Reviewed and approved c change on pages 11 and 15 after discussion c Jon Owens NHA and Peggy ... 8/17/06 @ 9:15 pm Linda ... RN

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

PRINTED: 08/15/2006
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
	535038	A. BUILDING ______ B. WING ______	R-C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

(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 226} SS=E	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 policy review, review of new employee personnel records, and staff interview, the facility did not consistently implement policies related to misappropriation of property in 1 of 5 reviewed personnel records and did not ensure their policies provided accurate information required to reporting abuse allegations to the State Survey Agency (SSA). Findings were: 1. Review of personnel record information for staff member #37, who was employed as a housekeeper, revealed the individual's employment application had the following concerns: a. Blank spaces were noted for dates of employment at two previous jobs noted on the application. The individual at the facility who had checked the references documented "verified dates of service," yet not dates of service were indicated. There was no indication as to why the individual left his/her last employer. Interview on 3/15/06 at 2:45 PM with staff member #36 revealed the staff member (#37) had worked at their facility at some prior time, yet that was not indicated on the application. b. The applicant indicated s/he had been convicted of delivery of a controlled substance and conspiracy to deliver a controlled substance. The local criminal background check also revealed the staff person had been arrested for	{F 226}	F226 The facility will ensure that written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident's property are reviewed, revised, developed and implemented. This will be accomplished by: 1. Staff member # 37 was terminated on 3/15/06. a. When a prospective employee has completed an application for employment, the HR Manager will ensure that all applicable information has been completed on the application form. b. The HR Manager will then complete a criminal background check on the prospective employee prior to employment. Once the criminal background check is complete, the HR Manager will check negative findings against the prospective employee's application.	5/19/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/16/06

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(F 226)	Continued From page 1 shoplifting, which was not noted by the employee on his/her application. c. Review of the facility's policy #2029, Abuse Prevention, revealed if the screening process indicates any history of abuse or misappropriation of property, the individual will not be hired. In this instance, the facility did not follow their own policy. d. Interview with a resident in the dining room on 3/14/06 at 6 PM revealed the resident had a gold cross stolen by a staff member who currently worked in the facility. The resident stated this was reported to the facility, and no one believed her. 2. Review of policy #2001 regarding Abuse--Prohibiting, Investigating, and Reporting, last revised on 11/10/03, the following concerns were noted: a. Under the heading Screening of Staff, number 6 indicated a yearly criminal background investigation would be completed on all staff at the time the facility applied for its annual license renewal, where applicable by state law. In longhand someone had added: "-Not Wyoming." b. Another heading was: Regulation for Reporting Pursuant to Utah Code Annotated 62A-3-303. The information was not specific to Wyoming, where the facility is located and licensed. c. Under the heading entitled Investigation and Reporting Procedures the policy indicated only "severe" cases of sexual or physical abuse need be reported. d. Section 3 under this heading indicated the State Survey and Certification Agency at 801-538-6158 or the Office of Health Quality at 307-777-7121 would be notified of significant incidents between residents or abuse and	(F 226)	c. Rocky Mountain Care's policy # 2029 regarding abuse has been updated to reference policy # 4017, titled *Employment Process* to direct the Administrator on how to respond to negative criminal background findings. d. Items that are reported as missing or lost will be reported to the Social Services designee immediately and will be reviewed at the facility "Stand Up" meeting. The Social Service designee will maintain a log of items that have been lost or found. 2. Rocky Mountain Care's policy #2001 has been revised to correct the following errors that were noted during the survey: a. Under the section "Screening of Staff", annual background checks will be completed every April. b. The section "Regulation for Reporting" has been removed from the policy.	

