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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	C 03/23/2006

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 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a significant change assessment was completed for two (#45, #102) of three sample residents who experienced	F 272	**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."** F272 1. **Resident's #45 and #102 will have Significant change of condition MDS's completed.** 2. **All residents have the potential to be affected by this practice.** 3. **An audit of all in house MDS's will be completed to identify any other missed significant change of condition. Education will be provided to Utilization Coordinator and MDS Coordinator on what triggers a significant change.** MDS coordinators will monitor. 4. **Results of the audit will be brought to the Performance Improvement Committee monthly for review, recommendations and comments.** 5. **Compliance date: 04/27/06**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lyucia Patterson, NHA — TITLE: Executive Director — (X6) DATE: 4/17/06

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.

APR 18 2006 POC was reviewed & A'les made on 4/24/06 @ 1410 by Toni Wynn, RN, DNS & Karen Womack, RN, Health Surveyor.

WYOMING DEPT. OF HEALTH
HEALTH FACILITIES

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F 272	Continued From page 1 a decline in condition. The findings were: 1. Medical record review for resident #45 revealed the resident had declined in the areas of locomotion, and bowel and bladder incontinence as follows: a. Review of the quarterly Minimum Data Set (MDS) assessment dated 9/26/05 revealed the resident was assessed as requiring limited assistance for locomotion on and off the unit. Yet, review of the quarterly assessment dated 12/21/05 and the most recent quarterly assessment dated 3/8/06, the resident was assessed as having a decline and now required total dependence for locomotion on and off the unit. b. Review of the quarterly MDS assessment dated 9/26/05 revealed the resident was assessed as usually continent of bowel with incontinent episodes less than weekly and usually continent of bladder with incontinent episodes once a week. Yet, review of 12/21/05 quarterly MDS assessment revealed the resident declined to frequently incontinent of bowel and bladder. c. Further medical record review failed to reveal a significant change assessment had been completed. d. Interview with both MDS coordinators on 3/23/06 at 3:38 PM revealed neither realized the declines required a significant change assessment. 2. Medical record review for resident #102 revealed the resident had declined in the areas of ability to transfer, dress, maintain his/her hygiene, and in the area of bowel and bladder incontinence as follows: a. Review of the resident's annual MDS	F 272		

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F 272	Continued From page 2 assessment, which was a total resident assessment instrument (RAI) assessment, dated 9/13/05 revealed the resident was independent with transferring, dressing, and required supervision for hygiene. Comparison with a quarterly MDS assessment dated 12/21/05 revealed the resident had a decline and required extensive assistance with transfer, dressing, and hygiene. b. Review of the resident's annual MDS assessment revealed the resident was coded as continent of bowel and usually continent of bladder (incontinent episodes once a week or less). Yet, the resident's quarter MDS assessments dated 12/21/05 and 2/28/06 documented the resident declined to occasionally incontinent of bowel on 12/21/05 and further declined to frequently incontinent of bowel by the 2/28/06 assessment. Review of bladder continence revealed the resident was assessed as frequently incontinent of bladder on both the 12/21/05 and 2/28/06 MDS assessments. c. A significant change RAI assesment was not found in the medical record for the declines. d. Interview with both MDS coordinators on 3/23/06 at 3:38 PM revealed neither realized the declines required a significant change assessment. According to the "Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0," (a reference manual for completing MDS assessments) a significant change assessment is appropriate if there is a consistent pattern of changes, with two or more areas of decline. The manual instructs that this includes changes with a particular domain (pg 2-8).	F 272		

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F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and resident interview, and review of daily certified nurse aide (CNA) assignment sheets, the facility failed to ensure one (#57) of eight dependent sample residents received their scheduled bath. The findings were: Interview with resident #57 on 3/21/06 at 5:39 PM revealed the resident required staff assistance with care such as transfer and bathing. The resident stated he/she was "upset" that his/her last shower was Wednesday (3/15/06) and he/she did not get bathed on Sunday (3/19/06). The resident stated his/her scheduled shower days were Wednesdays and Sundays. The resident stated, "I'm upset about it!" And, pointed out that his/her hair was "greasy". Observation at that time revealed the resident had unwashed hair. Review of the resident's medical record revealed an activity of daily living (ADL) flow record for March 2006. No care was documented for Sunday, 3/19/06. Interview with the unit manager on 3/23/06 at 3:13 PM revealed CNA staff should document on the ADL flow sheet, but baths were also documented on the daily communication assignment sheets. Review with the unit manager of these assignment sheets on 3/23/06 at 4:28 PM revealed no documentation of the resident's bath. Medical record review	F 312	F312 1. **Resident #57 will receive a minimum of two baths per week per schedule.** 2. **All residents have the potential to be affected by this practice.** 3. **Bath audits will be completed weekly by Unit Managers to ensure all residents are receiving their scheduled baths. All nursing staff will be inserviced on bath documentation.** 4. **Results of audits and inservice will be brought to the monthly Performance Improvement Committee meeting for review, comments, and recommendations.** 5. **Compliance Date: 04/27/06**	

