PRINTED: 09/13/2007
FORM APPROVED
OMB NO. 0938-0391

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 _____	R-C 08/29/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure personal privacy during care for one (#7) of 13 sample residents. The findings were: Observation of resident #7 on 8/27/07 at 2:29	F 164	*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 the 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.* F-164: The facility will ensure personal privacy will be maintained for each resident. This will be accomplished by: The Charge Nurse on the evening shift will observe the nurse aides as they provide transportation to and from the tub rooms with resident #7. The Charge Nurse will observe for maintenance of personal privacy when resident #7 is being transported to and from the tub room. The Charge Nurse will observe tub room transportation and if inadequate draping of the resident is identified, immediate in-servicing and corrective action will be taken with the aide. The Staff Development Coordinator or designee will provide education to the nursing staff on the resident's right to personal privacy and dignity with emphasis on proper draping of residents as they are transported to and from the tub rooms. Results of the observation audits will be provided to the QA&A Committee monthly times 3 months. Date of compliance is September 16, 2007.	

ok. Audit, ok. Education, ok. Audits ok.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

DLS — LTA — 9-14-07

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

approved ☆ corrections to date of compliance

ok 9/14/07 10:14 AM

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F 164	Continued From page 1 PM revealed the resident was assisted with undressing for a shower. As the resident was wheeled out of his/her room across the hall to the shower room, the observation revealed the resident was not draped past the back of the shower chair seat, exposing the residents buttocks and genitalia. Interview at that time with the certified nurse aide revealed she did not realize the resident was exposed. Interview on 8/29/07 at 1:55 PM with the unit managers for the first and second floors revealed the facility expectation during transport to the shower room was that the resident be draped from their ankles to the their neck.	F 164		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	*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 the 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.* F279 – The facility will develop a care plan to include adequate behavior interventions. This will be accomplished by: Behavior care plan for resident #43 has been revised to include specific behaviors, counseling, and specific limits and triggers. Participation in outings has not been restricted.	

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F 279	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on medical record review, resident interview, and staff interview, the facility failed to ensure the care plan was developed to include adequate behavior interventions for one (#43) of 3 sample residents who were identified as having behavioral issues. The findings were: Review of the medical record face sheet showed the resident had diagnoses that including mental retardation. Review of the 3/9/07 annual Minimum Data Set (MDS) assessment showed the resident displayed socially inappropriate/disruptive behaviors, and resisted cares 1-3 times in the previous 7 days. Review of the 8/13/07 quarterly social services assessment note showed the resident had "occasional outbursts and is rude but easily redirected." The following concerns were noted with the lack of care plan development related to behaviors: a. Interview with resident #43 on 8/28/07 at 9:46 AM revealed s/he was upset about being "grounded" from attending outings. The resident stated at an outing in July 2007, s/he behaved badly and was told by the activity director, who was on leave at the time of the survey, that s/he was grounded based on that behavior. Review of the medical record failed to reveal what the specific behavior was. There was also no evidence of counseling for the resident related to the behavior. b. Review of the behavior care plan last reviewed on 8/22/07 showed the resident had behavior problems including: "socially inappropriate/disruptive behavior of comments of other residents...exhibits verbally loud laughing outbursts...criticism or conflict of staff and residents...intrusive behavior." However, the	F 279	An audit will be performed by the Social Services Director or designee on other residents behavior problems to confirm that care plans reflect resident's specific behaviors. done The Director of Nurses or designee will in-service the IDT on how to write appropriate interventions related to behavior management on care plans and how to appropriately address the resident's behaviors. ok done Random audits will be performed monthly times 3 months by the Social Services Director or designee to confirm that behaviors are appropriately care planned. Results of the random audits will be presented to the QA&A Committee monthly times 3 months. Date of compliance is September 16, 2007. JAW 9-14-07 DS 9-14-07	

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F 279	Continued From page 3 approaches listed were for staff to "confront behavior as it occurs and set limits...monitor for triggers that upset resident and attempt to avoid...be careful of invasion of personal space...set firm limits on behavior as occurs..." Nowhere in the care plan did it show an intervention of restricting participation in outings. The care plan also failed to describe what the limits were that should be set, or what triggers should be monitored. c. Interview with activity aide #1 on 8/29/07 at 11:45 AM revealed she was not aware of any plan to monitor the resident's behaviors or what to do when the resident exhibited inappropriate behaviors.	F 279	*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 the 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.* F-281 – The facility will confirm that physician orders related to the documentation of blood pressure and fentanyl patch placement are followed.	
{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 and staff interview, the facility failed to ensure physician orders were followed for two (#53 and #71) of 13 open sample residents. The findings were: Review of the medical for resident #53 revealed physician orders dated 8/23/07 in which the physician ordered, "Daily BP [blood pressure] for one week." Review of medical record failed to reveal documentation of the ordered blood pressures. Interview and record review on 8/28/07 at 3:58 PM with the registered nurse (RN) for the resident and the RN admission coordinator revealed they stated the blood pressures were not done as ordered.	{F 28	Resident #53's blood pressure is within normal limits and currently has a physician order for weekly blood pressure checks. were on log Resident #71 has a fentanyl patch in place and is currently being monitored q shift for fentanyl patch placement. The Director of Nurses or designee will conduct a facility audit to identify that other residents with orders for fentanyl patch placement and vital signs are documented as indicated. The Director of Nurses or designee will educate nursing staff on the following of physician orders for fentanyl patch placement and the documentation of vital signs.	8/5/07