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(F 226)	Continued From page 2 misappropriation of property. However the number listed first in the policy is the Utah agency SSA, which has no authority to investigate in Wyoming, and is not the Wyoming agency. In addition, the name of the Wyoming Agency is incorrect and the Wyoming phone number requires updating. e. Section 4 identifies what the administrator will do to initiate the investigative process. According to this policy the facility will use the "State's Investigation Form," which Wyoming does not have. Part 9 under this section says that after the investigation is complete if notification was made to the Utah State Survey and Certification Agency, the written report will be faxed within five days of the incident to the Utah State Agency attention: Complaint Team Manager, fax number 801-536-0948. None of this information is applicable to a facility operating in Wyoming. 3. Review of the facility's incident reports revealed an incident of resident to resident abuse was reported to the Wyoming Long Term Care Ombudsman, however it was not reported to the Wyoming SSA. Interview with the Social services director on 3/15/06 at 3 PM verified this was not reported. The director stated she was not certain at the time of the report to the Ombudsman whether or not this was a reportable incident. Based on policy review, review of the facility's abuse file, and staff interview, the facility failed to implement written policies regarding reporting in three of four allegations of abuse or neglect reviewed. The findings were:	(F 226)	c. Under the "Investigation and Reporting Procedures" section the word "severe" has been removed. d. Item # 3 under the same section has been updated to reflect the appropriate name (Office of Health Care Licensing & Surveys) and the appropriate phone number. e. Item # 4 under the same section has been updated by removing "State's Investigation Form" and removing the reporting information for the State of Utah; and inserting reporting information for the State of Wyoming. 3. All allegations of abuse or neglect will be reported immediately to the State of Wyoming, Office of Health Care Licensing & Surveys and to the State of Wyoming, Division of Family Services. An investigation will be completed within five (5) days and a written report sent to the aforementioned. The items noted above will be monitored by the Administrator, HR Manager, and Social Service Designee. The Administrator will report to the	

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{F 226}	Continued From page 3 Review of the facility's policy "Abuse- Prohibiting, Investigating and Reporting" (#2001, updated 8/9/06) revealed "...Any person, who suspects that abuse, neglect or misappropriation of property may have occurred, will immediately report the alleged violation to the charge nurse who immediately notifies the administrator and advocacy agencies...the administrator will notify the Division of Family Services or local law enforcement authorities within twenty-four (24) hours of the reported abuse. The State Survey and Certification Agency must also be notified....Injuries of unknown origin, where abuse cannot be ruled out, significant incidents between residents, abuse and misappropriation of resident's property must immediately be reported to the Office of Health Care Licensing & Surveys..." The following concerns were identified: a. Review of the facility's documentation for a 7/22/06 allegation of neglect involving resident #25 revealed the Department of Family Services (DFS) or law enforcement were not notified. During an interview on 8/9/06 at 1:35 PM, the social services director (SSD) and the administrator stated DFS or law enforcement were not notified. b. Review of the facility's documentation for a possible allegation of abuse (increased bruising to the resident) involving resident #27, dated 7/12/06, showed DFS or law enforcement were not notified. On 8/9/06 at 1:35 PM, the SSD and administrator stated DFS or police were not notified. c. Review of the facility's documentation showed on 6/29/06, male resident #24 was found in female resident #23's room with his pants down. The documentation showed the	{F 226}	Quality Assurance Committee at least quarterly regarding progress. **This will be completed by 08/16/06** *New Findings* 1. Rocky Mountain Care's policy # 2001, *Abuse-Prohibiting, Investigating and Reporting* has been updated as of 08/09/06. a. The Social Service Designee has reported the allegation of neglect on 7/22/06 regarding resident #25 to the Department of Family Services. This was done on 08/15/06. b. The Social Service Designee has reported the allegation of abuse involving resident # 27 to the Department of Family Services. This was done on 08/15/06.	

