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

PRINTED: 11/22/2013
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 _____	C 11/07/2013

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

1/3/14 ce

(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: ADL - Activities of Daily Living CAA - Care Area Assessment CNA - Certified Nurse Aide DON - Director of Nursing LPN - Licensed Practical Nurse MDS - Minimum Data Set PRN - Pro re nata (as needed) RD - Registered Dietitian RN - Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	F 241 1-Staff were instructed on 12/13/13 regarding privacy of residents. Doors will be closed or privacy curtains used when residents are or could be exposed. 2-Resident #23 was dc'd from the facility on 11/19/13. Any resident who is identified as needing nail care, on admission or otherwise, from the podiatrist will be added to the monthly podiatrist list by the nursing staff. If the facility podiatrist has already been in for the month, the resident will be referred to a different provider if necessary.	12/31/13
F 241 SS=E	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 observation, medical record review and staff and resident interviews the facility failed to ensure dignity was maintained for 2 of 9 sample residents (#1, #23) and 3 non-sample residents (#8, #25, #36). The findings were: 1. Medical record review showed resident #8 was admitted to the facility on 10/17/13 with diagnoses including dementia. Review of the admission MDS assessment dated 10/24/13 showed the resident was severely cognitively impaired and	F 241	Nursing staff was in-serviced on this procedure on 12/13/13. 3-Resident #1 was assisted with hair removal on 11/7/13. Her care plan was revised to include hair removal from face as part of her routine grooming. An audit tool was implemented on 12/13/13 after the staff were in-serviced on its use. The unit manager or designee will be reviewing residents at random on a weekly basis to ensure their facial hair is being addressed and they are receiving nail care per his/her care plan. The audit tool will be used for two months, or until the QA committee feels it appropriate to discontinue its use, to ensure residents are receiving proper nail care and grooming.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	12/30/13

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.

RECEIVED
DEC 30 2013
Healthcare Licensing and Surveys

1/13/14 POC was accepted on 1/3/14 @ 12:00PM with verbal corrections from Nancy Bunot Adm - Chapin RN

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F 241	Continued From page 1 required extensive assistance with ADLs. The following concerns were identified: a. Observation on 11/4/13 from 4:55 PM to 5:17 PM revealed the resident's door was open and the resident was visible laying in bed wearing an adult brief. The resident was uncovered from the waist down. At 5:05 PM CNA #1 walked by resident's room and looked into the room; the resident was not covered and the door was left open. During this observation, numerous staff were observed assisting residents to the dining room for the evening meal. Family members were also observed walking in the hallway. At 5:17 PM CNA #1 closed the resident's door. b. Interview with the DON on 11/7/13 at 10:05 AM revealed he expected staff to maintain the resident's privacy by closing doors or covering exposed residents. 2. Medical record review showed resident #23 was readmitted to the facility on 10/22/13 with diagnoses including multiple sclerosis. Review of the 10/29/13 admission MDS assessment showed the resident was cognitively impaired and totally dependent on staff for ADLs. The following concerns were identified: a. Observation on 11/4/13 at 5:42 PM revealed the resident was seated in a reclining chair in the main dining room. The resident was being fed by staff, and was observed to have thick, white facial hair approximately 1/4 to 1/2 inch long. Additional observations were made on 11/5/13 at 12:50 PM and 11/7/13 at 9:30 AM and the thick, white facial hair remained. Interview with the resident on 11/6/13 at 1:50 PM revealed the resident was conscious of the facial hair and it "bothered" him/her. The resident also indicated the staff had not offered to remove the facial hair. b. Observation on 11/5/13 at 12:50 PM	F 241	4-Inservice was held with nursing staff on 12/13/13. Staff was told that insulin is not to be administered in the dining room. 5-Inservice was held with nursing staff on 12/13/13. Staff was told that finger stick blood glucose checks are not to be performed in the dining room. Unit manager or designee will be observing nurses while in the dining room to ensure no insulin is administered and that no glucose checks are being done in the dining area. These observations will be conducted weekly for a period of six weeks and as needed thereafter. Social service staff will provide additional in-service training on dignity on an annual basis. Topics covered will include: personal cares, personal appearance, and privacy. Any concerns regarding dignity and/or respect for individuality will be reported to the QA committee.	

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F 241	Continued From page 2 revealed the resident was seated in the main dining room with his/her feet uncovered. The resident's toenails were long, jagged, thick, and partially covered with chipped red polish. Interview with the resident on 11/6/13 at 1:50 PM verified facility staff had polished his/her toenails "about 6 weeks" previously. c. Interview with the DON on 11/7/13 at 10:05 AM revealed staff were responsible for trimming residents' toenails except when the nails were thick, then the resident was referred to the podiatrist. The DON verified the podiatrist had been in the facility that day, however, the resident had not been referred to have his/her toenails trimmed. 3. Medical record review showed resident #1 was admitted to the facility on 4/12/04 with diagnoses including non-Alzheimer's dementia. Review of the quarterly MDS assessment dated 8/8/13 showed the resident was severely cognitively impaired and required total assistance from staff for ADLs. Review of the care plan updated 8/11/11 identified the resident as having a self-care deficit, communication deficit, and vision impairment. Interventions included staff assisting the resident with ADLs as needed and anticipating needs. The following concerns were identified: a. Observation on 11/5/13 at 8:50 AM revealed the resident had thick, white facial hair above the lip and on the chin that was approximately 1/2 inch long. Subsequent observations on 11/6/13 at 1:10 PM and 11/7/13 at 9:00 AM revealed the resident continued to have thick, white facial hair above the lip and on the chin. Interview with CNA #2 on 11/6/13 at 9:28 AM verified the resident depended on staff for ADLs including bathing and grooming. The interview further revealed CNA #2	F 241		

