AM revealed the resident was not toileted for 2 hours and 40 minutes. Observation at 9:05 AM revealed the resident was wheeled away from the dining table and was placed next to the nurses' station. At 9:15 AM the resident was taken into his/her room and waited while certified nurse aide (CNA) #1 and nursing assistant (NA) #2 assisted the resident's roommate. At 9:40 AM CNA #1 and NA #2 transferred resident #40 from the wheelchair into bed using a Hoyer lift. Next, they checked and changed the resident, who was found to be incontinent of urine. Interview with CNA #1 on 8/3/06 at 9:44 AM revealed the resident should be checked and changed "at least every two hours."

3. Review of the 9/9/05 annual MDS assessment for resident #35 showed s/he had partial loss of voluntary movement and limited range of motion (ROM) on both sides affecting the arms and legs. Review of the 5/11/06 quarterly assessment showed the resident continued to have the same ROM limitations without decline. Review of the 6/29/06 restorative care plan for the resident showed passive ROM services were to be done 5 times per week for lower extremities. However, review of the restorative care flow records revealed there was no evidence of any restorative services provided on 6/29/06 or 6/30/06. In addition, the July 2006 restorative care flow record for the first week of July (7/1/06-7/7/06) was blank, and there were no refusals documented. Interview with the restorative nurse on 8/3/06 at 11:30 AM revealed any refusals should be documented on the care flow record. The restorative nurse further confirmed the reason the services were not completed as care planned was because there were not always staff

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 08/03/2006

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 282	Continued From page 16 available to provide it. 4. Review of the 7/25/06 quarterly MDS assessment showed resident #87 was frequently incontinent of urine (daily, but with some control present). According to the 7/25/06 care plan staff were to check and change the resident's incontinence brief "q AM, AM, PC, HS, and PRN" (every morning, in the morning, after meals, at bedtime and as needed). Interview with the DNS on 8/3/06 at 4:48 PM revealed "q AM, AM..." was an error; the second "AM" should have been "ac" or before meals. Observation on 8/1/06 showed the resident was seated in a geriatric chair (wheeled chair that reclines) from 7:58 AM until observation ceased at 11:57 AM when the resident was wheeled out for lunch. The resident's incontinence brief was not checked or changed during that four hour period. On 8/1/06 at 11:57 AM, interview with CNA #7 revealed she assisted the resident up that morning and changed the resident's brief before breakfast, which was scheduled at 7:40 AM. Interview with CNA #3 on 8/1/06 at 1:25 PM revealed she assisted the resident to bed at approximately 1 PM and changed the wet incontinence brief at that time. The entire length of time the resident's incontinence brief was not checked or changed was over five hours and included time after breakfast and before lunch. 5. Review of the 6/27/06 MDS assessment revealed resident #101 was incontinent of bowel two to three times per week. According to the 6/27/06 care plan, staff were to check and change the resident's incontinence brief "q AM, AM, PC, HS, and PRN." Interview with the DNS on 8/3/06 at 4:48 PM revealed "q AM, AM..." was	F 282		

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 08/03/2006

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 17	F 282		

an error; the second "AM" should have been "ac" or before meals. The DNS further stated "PRN" covered all other times.

Observation on 8/1/06 showed the resident was seated in a geriatric chair and remained in the dining room from 7:58 AM until 11:40 AM. At that time CNAs #3 and #7 took the resident to his/her room and changed the incontinence brief. The resident was incontinent of bowel and had feces down his/her legs to the knees. CNA #3 confirmed the resident was last changed when assisted up for breakfast, which was scheduled for 7:40 AM. The resident was not checked or changed for over 3 hours and 42 minutes.

6. According to the 7/31/06 quarterly MDS assessment, resident #122 was frequently incontinent of urine. Review of the 8/1/06 care plan revealed staff were to toilet and/or check and change the resident upon arising, before and after meals, at bedtime, and as needed. Observation on 8/1/06 showed the resident was in the dining room from 7:58 AM until the observation ceased at 11:48 AM when the resident was eating lunch. The resident was not toileted, nor the incontinence brief checked or changed, during that four hour time period. Interview with CNA #10 on 8/1/06 at 2:20 PM revealed she toileted the resident at approximately 12:45 PM. A total of over 4 and 3/4 hours actually elapsed before the resident was toileted and the incontinence brief changed.

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 08/03/2006

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 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interviews, the facility failed to assure staff provided care and services to maintain as much bowel continence as possible for 1 (#101) of 9 sample residents who were incontinent of bowel. The findings were: Review of the 6/27/06 Minimum Data Set (MDS) assessment revealed resident #101 had moderate cognitive impairment (made poor decisions, required cues and supervision), was totally dependent on staff for toilet use, and was incontinent of bowel two to three times per week. According to the 6/27/06 care plan, staff were to check and change the resident's incontinence brief "q AM, AM, PC, HS, and PRN" (every morning, in the morning, after meals, at bedtime and as needed). Interview with the director of nursing services (DNS) on 8/3/06 at 4:48 PM revealed "q AM, AM..." was an error; the second "AM" should have been "ac" or before meals. The DNS further stated "PRN" covered all other times. Observation on 8/1/06 showed the resident seated in a geriatric chair (wheeled chair which reclines) eating breakfast in the dining room at 7:58 AM. Further observation showed the resident remained there until 11:40 AM, a time	F 309	F309 1. Resident #101 will be toileted per care plan. 2. All residents have the potential to be affected by this practice. All residents will be toileted per their individual care plans. 3. Nursing staff will be inserviced on toileting plans per individual resident care plans. Unit managers will monitor daily or 5 x a week during rounds on each unit for compliance. 4. Results of the inservicing and monitoring will be brought to the monthly Performance Improvement Committee for review, comments, and recommendations. 5. Compliance Date: 09/15/06	

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 06/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 19 period of 3 hours and 42 minutes. At that time certified nurse aides (CNAs) #3 and #7 took the resident to his/her room, and without offering to place the resident on the toilet, transferred the resident to bed and changed the incontinence brief. During the observation, CNA #7 stated the resident was last changed when assisted up for breakfast, which was scheduled at 7:40 AM, and CNA #3 verified the statement. Observation of the procedure showed the resident was incontinent of bowel and had feces down his/her legs to the knees.	F 309	F311 1. Resident #40 will receive her restorative program as care planned. 2. All residents on Restorative caseload have the potential to be affected by this practice. All residents on a restorative program will receive these services as care planned. 3. Restorative aides will be inserviced on providing all required programs as care planned and documenting any refusals. Restorative Nurse will audit restorative documentation daily or 5 x week for compliance. 4. Results of the inservicing and audits will be brought to the monthly Performance Improvement Commitee for review, comments, and recommendations. 5. Compliance Date: 09/15/06	
F 311 SS=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure restorative services were provided as care planned for 1 (#40) of 2 sample residents receiving restorative services to maintain activities of daily living (ADLs). The findings were: Review of the 6/16/06 quarterly Minimum Data Set (MDS) assessment showed resident #40 was totally dependent on staff for Activities of Daily Living (ADLs), and had no range of motion (ROM) limitations. Review of the 5/22/06 restorative care plan for the resident showed preventive ROM services were to be done 4 times per week for both lower extremities. However, review of the	F 311		

