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

PRINTED: 12/19/2012
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
	535029	A. BUILDING _____ B. WING _____	C 12/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET SUNDANCE, WY 82729

(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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CEO Chief Executive Officer CNA Certified Nurse Aide DON Director of Nursing DPOA Durable Power of Attorney MDS Minimum Data Set SSD Social Services Director Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(6)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph	F 203		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan Van Beek — TITLE: Administrator — (X6) DATE: 12-28-12

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

1/2/13 This POC accepted between Jan Van Beek, CEO and Tony Madden-Surveyor on 1/2/13 with a DAC of 1/19/13.

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F 203	Continued From page 1 (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and review of the facility's policies and procedures, the facility failed to include all the required information in the 30 day notice for discharge for 1 of 1 sample resident (#24) who received such a notice. The findings were: Review of the Notice of Transfer/Discharge for	F 203	**F203** Resident #24 no longer resides at facility. An Admit/Discharge Team (ADT), consisting of the Administrator, DON or designee, MDS nurse, Social Services Designee (SSD) and a physician, has been formed to review all admits and discharges for appropriateness and to assure proper requirements are met. All members will be given a copy of facility policy "Admission, Transfer and Discharge Rights" and all nursing home policies will be kept at the nursing home nurse's station to assure access by all employees. A sample 30-day notice with all the correct information will be included with "Admission, Transfer and Discharge Rights" policy. SSD will monitor all discharges/transfers to assure proper notice has been given. SSD will report to the QAPI Committee quarterly for 1 year or until committee recommends completeness.	01-19-13

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F 203	Continued From page 2 resident #24 showed the resident was given a 30 day notice because the facility could not meet his/her needs. Further review showed the notice did not include the resident's right to appeal the transfer/discharge to the State; or the name, address, and phone number of the State long term care Ombudsman. Interview with the administrator on 12/5/12 at 1 PM revealed she was unaware the information was to be included in the 30-day notice letter sent to the resident. Review of the policy and procedure entitled Nursing Home-Admission, Transfer and Discharge Rights, revised 7/28/2008 showed; Contents Of The Notice: The written notice will include the following: d. A statement that the resident has the right to appeal the action to the State. e. The name, address and telephone number for the State long term care Ombudsman.	F 203		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		

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F 225	Continued From page 3 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility investigations, medical record review, staff interview, and review of policy and procedure, the facility failed to ensure 2 of 5 allegations of resident abuse (#1, #24) were reported as required and were thoroughly investigated. The findings were: 1. Review of the 11/27/12 annual MDS assessment showed resident #1 had a BIMS (brief interview for mental status) score of 9/15 (moderately impaired). Review of the facility's investigations of alleged abuse and neglect from July 2012 through November 2012 confirmed an incident that was reported via fax to the state survey agency on 11/20/12 at 8:01 PM which	F 226	F225 1. Resident #1 no longer resides at facility. All complaints and incidents must be reported to the Administrator/Director of Nursing (DON) immediately and the investigation, including any physical exams and/or other agency notification, will be conducted according to facility policy LTC1 – "Abuse: Prevention of Abuse and Abuse Reporting." Policy LTC1 will be revised to include notification of the primary physician. 2. Resident #24 no longer resides at facility. All staff will be educated on Abuse, including the definitions of Abuse, when and who to report to and what your individual responsibilities are.	01-19-13

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F 225	Continued From page 4 concerned an allegation of sexual abuse regarding the resident. The following concerns were noted: a. Review of the incident showed the facility CEO was made aware of the allegation on 11/8/12, but failed to contact the state survey agency until 11/20/12 (12 days after the facility was aware of the allegation). b. Incident review showed the CEO interviewed the activity director/social services designee on 11/8/12 concerning this incident, and reviewed the resident's medical record which included the most recent weekly skin assessment documentation (uncertain of date). However, review of the incident report showed the facility failed to interview anyone else, including the resident. c. The facility failed to contact local law enforcement or adult protective services in accordance with state law. The report showed local law enforcement officer #1 came to the facility on 11/20/12 after being notified of the abuse allegation from a source outside of the facility (12 days after the facility was aware of the allegation). d. The facility failed to complete the investigation at the request of the resident's DPOA. The facility investigation also stated the following, "Officer [officer's name] and I discussed that [resident's name] does have memory problems and is not the best historian and that combined with the possible "shame" factor do not necessarily rule out this happening. We also discussed the complications of investigating this so far after the fact-even 1 week had everything compromised plus the fact that the DPOA [DPOA's gender] doesn't wish us to speak with [the resident]."	F 225	F225 cont- Social Services Designee, Charge nurses, MDS coordinators, DON and the Administrator will review the Abuse reporting and investigations and what their individual responsibilities are. DON/Administrator will review all incident reports for timely reporting and investigating completeness and will report quarterly to the QAPI committee for 1 year or until committee recommends completeness.	