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(F 226)	Continued From page 4 administrator was not notified until 7/4/06, and the State Survey and Certification Agency and DFS were not notified until 7/5/06. During an interview on 8/9/06 at 1:35 PM, the administrator stated the allegation happened right after he started, it was over a weekend, and at the time the facility did not have a good process for reporting.	(F 226)	c. The process for reporting allegations of abuse or injuries of unknown origin after hours or on weekends has been updated. The administrator is to be notified immediately. Notification will then be made to Office of Health Care Licensing and Survey and to the Department of Family Services. The Administrator, Director of Nursing Services and the Social Service Designee will be responsible for monitoring compliance in this area daily. Progress will be reported to the Quality Assurance Committee at least quarterly. **This will be completed by 08/16/06.**	

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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 assure a comprehensive assessment for all needed areas was completed for one (#25) of six sample	(F 272)	F272 The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. This will be accomplished by: *New Findings* A physician order was obtained to change the Rozerem 8 milligrams to PRN and a sleep assessment was completed for Resident #25 on 08/16/06. The MDS Coordinator has reviewed and revised the MDS and has added hypnotics to the MDS. This was completed on 08/15/06. A psychotropic RAP has been initiated and an updated careplan has been placed in Resident #25's medical record. The Director of Nursing met with the MDS Coordinator on 08/15/06 to discuss the use of hypnotics and the completion of section "O" on the MDS, the initiation of RAPs and updating of the careplan. On admission and through the IDT process, residents will be assessed for the appropriate use of hypnotics. The Director of Nursing will periodically audit the MDS to ensure the appropriate completion of the assessment.	5/19/06

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{F 272}	Continued From page 6 residents. The findings were: Review of physician orders showed on 7/13/06 Rozerem 8 milligrams (mg) at bedtime was ordered for resident #25. Review of prescribing information (www.Rozerem.com) revealed Rozerem is indicated for the treatment of insomnia characterized by difficulty with sleep onset. The prescribing information also documented "...Warnings: Since sleep disturbances may be the presenting manifestation of a physical and/or psychiatric disorder, symptomatic treatment of insomnia should be initiated only after careful evaluation of the patient." Review of the medical record revealed no evidence a comprehensive sleep assessment was completed to determine the resident's usual sleep disturbance and possible reasons for insomnia such as noise, pain, side effects of medication, etc. During an interview on 8/9/06 at 10:05 AM, the director of nursing (DON) stated there had been no comprehensive sleep assessment for this resident. Based on staff interview and medical record review, the facility failed to ensure a comprehensive assessment was completed for two (#24, #45) of eleven sample residents in a variety of areas. The findings were: 1. Review of the 3/25/05 Initial Minimum Data Set (MDS) assessment and the 9/19/05 and 12/17/05 quarterly MDS assessments for resident #24 revealed s/he had a history of falls. Review of the	{F 272}	The Director of Nursing will report to the Quality Assurance Committee at least quarterly. **This will be completed by 08/16/06.** 1. Resident # 24 was reassessed for falls and the least restrictive interventions were initiated to safeguard the resident from continued falls. Upon admission and every 90 days or as necessary, a comprehensive assessment will be completed to identify each residents needs and to develop a plan of care to meet those needs. The assessment will be updated as often as necessary to reflect any change in the resident's condition. The Director of Nursing will periodically audit the MDS to ensure the appropriate completion of the assessment. 2. Closed record #45 has been reviewed and corrected interventions have been put in place to ensure residents will not be at risk for bed entrapment. Nursing staff received additional training in regards to the comprehensive assessment on 03/31/06. Specific training was also provided to the nurse's aides regarding fall interventions and the appropriate use of restraints.	

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(F 272)	Continued From page 7 entire medical record revealed the following concerns: a. The resident had a fall on 10/20/05 and sustained a one to two inch jagged laceration on the head which required transfer to the emergency room for treatment. b. The resident had a fall on 11/8/05 in which s/he sustained a deep star shaped head wound. c. The resident was found on the floor on 12/14/05 d. The resident was found on the floor on 12/28/05. e. The resident had a fall on 1/1/06. While the resident was assessed for risk of falls on a quarterly basis, no comprehensive assessment to determine the cause of the falls was completed. Interview with the director of nursing on 3/16/06 at 8:08 AM confirmed no comprehensive assessment was completed. 2. Closed record review revealed resident #45 had an order for two side rails up to prevent independent transfers and for bed mobility every day, every shift. Nurses' notes on 2/7/06 at 10:15 PM revealed the resident had experienced a fall while ambulating independently and had sustained an injury to the right knee. The resident was quoted in the note as stating, "I crawled out the end of my bed to go to the bathroom and fell in the bathroom on my right knee. I got back up and crawled into bed." The nurses' note indicated the side rails had been up on both sides of the bed and the call light had been within reach. The bed entrapment assessment completed on 2/23/06 had a section headed as "Behaviors." Under that section the document inaccurately showed the resident used side rails/restraints appropriately. The assessment had two places	(F 272)	Each resident will be assessed by the IDT team upon admission, every 90 days thereafter or as necessary for fall risks. The appropriate least restrictive interventions will be initiated following the assessment. The Director of Nursing and MDS Coordinator will be responsible for monitoring this area for compliance on a daily basis. The Director of Nursing will report progress to the Quality Assurance Committee at least quarterly. **This will be completed by 08/16/06.**	