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	535013	A. BUILDING _____ B. WING _____	C 08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 311	Continued From page 20 restorative care flow record for May, June and July 2006 revealed seven weeks when the services were not provided as indicated by the care plan. There were no documented refusals for any of those weeks. The services were provided during those seven weeks as follows: a. 5/22-5/28, completed 3 times b. 5/29-6/4, completed 2 times c. 6/5-6/11, completed 2 times d. 6/12-6/18, completed 2 times e. 6/19-6/25, completed 3 times f. 6/26-7/2, completed 3 times g. 7/10-7/16, completed 3 times Interview with the restorative nurse on 8/3/06 at 11:30 AM revealed refusals should be documented on the care flow record. The restorative nurse further confirmed the reason the services were not completed as care planned was because there were not always staff available to provide them.	F 311		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315		

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 08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 21 Based on observation, medical record review, and family and staff interviews, the facility failed to assure staff provided treatment and services to attain or maintain as much bladder continence as possible for 3 (#40, #87, #122) of 11 sample residents who were incontinent of urine. The findings were: 1. Review of the 7/25/06 Minimum Data Set (MDS) assessment showed resident #87 had moderate cognitive impairment (made poor decisions, required cues and supervision), was frequently incontinent of urine (incontinent daily, but with some control present), and required total staff assistance to use the toilet. Review of the 4/28/06 Resident Assessment Protocol (RAP) summary, identified as the comprehensive assessment for urinary incontinence, revealed "Staff to continue toilet, check & change schedule. Staff to keep...clean and dry at all times." According to the 7/25/06 care plan, staff were to check and change the resident's incontinence brief "q AM, AM, PC, HS, and PRN" (every morning, in the morning, after meals, at bedtime and as needed). Interview with the director of nursing services (DNS) on 8/3/06 at 4:48 PM revealed "q AM, AM..." was an error; the second "AM" should have been "ac" or before meals. Observation on 8/1/06 showed the resident was sitting up in a geriatric chair (wheeled chair which reclines) in the dining room from 7:58 AM until observation ceased at 11:57 AM while the resident was eating lunch. The resident was not toileted, nor was the incontinence brief checked or changed, during that four hour period. On 8/1/06 at 11:57 AM, interview with certified nurse aide (CNA) #7 revealed she assisted the resident	F 315	F315 1. **Residents #'s 40, 87, and 122 will be toileted per their individual care plan.** 2. **All residents have the potential to be affected by this practice. All residents will be toileted per their care plan of AC, PC, AM, PM, HS, and PRN and/or check and change.** 3. **Nursing staff will be inserviced on toileting plans per individual resident care plans. Unit managers will monitor daily or 5 x week during rounds for compliance on each unit.** 4. **Results of the inservicing and monitoring will be brought to the monthly Performance Improvement Committee for review, comments, and recommendations.** 5. **Compliance Date: 09/15/06**	

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 08/03/2006

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F 315	Continued From page 22	F 315		

up that morning and changed the resident's incontinence brief before breakfast, which was scheduled at 7:40 AM. Interview with CNA #3 on 8/1/06 at 1:25 PM revealed she assisted the resident to bed at approximately 1 PM and changed the incontinence brief at that time. The CNA stated the resident was incontinent of urine when changed. Although the resident was capable of sitting upright, the CNA also stated she did not place the resident on the toilet or bedside commode. The entire length of time the resident was not toileted, nor the incontinence brief checked or changed, during that observation period was over five hours.

A second observation period on 8/1/06 showed the resident remained in bed from 1:25 PM until 4:30 PM. Interview with CNA #3 at that time revealed she had changed the resident's incontinence brief and assisted him/her out of bed at 4:20 PM. The CNA stated she did not assist the resident to the toilet as s/he "was already wet." During an interview on 8/1/06 at 5 PM, a family member stated the resident was not toileted as planned and was frequently wet.

2. Review of the 6/16/06 quarterly MDS assessment showed resident #40 was totally dependent on staff for activities of daily living (ADLs) including toileting. Review of the updated 9/20/06 care plan for incontinence showed a scheduling regime of "AC [before meals], PC [after meals], AM, PM, HS [bedtime], and PRN [as needed] and/or check and change." Interview on 8/3/06 at 4:48 PM with the director of nursing services clarified the timeline for AC was directly before the resident was taken into the dining room, and PC was after the meal when the resident was taken away from the dining room.

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 08/03/2006

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F 315	Continued From page 23 Observation on 8/1/06 from 7 AM until 9:40 AM (2 hours and 40 minutes) revealed resident #40 was not toileted, checked for incontinence or changed. Observation at 7 AM showed the resident was up at the table for the breakfast meal. at 9:05 AM the resident was wheeled away from the dining table and was placed next to the nurses' station. At 9:15 AM the resident was taken into his/her room and waited while CNA #1 and nursing assistant (NA) #2 assisted the resident's roommate. At 9:40 AM CNA #1 and NA #2 transferred resident #40 from the wheelchair into bed using a Hoyer lift. Next, they checked and changed the resident, who was found to be incontinent of urine. Interview with CNA #1 on 8/3/06 at 9:44 AM revealed the resident should be checked and changed "at least every two hours." 3. According to the 7/31/06 quarterly MDS assessment, resident #122 had moderate cognitive impairment, required extensive assistance from staff to use the toilet, and was frequently incontinent of urine. Review of the 8/1/06 care plan revealed staff were to "Follow toileting regime/schedule: Q AM, AC, PC, HS and PRN/and/or check and change." Observation on 8/1/06 showed the resident was seated in a wheelchair in the dining room from 7:58 AM until the observation ceased at 11:48 AM while the resident was eating lunch. The resident was not toileted, nor was the incontinence brief checked or changed, during that four hour time period. Interview with CNA #10 on 8/1/06 at 2:20 PM revealed she toileted the resident at approximately 12:45 PM. A total of over 4 and 3/4 hours elapsed before the resident was toileted and the incontinence brief changed. A second observation period revealed the	F 315		

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 08/03/2006

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 315	Continued From page 24 resident was not toileted from 12:45 PM through 4:50 PM (4 hours and 5 minutes). At that time, NA #16, who was assigned to care for the resident that afternoon, confirmed the resident was not toileted since he came on duty at 2 PM.	F 315	F328 1. Resident #8's physician will be notified of any significant change of condition per facility policy and procedure. 2. All residents have the potential to be affected by this practice. 3. Guidelines will be put into place for notification of change of condition. Nursing staff will be inserviced on guidelines and proper assessment techniques. Per 24 hour report and Nurse to Unit Manager report in a.m. Unit Managers will monitor for appropriate assessments and followup daily or 5 x a week on any significant change of condition for compliance. 4. Results of inservices and monitoring will be brought to the monthly Performance Improvement Committee meeting for review, comments, and recommendations. 5. Compliance Date: 09/15/06	
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide a timely assessment to assure proper respiratory care was provided to 1 (#8) of 9 sample residents who utilized oxygen. The findings were: Review of the July 2006 physician's orders for resident #8 revealed diagnoses including emphysema and chronic obstructive pulmonary disease (COPD). In addition, the orders included titrating (adjusting) the resident's oxygen to keep the saturation levels greater than 90 percent, and duo nebulizer treatments (inhaled medications for breathing) every 4 hours as necessary. Further	F 328		