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F 241	Continued From page 3 had noticed the resident had thick facial hair but staff did not routinely remove facial hair. Interview with the DON on 11/7/13 at 10:05 AM revealed the removal of excess facial hair was not provided as part of routine grooming for dependent female residents. 4. Observation on 11/6/13 at 5:45 PM revealed RN #2 prepared insulin for injection in the main dining room. RN #2 pulled up resident #36's shirt and administered prepared insulin in the resident's abdomen while the resident was seated at the dining table with other residents. Interview with RN #2 at 5:50 PM verified insulin was not supposed to be administered in the dining room. 5. Observation on 11/6/13 at 5:55 PM revealed RN #2 performed a finger stick blood glucose on resident #25 in the main dining room. The resident was seated at the dining table with other residents. 6. Interview with RN #1 on 11/7/13 at 1:15 PM verified insulin administration and finger sticks were not supposed to be performed in the dining room.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278	F 278 1-Resident #28's care plan for incontinence was revised on 12/3/13 to include incontinence cares being provided to him/her as he/she is not a candidate for a toileting program. 2-Resident #1's care plan was reviewed on 12/3/13 and found to be an accurate reflection of his/her needs. Incontinence care will continue to be provided to him/her as the resident is not able to communicate toileting needs most times. 3-Resident #23 was discharged from the facility on 11/19/13.	12/31/13

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F 278	Continued From page 4 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure accurate MDS assessments for 4 of 9 sample residents (#1, #11, #23, #28) with regard to toileting programs. The findings were: 1. Review of the medical record revealed resident #28 was admitted to the facility on 9/26/12 with diagnoses that included peripheral enthesopathy (a disease of bone attachments). Review of the 10/9/13 annual MDS assessment revealed the resident required the total assistance of two or more persons for ADLs such as bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. Additionally, the same MDS assessment showed the resident was on a toileting program for both urinary and bowel	F 278	4-Resident #11's care plan for incontinence was revised on 12/3/13. The care plan is now accurate to the residents incontinence needs and does not include a toileting plan for him/her. Training will be conducted by the MDS consultant on or before 12/13/13 with the MDS nurse and DON regarding the definition of a "toileting program." MDS nurse will begin using appropriate definition immediately. Ten percent of all completed MDS assessments will be audited for accuracy by the MDS consultant once per month for next three months and as needed thereafter. Any concerns will be addressed immediately and reported to the QA committee on a monthly basis.	

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F 278	Continued From page 5 incontinence. The following concerns were identified: a. Observation on 11/5/13 at 9:47 AM revealed s/he was transferred from wheelchair to bed with the assistance of a Hoyer lift. The resident was not transferred to the toilet for voiding. The resident was lowered onto the bed, and provided incontinence care. Interview with CNA #4 and CNA #5 at that time revealed the resident was not routinely transferred to the toilet, but was instead provided incontinence care in bed. b. Review of the resident's care plan for incontinence, with a start date of 10/11/13, revealed the following approaches: answer call light in a timely manner, check and change every 2-3 hours and PRN, provide disposable briefs for the resident to use, monitor incontinence, provide peri care with each change and keep skin clean and dry. No approaches involving prompted voiding, scheduled toileting or bladder training were found. 2. Medical record review showed resident #1 was admitted to the facility on 4/12/04 with diagnoses that included non-Alzheimer's dementia. Review of the quarterly MDS assessment dated 8/8/13 showed the resident was severely cognitively impaired, required total assistance from staff to perform ADLs and was always incontinent of bowel and bladder. The MDS further indicated the resident was on a toileting program. Review of the care plan updated 8/8/13 identified the resident was incontinent of both bowel and bladder and interventions included staff, "check and change every 2-3 hours and as needed." The goal was for the resident to be kept dry with no odor by next review. Observation on 11/6/13 at 4:40 PM revealed the resident was	F 278		

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F 278	Continued From page 6 incontinent. Interview with CNA #6 on 11/6/13 at 2:30 PM revealed the resident was incontinent and not able to communicate toileting needs most times. 3. Medical record review showed resident #23 was admitted to the facility on 8/13/13 with diagnoses that included multiple sclerosis and neurogenic bladder. Review of the readmission MDS assessment dated 10/29/13 showed the resident was always incontinent of bowel and bladder, and dependent on staff to perform ADLs. The MDS also showed the resident was on a toileting program. Review of the CAA dated 10/11/13 identified the resident as being incontinent of bowel and bladder. Review of the care plan, updated 10/11/13, identified the resident was incontinent of bowel and bladder. Interventions included check and change every 2 hours and as needed. The goal was for the resident to participate in the current toileting plan of check and change between now and the next review. Periodic observations on 11/5/13 and 11/6/13 revealed the resident had contractures in both hands, speech was limited to occasional short responses, and the resident was incontinent. 4. Medical record review showed resident #11 showed the resident was admitted to the facility on 7/11/13 with diagnoses that included non-Alzheimer's dementia. Review of the significant change MDS assessment, dated 10/24/13, revealed the resident was always incontinent of bladder and frequently incontinent of bowel. The MDS assessment further showed the resident was on toileting programs for both bladder and bowel. Review of the resident's care plan for bowel	F 278		

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F 278	Continued From page 7 and bladder incontinence showed it was started on 10/29/13. The goal showed the resident would be able to follow his/her "toileting plan between now and the next review." The approaches then showed the resident was to be "checked and changed" by the staff every 2 hours and as needed. No approaches involving prompted voiding, scheduled toileting or bladder training were found. 5. Interview with the MDS data entry nurse (LPN #1), on 11/7/13 at 12:37 PM verified residents #1, #11, #23 and #28 were not continent of bowel and bladder and were not regularly taken to the bathroom for toileting. Further interview revealed she considered checking residents for incontinent episodes every 2 to 3 hours, providing perineal care and a dry adult brief to be a toileting program, and that these interventions were not intended to maintain or improve resident continence. 6. According to CMS's RAI Version 3.0 Manual, dated May 2013 (page H-4), "Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to simply tracking continence status, changing pads or wet garments, and random assistance with toileting or hygiene."	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

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F 279	Continued From page 8 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). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and resident, family and staff interview, the facility failed to ensure care plans were developed to include measurable objectives and individualized approaches for 3 of 9 sample residents (#11, #23, #24) and one non-sample resident (#25). The findings were: 1. Review of the 11/1/13 significant change MDS assessment, section V showed resident #11 triggered for areas including urinary incontinence, communication, ADLs, and weight loss. The decision to care plan these areas had been made, and review of the care plan showed these areas were addressed. However, the problems and goals were not well-defined, and the approaches were not tailored to the individual. The following areas were noted to be lacking:	F 279	F 279 1-The care plans for resident #11 covering the following areas: ADL functioning, weight loss, impaired communication, and bowel and bladder incontinence, were revised to include well defined goals and individualized approaches. 2-Resident #25 was dc'd from the facility on 12/15/13. 3-Resident #23 was discharged from the facility on 11/19/13. 4-Resident #24's record was reviewed and care plan written to include infection and risk of infection related to the knee infection and the PICC line. Training will be conducted by the MDS consultant for the MDS nurse and DON on 12/12/13. Emphasis will be placed on individualized care plan writing. The facility will implement a program where new physician orders will be reviewed by unit manager or designee and care plans revised as necessary. Ten percent of all completed care plans will be audited for individualized approaches by the MDS consultant once per month for next three months. Any concerns will be addressed immediately and reported to the QA committee.	12/31/13