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F 225	Continued From page 6 e. Review of the medical record failed to show evidence that the facility notified the physician of the allegation of sexual abuse. f. During an interview with the CEO on 12/5/12 at 1 PM, she confirmed the facility failed to complete the investigation at the request of the DPOA, who demanded the facility not interview the resident. She further confirmed the facility had failed to notify local law enforcement at any time, or any other outside agency of this allegation until 11/20/12. She also acknowledged the resident did not receive an examination by the charge nurse per facility policy. The CEO further acknowledged the facility failed to notify the physician. 2. Review of the nurse's note dated 8/28/12 at 7:30 AM showed the nurse was told by a tearful resident #24 that a man had come into the bathroom while s/he was in there. Review of the incident log showed there was no investigation of the allegation of possible mental abuse, which by CMS's definition includes humiliation. Interview with RN #1 on 12/5/12 at 12:45 PM revealed she made the notation to show the resident was at times confused, and mentioned the incident to the DON at the time of the incident. Interview with the administrator on 12/5/12 at 1 PM revealed she was aware of the incident. She stated there was a male nurse working at the time of the allegation, and as a result instructed the male nursing staff not to care for the resident. She acknowledged she had failed to thoroughly investigate the allegation. Review of the facility policy and procedure titled, "Abuse, Prevention of Abuse and Abuse Reporting," last revised May 2012, showed, "IV. Identification and Reporting Abuse...2. The	F 225		

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F 225	Continued From page 6 charge nurse on duty will conduct a physical examination of any alleged victim as soon as possible. 3. All alleged violations including mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of resident/patient property will be reported to the Administrator, to the State Health Department and to law officials if warranted. 4. Resident/Patient to Resident/Patient and Visitor to Resident/patient will be reported to state agencies." "V. Investigation of the Abuse Allegation...1. All allegations must be thoroughly investigated by the Administrator/Director of Nursing. This may include but is not limited to interviewing all persons associated with the situation, medical record review and physical and psychological assessment of the alleged victim. 2. Investigations must be documented and all findings including the initial report will be in writing as soon as possible but no later than 24 hours following the alleged incident. The Administrator/Director of Nursing will report the results of the investigation to the State Health Department and to law enforcement officials (if warranted) within 5 working days after the incident."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:	F 226		

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F 226	Continued From page 7 Based on medical record review, staff interview and review of the facility's policies and procedures, the facility failed to effectively educate 2 of 6 staff members (RN #1 and housekeeper #1) interviewed regarding abuse. In addition, the facility failed to follow policies and procedures regarding allegations of abuse which involved 2 sample residents (#1, #24). The findings were: 1. Review of the facility's investigations of alleged abuse and neglect from July 2012 through November 2012 confirmed an incident was reported via fax to the state survey agency on 11/20/12 at 8:01 PM which concerned an allegation of sexual abuse regarding resident #1. Review of the incident showed the only person interviewed was the activity director/social services designee. During an interview with the CEO on 12/5/12 at 1 PM, she acknowledged the facility failed to follow their policy and procedure for abuse investigations by failing to thoroughly investigate the allegation, report the allegation to state agencies and local law enforcement, and have a nurse assess the resident. 2. Review of the nurse's note dated 8/28/12 at 7:30 AM showed the nurse was told by a tearful resident #24 that a man had come into the bathroom. Further review of the medical record showed there was no further documentation of the incident. Review of the incident log showed there was no investigation of the allegation of possible mental abuse, which by CMS's definition includes humiliation. Interview with RN #1 on 12/5/12 at 12:45 PM, concerning the nurse's note she had written, revealed she made the notation to show the resident was at times confused. In	F 226	**F226** All staff, including RN #1 and Housekeeper #1, will be educated on Abuse - recognition, reporting and their responsibilities as well as how to deal with stress and burnout and aggressive residents. Quarterly reviews of this education will be held by Department managers at their staff meetings. All new employees will complete the web-based education on Abuse and Neglect before they have face-to-face contact with residents as well as receiving any training handouts on dealing with stress and burnout, aggressive residents and a copy of the Abuse Reporting policy. Human Resources Director will monitor new employees for completing training and for quarterly reviews by Departments and will report quarterly to the QAPI committee for 1 year or until committee recommends completeness.	01-19-13