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 08/03/2006

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 328	Continued From page 25	F 328		

medical record review showed a form titled "Change In Medical Condition Assessment" dated 7/28/06 that documented the following problem: "Res [resident] cont [continues] to be decreased L [left] lobes O2 sats [oxygen saturation levels] cont to fluctuate between 62% et [and] 88%. Res currently on 3.5 L [liter] O2/NC [oxygen per nasal cannula]. Sats @ [at] 88%. When res moves O2 sats drop into low 70's. PRN [as necessary] neb tx [nebulizer treatment] given, little improvement noted." The following suggestion to the physician was noted: "schedule neb tx [schedule routine nebulizer treatment]?" The following concerns were identified:

A handwritten note on the 7/28/06 "Change in Medical Condition Assessment" documented the form was sent to the physician via facsimile on 7/28/06 at 2 AM; however, there was no evidence the physician was ever contacted in regard to the resident's change in condition.

No documented response from the physician was on the aforementioned form, or in the medical record.

Interview with the restorative nurse on 8/2/06 at 9:10 AM confirmed a physician was never contacted. The restorative nurse further confirmed the physician should have been notified, and if the resident's physician was not available, the nurse should contact either the physician on call, or the facility's medical director.

Review of nurses' notes dated 7/30/06 at 3:30 AM, and on 7/31/06 at 4:30 AM, revealed the resident's lungs were assessed as clear to auscultation (sounds). In addition, review of the treatment record for 7/30/06 showed the resident's oxygen saturation levels were 93% (6 AM - 2 PM), 88% (2 PM - 10 PM), and 95% (10

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 08/03/2006

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 328	Continued From page 26	F 328		

PM - 6 AM). Further review of the treatment record for 7/31/06 showed the resident's oxygen saturation levels were 94% (6 AM - 2 PM), 90% (2 PM - 10 PM), and 89% (10 PM - 6 AM). Even though the resident respiratory status was assessed as improved, observation on 8/1/06 at 8 AM showed s/he was transported out of the facility via an ambulance. Review of a nurse's note dated 8/1/06 at 11:15 AM revealed the resident was admitted to the hospital with a diagnosis of pneumonia.

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 08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family and staff interviews, medical record review, and review of the posted schedule and the resident roster, the facility failed to maintain sufficient staff to provide care and services for 9 of 21 sample residents to minimize bowel (#101) and bladder (#40, #87, #122) incontinence, complete bathing (33, #42, #59), and provide the restorative program (#35, #40). The listed residents resided on the second and third floors. The findings were: 1. Observation on the days of the survey (7/31/06	F 353	F353 1. Resident #'s 101, 40, 87, and 122 will have staff provided to minimize bowel and bladder incontinence. Resident #'s 33,42, and 59 will have staff provided to complete bathing. Resident #'s 35, and 40 will have staff provided to provide restorative programs. 2. All residents have the potential to be affected by this practice. All residents will have adequate staff to provide necessary cares per individual resident care plans. Daily staffing grid will be revised based on resident acuity per floor. Facility will continue to recruit and hire as needed. 3. Mandatory shifts will be scheduled for C.N.A's and/or nurses to maintain appropriate staffing levels. Nursing staff will be inserviced on mandatory shifts. Director of Nursing and Scheduler will monitor staffing daily for compliance. 4. Results of inservicing and monitoring will be brought to the monthly Performance Improvement Committee for review, comments, and recommendations. 5. Compliance Date: 09/15/06	

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 08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 353	Continued From page 28	F 353		

- 8/3/06) revealed additional staff present at meal times on the third floor to assist with serving. Interview with the business office manager on 8/1/06 at 5:45 PM revealed she was assigned to the floor to assist with meals. However, the manager kept asking staff to identify residents and the kinds of fluids they drank.

2. At the time of the survey 30 residents resided on the first floor, 54 on the second floor, 38 on the third floor, and 14 in the secure unit. Review of the posted nursing schedule showed the facility was unable to fill the following vacancies listed on that schedule:

a. 7/29/06, Saturday - one certified nurse aide (CNA) for nights on first floor; two CNAs for days, two for evenings, and one for nights on second floor; one CNA for days and evenings for third floor.

b. 7/30/06, Sunday - one CNA for days and one for nights on second floor.

c. 8/1/06, Tuesday - one CNA for nights on second; two CNAs for evenings on third (one CNA was called in but not listed on the schedule).

d. 8/2/06, Wednesday - one CNA called off on days for third floor and was not replaced, and one CNA arrived at 8 AM (the shift started at 6 AM). For the evening shift on third floor, one CNA arrived at 3 PM (shift started at 2 PM) another arrived at 6 PM.

e. 8/3/06, Thursday - one CNA for nights on second floor; and one CNA for half the evening shift on third floor.

3. Incontinence:

a. Review of the 6/27/06 Minimum Data Set (MDS) assessment revealed resident #101 was totally dependent on staff for toilet use, was

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 08/03/2006

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 353	Continued From page 29	F 353		

incontinent of bowel two to three times per week, and was on a scheduled toileting plan. Observation on 8/1/06 showed the resident seated in a geriatric chair (wheeled chair which reclines) in the dining room at 7:58 AM. Further observation showed the resident remained there until 11:40 AM, a time period of 3 hours and 42 minutes. At that time CNAs # 3 and #7 took the resident to his/her room, and without offering to place the resident on the toilet, transferred the resident to bed and changed the incontinence brief. During the observation, CNA #7 stated the resident was last changed when assisted up for breakfast, which was scheduled at 7:40 AM, and CNA #3 verified the statement. The resident was incontinent of bowel and had feces down his/her legs to the knees.

b. Observation on 8/1/06 revealed resident #40 was not toileted from 7 AM until 9:40 AM (2 hours and 40 minutes). At that time the resident was incontinent of urine. Interview with CNA #1 on 8/3/06 at 9:44 AM revealed the resident should be checked and changed "at least every two hours."

c. Review of the 7/25/06 MDS assessment showed resident #87 was frequently incontinent of urine, required total staff assistance to use the toilet, and was on a scheduled toileting plan. Observation on 8/1/06 showed the resident was sitting up in a geriatric chair (wheeled chair which reclines) in the dining room from 7:58 AM until observation ceased at 11:57 AM while the resident was eating lunch. The resident was not toileted, nor was the incontinence brief checked or changed. Interview with CNA #3 on 8/1/06 at 1:25 PM revealed she assisted the resident to bed at approximately 1 PM and changed the wet incontinence brief at that time. Although the

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 08/03/2006

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 353	Continued From page 30	F 353		

resident was capable of sitting upright, the CNA also stated she did not place the resident on the toilet or bedside commode. The entire length of time the resident was not toileted, nor the incontinence brief checked or changed, was over five hours.