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F 279	Continued From page 9 a. Review of the care plan for ADL functioning showed the resident "requires assistance with ADLs" and the goal was for the resident "to be able to assist with ADLs between now and the next review." The care plan failed to describe what ADLs required staff assistance and to what degree staff provided assistance. The approaches showed staff were to explain to the resident what was being done, to approach in a calm manner, allow the resident time to assist as able, and to encourage the resident to assist as able. b. Review of the care plan for weight loss showed it was initiated on 10/29/13, and the goal was for the resident to maintain an adequate weight between then and the next review. The care plan failed to define what an adequate weight was for the resident. In addition, the care plan approaches failed to be individualized and did not include the resident's need for a modified diet or adaptive equipment. Observation on 11/6/13 at 12:30 PM showed the resident required total assistance with eating and had a mechanically altered meal. In addition, the CNA provided drinking straws with each of the resident's beverages. c. Review of the care plan for impaired communication showed it was started on 10/29/13. The problem was defined as "communication impaired related to dementia and visual difficulty." The goal showed the resident would be able to make his/her needs known between now and the next review. Observation on 11/6/13 at 2 PM showed the resident did not communicate verbally with two CNAs who assisted with cares. Interview with CNAs #3 and #2 at that time revealed the resident "doesn't usually talk." The care plan failed to include that the resident was mostly non-verbal. In addition,	F 279		

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F 279	Continued From page 10 the approaches were not individualized. d. Review of the care plan for bowel and bladder incontinence showed it was started on 10/29/13. The goal showed the resident would be able to follow his/her "toileting plan between now and the next review." The approaches then showed the resident was to be "checked and changed" by the staff every 2 hours and as needed. The approaches failed to define a toileting plan in which the resident could participate. 2. Review of the 9/18/13 admission MDS assessment showed resident #25 triggered for weight loss related to cerebrovascular accident, choking, and gastroesophageal reflux disease. Review of the speech language therapist plan of care dated 9/23/13 showed the resident was taught to utilize compensatory strategies that included chin tuck and double swallow. However, review of the nursing care plan showed the plan failed to include these approaches. The goal on the care plan showed the resident would maintain an adequate weight, however, no weight was included. Further, the approaches on the nursing care plan failed to show individualized interventions including the modified diet texture ordered by the physician. 3. Medical record review showed resident #23 was admitted to the facility on 8/13/13 with diagnoses including multiple sclerosis, joint contractures, neurogenic bladder, and muscle atrophy (degeneration). Review of the admission MDS assessment dated 9/4/13 showed the resident was cognitively impaired and was totally dependent on staff for ADLs including eating. Additional review of the MDS showed the resident had limited range of motion in his/her bilateral	F 279		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 11 upper extremities. Review of the CAA dated 8/29/13 identified the resident as being at risk for dehydration and indicated a care plan should have been developed. Review of the care plans dated 8/29/13 and updated 10/11/13 revealed there was no care plan for dehydration. a. Observation on 11/6/13 from 12:50 PM through 4:45 PM (almost 4 hours) showed no staff offered or provided the resident with any fluids. b. Interview on 11/6/13 at 9:40 AM with the resident's family member revealed s/he was concerned staff were not providing the resident with fluids between meals. This was a concern because, "both of [resident's name] hands are contracted and [s/he] cannot drink independently and has been treated for a urinary tract infection." c. During an interview with the resident on 11/6/13 at 1:50 PM the resident stated, "I can't move my hands, can't pick up cup." The resident also indicated staff did not offer fluids between meals. 4. Review of the medical record for resident #24 showed the resident was admitted to the facility on 10/22/13 with diagnoses including post operative knee infection, intravenous (IV) antibiotic therapy and peripherally inserted central catheter (PICC) line. Review of the admission MDS assessment dated 11/4/13 showed the resident was cognitively intact. Review of the care plan dated 10/31/13 identified the resident was at risk for dehydration related to wound infection and IV therapy. There were no interventions listed related to the resident's PICC line. In addition, there were no care plans developed identifying the resident as treated with Vancomycin (an IV antibiotic) that required a blood test for proper dosing. There was no care plan identifying the	F 279		

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F 279	Continued From page 12 resident as having an actual infection or the potential for an infection related to the knee infection and the PICC line. Interview with the MDS data entry nurse (LPN #1) on 11/7/13 at 1:35 PM verified care plans needed to be individualized to reflect the specific needs and approaches being used for the residents.	F 279	F 309 1-Wound care nurse/wound care team will assess and complete comprehensive documentation of wound characteristics on a weekly basis as well as on admission and on discharge.	12/31/13
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record and facility policy and procedure review, and staff interview, the facility failed to gather accurate, objective and consistent data on wounds, including regular wound measurements and descriptions, for 2 of 2 sample residents (#23, #38) and 1 non-sample resident (#16) with wounds. The failure to comprehensively and objectively assess and monitor resident wounds negatively impacted the facility's ability to provide timely interventions resulting in an emergent surgical procedure for resident #38 on the same day s/he was discharged from the nursing home. The findings were: 1. Review of hospital medical records revealed	F 309	In-service for nursing staff was conducted on 12/2/13 and 12/13/13 to review the appropriate documentation of skin issues. CNA staff were in-serviced on 12/31/13 regarding the reporting of skin issues. Staff was also instructed on the timeliness of documentation. 2-Resident #23 was discharged from the facility on 11/19/13. 3-Resident #16's wound was comprehensively assessed on 11/22/13. This assessment included size/measurement and description. The wound is being monitored and cared for per physician orders. Wound documentation is occurring weekly and will continue weekly until resolved. In-service for nursing staff was conducted on 12/2/13 and 12/13/13 to review the appropriate documentation of skin issues. Staff were instructed to include comprehensive documentation of wound characteristics (including, but not limited to: location, measurements, color, odor, drainage, etc.) when completing wound documentation.	

Resident #38? Res. #38 was discharged on 10/16/13 per Nancy Burnett Adm.