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{F 281}	Continued From page 4 Review of physician's order for resident #71 showed a 2/25/07 order for a Fentanyl (a narcotic pain medication) patch. The order included the instructions to check the placement of the patch every shift. Review of the August 2007 medication administration record from 8/1 to 8/28 showed 5 evening shifts (8/14, 8/15, 8/22, 8/23, and 8/27) with no initials to indicate the patch placement was checked. Interview with LPN #1 on 8/29/07 at 9:15 AM stated she had not worked those evenings, but if there were no initials she had to assume it was not done. According to "Nursing Malpractice: Sidestepping Legal Minefields," copyright 2003, the medical record provides legal proof of the nature and quality of care received. The author further states that when it comes to documentation, if it was not documented, it was not done.	{F 281}	The Director of Nurses or designee will conduct random weekly audits times 4 and then monthly times 2 to confirm that ordered fentanyl patch placement checks and vital signs are documented as ordered. Results of the audits will be reviewed by the QA&A Committee for recommendation and continued compliance. Data will be reviewed monthly x3 months. Date of compliance is September 17, 2007. 16 9-14-07 9-14-07 *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 the 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.*	
{F 282} SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure one (#53) of 13 sample residents received care as planned within their care plan. The findings were: Observation of resident #53 on 8/28/07 from 8:08 AM to 12:58 PM by two surveyors, revealed the resident was not cued to reposition and was	{F 282}	F-282 – Resident #53's care plan was re-evaluated for repositioning and toileting and adjusted to reflect the resident's needs. The Director of Nurses or designee will conduct a facility audit to confirm that residents are repositioned and cued to use the bathroom in accordance with their care plan. The Director of Nurses or designee will confirm that the aide's ADL worksheets match the resident's care plan and that nursing staff are educated on the need to toilet and reposition residents in accordance with the care plan.	8/5/07 done

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{F 282}	Continued From page 5 not cued to use the bathroom. Although the resident requested to use the bathroom at 12:58 PM (four hours and 50 minutes from the start of the observation), s/he required assistance to stand and pivot. Interview on 8/28/07 at 1:10 PM with the certified nurse aide (CNA) caring for the resident revealed the last time the resident was repositioned was when the resident was walked to breakfast. Review of the medical record revealed a care plan developed on 8/21/07 which directed staff to change the resident's position every two hours by toileting, boosting, shifting of weight, ambulation, or returning her to bed for rest. It further directed staff to plan scheduled toileting every morning, before meals, after meals, at bedtime and as needed, as well as, to check and change the resident.	{F 282}	The Director of Nurses or designee will conduct random weekly audits times 4 to confirm that residents are toileted and repositioned according to the care plan. Results of the audits will be reviewed by the QA&A Committee for recommendation and continued compliance. Data will be reviewed monthly x3 months. Date of compliance is September 14, 2007 9-14-07	
F 386 SS=D	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure physician progress notes were documented when visits were made for two (#80, #89) of 14 sample residents. The findings were:	F 386	*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 the 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.* F-386 – Comprehensive physician progress notes will be documented for residents #80 and #89. Medical Records staff will conduct a random audit of residents to confirm that comprehensive physician notes are documented in the medical record. The Administrator or designee will review the federal requirements cited in this survey with the physician. done	

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F 386	Continued From page 6 1. Medical record review showed resident #89 was admitted to the facility on 4/11/07. Review of physician progress notes for the resident showed the following notes that were signed by the physician: on 5/28/07 "UTI, refusing meds [medications]." On 6/20/7 "Pt [patient] seen." On 7/23/07 the note showed "Comfort care." Interview with the director of nursing (DON) on 8/29/07 at 2:15 PM revealed she had contacted the physician, and there were no additional notes related to these visits with the resident. 2. Review of physician progress notes for resident #80 showed a visit dated 7/19/07 that showed "Pt [patient] seen dictation to follow." Further medical record review showed there was no evidence of the dictated progress note. Interview with the DON on 8/29/07 at 2:15 PM revealed she had contacted the physician, there was no additional progress note documentation.	F 386	Medical Records staff will conduct a weekly audit times 4 and then monthly times 2 to confirm that comprehensive physician notes are present in the resident's medical record. Results of the audits will be reviewed by the QA&A Committee for recommendation and continued compliance. Data will be reviewed monthly times 3 months. Date of compliance is September 16, 2007. 9-14-07 9-14-07	

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535013	A. Building B. Wing	8/29/2007

Name of Facility	Street Address, City, State, Zip Code
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 08/05/2007	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 08/05/2007	ID Prefix F0246 Reg. # 483.15(e)(1) LSC	Correction Completed 08/05/2007
ID Prefix F0250 Reg. # 483.15(g)(1) LSC	Correction Completed 08/05/2007	ID Prefix F0272 Reg. # 483.20, 483.20(b) LSC	Correction Completed 08/05/2007	ID Prefix F0278 Reg. # 483.20(g) - (j) LSC	Correction Completed 08/05/2007
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 08/05/2007	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 08/05/2007	ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 08/05/2007
ID Prefix F0324 Reg. # 483.25(h)(2) LSC	Correction Completed 08/05/2007	ID Prefix F0385 Reg. # 483.40(a) LSC	Correction Completed 08/05/2007	ID Prefix F0406 Reg. # 483.45(a) LSC	Correction Completed 08/05/2007
ID Prefix F0441 Reg. # 483.65(a) LSC	Correction Completed 08/05/2007	ID Prefix F0492 Reg. # 483.75(b) LSC	Correction Completed 08/05/2007	ID Prefix F0514 Reg. # 483.75(l)(1) LSC	Correction Completed 08/05/2007

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	TB	9/18/07	[signature]	9/13/07
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/21/2007

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO