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

RECEIVED
WY Dept of Health
NOV 25 2013
Healthcare Licensing

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 10/30/2013

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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to ensure the Foley catheter bags were covered while the residents were in common areas of the facility for 2 of 3 sample residents (#1, #3). The findings were: 1. Review of the 10/7/13 physician's orders showed resident #3 had diagnoses to include urine retention and the resident had a Foley catheter(tube inserted in the bladder for urine drainage). Observation on 10/30/13 at 9 AM showed the resident was transported down the hallway in his/her wheelchair with the Foley catheter bag attached to the bottom of the chair. The bag was uncovered exposing the resident's urine. During an interview with the Assistant Director of Nursing (ADON) on 10/30/13 at 10:10 AM, she acknowledged the drainage bag needed to be covered. Observation at 12:50 PM that same day revealed the resident was in the dining room and his/her drainage bag remained uncovered. 2. Medical record review showed resident #1 had diagnoses to include urine retention and incontinence. Further, the resident had a Foley catheter. Observation on 10/30/13 at 9:10 AM showed the resident was transported from	F 241	**F 241** Resident #1 and #3's catheter bags were put in "bags" to cover them. All residents that have catheter bags will have them covered so as not to expose their urine, especially while they are in a commons area. Staff will be in-serviced → by the DON/Designee KKm on the importance of keeping all catheter bags covered at all times. Assistant Director of Nursing (ADON) will check all catheter bags on a weekly basis → using an auditing tool to ensure KKm for one month ~~to make sure~~ that they are covered and then monthly for one year. Any non-compliance noted will be immediately corrected and in-serving provided KKm ADON will report quarterly to QAPI for one year or until committee recommends completeness.	12-01-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jan VanBeek	Administrator	11-22-13

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.

POC is approved with correction. Amber Ondriezek DON was notified on 12/4/13 at 1020 AM. K Mary Kuhrt State Surveyor

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 10/30/2013

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 241	Continued From page 1 outside his/her room, down the hallway to the shower in a wheel chair. The resident's Foley catheter bag was hung under the wheelchair and was not covered exposing the urine that was in the bag. 3. During an interview with the Director of Nursing and ADON on 10/30/13 at 3:40 PM, they acknowledged the Foley bags needed to be covered.	F 241		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		

11-22-13

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 10/30/2013

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 441	Continued From page 2 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to ensure staff followed acceptable infection control standards of practice in regard to the placement of Foley catheter bags for 2 of 3 sample residents (#3, #4) with catheter bags. The findings were: 1. Review of the medical record for resident #4 showed s/he had urinary tract infections on 4/19/13, 6/30/13 and 9/26/13. Observation on 10/30/13 at 10 AM revealed the resident had a Foley catheter (tube inserted into the bladder to drain the urine). The Assistant Director of Nursing (ADON) transferred the resident to the bathroom and removed the drainage bag from his/her wheelchair and placed it on the floor. An interview with the ADON at that time acknowledged the bag should not be placed on the floor. 2. Observation on 10/30/13 at 9 AM revealed resident #3 was transferred to his/her room in a wheelchair. The resident's Foley catheter bag was attached under the seat of the wheelchair, uncovered and dragging on the floor.	F 441	**F 441** Resident # 3 and #4's catheter bags were covered and not set on the floor. All residents with catheter bags will have their bags covered and not be allowed to lay or be dragging on the floor. Staff will be in-serviced by the DON/Designee on the importance of keeping catheter bags covered and not touching the floor. Assistant Director of Nursing (ADON) will monitor using an auditing tool to ensure that all catheter bags are kept covered and not allowed to drag on the floor on a weekly basis for one month and then monthly thereafter. ADON will report to QAPI committee on a quarterly basis for one year or until the committee recommends completeness. Any non-compliance noted will be immediately corrected and in-serving provided QMB 11-22-13	12/1/13 KLm KLm KLm

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 10/30/2013

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 441	Continued From page 3 3. Review of the infection control logs for September 2013 showed there was one documented urinary tract infection. Review of the October 2013 logs showed there had been six residents with urinary tract infections. An interview with the Director of Nursing (DON) on 10/30/13 at 2:10 PM stated she had not completed an analysis to determine possible causes of the increase in the infections. 4. During an interview with the ADON and DON on 10/30/13 at 3:40 PM, acknowledged the urine collection bags needed to be kept off the floor.	F 441		

11-22-13