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{F 272}	Continued From page 8 where the evaluators could indicate by a check mark of the resident "attempts to climb over/around side rails" or "attempts transfers/ambulation without assistance recommended for safety." Despite the documented incident on 2/7, neither of these areas was checked. The restraint review progress note also written by the same committee on 2/23/06 recommended continued restraint use for 90 days with a reassessment at that time. There was no evidence this recommendation was based on an accurate restraint assessment.	{F 272}		
{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 observation, staff interview, and medical record review, the facility failed to ensure professional standards were followed. The findings were: 1. Observation of medication administration on 3/14/06 revealed the following concerns: a. From 8:25 AM until 8:29 AM (4 minutes) the medication cart was left unlocked. During this time licensed practical nurse (LPN) #1 had her back to the medication cart. b. From 8:33 AM to 8:42 AM (9 minutes) the medication cart was left unlocked. During this time LPN #1 was across the dining room and did not have the medication cart within her sight. c. From 5:50 PM until 5:52 (2 minutes) the	{F 281}	F281 The facility will ensure the services provided or arranged by the facility meet professional standards of quality by: 1. The Administrator, Director of Nursing and Charge Nurse will ensure that medication carts are locked at appropriate times each day. Progress will be reported to the Quality Assurance Committee at least quarterly. 2. The Director of Nursing will ensure that all nursing staff cleans their hands appropriately (between residents) when dispensing medications to residents. The Director of Nursing will provide	5/19/06

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{F 281}	Continued From page 9 medication cart was left unlocked. During this time LPN #3 had her back to the medication cart. d. From 6:15 PM until 6:16 PM (3 minutes) the medication cart was left unlocked and the bottom drawer was left pulled out while LPN #3 crossed the dining room to administer medications to a resident. The following medications were accessible to residents in the open bottom drawer: Lexapro (antidepressant), Lipitor (for high cholesterol), Candesartan celexetil (antihypertensive), Synthroid (for hypothyroidism), Toprol XL (antihypertensive), Terazosin (antihypertensive), Omeprazole (for acid reflux), Flagyl (anti-infective), Pentasa CR (for ulcerative colitis), Fosamax (for prevention or treatment of osteoporosis), Cymbalta (antidepressant), Digitek (cardiac drug), Pericolace (stool softener/laxative), Nexium (for acid reflux and erosive esophagitis), Plavix (antiplatelet drug), Tramadol (analgesic), Zyrtec (antihistamine), Celebrex (for arthritis), Plendil (antihypertensive), Avandia (antidiabetic), Levothyroxide (for hypothyroidism), Lasix (diuretic), Zyprexa (antipsychotic) disintegrating tablets 27 5 milligram (mg) tablets and 15 20 mg tablets, Acetominophen (analgesic), Docusate Sodium liquid (laxative), Miralax powder (laxative) 9 containers, ASA (Aspirin-analgesic), Vitamin E, Guiatuss DM syrup (expectorant/cough syrup), Laculose (laxative), 13 syringes, and Medicated chest rub with a warning "Keep out of reach of children. If swallowed get medical help or contact a Poison Control Center right away." According to the "Medication Guide for the Long-Term Care Nurse", sixth edition, 2003, page 67, medication carts should be kept locked when unattended.	{F 281}	education and training to the nursing staff and will monitor this area for compliance weekly and report progress to the Quality Assurance Committee at least quarterly. 3. The weekly weight orders for Resident # 11 have been revised on the vital sign flow sheet and resident is being weighed weekly as ordered by the physician. The Director of Nursing and MDS Coordinator will ensure that residents are weighed in accordance with physicians order and comprehensive assessment. This will be done at least monthly and progress will be reported to the Quality Assurance Committee at least quarterly. 4. The Director of Nursing will audit the MAR at least weekly to ensure that each resident is receiving their medication as ordered by their physician. Progress will be reported to the Quality Assurance Committee at least quarterly. **This will be completed by 08/16/06.**	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

(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 281}	Continued From page 10 2. Observation on 3/14/06 from 8:05 AM until 8:15 AM, LPN #1 did not cleanse her hands between administration of medications to non-sample resident #9 and non-sample resident #42. Observation on 3/14/06 from 5:40 PM until 6 PM revealed LPN #3 did not cleanse her hands after she administered medications to non-sample residents #19, #21, #39, #32, and #16. Interview with the DON on 3/16/06 at 8:08 AM confirmed hands should be cleansed between residents when medications were administered. 3. Review of the 3/06 physician's orders for resident #11 revealed an order dated 8/29/05 for weekly weights. Review of the vital signs flow sheet revealed the resident was not weighed from 8/24/05 until 2/21/06 (almost 26 weeks). Interview with the DON revealed the resident was not weighed because the Hoyer scale was broken. According to the Wyoming Nursing Practice Act and Administrative Rules and Regulations dated July 2005 nurses must follow physicians orders. 4. Review of the March 2006 recapitulation physician orders and medication administration record (MAR) for resident #28 showed an order for Digoxin 0.25 milligrams (mg) every other day, and skip the third day (however, the resident received the medication every two days, and skipped the third). Review of the previous recapitulation orders and MARs revealed the order was for Digoxin 0.25 mg everyday, and skip the third day. There was not a physician's order to change the order to every other day. During an interview on 3/15/06 at 5:10 PM, the DON stated she did not know where the every other day came from, because there was not an order for that. She stated the order was typed in wrong on the	{F 281}	*New Findings* 1. Each nurse will administer medications as ordered by the physician and will document that the medication has been given on the MAR by initialing in the appropriate place. Resident #17 was assessed on 8/9/06 seen by the Director of Nursing and the nurse to ensure medications were given appropriately in the presence of a surveyor. The Director of Nursing held an in-service on for all nursing staff on 08/15/06 to discuss the Rules and Regulations of medication administration and documentation. Medication pass reviews will be conducted by the Director of Nursing randomly, each week to ensure that nurses are appropriately administering medication. The Director of Nursing will continue to monitor for compliance and will report to the Quality Assurance Committee at least quarterly on the progress. **This will be completed by 08/16/06.** added per request of Jon Owens with a Peggy Duncan DON but phoned on 8/17/06 at 3:15 pm LB	

LB

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	R-C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

(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 281)	Continued From page 11 recapitulation, and the nursing staff should have caught the mistake. Based on staff interview, review of facility policy, and medical record review, the facility failed to assure professional standards were followed related to documentation of medication administration for one (#17) of six sample residents. The findings were: 1. Review of physician orders for resident #17 revealed that on 7/11/06 the physician ordered Risperdal 4 milligrams (mg) BID (twice a day). However, review of the August 2006 medication administration record (MAR) showed no documentation that the morning dose of the Risperdal was given on the first four days of the month. Interview with licensed practical nurse (LPN) #1 on 8/8/06 at 4:48 PM revealed the nurse responsible for administering the medication should have initialed the MAR after administering the medication. At 5:10 PM, LPN #1 brought the bubble pack medication card to the surveyor and stated she had counted backwards and determined the resident had in fact received the medication as ordered the first four days of the month, but the MAR had not been initialed. 2. Interview with the director on nursing (DON) on 8/9/06 at 3:23 PM revealed it is the policy of the facility that nursing staff are responsible for initialing the MAR upon administering medication. Review of the facility policy and procedure (#2026) titled "Medications - Administration of Drugs" revealed the following: "...13. Medications must be charted immediately following the administration by the person administering the	(F 281)		