A second observation period on 8/1/06 showed the resident remained in bed from 1:25 PM until 4:30 PM. Interview with CNA #3 at that time revealed she had changed the resident's incontinence brief and assisted him/her out of bed at 4:20 PM. The CNA stated she did not assist the resident to the toilet as s/he "was already wet."

d. According to the 7/31/06 quarterly MDS assessment, resident #122 required extensive assistance from staff to use the toilet, was frequently incontinent of urine, and was on a toileting schedule. Observation on 8/1/06 showed resident #122 seated in a wheelchair in the dining room from 7:58 AM until the observation ceased at 11:48 AM. Interview with CNA #10 on 8/1/06 at 2:20 PM revealed she toileted the resident at approximately 12:45 PM. A total of over 4 and 3/4 hours elapsed before the resident was toileted and the incontinence brief changed.

A second observation period revealed the resident was not toileted from 12:45 PM through 4:50 PM (4 hours and 5 minutes). At that time, nursing assistant (NA) #16 who was assigned to care for the resident that afternoon, confirmed the resident had not been toileted since s/he came on duty at 2 PM.

e. Confidential interview with a family member on 8/1/06 at 9:50 AM revealed twice last week when he/she visited, their loved one was incontinent of bowel and was not cleaned up until s/he called for staff.

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 08/03/2006

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 353	Continued From page 31	F 353		

4. Restorative Program:

a. Review of the 9/9/05 annual and 11/5/06 quarterly Minimum Data Set (MDS) assessments showed resident #35 had partial loss of voluntary movement and range of motion (ROM) limitations on both sides affecting the arms and legs; passive ROM services were care planned 5 times per week for the lower extremities. However, review of the restorative care flow records revealed there was no evidence of any restorative services provided on 6/29/06 or 6/30/06. In addition, the July 2006 restorative care flow record for the first week of July (7/1/06-7/7/06) was blank, and there were no refusals documented.

Interview with the restorative nurse on 8/3/06 at 11:30 AM revealed any refusals should be documented on the care flow record. The nurse stated the reason the services were not completed as care planned was because there were not always staff available to provide them.

b. Review of the 6/16/06 quarterly MDS assessment showed resident #40 was totally dependant on staff for activities of daily living (ADLs) and had no ROM limitations, but the 5/22/06 restorative care plan showed preventative ROM services were to be done 4 times per week for both lower extremities. However, review of the restorative care flow record for May, June and July 2006 revealed seven weeks when the services were not provided as indicated by the care plan. There were no documented refusals for any of these weeks.

Interview with the restorative nurse on 8/3/06 at 11:30 AM revealed refusals should be documented on the care flow record. The restorative nurse further stated the reason the

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 08/03/2006

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 353	Continued From page 32	F 353		

services were not completed as care planned was because there were not always staff available to provide them.

5. Bathing:
Review of medical records revealed residents #33, #42, and #59 were currently care planned to received baths or showers at least twice a week. Review of Activities of Daily Living (ADL) Flow Records for these residents raised the following concerns:

a. The 2006 ADL Flow Records for resident #33 documented baths were given on June 2, 13, 16, 23, and 30; indicating baths were not given for periods of 11 days (2-13 June), 6 days (16-23 June), and 6 days (23-30 June). These records failed to document any instance in which the resident refused a bath or a bath was contraindicated based on medical conditions. Similarly, the April and May ADL Flow Records revealed 4 periods in which only one bath was documented in a week 's time; 3-10 April (6 days), 13-19 April (6 days), 9-16 May (6 days), and 24-30 May (6 days).

b. Resident #42 received baths on June 5, 8, 15, 19, 22, and 29; a 7-day period elapsed between 8-15 June with only a single bath given in a week's time. In addition, review of the May 2006 ADL Flow Record revealed this resident received only one bath in a 15-day period (16-31 May); this being annotated as "B/B" on 29 May. Interview with licensed practical nurse (LPN) #23 on 8/3/06 at 8:50 AM confirmed the "B/B" notation stood for "bed bath." No further documentation existed to explain why resident #42 was not bathed as care planned.

c. Review of the 2006 ADL Flow Record for resident #59 revealed s/he repeatedly failed to

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 08/03/2006

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 353	Continued From page 33	F 353		

receive a bath for periods of at least 6 days (15-22 May, 3-10 April, 6-13 March, 16-23 March, and 23-30 March. The resident 's medical record failed to document any condition or refusal to indicate a necessity for not implementing the resident 's care plan.

6. Confidential resident, family and staff interviews from 7/31/06 through 8/3/06 revealed the following:

a. A resident stated incoming telephone calls were not answered in a timely fashion. S/he indicated a spouse's telephone calls were frequently unanswered or answered only after an extended period. The resident stated this pattern of delayed answering was particularly evident on weekends and nights. The resident further stated that nursing personnel were diverted from direct care activities to answer facility telephones on weekends.

b. Seven residents revealed they were concerned in regard to the lack of nursing staff. The residents stated that when the facility is "short" of nurse aides, they do not receive their baths as scheduled, and call lights go unanswered for as long as 30 minutes. The residents further stated that the lack of staff was particularly a problem on weekends.

c. A resident stated there was not enough help for adequate care and the facility was losing more staff. The resident further stated that, at times, there was one CNA for 54 residents and s/he "can't take care of them." Residents are left wet and soiled and showers are not given as "the CNA can't go off the floor for 30 to 45 minutes" and no one extra can come in. In addition, the resident stated the experienced staff were moved to the first floor and the resident felt s/he "has to

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 08/03/2006

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 353	Continued From page 34	F 353		

train" the inexperienced ones.

d. A resident asked a surveyor if she was from the State. When the surveyor replied affirmatively, the resident stated, "I thought so; that's why everything is being peachy, peachy."

e. A family member stated there were usually not so many staff around; the number of staff was increased because of the survey.

f. A family member stated their loved one was not toileted as planned and was frequently wet.

g. A family member stated the facility was frequently short staffed with three CNAs and one LPN for 39 residents. The family member stated residents' faces are not washed, they are not assessed for pain, and this was the worst "it's [staffing] ever been."

h. One family member and one CNA stated there was seldom this large number of staff available to assist with care and meals.

i. On 8/1/06 at 3:40 PM, a staff member stated this is the worst s/he "has seen the building."

j. One family member states s/he had been told by a licensed nurse that all they had time to do was poke pills down the residents and run. On 8/2/06 at 11:30 AM, a staff member also stated sometimes it seemed like all s/he got done was passing medications.

k. A facility staff member stated restorative aides sometimes get pulled to work the floor, usually on the weekends.

l. A staff member stated anonymously to the state agency that staff were instructed not to talk with the surveyors or say anything negative. The staff member also stated the facility was short staffed and out of some supplies.

m. A family member expressed a concern with "not enough staff."

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 08/03/2006

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 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of product information, and review of facility policy and procedure, the facility failed to ensure proper handwashing techniques were followed, and that ice tea was discarded timely. In addition, the facility failed to ensure kitchen equipment was in good condition, and free from soil build-up. The findings were: 1. Observation of the kitchen on 8/1/06 from 3:43 PM to 4:50 PM revealed two occasions when dietary staff entered the kitchen and used hand sanitizer in place of washing their hands. The sanitizer was a large pump bottle located on the wall by the entrance to the kitchen. Observation on 8/1/06 at 4:25 PM revealed the dishwasher loaded dirty dishes into the dish machine, then put away clean dishes without washing her hands. Instead of washing her hands, the dishwasher used a pump bottle of hand sanitizer that was located on the wall next to the dish room. Interview with the dietary manager on 8/1/06 at 4:50 PM confirmed it was common practice for her staff to just use hand sanitizer when they returned to the kitchen from delivering carts to the various areas of the facility. However, she stated staff were expected to wash their	F 371	F371 1. There was no individual resident identified in this deficiency therefore no individual plan of correction can be addressed. 2. All residents have the potential to be affected by this practice. Dietary staff will wash hands appropriately. Iced Tea dispensers will be cleaned and filled on a daily basis. The inside of ovens, hood vents, ceiling vent, and pan wash device will be cleaned. The three white cutting boards will be thrown away and new ones acquired. 3. Dietary staff will be inserviced on handwashing. A documentation tool will be created and monitored by Dietary Manager weekly for cleaning of equipment. All equipment will be monitored on a monthly basis by dietary manager to address condition and/or need for replacement for compliance. 4. Results of inservicing and monitoring will be brought to the monthly Performance Improvement Committee meeting for review, comments, and recommendations. 5. Compliance Date: 09/15/06	

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 08/03/2006

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 371	Continued From page 36 hands when going from the dirty to clean side of the dish room. Review of the facility policy and procedure for hand washing dated 4/28/06 showed "...using hand sanitizer is not a replacement for washing ones hands with soap and running water." According to Food Code 2005, U.S. Public Health Service, 2-301.14: "Food employees shall clean their hands and exposed portions of their arms ... (E) After handling soiled equipment or utensils;... (H) Before donning gloves for working with food; and (I) After engaging in other activities that contaminate the hands." According to Food Code 2005, U.S. Public Health Service 2-301.16: "(A) A hand antiseptic used as a topical application, a hand antiseptic solution used as a hand dip, or a hand antiseptic soap shall: (1) Comply with one of the following ...(3) Be applied only to hands that are cleaned as specified under 2-301.12." 2. Observations on 8/1/06, 8/2/06, and 8/3/06 revealed ice tea dispensers were located in the second and third floor dining areas. The dispensers were labeled with expiration dates of 8/3/06, and 8/4/06 respectively. Both ice tea dispensers were approximately half full, and stored at room temperature. Interview with the dietary manager on 8/1/06 at 4:50 PM revealed the ice tea was a concentrated brewed tea product that stayed good for several days; however, review of the product label and case information revealed there was no mention of how long it could be kept once prepared. Review of additional product information provided by the manufacturer on 8/7/06 showed, "Once the tea concentrate has been properly prepared...the estimated refrigerated shelf life is 2 -3 days...we define refrigerated temperature as	F 371		

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 08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3126 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 ACT ON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 37	F 371		

38-40 degrees F." Further interview with the dietary manager on 8/8/06 at 11:15 AM revealed she was unaware the product needed to be refrigerated. She also confirmed the usual routine was for staff to fill the ice tea dispensers and once they reached the expiration date (3-4 days later), the tea was discarded and the dispensers were cleaned, sanitized and re-filled.

According to Food Code 2005, U.S. Public Health Service 4-602.11: "(E) surfaces of utensils and equipment contacting food that is not potentially hazardous... shall be cleaned: (2) At least every 24 hours for iced tea dispensers"

3. Observation of the kitchen on 7/31/06 at 3:30 PM and again on 8/1/06 at 3:43 PM showed the inside of two ovens, the hood vents over the range/oven area and a ceiling vent next to a clean rack of dishes were soiled with excessive build-up of grease and dust. In addition, a pan wash device attached to the inside of the three compartment sink was soiled with excessive amounts of dried-on food particles. Interview with the dietary manager on 8/1/06 at 4:50 PM revealed the ovens and hoods should be cleaned weekly; however, she did not keep any documentation on when these items were last cleaned.

According to Food Code 2005, U.S. Public Health Service, 4-60.11: "...(B) The food-contact surfaces of cooking equipment and pans shall be free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."

4. Observation of the kitchen on 8/1/06 at 3:43 PM revealed three white cutting boards stored on

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 08/03/2006

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 371	Continued From page 38 a rack. The cutting boards had brown burn marks, melted areas, and deep scoring on both sides. At 4:20 PM on 8/1/06 dietary aide #1 took one of these white cutting boards from the rack, and proceeded to use it to prepare and cut sandwiches. Interview with the dietary manager on 8/1/06 at 4:50 PM confirmed the cutting boards were in bad condition and should be thrown away. According to Food Code 2005, U.S. Public Health Service, 4-501.12: "Surfaces such as cutting...boards that are subject to scratching and scoring shall be resurfaced if they can no longer be cleaned or sanitized, or discarded..."	F 371	F426 1. There was no individual resident identified in this deficiency therefore no individual plan of correction can be addressed. 2. All residents have the potential to be affected by this practice. All expired meds will be removed from med rooms and med carts. The pharmacy consultant will check medication storage facilities and the medication carts during each visit. 3. Pharmacy Consultant will check medication storage facilities and the medication carts monthly for expired medications. Unit managers will monitor med rooms and med carts weekly for expired meds. Nursing staff will be inserviced regarding policy and procedure for expired meds. Director of Nursing will audit med rooms and med carts monthly for three months then quarterly for compliance. 4. Results of inservicing and monitoring will be brought to the monthly Performance Improvement Committee meeting for review, comments, and recommendations. 5. Compliance Date: 09/15/06	
F 426	483.60(a) PHARMACY SERVICES - PROCEDURES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of policies and procedures, the facility failed to assure expired medications were secured or removed from 2 of 3 medication rooms and 2 of 6 medication carts. The findings were: 1. Observation on 8/3/06 at 11 AM revealed the following expired medications were on the 3rd floor medication cart:			

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 08/03/2006

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 PRECEEDED 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 426	Continued From page 39 a. A stock bottle of Siltussin (cough med), expired 12/05. b. A 160 tablet bottle of Tums for resident #113, which was approximately 1/5 full and expired at the end of 7/06 . Interview with licensed practical nurse (LPN) #15 at the time of the observation confirmed the expiration dates and revealed the Tums were currently used for resident #113. In addition, the LPN verified the cough medicine was available for all residents. 2. On 8/3/06 at 11:15 AM, observation of the 3rd floor medication room showed the following expired medications: a. An unopened 1000 tablet bottle of Aspirin, expired 6/04. b. A 30 milliliter (ml) vial of Heplock flush, expired 4/05 c. Three 100 tablet bottles of Thera-Tab M, expired 4/06 d. Two bottles of Calcium 600, expired 7/06 e. A 30 ml vial of Heplock flush, expired 8/1/06 Interview with LPN #11 during the observation confirmed the expiration dates and verified that all medications were available for resident use. 3. On 8/3/06 at 11:30 AM, observation with registered nurse (RN) #9 revealed 51 Dulcolax suppositories, expired 5/06, were in the medication room on the 1st floor. The suppositories were in a bag mixed in with those which had not expired. In addition, a bottle of Calcium 600 which expired at the end of 7/06 was on the medication cart. Interview with the RN during the observation confirmed the expiration dates and verified the medications were available	F 426		

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 08/03/2006

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 PRECEEDED 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 426	Continued From page 40 for resident use. 4. Interview with the director of nursing services (DNS) on 8/3/06 at 2 PM revealed both pharmacy and nursing were to check for outdated medications. The DNS stated pharmacy was to check the carts and medication rooms monthly and nursing was to check on an ongoing basis. According to the facility's 7/02 policy and procedure, "Consultant Pharmacist Services Provider - Requirements," the consultant pharmacist provides pharmaceutical services which include..."Checking the medication storage facilities and the medication carts....and removal of expired medications."	F 426	F431 1. **Resident #22's medications will be labeled appropriately.** 2. **All residents have the potential to be affected by this practice. All resident medications will be labeled per guidelines.** 3. **Unit managers will monitor med rooms and med carts weekly for compliance. Nursing staff will be inserviced on appropriate medication labeling.** 4. **Results of monitoring and inserviews will be brought to the monthly Performance Improvement Committee meeting for review, comments, and recommendations.** 5. **Compliance Date: 09/15/06**	
F431 SS=D	483.60(d) LABELING OF DRUGS AND BIOLOGICALS Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to assure medications were labeled as required for 1 (#22) of 1 non-sample residents on an experimental drug regimen. The findings were: On 8/3/06 at 11:15 AM, observation of the 1st floor medication room and cart revealed multiple	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535613	A. BUILDING _____ B. WING _____	C 08/03/2006

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 431	Continued From page 41	F 431		

containers of medications which were unlabeled. Interview with registered nurse (RN) #9 verified the labels were lacking. The RN stated the medications were for resident #22 who was on an experimental drug regimen for Parkinson's disease. Each container had the manufacturer's name for the product, and included AO, Ambrotose, Phyt-Aloe, Cardiobalance, Argalse Powder, Catalyst Plus, Sport, and Memorin. The RN further stated she had no idea what the medications were or what they did. Each lacked a label with the resident's name; dosage, frequency, and route of administration; pharmacy name, address, and phone number; prescription number; practitioner's name; date dispensed; initials of dispensing pharmacist; and any cautionary instructions.

According to the "State of Wyoming Pharmacy Act, Rules & Regulations, Chapter 2 Section 11 Labeling Prescription Drug containers.

(c) All unit dose or unit of issue packaging shall be labeled as follows:

(i) Brand name and/or generic name of prescription drug;

(ii) Strength;

(iii) Manufacturers lot number; and

(iv) Manufacturers expiration date...

(v) All unit of issue packaging dispensed shall include the following information on the label in addition to that required by Chapter 2, Section 11 (c) (i) through (iv) of the Board's rules:

(A) Name, address, and phone number of pharmacy;

(B) Prescription number;

(C) Name of the patient;

(D) Name of practitioner;

(E) Directions for use;

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 08/03/2006

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 431	Continued From page 42 (F) Date dispensed; (G) Initials of dispensing pharmacist; and (H) Accessory cautionary labels for patient safety." Review of the facility's July 2002 policy and procedure, "Consultant Pharmacist Services Provider - Requirements" showed the consultant pharmacist agreed "to render the required service in accordance with local, state, and federal laws, regulations, and guidelines...and professional standards of practice."	F 431	**F441** 1. **Resident #'s 35 and 42 will have their labs followed up on and appropriate treatment acquired.** 2. **All residents have the potential to be affected by this practice. Staff will follow infection control policies and procedures. Lab policies and procedures will be followed for all residents. Cleaning of equipment will be done appropriately and timely.** 3. **Appropriate staff will be inserviced on cleaning procedures for equipment. New lab tracking procedure will be implemented and inserviced to appropriate staff. All diagnostic reports will be followed up on within 24 hours of receipt. All diagnostic reports with critical values will be followed up on within one hour of receipt. Staff will be inserviced on handwashing policy and procedures. Unit managers will randomly audit lab tracking system weekly for compliance.** 4. **Results of inservicing and audits will be brought to the monthly Performance Improvement Committee meeting for review, comments, and recommendations.** 5. **Compliance Date: 09/15/06**	
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedures, medical record review, and staff interview, the facility failed to systematically monitor staff compliance with established infection control policies. Further, the facility failed to maintain an environment for residents that minimized the potential spread of infection during 1 of 2 observed meals. In addition, the facility	F 441		

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 08/03/2006

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 441	Continued From page 43	F 441		

failed to follow-up on requests for microbiology culture reports for 2 (#35 and #42) of 21 sample residents in a manner that promoted timely and effective antimicrobial treatment. The findings were:

1. Observation on 7/31/06 from 5:32 PM to 6:07 PM revealed certified nurse aide (CNA) #21 handled potentially contaminated items, soiled linens, residents' bare skin, and rubbed his face while preparing cups and glassware for resident use, serving meal trays, and assisting resident #43 to eat. At no time during the 35 minute observation was CNA #21 observed to exercise appropriate hand hygiene procedures. During the same meal observation, CNA #12 used her finger to apply lip gloss and, without washing her hands, continued to serve resident food and assist one resident with opening a milk carton. Review of the facility handwashing protocol revealed staff were to wash hands "...before and after eating or handling food..." and "...between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents; and after exposure to bare parts of the body...".

Interview with the infection control nurse on 8/3/06 at 9:20 AM revealed monitoring staff for compliance with hand hygiene policies was a random process and was not otherwise conducted in a systematic or persistent fashion. She further stated that staff were expected to observe hand hygiene policies, particularly when assisting residents with activities such as eating. Interview with the laundry manager on 8/2/06 at 9:45 AM revealed laundry staff attended a recent in-service training on hand hygiene, but he did not routinely monitor his staff for compliance with infection control policies.

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 08/03/2006

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 441	Continued From page 44	F 441		

2. Observation on 8/2/06 at 10:15 AM revealed 3 nebulizers (medical devices used to deliver medications through the respiratory tract) on the counter in the soiled utility room on the 2nd floor. One of the nebulizers was inside a clear plastic bag and included a note that the unit needed to be cleaned. The other 2 nebulizers were uncovered. Interview with the unit manager licensed practical nurse (LPN) #23 on 8/2/06 at 10:20 AM indicated the nebulizers should have been disinfected by the night nursing staff, bagged, and taken to central supply for storage. This interview ultimately revealed unit staff did not know how long the nebulizers had been in the soiled utility room, when they would actually be cleaned, and who was responsible for transporting the disinfected equipment to central supply. Interview with the infection control nurse on 8/2/06 at 10:40 AM revealed a policy addressing cleaning and disinfecting of respiratory equipment was available from an on-line source. The infection control nurse further revealed the nebulizers were to be disinfected by nursing personnel after use, put into clean plastic bags, and taken by unit staff to the central supply room.