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F 309	Continued From page 13 resident #38 underwent surgery for a total right knee arthroplasty on 9/17/13. According to the hospital discharge summary (discharge date 9/26/13), post-operative complications included a large hematoma in the operative leg, which required the resident to undergo surgery for evacuation and debridement. Further review of the same hospital discharge summary revealed the resident improved, and "the hematoma did not recur." Hospital discharge diagnoses were: 1. Status post right total knee arthroplasty. 2. Right fifth metatarsal healing ulcer. 3. Chronic bilateral lower leg edema. 4. Status post evacuation, right lower leg hematoma. The following concerns with wound assessment at the nursing facility were identified: a. Review of the nursing home medical record revealed the resident was admitted to the nursing facility on 9/26/13 for rehabilitation following surgery, and was discharged on 10/16/13. A skin check from the date of admission showed the resident was admitted with "Bruises, Open Lesions/Pressure Ulcers, Surgical Wounds" and further noted s/he had an "ulcer on heel that is dressed that is below the ankle and above the pad of the foot." No other description of this ulcer, such as measurements or wound stage was included. Also noted on the same skin check was "resident has only one surgical wound that I know of for now until tomorrow when we can remove leg wraps." No other objective description of the resident's wounds, such as location or measurements, on admission to the facility was recorded. b. Review of daily Medicare nursing notes from 9/27/13 to 10/16/13 revealed the resident was assessed as having "skin problems" on each day, and the skin color was within normal limits. On no days were any objective data (such as	F 309	Skin checks will be completed weekly by nursing staff and will include comprehensive documentation of wound characteristics. An audit tool will be used by DON or designee to monitor wound documentation. Weekly chart audits will be conducted for a period of three months to ensure staff are documenting appropriately on wound/skin care. Any concerns regarding wound/skin care will be addressed at a weekly skin meeting and will be brought before the QA committee on a monthly basis.	

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measurements) that would have allowed a determination of the progress of the wounds recorded.

c. Review of skin checks dated 9/30/13, 10/7/13, and 10/14/13 revealed the resident had "Bruises, Open lesions/Pressure Ulcers, Surgical Wounds" but failed to document any objective assessment of the wounds, such as measurements, which would have indicated whether the wound was, or was not, improving with treatments.

d. Notation of a communication with the physician, dated 10/10/13 and timed at 11 AM, but entered into the computerized record system on 10/21/13 (5 days after the resident was discharged) revealed the resident "saw Dr. [physician name] in his office and he wants [him/her] to do whirlpool treatments to [his/her] hematoma at the hospital. I called Dr. [physician name] and asked if it was ok to do whirlpool treatment here as [s/he] is here on a Medicare stay. He agreed and stated his office would fax me an order." This documentation was not noted as a late entry.

e. Notation of a communication with the physician, dated 10/11/13 and timed at 1 PM, but entered into the computerized record system on 10/21/13 (5 days after the resident was discharged) revealed "[the resident] was reported to refuse whirlpool therapy by the PT [physical therapy] staff. I called Dr. [physician name] and made him aware. He stated that [the resident] need (sic) to be informed that if [s/he] did not do the therapy [s/he] would end up in surgery for [his/her] hematoma. I went in and talked to [the resident] and [s/he] said [s/he] was aware of the risks and told me about a doctor telling [his/her] father that [s/he] could get MERSA (sic) from using one of those 'things.' I stated that the

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F 309	Continued From page 15 Whirlpool was cleaned and that no other residents would be using it. I further stated that infection control processes are much better than in the past. [The resident] said [s/he] would use the whirlpool on Monday." This documentation was not noted as a late entry. f. Notation of a communication with the physician dated 10/14/13 and timed at 11 AM, but entered into the computerized record system on 10/21/13 (5 days after the resident was discharged) revealed "[the resident] continues to refuse the whirlpool for skin care. I talked to [the resident] and [s/he] stated [s/he] wanted to see Dr. [physician name] first. I called Dr. [physician name]'s office and made an appointment for [the resident] on Friday as that was the soonest they could see her. I notified them of the issues and they stated Dr. [physician name] and [another physician] had been talking and were on the same page. [The resident] was advised to do the wound care therapy already ordered. I notified [the resident] that both doctors were aware of [his/her] need for wound care to [his/her] hematoma and that it was recommended [s/he] do the therapy in the whirlpool." This documentation was not noted as a late entry. g. Review of the nursing home discharge summary dated 10/16/13 revealed the resident required dressing changes "Right calf - Hematoma - every other day - clean - oil emulsion then ABD pads - cover with Ace wrap." No summary of the resident's course of treatment for his/her wounds was included. No description of the wound, such as measurements, was included. No mention was made of any heel or foot ulcers. The discharge summary further revealed the resident was discharged to an assisted living facility. h. Review of the hospital history and physical	F 309		

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F 309	Continued From page 16 dated 10/16/13 revealed the resident was sent from the assisted living facility to the emergency room on that same day (10/16/13) for evaluation of the wound on his/her right leg. From the emergency room, the resident was taken to the operating room, where s/he underwent incision and drainage of "right lower extremity necrotic eschar." Review of the hospital operative report dated 10/16/13, timed at 9:14 PM, revealed findings of "a 14 X [by] 17 cm necrotic eschar on [his/her] right lower extremity in the medial calf. This had skin that was completely nonviable and was petrified. Underlying this, there was coagulated old hematoma. The necrotic skin was removed entirely. The hematoma was evacuated. After debriding the wound surface, I pulse irrigated the wound with 3 L [liters] of pulse irrigation. " i. No evidence was provided that demonstrated regular, comprehensive assessment of this resident's wound, with ongoing communications of the wound status to the physician for consideration of treatment options. Interview with RN #1 on 11/7/13 at 2:17 PM revealed, "We [the facility] don't usually measure hematomas." 2. Medial record review showed resident #23 showed the resident was admitted to the facility on 8/13/13 with diagnoses including multiple sclerosis. Review of the admission assessment MDS dated 9/4/13 identified the resident had a skin lesion that required the application of dressings, ointments, and/or medications. Review of the care plan dated 8/29/13 showed the resident was identified as being at risk for developing pressure ulcers. Interventions included turn and reposition frequently, include in skin meeting weekly and notify MD of skin issues.	F 309		

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F 309	Continued From page 17 The following concerns were identified: a. Review of the admission skin assessment dated 8/13/13 revealed the resident had a surgical site on the left lower leg where a basal cell carcinoma was removed. There was no description or measurement of the wound and there was no indication whether the wound was located on the front or the back of the leg. Review of skin checks dated 9/3/13, 9/10/13, 9/17/13, 9/24/13, and 10/1/13 also failed to identify the exact location, description or measurements of the left lower leg wound and listed the wound as a skin tear. The skin check dated 8/20/13 did not address any wounds on the left lower extremity. b. Additional review of the medical record showed the resident was hospitalized on 10/4/13 and readmitted to the facility on 10/6/13. Review of the skin assessment and wound documentation dated 10/6/13 showed the resident had a skin tear on the left lower leg that had a dressing. There was no documentation of the exact location, measurement or appearance of the wound. Review of additional skin checks revealed there was no documentation of the exact location, measurement or appearance of the wound on the left lower extremity. c. Further review of the medical record showed the resident was hospitalized for surgical repair of a left fractured femur on 10/16/13 and readmitted to the facility on 10/22/13. Review of a nursing note dated 10/29/13 showed the resident had an open wound on the posterior left lower calf that was, "large, open, moist with yellow slough,~ [approximately] 5 cm." Review of a late-entry nursing note dated 11/4/13 showed the wound was present on re-admission, a non-pressure ulcer, the wound was red/pink with yellow slough inside wound bed and had scant drainage with no odor. Measurements were 6.0	F 309		

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cm by 5.0 cm and the wound was 0.5 cm deep.

d. Observation of the posterior left lower leg wound on 11/7/13 at 2 PM with RN #1 revealed the RN assessed the wound measurements as 7.5 cm by 3.5 cm and the depth was not measured. The upper portion of the wound, approximately 25%, was bright red. The middle approximately 25% was covered with yellow slough and the lower portion, approximately 50% of the wound, was covered with eschar (black/brown leathery dead tissue). Interview with RN #1 at the time of the observation revealed the resident, "had the wound when [s/he] was admitted to the facility." There was no additional documentation of the exact location, appearance, or measurement of the wound on the posterior left lower leg provided.

3. Medical record review showed resident #16 was admitted to the facility on 10/25/13. Review of the admission MDS assessment dated 11/1/13 revealed diagnoses that included cellulitis and unspecified local infection of skin and subcutaneous tissue. Skin check documentation dated 10/25/13, timed 1:33 PM, indicated the resident had a "Hematoma to left inner calf - 11 cm X [by] 8 cm. Also has purple discoloration to inner buttocks - skin repair cr. [cream] applied." Additionally, "...Will also apply skin repair cr. [cream] TID [three times daily] to left inner calf open to air and area circled with a red pen." A physician's telephone order dated 10/25/13 revealed instructions to "Monitor hematoma left inner calf QD [every day] for increase in size." The following concerns with wound assessment were identified:

a. Review of nursing notes from 10/26/13 through 10/29/13 failed to show any evidence the lesion on the resident's left calf was being

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F 309	Continued From page 19 monitored for size. b. Skin check documentation dated 10/31/13, timed 10:27 PM reiterated the size of the hematoma as "11 cm X 8 cm." No further measurements of the lesion were found in the record. c. Review of the wound rounding report dated 11/4/13 revealed only that the resident had a hematoma to the left lower extremity, the treatment was recorded as "opsites - stratasorb?" and the wound progress was recorded as worsening. No indication of how the lesion was worsening was recorded. No objective data, such as measurements of the lesion, were recorded. d. Wound progress notes dated 11/6/13, timed 7:23 AM, revealed documentation of a "raised hematoma with cellulitis" to the left lower leg. The lesion was described as "Large hematoma, black/red, draining bloody fluid, peri wound is red, warm, painful with cleansing, no odor. Cleansed, dried, maxsorb (sic) extra ag and kerlix applied." No measurement of the lesion was recorded. e. Observation of a change of the resident's dressing on 11/7/13 revealed a large, raised lesion on the resident's lower left medial leg. In the center of the raised lesion was an area of eschar. The dressing that had been applied to the lesion was stuck to this area of eschar. The entire lesion had been outlined in red ink. The raised area of the lesion continued to the line of red ink, but did not extend beyond it. RN #1 stated at the time of the observation, "We [the facility] don't usually measure hematomas." At the request of the surveyor the lesion was measured. Measurements taken by RN #1 at the time of the observation revealed the overall size of the lesion was 8 1/2 cm by 7 cm. The area of eschar in the center of the lesion was also measured at that	F 309		

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F 309	Continued From page 20 time, and measured 5 cm by 3 cm. 4. Review of the facility's policy and procedures on the subject of "Pressure Ulcer Prevention/Skin Assessment/ Documentation/ Staging/Treatment" reveals the purpose of the policy is to "Identify all skin abnormalities that are present on admission and throughout the resident's length of stay" and "Gather accurate, objective and consistent data for the purpose of implementing an individualized Plan of Care designed to meet the resident's skin care needs." 5. Interview with RN #1 on 11/7/13 at 1:15 PM revealed that facility nursing interventions were derived from "Nursing Interventions and Clinical Skills" by Perry, Potter and Elkin. According to Perry, Potter and Elkin, "Nursing Interventions & Clinical Skills" 5th ed. St. Louis, MO: Mosby, 2012, page 585 "Wound assessment is essential in wound management. The assessment of the following factors: location, dimensions, undermining, drainage, tissue type, exudate, wound edges, and pain, plays an important role in correct diagnosis and proper treatment of wounds and hard-to-heal pressure ulcers. A uniform approach to wound assessment that uses measurements can identify the appropriate treatment plan and appropriately evaluate progress to healing."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview the facility failed to ensure grooming needs were met for 1 of 9 sample residents (#23) and 2 non-sample residents (#19, #25) who were dependent on staff for ADLs. The findings were: 1. Medical record review revealed resident #23 was readmitted to the facility on 10/22/13 with diagnoses including multiple sclerosis. Review of the 10/29/13 admission MDS assessment showed the resident was cognitively impaired, had limited range of motion in bilateral upper and lower extremities, and was totally dependent on staff for ADLs. The following concerns were identified: a. Observation on 11/6/13 at 12:50 PM revealed the resident was seated in the main dining room with his/her feet uncovered. The resident had visible contractures of his/her hands and feet. The resident's toenails were long, jagged, thick, and partially covered with chipped red polish. Interview with the resident on 11/6/13 at 1:50 PM verified facility staff had polished his/her toenails "about 6 weeks" previously. b. Interview with the DON on 11/7/13 at 10:05 AM revealed staff were responsible for trimming resident's toenails except when the nails were thick, then the resident was referred to the podiatrist. The DON verified the podiatrist had been in the facility that day, however, the resident had not been referred to have his/her toenails trimmed. 2. Medical record showed resident #19 was	F 312	F 312 1-Resident #23 was dc'd from the facility on 11/19/13. CNA staff was in-serviced on 12/31/13 on what they can/cannot do for residents toenail care. Nursing staff will not be cutting resident's toenails. They will be responsible to keep their nails clean. Residents needing toenail care/nails cut will be added to monthly podiatrist visit list. 2-Resident #19 was assisted with nail care on 11/7/13. 3-Resident #25 was discharged from the facility on 12/15/13. Staff was educated on 12/31/13 regarding the resident's right to refuse treatment and that the charge nurse will be notified when a resident is refusing treatment. In-service was held with nursing staff on 12/13/13 regarding nail care. Supplies will be purchased to make nail care easier and more efficient for staff and residents. An audit tool was implemented on 12/13/13 after the staff were in-serviced on its use. Audits will be conducted by unit manager or designee. The audit tool will be used at least once per week for a period of three months to ensure residents are receiving proper nail care. Any concerns will be brought to the QA committee.	12/31/13