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F 226	Continued From page 8 addition, she stated she had told the DON at the time of the incident. However, this was not documented as per facility policy and procedure. Interview with the administrator on 12/5/12 at 1 PM revealed she was aware of the incident. Further, she stated there was a male nurse working at the time of the allegation, and as a result instructed the male nursing staff not to care for the resident. She acknowledged she had failed to thoroughly investigate the allegation or conduct interviews to determine if the man the resident allegedly saw was the male nurse scheduled that day. 3. Interview with housekeeper #1 on 12/4/12 at 8 AM revealed she had computer-based abuse training within the last 2 months but did not recall what she had seen. She defined abuse to include verbal abuse and intentionally "dropping a resident." Further, she wasn't clear what she should report as abuse, nor did she understand allegations of abuse needed to be reported immediately. Review of the policy and procedure for Abuse, Prevention of Abuse and Abuse Reporting revised May 2012 showed, "All allegations must be thoroughly investigated by the Administrator/Director of Nursing. This may include but not limited to interviewing all persons associated with the situation, medical record review and physical and psychological assessment of the alleged victim. Further, "Staff Education,..will include: appropriate interventions to deal with aggression and/or catastrophic reactions of residents/patients, how staff should report their knowledge related to allegations without fear of reprisal, how to recognize signs of	F 226		

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F 226	Continued From page 9 burnout, frustration and stress that may lead to abuse and what constitutes abuse, neglect and misappropriation of resident/patient property." Review of the policy and procedure titled, Abuse: Seven Key Points revised July 11, 2008 showed; "V. Reporting Procedure: 1. Report abuse immediately to the LTC charge nurse. The LTC charge nurse is to notify the ADON or DON immediately. Document time notified."	F 226		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure staff assessed 1 of 1 sample resident (#1) who verbalized suicidal ideations in a timely manner. The findings were: Review of the 11/27/12 annual MDS assessment showed resident #1 had a BIMS (brief interview for mental status) score of 9/15 (moderately impaired). During review of an incident investigation for the resident that involved an allegation of sexual abuse, a CNA chart book note dated 10/21/12 at 10:25 AM was reviewed which stated, "[The resident] then said under [his/her] breath that [s/he] should just commit suicide, so I asked [him/her] to repeat what [s/he]	F 250		

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F 250	Continued From page 10 had just said and [s/he] said again that "[s/he] wants to commit suicide. I then told [him/her] that a lot of people would miss [him/her] and love [him/her] very much and [s/he] shouldn't talk like that. After leaving the room I immediately reported this to the nurse." The following concerns were noted: a. Review of the medical record showed facility staff failed to document this incident in the medical record. b. Review of the facility incidents for July 2012 through November 2012 showed this incident was not investigated. c. During an interview with the CEO and DON on 12/5/12 at 1 PM, they acknowledged the facility failed to assess the resident or address this incident in a timely manner. d. During an interview with the SSD on 12/5/12 at 1:30 PM, she was unaware of the 10/21/12 CNA documentation of suicidal ideations by the resident. However, she became aware on 11/26/12 of a 10/14/12 CNA chart book note that stated, "[Resident's name] kept saying [s/he] was going to die when I was getting [him/her] for bed & I asked [him/her] why. [S/he] claims [s/he] is just going to die." The SSD started investigating this incident on 11/26/12 (43 days after the incident was documented).	F 250	1'250 Resident #1 no longer resides in facility. All staff will be educated on incidents to report, including suicidal ideations, and their individual responsibilities which may include documentation, reporting and investigating. All nursing staff will be educated on Suicide Prevention/interventions and their responsibilities. Director of Nursing (DON)/Administrator will review all incident reports to ensure correct documentation; reporting and interventions have been completed in a timely manner. DON will report to the QAPI committee on a quarterly basis for 1 year or until committee recommends completeness.	01-19-13
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 333		

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	535029	A. BUILDING _____ B. WING _____	C 12/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET SUNDANCE, WY 82729

