3/19/13

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

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WY Dept of Health
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Healthcare Licensing

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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 02/21/2013

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 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure effective supervision and interventions to prevent falls for 1 of 5 sample residents (#20). As a result a serious avoidable injury was sustained by the resident. The findings were: Review of the 1/31/13 nursing notes showed resident #20 was admitted to the nursing facility that day at 9:35 AM. The note showed the resident was ambulatory, was weepy, and had memory loss and confusion. Interview with the DON on 2/20/13 at 4:55 PM revealed the resident's son, who was present at the admission, stated the resident had not slept "for days." Review of nursing notes from the previous facility, provided during the nursing home admission process, verified the resident had not been sleeping and was having considerable trouble with confusion. Review of the fall risk assessment dated 1/31/13 showed the resident was at high risk for falls due to intermittent confusion, having had a fall in the past 3 months, being ambulatory and incontinent, and taking anti-hypertensive and cathartic medications. The attending physician	F 323	**F323** Resident # 20 is no longer in our facility. All residents admitted to Long Term Care will go thru the IDT Admission team for screening to ensure we are able to meet their needs and are able to provide a safe environment. An assessment will be done prior to admission to ensure that the information that we are provided is accurate regarding the prospective resident's physical needs and any behavioral issues. All new residents will have hourly "checks" for 48 hours. After 48 hours, the resident will be reassessed to ensure that all appropriate safety measures are in place. All new residents will have a fall reassessment conducted by the Director of Nurses (DON)/Assistant Director of Nurses, RN designee, or Social Services Designee. Weekly collaboration at Care	04-05-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jen VanBeek — TITLE: Administrator — (X6) DATE: 03-15-13

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.

Accepted with No Changes DHA notified on 3/19/13 by Lori Lees

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F 323	Continued From page 1 further addressed the resident's diagnoses and behaviors in the 1/31/13 history and physical (H&P). Review of the H&P showed the resident had Alzheimer's type dementia with "frequent anxious features" and an ongoing history of "tearfulness and weeping." In addition, the physician noted the resident had "significant insomnia difficulties...has remained ambulatory and tends to wander with increasingly frequent visits and intrusions into other resident's rooms. [S/he] requires continuous supervision for [his/her] safety and well being." The following concerns were identified: a. Review of the interim care plan dated 1/31/13 showed the resident was assessed as being at high risk for falls, and the resident walked independently. However, the only approach documented was for staff to monitor the resident's whereabouts. b. Review of the 2/1/13 8:30 PM nurse's note showed the resident had a witnessed fall while ambulating in the hallway holding a baby doll and blanket. The note showed the resident began to drop the doll and tripped over his/her own feet in an attempt to catch the doll. The resident was assisted by three staff to a wheelchair and then to bed. The note further showed the resident yelled out with pain upon weight bearing. c. Review of the 2/1/13 nurse's note timed at 9:30 PM showed the physician was at the bedside to assess the resident. There were no notes for the hour between the fall and the arrival of the physician to show what/if any fall prevention/interventions were in place during that time. The 2/1/13 9:30 PM nurse's note further showed physician orders were received to transfer the resident for x-rays of the right leg and hip. The note also showed nursing applied a tab	F 323	Conferences will occur and PRN if more immediate action is needed. The fall protocol will be re-evaluated and updated to include frequent checks immediately after a fall for possible causes and injuries. Immediate interventions will be implemented after the fall to prevent reoccurrence and to assure resident safety. Fall assessments are conducted upon Admission, quarterly and PRN due to change of status or a fall. The fall protocols and new resident hourly checks will be monitored weekly for one month and then monthly afterward and results will be reported monthly by the DON to the Risk and Safety committee as well as the Quality Assurance Committee for one year.	

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F 323	Continued From page 2 alarm (a device to alert staff a resident is getting up) on the resident while awaiting the transfer for x-rays. This same note documented that after the tab alarm was placed, staff left the room and at an unidentified time, the resident fell again while getting out of bed unassisted. d. Review of the 2/1/13 10 PM nurse's note showed the resident was taken for x-rays, found to have a right hip fracture, and was transferred to a larger hospital. e. Interview on 2/20/13 at 7:20 PM with the nurse (LPN #1) and CNAs #1 and #2, who were all three on duty during this incident, revealed they were not sure how much time had passed between the time that staff left the room and the second fall. However, they verified it happened "quickly" after staff left the room. The staff further revealed the tab alarm did not sound. At this time, LPN #1 and CNAs #1 and #2 verified the resident was not continuously supervised after the first fall when she was placed into bed awaiting the physician.	F 323		