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	535038	A. BUILDING _____ B. WING _____	C 11/07/2013

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

1/3/14 dc

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F 312	Continued From page 22 admitted to the facility on 6/22/04 with diagnoses including non-Alzheimer's dementia. Review of the quarterly MDS assessment dated 8/28/13 showed the resident was severely cognitively impaired and was dependent on staff for ADLs including bathing and grooming. Review of the care plan updated 8/28/13 identified the resident as having a self-care deficit and impaired visual function. Interventions included providing assistance with ADLs as needed and staff anticipating the resident's needs. Review of the medical record further showed the resident received a "dependent bath/shower" on 11/6/13. The following concerns were identified: a. Observation on 11/6/13 at 1:22 PM revealed the resident had long, polished fingernails. When the resident's hands were turned over the nail beds were encrusted with thick, brown matter. Observation on 11/6/13 at 5:40 PM revealed the resident eating finger foods in the dining room. Subsequent observation with the DON on 11/7/13 at 10:05 AM verified the resident's nail beds continued to have encrusted brown matter under the nail beds. 3. Medical record review revealed resident #25 was admitted to the facility on 8/20/13 with diagnoses including cerebrovascular accident. Review of the admission MDS assessment dated 9/18/13 showed the resident was cognitively impaired and required total assistance from staff with hygiene and bathing needs. Review of the care plan dated 9/2/13 identified the resident as having impaired ADL functioning. Interventions included assisting with ADLs. Review of bathing notes dated 10/4/13 through 11/4/13 showed the resident had refused showers 3 times. No follow-up documentation was provided related to the resident refusing showers. The following	F 312		

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F 312	Continued From page 23 concerns were identified: a. Observation after the noon meal on 11/6/13 at 1:10 PM revealed the resident seated in a wheelchair near the nursing station. The resident's fingernails were long and jagged. The nail beds were encrusted with thick brown matter. Subsequent observations on 11/6/13 during the evening meal at 5:40 PM and 11/7/13 at 8:50 AM revealed the resident continued to have long, jagged fingernails encrusted with thick, brown matter. b. Interview with CNA#2 on 11/6/13 at 9:28 AM revealed CNAs were responsible for cleaning resident's fingernails during showers, but nurses were responsible for trimming the resident's fingernails. Interview further revealed CNAs were supposed to inform nurses when a resident refused care. c. Interview with the DON on 11/7/13 at 10:05 AM revealed he expected staff to provide nail care during bathing.	F 312	F 314 Resident #23 was discharged from the facility on 11/19/13. Training will be conducted by the MDS consultant for the MDS nurse and DON on or before 12/24/13. Emphasis will be placed on individualized care plan writing. DON or designee will be responsible for ensuring that care plans are current and reflect any changes in resident care. Nursing staff will review new physician orders and add additional interventions to care plans as needed.	12/31/13
F 314 D 1/16/14 ae	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review	F 314	Wound care nurse/wound care team implement preventative measures as needed for residents who are identified as being at risk for skin breakdown. These preventative measures will be discussed in weekly skin meeting and will be documented in the resident's medical record. CNA staff were in-serviced on 12/31/13 regarding the reporting of skin issues to nursing staff. Ten percent of all completed care plans will be audited for individualized approaches by the MDS consultant once per month for next three months. Any concerns will be reported to the QA committee.	

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F 314	Continued From page 24 and staff and family interview the facility failed to ensure measures were in place to prevent the development of pressure ulcers for 1 of 9 sample residents (#23) identified as being at risk for developing pressure ulcers. The findings were: Medical record review revealed resident #23 readmitted to the facility on 10/22/13 with diagnoses including multiple sclerosis and post surgical femur fracture repair. Review of the readmission MDS assessment dated 10/29/13 showed the resident had limited range of motion in bilateral upper and lower extremities and was dependent on staff for ADLs. The MDS further showed the resident did not have any pressure ulcers. Review of the resident's closed medical record showed a nursing note dated 10/2/13 documenting the resident went out to the hospital for an x-ray and returned wearing a knee immobilizer. Review of the CAA dated 10/13/13 showed the resident was at risk for developing pressure ulcers related to decreased mobility and fractured femur. The CAA also showed the resident required frequent repositioning and was unable to do that independently. Review of the care plan dated 10/11/13 identified the resident as being at risk for pressure ulcers. Interventions were not individualized and did not reflect the resident's current wounds or the immobilizer brace on the resident's left leg. The interventions included using heel protectors and notifying MD of skin issues. Review of nursing skin assessments dated 10/29/13 and 11/4/13 showed the resident had a surgical incision on the left knee and an "open lesion/pressure ulcer" on the posterior left lower leg. Review of the resident's hospital discharge summary dated 10/22/13 revealed the resident had a left knee post-surgical incision and a venous stasis ulcer	F 314		