(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 333	Continued From page 11 interview, the facility failed to ensure a significant medication error for one sample resident (#1) and one non-sample resident (#5) did not occur. The findings were: 1. Review of the nurse's notes dated 8/4/12 at 10:15 AM showed resident #1 received the incorrect medications and the resident was sent to "acute cares at Hospital for observation" at 9:25 AM after the physician was notified. Review of the Consultation Report dated 8/4/12 showed the resident received the following medications in error; Norvasc 5 mg (antihypertensive) losartan/hydrochlorothiazide 50/12.5 mg (antihypertensive) and bisoprolol 12.5 mg (antihypertensive). The resident did not have a history of hypertension (high blood pressure) and was treated with intravenous fluids and calcium gluconate to reverse the effects of the Norvasc. Review of the incident report dated 8/4/12 showed the incident occurred at 8:45 AM. Further, the nurse that had dispensed the wrong medication did not know how it had occurred. At the time there were two nurses passing medications from the same medication cart. The pharmacist who was consulted at the time recommended only one nurse should pass medications during medication pass. 2. Review of the incident report dated 7/8/12 for non-sample resident (#5) showed s/he was given the incorrect medications to include; aspirin 81 mg, Zyprexa 5 mg (schizophrenia, bipolar disorders), Prilosec 20 mg (heartburn) and levothyroxine (hypothyroidism). The time of the incident was 6 AM. Further review showed the physician was notified. Review of the nurse's notes dated 7/8/12 at 10:40 AM showed the	F 333	F333 Nursing Staff will be educated on medication administration and techniques to reduce errors. Nursing staff will also be educated on incident reporting and medication error reporting requirements. The Director of Nursing (DON) will investigate all Medication errors and analyze all reports to look for any patterns that may occur, as well as any high risk behaviors or circumstances that my contribute to these errors. DON will report findings to Medical Staff monthly and to the QAPI committee quarterly for 1 year or until committee recommends completeness.	01-19-13

QMB 12-28-12

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F 333	Continued From page 12 resident became very lethargic and was unable to ambulate well. Nurse's notes dated 7/9/12 at 3:30 AM showed s/he remained lethargic. Further review of the incident report and nurse's notes did not show an investigation was conducted to indicate why the medication error occurred. During an interview with the CEO and DON on 12/5/12 at 1 PM, they confirmed the medication errors for residents #1 and #5.	F 333		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		

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F 520	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on staff interview, review of the 7/26/12 CMS-2567 (Centers for Medicare and Medicaid Statement of Deficiencies) and review of facility documents, the facility failed to ensure the quality assurance and performance improvement (QAPI) program was effective in resolving identified concerns. The findings were: Interview with the CEO and DON on 12/5/12 at 1 PM revealed quality assurance data was collected and analyzed. However, the following issues were identified: a. The facility failed to ensure incidents were completed and analyzed to identify interventions for future abuse prevention. Review of the monthly QAPI data from July 2012 through November 2012 at that time confirmed incidents were not addressed. b. The facility failed to ensure the medication program was adequately monitored to investigate and prevent medication errors. Review of 6 incident reports showed 6 medication errors (2 of them significant) were identified by staff from July 2012 through November 2012. On the incident report documentation, each nurse who committed the error was counseled. However, no analysis for identification and prevention of medication errors was performed. Review of the monthly QAPI data from July 2012 through November 2012 at that time confirmed medication errors were not addressed. c. Review of the CMS-2567 for the last survey, dated 7/26/12, revealed a deficiency was written for F225 related to abuse investigations, and F520 was cited related to an ineffective QAPI	F 520	**F520** All incident reports and investigations, including medication errors and abuse allegations, will be reviewed on an on-going basis to identify patterns (when, where, why, who, etc). Education and/or procedure changes will be implemented based on the analyzed findings. Director of Nursing will report patterns/findings and interventions to QAPI committee on a quarterly basis. All QAPI members will be educated on facility requirements for proper analyzing and reporting of data. QAPI officer (Medical Records Manager) will monitor QAPI meetings and reports for compliance with facility required reporting.	01-19-13

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F 520	Continued From page 14 program. These same issues were identified as concerns during the current survey conducted 12/3/12 through 12/5/12. During an interview on 12/5/12 at 1 PM, both the CEO and DON confirmed the facility's failure to thoroughly investigate some incidents, or analyze medication errors to determine what measures might be implemented to prevent future errors.	F 520		

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