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 04/13/2006

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 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of an education outline, and review of Material Safety Data Sheets (MSDS), the facility failed to assure chemicals and potentially hazardous materials were properly stored throughout the facility. The findings were: 1. Observation of the first floor shower/bathroom on 4/13/06 at 8:50 AM revealed it was unlocked and not in use. A spray bottle about three-quarters full was hanging on a grab bar. The label showed it was, "U-1 + Germicidal Cleaner." Review of the MSDS for this product revealed it was a disinfectant cleaner and an eye and skin irritant. It also instructed "call a physician" if ingested. There was also a container (approximately one gallon) of Lacrosse Total Body Shampoo sitting on the floor next to the shower. Review of the MSDS sheet for this product revealed it was an eye and skin irritant, and it instructed "seek medical attention if swallowed." Interview with CNA #5 confirmed the shower/bath room should be locked when not in use. 2. Observation of the second floor on 4/13/06 revealed the following concerns: a. The second floor west shower/bathroom was unlocked at 9 AM. A gallon bottle, without a lid and approximately one-third full of Lacrosse Total Body Shampoo, was inside the room. The	F 323	**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." F323 1. No individual resident was identified in this deficiency therefore, no individual plan of correction can be written. 2. All residents have the potential to be affected by this practice. 3. All chemicals will be stored appropriately in locked cabinets per policy and procedure. All doors that meet criteria for safety reasons will be locked appropriately. Executive Director, Director of Nursing, Unit Managers, and department heads will monitor on daily rounds. An inservice will be conducted for all staff regarding chemicals and safety. 4. Results of rounds will be brought to the monthly Performance Improvement Committee meeting for review, comments, and recommendations. 5. Compliance Date: May 19, 2006	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lyncea Patterson, NHA — TITLE: Executive Director — (X6) DATE: 5/8/06

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. POC accepted, message left for Lyncea Patterson on 5/10/06 @ 0950. Janeece Gordon, RN

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	535013	A. BUILDING _____ B. WING _____ 5/12/06	C 04/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3123 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
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bottle was sitting on the waist-high ledge of the shower. Review of the MSDS sheet for this product revealed it was an eye and skin irritant, and it was necessary to "seek medical attention if swallowed." A cabinet equipped with a padlock on both the top and bottom doors was also inside the room; however, the locks were undone and the cabinet doors were partially opened. On the upper shelf of the cabinet was a spray bottle approximately half full of a solution labeled "U-1 + Germicidal Cleaner." Review of the MSDS for this product revealed it was a disinfectant cleaner and an eye and skin irritant. It also instructed "call a physician" if ingested. On the bottom shelf of the cabinet was a one-half gallon container of "Whirl-Sol" (a bath additive) without a lid According to the MSDS sheet for this product, it was "for external use only." Interview with the director of nursing (DON) on 4/13/06 at 10:30 AM confirmed it was her expectation that all shower/bath doors be locked.

b. At 9:05 AM the clean utility room was unlocked and contained an unlocked cabinet. A spray bottle labeled "Liminate Mal-odor Eliminator" was sitting in the bottom of the cabinet. Review of the MSDS sheet for this chemical showed it was an eye and skin irritant and harmful if ingested.

c. At 9:07 AM the padlock on a cabinet in the restorative area was unlocked; no staff were in the area. Inside the cabinet were two bottles of "LaCrosse Antiseptic Gel Handrinse." According to the label on the bottles, this product was "For external use only, if taken internally serious gastric disturbance will result." Review of the MSDS sheet for the product showed "seek medical attention" if taken internally. In addition, there was a spray bottle in the cabinet labeled

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	535013	A. BUILDING _____ B. WING _____ 5/12/06	C 04/13/2006

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 323	Continued From page 2 "Bul-It soap scum remover." The label included a caution that showed, "May cause eye or skin irritation. Harmful if swallowed. Keep out of reach of children." Interview with the DON and restorative CNA #9 on 4/13/06 at 10:25 AM confirmed the cabinet should be locked at all times when staff were not using the items. 3. The following concerns with possible accident hazards on the third floor and in the secure care unit (SCU) were identified on 4/13/06: a. At 8:45 AM observation showed a 5.75 ounce (oz) tube of foot therapy lotion stored in an unlocked drawer in the dining area of the SCU. The label on the lotion instructed: "Keep out of reach of children...Do not use near eye or mouth area." The drawer had a lock which was not engaged. All residents in the SCU had potential access to the lotion. Interview with licensed practical nurse (LPN) #19 revealed the lotion should have been in the locked storage area. The LPN stated she did not know to whom the lotion belonged. b. Observation at 8:52 AM revealed a 67.6 oz bottle of hand sanitizer and a 4 oz squeeze bottle of Isogel (hand sanitizer) sitting on the ledge around the nurses' station of the SCU. Observation at 9:52 AM showed both bottles remained on the ledge. Review of the label on the 67.6 oz bottle of sanitizer showed the solution contained isopropyl alcohol and was "For external use only." According to the MSDS sheet, Isogel causes excessive redness and irritation with eye contact; irritation of the respiratory tract, chest pain, and coughing when inhaled; and dizziness, faintness, decreased awareness and responsiveness, nausea, vomiting, and coma when ingested. Potentially, all residents in the	F 323		

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SCU had access to both hand sanitizers.

c. At 9 AM observation revealed the dirty utility room on the third floor was unlocked and held a large biohazard container with an unsecured lift-up lid.

d. Observation showed the clean utility room on the third floor was unlocked at 9:01 AM. A 4 oz bottle of "Xtra Care skin lotion" and a 4 oz bottle of baby lotion were stored on the top shelf. Both lotions contained alcohol, and the label on the "Xtra Care" lotion instructed "For external use only."

e. Observation at 9:38 AM showed a 67.6 oz bottle of hand sanitizer and a 40 oz bottle of "Germ-X" sitting on the ledge above the third floor nurses' station. The label on the 67.6 oz bottle of sanitizer showed the solution contained isopropyl alcohol and was "For external use only." According to the MSDS sheet, "Germ-X" can cause eye and skin irritation, and ingestion of a toxic dose can cause gastrointestinal irritation, narcosis (death of tissue) and injury to the kidneys and liver. The label instructed "For external use only."

f. Interview with the unit manager, registered nurse (RN) #13, at 9:52 AM revealed the sanitizers were only on the ledges during medication passes. However, no medications were being administered at that time.

g. Interview with the DON on 4/13/06 at 10:26 AM revealed the clean linen room should have been locked and should not have contained lotions. In addition, the DON stated staff were not always at the nurses' station or with the medication carts. The DON confirmed the sanitizers and lotions were accessible to residents.

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F 323	Continued From page 4 4. Review of the "Hazard Communication Education Outline", used to educate staff about chemicals and dated 12/11/04, revealed it provided information on chemicals and referred staff to the MSDS sheets. However, there was no evidence it addressed storage of chemicals in relation to the protection of residents.	F 323		