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F 314	Continued From page 25 on the back of the left lower leg. The following concerns were identified: a. Observation on 11/6/13 at 1:30 PM revealed the resident had an immobilizer brace in place on the left leg. The visible skin on the upper posterior thigh at the edge of the brace was bright red with a partially visible scab. RN #1 pulled the brace down and the skin underneath the edge of the brace was bright red with a loose quarter-sized scab. There was no barrier between the brace and the resident's skin, and no dressing or creams were applied. Interview with RN #1 at the time of the observation revealed the resident was readmitted to the facility with current wounds. Observation on 11/7/13 at 2 PM revealed RN #1 removed the resident's brace and the resident's skin on the upper posterior thigh where the skin was in contact with the edge of the brace was bright red with a quarter sized scab. The wound was not measured but the area of redness was approximately hand-width. The resident was also observed to have reddened skin and a dime-sized open area behind the left knee. Interview with CNA #7 at the time of the observation revealed the resident's, "brace rubbed the skin" and the upper posterior thigh had been that way for about a week. CNA #7 further revealed the open area and redness behind the knee was new. b. Interview with the resident's family member on 11/8/13 at 9:40 AM revealed the family member was concerned about the, "new skin breakdown from the brace rubbing the leg." The family member indicated s/he had discussed this with facility staff, however, nothing had been changed.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		

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F 318	Continued From page 26 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview with staff and family, the facility failed to ensure range of motion exercise was provided to maintain the highest level of functioning for 1 of 7 sample residents (#23) identified as having range of motion limitations. The findings were: Review of the closed medical record for resident #23 showed the resident was originally admitted to the facility on 8/13/13 with diagnoses including multiple sclerosis. Review of the admission MDS assessment dated 9/4/13 showed the resident was totally dependent on staff for ADLs and had limited range of motion in bilateral upper and lower extremities. Review of the care plan dated 8/29/13 identified the resident as having impaired ADL functioning related to multiple sclerosis and contractures (immoveable, fixed joints). Interventions were not individualized and included "assist the resident with ADLs." Review of a nursing assessment note dated 8/17/13 showed the resident was supposed to have active and passive range of motion exercises to all extremities daily. The following concerns were identified: a. Periodic observations from 11/4/13 through	F 318	F318 Resident #23 was dc'd from the facility on 11/19/13. Restorative Therapy Aide (RTA) staff was in-serviced regarding the importance of RTA treatments by the DON on 11/8/13. They were instructed to get treatments done on a daily basis. Audit of RTA treatment completion will be conducted once per week for six weeks by DON or designee. Monthly RTA review meetings will be held to ensure the plans are being followed. Results of audits or concerns identified due to lack of treatments will be reported to the QA committee.	12/31/13

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F 318	Continued From page 27 11/7/13 revealed no range of motion exercises were performed with the resident. Observation on 11/4/13 at 5:42 PM revealed the resident had visible contractures of both hands and feet. The resident also had hand splints in place. b. Review of the restorative documentation from 8/17/13 through 11/4/13 showed there were 41 entries of "no therapy today" documented. The restorative aide was not available for an interview. c. Interview with the resident's family member on 11/6/13 at 9:40 AM revealed s/he was concerned the resident was not receiving range of motion exercises to maintain current level of functioning. The family member revealed s/he was usually in the facility several times a day and had never witnessed staff performing range of motion exercises with the resident. d. Interview with the DON on 11/7/13 at 1 PM revealed restorative aides were responsible for performing range of motion exercises with residents and were supposed to document a reason if the exercises were not performed. He indicated no further documentation was available as to why the range of motion exercises were not performed with the resident.	F 318	F 327 1-Resident #23 was dc'd from the facility on 11/19/2013. 2-Resident #1's nutrition risk review was redone by the RD to reflect the resident's hydration needs. Staff were in-serviced on the need for proper hydration of residents on 12/13/13. A program will be implemented where staff will offer fluids to residents any time they are providing cares or having any interaction with a resident.	12/31/13
F 327 SS=E	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and family interview, the facility failed to ensure adequate interventions were implemented	F 327	Staff will begin charting in resident's medical record, fluid intakes between meals. Audits will be conducted by DON or designee to ensure staff are offering fluids when in a resident's room and to ensure staff are charting fluid intakes. These audits will be conducted on a weekly basis for six weeks. Any concerns with hydration will be reported to the QA committee.	

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F 327	Continued From page 28 related to hydration for 2 of 3 sample residents (#1, #23) identified as being at risk for dehydration. The findings were: 1. Medical record review revealed resident #23 was admitted to the facility 8/13/13 with diagnoses including multiple sclerosis, joint contractures, neurogenic bladder, and muscle atrophy (degeneration). Review of the admission MDS assessment dated 9/4/13 showed the resident was cognitively impaired and totally dependent on staff for ADLs including eating. Additional review of the MDS showed the resident had contractures to both hands. Review of the CAA dated 8/29/13 identified the resident as being at risk for dehydration and indicated a care plan should be developed. Review of the care plans dated 8/29/13 and updated 10/11/13 revealed there was no care plan for dehydration. Review of the medical records showed the resident was admitted to the hospital for treatment of "urosepsis" 10/4/13 through 10/6/13. Review of the nutrition risk assessment dated 10/8/13 showed the RD identified the resident's hydration needs which ranged from 1530 to 1890 cubic centimeters daily, and the resident's needs were not always met. Recommendations made by the RD included; "8 oz [ounces] extra fluid each meal and between meals." The following concerns were identified: a. Observation on 11/6/13 from 12:50 PM through 4:45 PM (almost 4 hours) showed no staff offered or provided the resident with any fluids. At 1:25 PM a volunteer came into the resident's room and filled the resident's water pitcher with ice but did not offer the resident any fluids. At 2:13 PM CNA #6 went into the resident's room to check the resident for incontinence, however, no fluids were offered. At 4:45 PM CNA	F 327		