3. The following concerns with timely and effective antimicrobial treatment were identified:

a. According to a nursing note on 7/20/06 at 1:40 PM resident #35 had "foul smelling urine." Review of a telephone order dated 7/22/06 at 3 PM revealed an order "May wait until Monday AM to collect U/A (urinary analysis). Further review of the medical record revealed the results of the U/A were lacking. Interview with LPN #17 on 8/2/06 at 11:10 AM revealed she was unaware of the

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 08/03/2006

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 441	Continued From page 45	F 441		

results of the UA. She called the offsite reference laboratory to request a report of the results. Review of the laboratory report for the UA showed it was collected on 7/26/06 and a culture showed Proteus mirabilis (a bacterium) was grown from the urine sample. After contacting the physician's office on 8/2/06, the LPN further revealed the physician had faxed an order on 7/27/06 to start an antibiotic for the positive UTI (urinary tract infection). However, the faxed order was not received. The LPN stated a fax machine was not working properly. A verbal order was received on 8/2/06, and the resident was started on an antibiotic to treat the positive UTI, 7 days after the antibiotic was first ordered by the physician.

b. Review of the medical record for resident #42 revealed a urine specimen had been submitted to the laboratory for analysis consistent with a physician's order dated 7/24/06. An initial analysis was completed by the laboratory and reported to the facility on 7/25/06; these results indicated the need for culture. A preliminary report provided to the facility on 7/25/06 indicated 2 different types of bacteria were present in the urine; further analysis was required to identify the microorganisms and provide a pattern of antibiotic susceptibility. The resident's medical record did not contain a final laboratory report. Interview with LPN #23 on 8/2/06 at 6:30 PM revealed a final report had not been received; subsequent telephone follow-up with the laboratory yielded a fax copy for the resident's record. Review of the faxed laboratory report showed the microbiology report was completed on 7/28/06. Telephone interview with the laboratory manager at the facility's reference laboratory revealed laboratory fax logs showed the final report was successfully transmitted to the

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 08/03/2006

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 PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 46 facility on 7/28/06 at 8:07 AM. Interview with the infection control nurse on 8/3/06 at 9:20 AM revealed an expectation that unit staff would follow up each laboratory request for culture and ensure results were posted in residents' records.	F 441	**F444** 1. **No individual resident was identified with this deficiency therefore no individual plan of correction can be addressed.** 2. **All residents have the potential to be affected by this practice. Staff will follow infection control policies and procedures.** 3. **Staff will be inserviced on handwashing and infection control policies and procedures. Unit Managers will monitor meal service daily or 5 x week for compliance with infection control policies and procedures.** 4. **Results of inservicing and monitoring will be brought to the monthly Performance Improvement Committee meeting for review, comments, and recommendations.** 5. **Compliance Date: 09/15/06**	
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, review of infection control policies and procedures, and staff interview, the facility failed to maintain appropriate hand hygiene standards to minimize the spread of potentially infectious agents during 1 of 2 meal observations. The findings were: Certified nurse aide (CNA) #21 was observed exiting a resident's room on 7/31/06 at 5:27 PM carrying a clear plastic bag containing soiled linens. He put the bag in the soiled linen room adjacent to the 2nd floor main dining room, and without washing his hands, began assisting with food service to residents in the 2nd floor main dining room. For a period of 35 minutes, from 5:32 PM to 6:07 PM, CNA #21 handled clean cups and glasses, took food trays to residents seated in the dining room, delivered food trays to residents eating in their rooms, opened a	F 444		

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 08/03/2006

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 444	Continued From page 47	F 444		

resident's milk carton, and assisted resident #43 to eat. At no time did the CNA wash his hands or use a hand sanitizing solution. The CNA briefly left the dining room to look for a banana in the kitchen, then returned and resumed feeding assistance to resident #43. CNA #21 did not wash or sanitize his hands after he reentered the dining area, touched common use items (such as the door knob), or scratched his face. During this same observation, CNA #12 applied lip gloss with her finger. The CNA served resident food and assisted opening a milk carton without washing or sanitizing her hands.

Interview with the infection control nurse on 8/3/06 at 9:20 AM revealed the facility had in place a handwashing policy (Kindred Policy PRO 56009, Handwashing, dated 04/28/06 R) that required staff to wash or sanitize their hands to minimize cross-contamination between residents and from the environment to residents. Further, the handwashing policy required staff to wash/disinfect their hands after touching bare skin and between resident contacts. The infection control nurse further stated that facility staff recently attended a mandatory training session on bloodborne pathogens, to include hand hygiene polices and practices. It was the expressed expectation of the infection control nurse that all staff adhere to the established policy on hand washing.

-23

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 08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 445 SS=E	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of infection control policies and procedures, and staff interview, the facility failed to handle and store soiled linens in a manner that would prevent the potential spread of infection. The findings were: 1. The 2nd floor soiled linen room was observed on 7/31/06 at 6:30 PM. It contained 3 smaller carts on wheeled dollies and a single larger laundry cart for soiled linens. A sign on the inside of the door stated clothing protectors were to be bagged and placed on top of the laundry cart after meals. A combination of bagged and unbagged soiled linens was observed; some on top of the soiled linen cart, others items were lying on the floor. Two bags containing soiled linens were not fully closed and portions of their contents spilled out onto the cart and the floor. At least one clothing protector was observed unbagged and lying on the floor. An interview with the laundry manager on 8/2/06 at 10:15 AM revealed an expectation that all soiled linens would be contained in biodegradable plastic bags and placed on top of the soiled linen cart. Interview with the infection control nurse on 8/3/06 at 9:40 AM reiterated an expectation that soiled linens be contained in clear biodegradable bags and placed in the soiled linen room. 2. Observation on 8/2/06 at 5:50 PM revealed resident #45 carried his/her clothing protector into	F 445	P445 1. Resident #45 will not be allowed to place own clothing into soiled utility rooms. 2. All residents have the potential to be affected by this practice. Soiled linens will be handled and stored in a manner to prevent the spread of infection. Soiled utility room floors will be stripped and waxed and placed on a routine cleaning schedule. 3. Housekeeping/laundry staff will be inserviced on cross contamination. Nursing staff will be inserviced on proper linen handling. Unit Managers will monitor soiled utility and linen rooms daily 5 x week for compliance. 4. Results of inservicing and monitoring will be brought to the monthly Performance Improvement Committee meeting for review, comments, and recommendations. 5. Compliance Date: 09/15/06	

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	535013	A. BUILDING _____ B. WING _____	C 08/03/2006

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F 445	Continued From page 49	F 445		

the soiled linen room. The resident was assisted by CNA #19 to open the door (required key code entry), allowed to enter the soiled linen room, and place the clothing protector on top of the laundry cart. In this process, resident #45 fully entered the soiled linen room, placed his/her right hand on one of the smaller soiled laundry carts, and then returned to his/her table to finish eating. Interview with CNA #19 revealed resident #45 had spilt "...something..." on his clothing protector and insisted on putting the wet item in the soiled cart without assistance. When specifically asked about concerns related to a resident entering the soiled linen room, CNA #19 suggested this practice was uncommon and did not seem to pose a significant problem. Interview with the infection control nurse on 8/3/06 at 9:40 AM offered a different opinion, stating such practice was inconsistent with the facility's infection control program.

3. Observations on 3 days of survey revealed the 2nd and 3rd floor soiled linen and soiled utility rooms were dirty with unknown debris and spots of dried material. Repeat observations revealed staff entered the soiled linen and soiled utility rooms and returned to clean area of the facility without regard for the transfer of potentially infectious or contaminated materials from the dirty floors. Interview with the infection control nurse confirmed the contents of these rooms would be soiled, contaminated, or of a nature that warranted relative isolation from residents and staff. It was further noted in the interview that housekeeping staff had recently been made aware of the need to clean/disinfect the soiled linen and soiled utility room floors.

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F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, interview with the manager of the reference laboratory, and staff interview, the facility failed to ensure laboratory services were completed in a timely manner for 3 (#35, #40, 42) of 21 sample residents. In addition, the facility failed to ensure the quality and potency of laboratory supplies used in the diagnosis and assessment of residents' conditions. The findings were: 1. Review of medical records revealed laboratory requests were not followed by nursing personnel to ensure timely completion of physician-ordered tests; for example: a. Medical record review showed according to a nursing note on 7/20/06 at 1:40 PM resident #35 had "foul smelling urine." Review of a telephone order dated 7/22/06 at 3 PM revealed an order "May wait until Monday AM to collect U/A (urinary analysis)." Further review of the medical record revealed the results of the urinalysis (UA) were lacking. Interview with licensed practical nurse (LPN) #17 on 8/2/06 at 11:10 AM revealed she was unaware of the results of the UA. She called the offsite reference laboratory to request a report of the results. Review of the laboratory report for the UA showed it was collected on 7/26/06 and a culture showed Proteus mirabilis (a bacterium) was grown from the urine sample. After contacting the physician's office on 8/2/06,	F 502	F502 1. Residents #'s 35, 40, and 42 will have their labs completed. 2. All residents have the potential to be affected by this practice. New lab tracking system will be implemented. 3. Staff will be inserviced on new lab tracking system. All diagnostic reports will be followed up on within 24 hours of receipt. All diagnostic reports with critical values will be followed up on within one hour of receipt. All reagents will be checked by Pharmacy Consultant monthly for expiration. Unit Managers will monitor lab tracking system weekly for compliance. Unit managers will monitor med rooms and med carts weekly for expired meds and/or reagents. 4. Results of inservicing and monitoring will be brought to the monthly Performance Improvement Committee meeting for review, comments, and recommendations. 5. Compliance Date: 09/15/06	

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F 502	Continued From page 51	F 502		

the LPN further revealed the physician had faxed an order on 7/27/06 to start an antibiotic for the positive UTI (urinary tract infection). However, the faxed order was not received. The LPN stated a facsimile machine was not working properly. A verbal order was received on 8/2/06, and the resident was started on an antibiotic to treat the positive UTI, 7 days after the antibiotic was first ordered by the physician.

b. Review of the medical record revealed a physician's telephone order for resident #40 to have a Hgb A1C test (a laboratory test to estimate blood sugar control of resident with diabetes over an extended time). The order was dated and timed 6/27/06 at 10:20 AM; however, further review revealed the results of the lab were not present in the medical record. Interview with LPN #23 on 8/2/06 at 11:10 AM confirmed the facility had not received the results and reiterated problems with a facsimile machine. She further stated she called the reference laboratory on 8/1/06 to get the results of the test and then transmitted the results to the requesting physician. Review of the laboratory report revealed the blood sample was collected on 7/28/06, 31 days after it was ordered.

c. Review of the recapitulation of physician's orders for July 2006 showed resident #35 was to have a lipid panel done every 3 months (Jan-April-July-October). Further review of the medical record revealed no evidence the July lipid panel was completed. The April lipid panel was posted in the record and had a collected date of 4/4/06. Interview with LPN #23 on 8/2/06 at 11:10 AM confirmed the lipid panel was not done for July. Review of the resident progress note dated 8/2/06 at 9 AM revealed the physician's office was called and orders were obtained to "...draw July's

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F 502	Continued From page 52 lipid panel today...". d. Review of the medical record for resident #42 revealed a urine specimen had been submitted to the laboratory for analysis consistent with a physician's order dated 7/24/06. An initial analysis was completed by the laboratory and reported to the facility on 7/25/06; these results indicated the need for culture. A preliminary report provided to the facility on 7/25/06 indicated 2 different types of bacteria were present in the urine; further analysis was required to identify the microorganisms and provide a pattern of antibiotic susceptibility. The resident's medical record did not contain a final laboratory report. Interview with LPN #23 on 8/2/06 at 6:30 PM revealed a final report had not been received; subsequent telephone follow-up with the laboratory yielded a faxed copy for the resident's record. Review of the faxed laboratory report showed the microbiology report was completed on 7/28/06. Telephone interview with the laboratory manager at the facility's reference laboratory revealed laboratory fax logs showed the final report was successfully transmitted to the facility on 7/28/06 at 8:07 AM. 2. Observation on 8/3/06 at 4:50 PM of the medicine rooms on the 2nd and 3rd floors revealed expired laboratory tests and reagents were stocked and available for use by nursing personnel. Expired tests and reagents included the following: a. Located in the 2nd floor medicine room: Hemacheck slide test and reagents (Bayer Diagnostics), lot number 0007092, reagent expiration date 3/2006 (1 box) and lot number 0005022, reagent expiration date 2/2006 (2 boxes). Interview with LPN #23 at the time of the	F 502		

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

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F 502	Continued From page 53 observation verified the expiration dates. At 5 PM on the same day, the LPN stated facility staff would perform the tests if ordered. b. Located in the 3rd floor medicine room: BBL Port-A-Cul specimen and transport tubes, lot number 5194748, expiration date 7/7/06 (9 tubes). Copan Venturi Transystem (Aerobe), lot number 443788, expiration date 9/2005 (4 units). BBL Culture Swab, lot number 454333, expiration date 9/2005 (5 units). Interview with LPN #11 at the time of the observation confirmed the expiration dates. Interview with RN #18 on 8/3/06 at 5:05 PM revealed the facility did obtain cultures.	F 502	**F513** 1. **Resident # 7's results of Modified Barium Swallow test will be placed in chart.** 2. **All residents have the potential to be affected by this practice. All residents diagnostic reports will be placed in charts timely.** 3. **A new diagnostic report tracking system will be implemented and inserviced to nursing staff. Unit Managers will monitor weekly for compliance.** 4. **Results of inservicing and monitoring will be brought to the monthly Performance Improvement Committee meeting for review, comments, and recommendations.** 5. **Compliance Date: 09/15/06**	
F 513 SS=D	483.75(k)(2)(iv) RADIOLOGY AND OTHER DIAGNOSTIC SERVICES The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure radiology reports were filed in the medical record for 1 (#7) of 1 sample resident with physician orders for barium swallow evaluations. The findings were: Medical record review for resident #7 revealed a physician's order dated 6/8/06 for a modified barium swallow, and an additional physician's order dated 7/6/06 for a "modified barium swallow without teeth." Further review showed the results of the swallowing evaluations were not filed in the			

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F 513	Continued From page 54	F 513		

medical record. Interview with the Minimum Data Set assessment coordinator on 8/3/06 at 8 AM confirmed the reports were not in the record.