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	535038	A. BUILDING _____ B. WING _____	R-C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 281}	Continued From page 12 drugs. The date, time administered, dosage, etc., must be entered in the medical record and signed by the person entering the data. The nurse administering the medications must initial the resident's MAR, on the appropriate line and date for that specific day."	{F 281}	F329 Each resident's drug regimen must be free from unnecessary drug. This will be accomplished by: *New Findings* A physician order was received to change Resident #25's Rozarem 8 mg to PRN. A quality monitoring tool will be implemented to ensure unnecessary drugs are not included in any resident's drug regimen, including Resident #25's use of hypnotics. All nursing staff responsible for medication orders and medication administration received education and training by the Director of Nursing on 08/15/06 regarding the appropriate use of medications and proper documentation on behavior tracking sheets and sleep assessment for hypnotics. A sleep assessment was initiated and completed on 08/16/06 for Resident # 25 to assess the appropriate use of Rozarem each night. The order was changed to PRN, as needed for insomnia.	
{F 329} SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the drug regimen was free of unnecessary drugs for one (#25) of five sample residents who received psychoactive medications. The findings were: Review of physician orders showed on 7/13/06 Rozerem 8 milligrams (mg) at bedtime was ordered for resident #25. Review of the July and August 2006 medication administration records (MARs) revealed the resident received the medication each night except for 7/25/06. Review of prescribing information (www.Rozerem.com) revealed Rozerem is indicated for the treatment of insomnia characterized by difficulty with sleep	{F 329}		4/28/06

AUG. 15. 2006 3:21PM NO. 0282 P. 19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING _____ B. WING _____	R-C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

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{F 329}	Continued From page 13 onset. The prescribing information also documented "...Warnings: Since sleep disturbances may be the presenting manifestation of a physical and/or psychiatric disorder, symptomatic treatment of insomnia should be initiated only after careful evaluation of the patient." Review of the medical record revealed no evidence a comprehensive sleep assessment was completed to determine the resident's usual sleep disturbance and possible reasons for insomnia such as noise, pain, side effects of medication, etc. In addition, there lacked evidence non-pharmacological interventions were tried. Furthermore, there lacked evidence the facility was monitoring for the effectiveness of the medication or any side effects. During an interview on 8/9/06 at 10:05 AM, the director of nursing (DON) stated there was no sleep assessment, nor physician documentation regarding the use of the medication. The DON stated the resident was re-admitted from the hospital with this medication, and the facility had not addressed it yet. The DON further stated the medication should have been monitored for effectiveness and side effects on a psychoactive monitoring sheet in the MAR, but she just realized this week there was not a monitoring sheet for this resident. Based on medical record review and staff interview, the facility failed to assure the drug	{F 329}	a monitoring form for side effects and effectiveness was implemented on 8/10/06. added per request of Deborah Bopp via phone on 8/17/06 @ 3:15 pm LB The Psychotropic Review Committee will meet each month to review the drug regimens for residents and make appropriate recommendations to attending physicians. The Director of Nursing will represent the Psychotropic Review Committee at the Quality Assurance Committee meeting to be held at least quarterly. **This will be completed by 08/16/06.** A quality monitoring tool has been implemented to ensure unnecessary drugs are not included in any resident's drug regimen, including Resident #30. All nursing staff responsible for medication orders or medication administration did receive education and training on 03/31/06 and on 08/15/06 that covered the appropriate use of medications and proper documentation on behavior tracking sheets. The Director of Nursing will continue to monitor at least weekly and then will report progress to the Quality Assurance Committee at least quarterly. **This will be completed by 08/16/06.**	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	R-C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