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F 312	Continued From page 4 revealed a March 2006 medication administration record which documented the resident received chlorophyl tablets twice a day for body odor. Review of the resident's most recent assessment, a quarterly assessment dated 12/28/05, revealed the resident was assessed with short term and long term memory as intact, having modified independence (some difficulty in new situations only) for cognition, total dependence for transfer, and required total dependence for hygiene and physical help in part of the bathing activity. Interview with the director of nursing on 3/23/06 at 3:38 PM revealed the facility routine was to bathe residents twice a week.	F 312	F514 1. Residents #45, #57, #72, #76, #58 and #62 will have their baths documented appropriately. 2. All residents have the potential to be affected by this practice. 3. All nursing staff will be inserviced on bath documentation policy and procedure. Unit Managers will audit weekly to ensure documentation is being completed appropriately. 4. Results of inservice and audits will be brought to monthly Performance Improvement Committee meeting for review, comments, and recommendations. 5. Compliance Date: 04/27/06	
F 514 SS=B	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on facility documentation, medical record review, resident, family, and staff interview, the facility failed to ensure residents' care was accurately documented for four (#45, #57, #72,	F 514		

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and #76) sample and two (#58, #62) non-sample residents on the second floor. During the survey a total of 54 residents resided on the second floor. The findings were:

Interview with resident #57 on (Tuesday) 3/21/06 at 5:39 PM revealed the resident was bathed twice a week on Wednesdays and Sundays. The resident stated his/her last shower was Wednesday (3/15/06) and he/she did not get bathed on Sunday (3/19/06). Review of the resident's medical record revealed an activity of daily living (ADL) flow record for March 2006. No care was documented for Sunday, 3/19/06. Interview with the unit manager on 3/23/06 at 3:13 PM revealed certified nurse aids (CNAs) should document on the ADL flow sheet, but baths were also documented on the daily communication assignment sheets. Review of the assignment sheet showed the shower was not signed off as completed. The unit manager identified the ADL sheet as part of the resident's medical record and stated the CNA staff needed to document care given on it.

Interview at 10:13 AM on 3/22/06 with a family member for non-sample resident #62 revealed the resident did not get a bath "last week". The family member stated the resident should get two baths per week. Review of the resident's March ADL sheet showed no documentation of a bath from 3/16/06 to 3/22/06. Interview with the second floor manager on 3/23/06 at 3:58 PM revealed she had CNA assignment sheets for the month of March. Review of these assignment sheets revealed the resident received a bath 3/17/06. Interview with CNA #1 on 3/23/06 at 3:58 PM revealed the

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resident did get his bath late Tuesday (3/21/06) night. Neither bath was documented.

In addition, further review of bathing documentation revealed the following inaccuracies:

a. Bath documentation from 3/1/06 to 3/22/06 for resident #45 revealed baths were documented on 3/1/06, 3/4/06, 3/15/06, 3/19/06, and 3/22/05. Review of assignment sheets with the second floor unit manager revealed the resident received baths which were not documented on 3/5/06, 3/8/06, and 3/12/06.

b. Bath documentation from 3/16/06 to 3/22/06 for non-sample resident #58 revealed the resident received a bath on 3/21/06. Review of assignment sheets with the second floor unit manager revealed the resident received a bath on 3/17/06 which was not documented.

c. Bath documentation from 3/16/06 to 3/22/06 for resident #72 revealed the resident never received a bath during the time period. Review of assignment sheets with the second floor unit manager revealed the resident received a bath on 3/19/06.

d. Bath documentation from 3/1/06 to 3/22/06 for resident #76 revealed baths were documented on 3/3/06 and 3/14/06. Review of assignment sheets with the second floor unit manager revealed the resident refused baths on 3/17/06 and 3/21/06 and the scheduled bath for 3/10/06 was not signed off as being completed.

According to "Nursing Assistant: A Nursing Process Approach," 9th ed., copyright 2004, the purpose of documentation is to communicate care given and the patient's response. Documentation is a true record of patient care,

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F 514	Continued From page 7 and is the first line of defense in proving accountability for excellent care.	F 514		