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(F 329)	Continued From page 14 regimen was free of unnecessary drugs for one (#30) of seven sample residents who received psychoactive medications. The findings were: Review of the 3/06 physician's orders for resident #30 revealed Ativan (anti-anxiety) 1-2 mg (milligrams) every 6 hours as needed for anxiety. Review of the 3/06 Medication Administration Record revealed the resident received Ativan on 3/3/06 at noon, 3/7/06 at 11 AM, and 3/10/06 at 11:30 AM. Review of the behavior monitoring form revealed the resident had no behaviors of aggression, agitation, or restlessness on these dates or at any time during the month of March. Interview with LPN #2 on 3/14/06 at 2:30 PM revealed the resident was sometimes given Ativan prior to his/her bath to prevent possible anxiety.	(F 329)		
(F 332) SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to assure it was free of medication error rates of five percent or greater. During observation of medication administration, three errors occurred in 48 opportunities, resulting in a medication error rate of 6.25%. The findings were: 1. Observation of medication administration on	(F 332)	F332 The facility will ensure that it is free of medication error rates of five percent or greater and will accomplish this by: *New Findings* 1. Resident # 19 had a clarification order written on 08/08/06 for Carafate and Reglan to be given at meals and HS per resident request. 2. The treatment sheet for Resident #17 has been updated to reflect the manufacturer recommendations related to the length of time between each puff. 3. An in-service has been held with all nurses on 08/15/06 to	5/19/06

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	R-C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 332}	Continued From page 15 8/8/06 at 5:50 PM revealed licensed practical nurse (LPN) #1 administered medications to resident #19, including Carafate 1 gram (gm) and Reglan 5 milligrams (mg). Observation revealed the resident was finishing up his/her meal. Review of the July 2006 physician orders showed the resident was ordered Carafate 1 gm and Reglan 5 mg to be given "ac"[before meals]. During an interview on 8/8/06 at 1:35 PM, LPN #1 stated it was the resident's preference to have the medications given at meals, and not before. The LPN stated there was no clarification order from the physician stating the medications could be given with meals. 2. Review of physician orders showed resident #17 was ordered Combivent inhaler MDI two puffs, three times per day. Observation on 8/8/06 at 2 PM revealed registered nurse (RN) #1 administered a Combivent inhaler to the resident. The RN gave the resident one puff, waited 30 seconds, then gave the resident a second puff. Interview with the RN at that time revealed she usually waited one minute between puffs. The RN then reviewed the product insert for the Combivent inhaler which instructed to wait "approximately 2 minutes" between puffs. Based on observation, medical record review, and staff interview, the facility failed to ensure medication errors were not greater than five percent. The medication error rate was 6.5 percent. The findings were:	{F 332}	discuss the proper administration and use of inhalers. Treatment sheets for each resident using inhalers have been updated to reflect the manufacturer's recommendations. 4. Random medication audits are being done weekly by the Director of Nursing to assess whether appropriate standards are being met. The Director of Nursing will report to the Quality Assurance Committee at least quarterly regarding progress. **This will be completed by 08/16/06.** 1. Resident # 20 is receiving the appropriate administration of inhaler per physician's order and according to the manufacturer's label. Resident #20's treatment sheets have been update to reflect the manufacturer's recommendations. 2. Resident #7 is receiving two (2) tablets of extended release Vitamin C as ordered by the physician. 3. Resident #32 is receiving Oscal with Vitamin D as ordered by the physician.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	535038	A. BUILDING _____ B. WING _____	R-C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE EVANSTON	476 YELLOW CREEK ROAD EVANSTON, WY 82930

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(F 332)	Continued From page 16 1. Observation of medication administration for resident #20 on 3/14/06 at 9:32 AM revealed licensed practical nurse (LPN) #2 administered Combivent inhaler two puffs but waited only 40 seconds between puffs. Review of the facility's protocol on spacing and proper sequence of inhaled medications revealed there should be a one minute wait between puffs to allow additional puffs to penetrate the lungs more effectively. Interview with the director of nursing on 3/16/06 at 9:30 AM confirmed there should be a wait of one minute between puffs. 2. Observation of medication administration on 3/14/06 at 6 PM revealed LPN #3 administered vitamin C 500 mg (one tablet) to resident #7 and review of the physician's orders revealed the order was for vitamin C extended release (two tablets). 3. Observation of medication administration on 3/14/06 at 5:59 PM revealed LPN #3 administered Oyster Calcium 500 mg (one tablet) to resident #32. Review of the physician's orders revealed the order was for Oscal with vitamin D. Review of the label on Oyster Calcium revealed there was no vitamin D. 4. Interview with LPN #3 on 3/15/06 at 3:45 PM confirmed the aforementioned were medication errors.	(F 332)	Random medication audits are being done weekly by the Director of Nursing to assess whether appropriate standards are being met. The Director of Nursing will report to the Quality Assurance Committee at least quarterly regarding progress. This will be completed by 08/16/06.	

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
535038	A. Building B. Wing	8/9/2006

Name of Facility	Street Address, City, State, Zip Code
ROCKY MOUNTAIN CARE EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

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 F0156 Reg. # 483.10(b)(5) - (10), 483.10(l LSC	Correction Completed 04/03/2006	ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 03/31/2006	ID Prefix F0164 Reg. # 483.10(e), 483.75(l)(4) LSC	Correction Completed 08/09/2006
ID Prefix F0169 Reg. # 483.10(h) LSC	Correction Completed 03/31/2006	ID Prefix F0221 Reg. # 483.13(a) LSC	Correction Completed 03/30/2006	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 05/19/2006
ID Prefix F0246 Reg. # 483.15(e)(1) LSC	Correction Completed 05/19/2006	ID Prefix F0248 Reg. # 483.15(f)(1) LSC	Correction Completed 05/19/2006	ID Prefix F0253 Reg. # 483.15(h)(2) LSC	Correction Completed 08/09/2006
ID Prefix F0254 Reg. # 483.15(h)(3) LSC	Correction Completed 05/19/2006	ID Prefix F0257 Reg. # 483.15(h)(6) LSC	Correction Completed 08/09/2006	ID Prefix F0276 Reg. # 483.20(c) LSC	Correction Completed 05/19/2006
ID Prefix F0278 Reg. # 483.20(g) - (i) LSC	Correction Completed 05/19/2006	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 05/19/2006	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 08/09/2006

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date: 8/9/06
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535038	A. Building B. Wing	8/9/2006

Name of Facility	Street Address, City, State, Zip Code
ROCKY MOUNTAIN CARE EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 04/28/2006	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 08/09/2006	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 08/09/2006
ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 08/09/2006	ID Prefix F0323 Reg. # 483.25(h)(1) LSC	Correction Completed 08/09/2006	ID Prefix F0331 Reg. # 483.25(l)(2)(ii) LSC	Correction Completed 05/19/2006
ID Prefix F0353 Reg. # 483.30(a) LSC	Correction Completed 08/09/2006	ID Prefix F0371 Reg. # 483.35(h)(2) LSC	Correction Completed 05/19/2006	ID Prefix F0430 Reg. # 483.60(c)(2) LSC	Correction Completed 05/19/2006
ID Prefix F0441 Reg. # 483.65(a) LSC	Correction Completed 08/09/2006	ID Prefix F0444 Reg. # 483.65(b)(3) LSC	Correction Completed 08/09/2006	ID Prefix F0454 Reg. # 483.70 LSC	Correction Completed 04/28/2006
ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 05/19/2006	ID Prefix F0493 Reg. # 483.75(d)(1)-(2) LSC	Correction Completed 04/12/2006	ID Prefix F0507 Reg. # 483.75(l)(2)(iv) LSC	Correction Completed 05/19/2006

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535038	A. Building B. Wing	8/9/2006

Name of Facility	Street Address, City, State, Zip Code
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(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0513 Reg. # 483.75(k)(2)(iv) LSC	08/09/2006
ID Prefix F0517 Reg. # 483.75(m)(1) LSC	04/28/2006
ID Prefix F0518 Reg. # 483.75(m)(2) LSC	04/28/2006
ID Prefix F0521 Reg. # 483.75(o)(2)-(4) LSC	05/19/2006

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/16/2006

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