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F 327	Continued From page 29 #6 again entered the resident's room to check for incontinence and no fluids were offered. b. Interview on 11/6/13 at 9:40 AM with the resident's family member revealed s/he was concerned staff were not providing the resident. with fluids between meals. This was a concern because, "both of [resident's name] hands are contracted and [s/he] cannot drink independently and has been treated for a urinary tract infection." c. During an interview with the resident on 11/6/13 at 1:50 PM the resident stated, "I can't move my hands, can't pick up cup." The resident also indicated staff did not offer fluids between meals. d. Review of the total fluid intake 10/1/13 through 11/7/13 showed for the 29 entries documented the resident's average daily intake was 430 cubic centimeters of fluid per day. No additional documentation was provided related to fluid intake. 2. Medical record review showed resident #1 was admitted to the facility on 4/12/04 with diagnoses including non-Alzheimer's dementia. Review of the quarterly MDS assessment dated 8/8/13 showed the resident was severely cognitively impaired and required total assistance from staff for ADLs including eating. Review of the CAA dated 5/13/13 identified the resident as being at risk for dehydration related to dementia and decreased perception of thirst. The care plan updated 8/8/13 indicated the resident was at risk for dehydration and interventions included offering fluids several times during the day and monitoring for signs of dehydration. Review of the nutritional risk review dated 3/13/13 showed it did not identify the resident's hydration needs. No additional hydration assessments or recommendations were provided. Current	F 327		

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F 327	Continued From page 30 recommended guidelines for determining baseline daily fluid need is to multiply the resident's body weight in kilograms (kg) times 30 cubic centimeters. Review of the medical record showed the resident's weight was 139 pounds or 63 kg on 11/2/13, therefore the resident's daily fluid need was approximately 1895 cubic centimeters. The following concerns were identified: a. Observation on 11/6/13 from 12:50 PM to 4:40 PM (almost 4 hours) revealed no staff offered or provided the resident with any fluids. At 1:45 PM a volunteer was observed filling the resident's water pitcher with ice, however the resident was not offered any fluids. At 2:30 PM a CNA was observed checking the resident for incontinence, no fluids were offered. At 4:40 PM CNA #6 was observed providing the resident with incontinent care, no fluids were offered to the resident. b. Review of the daily fluid intake documentation from 10/6/13 through 11/6/13 showed the resident's daily average fluid intake was 523 cubic centimeters, and on 10/21/13 there was no daily fluid intake documented. 3. Review of the facility policy and procedure on prevention of dehydration dated November 2000 showed the following: "1. Nurses and CNAs will be vigilant in assessing the residents for signs and symptoms of dehydration...9. Staff will offer fluids (water is recommended) when going into the resident's room as appropriate...10. Activity therapy staff and dietary will offer beverages with activities and meals as appropriate." 4. Interview with the DON on 11/7/13 at 8:53 AM verified fluid intakes at meals were recorded daily. However, between meal fluids were not	F 327		

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F 327	Continued From page 31 recorded unless there was a physician's order for intake and output measures.	F 327	F 371 1-Inservice by RD for all dietary staff conducted on 12/13/13. Staff instructed on the handling of ready-to-eat items, clean vs. dirty, hand washing, and glove use. Staff will be instructed to wear gloves when handling ready-to-eat items. Staff will be educated on these topics on an annual basis and on-hire. Audits will be conducted by the RD or designee on a monthly basis for three months to ensure compliance. Any concerns will be addressed immediately and reported to the QA committee. 2-Registered Dietician to in-service all dietary staff, including dietary manager, on food temps and food safety on 12/13/13. Food temps will be recorded for every meal. Audits will be conducted by the RD or designee on a weekly basis for three months to ensure compliance with recording food temps.	12/31/13
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure appropriate hand hygiene techniques were used and that food was served at the required temperatures during 1 of 1 meal service observation. In addition, various equipment was found to be maintained in an unsanitary manner. The findings were: 1. Observation on 11/6/13 at 4:30 PM showed the dietary manager, dietary aide #1, and cook #1 were preparing for the evening meal. During the food handling process the following hand hygiene concerns were identified: a. At 5:10 PM it was noted cook #1 was cutting ready-to-eat cucumber sticks with her bare hands. At 5:30 PM cook #1 started placing food onto resident plates. The menu included hot dogs on buns, and the cook was observed to handle the hot dog buns with her bare hands. b. At 5:12 PM dietary aide #1 came into the	F 371		

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	535033	A. BUILDING _____ B. WING _____	C 11/07/2013

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 371	Continued From page 32 kitchen from the dining room pushing a cart containing glasses of water. To enter the kitchen the aide used his gloved hands to open the door. Without any hand hygiene the dietary aide then proceeded to pick the water glasses up by the drinking rims to add thickening powder. The aide then delivered these thickened beverages back to residents in the dining room. c. At 5:14 PM the dietary manager used her gloved hands to open and enter into the walk-in refrigerator. The manager then proceeded with the same gloves to prepare resident meals of cottage cheese and peaches. d. At 5 PM the dietary manager opened a can of sauerkraut and placed it in a pan on the stovetop. The dietary manager was not wearing gloves, and her fingernails were long and painted. According to Food Code 2013, U.S. Public Health Service, 3-301.11: "...(B) Except when washing fruits and vegetables as specified under § 3-302.15 or as specified in ¶ (D) of this section, food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. (C) Food employees shall minimize bare hand and arm contact with exposed food that is not in a ready-to-eat form." According to Food Code 2013, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands.	F 371	3- The oven was cleaned on 11/26/13. The oven was added to a weekly cleaning schedule. The slicer power switch was cleaned on 11/7/13. The wall under the exhaust hood was cleaned on 11/7/13. The dish room wall was cleaned on 11/14/13. The adhesive was cleaned off the beverage pitchers on 11/18/13. Staff was instructed to remove labels prior to putting pitchers in dish machine. A deep cleaning was done in the kitchen on 11/14/13. A daily and nightly cleaning schedule was implemented for the kitchen. All cleaning checklists will be turned in to the dietary manager. RD will monitor for cleanliness and will bring any concerns to the dietary manager for immediate correction. RD will conduct quarterly kitchen inspection to ensure compliance with cleaning program. A quarterly deep cleaning will be conducted in the kitchen. The dietary manager will complete her certified dietary manager (CDM) course by 6/30/2014. Proof of course enrollment will be sent to the Department of Healthcare Licensing and Survey, as will a monthly progress report detailing course progress. Any concerns will be reported to the QA committee.	

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F 371	Continued From page 33 According to Food Code 2013, U.S. Public Health Service; 2-302.11: "(A) Food employees shall keep their fingernails trimmed, filed, and maintained so the edges and surfaces are cleanable and not rough. (B) Unless wearing intact gloves in good repair, a food employee may not wear fingernail polish or artificial fingernails when working with exposed food." 2. Observation on 11/6/13 at 5:30 PM showed the cook began to serve resident meals. At that time the surveyor asked if temperatures of the food items had been taken. The dietary manager looked at the temperature log and there were none recorded. At that time the surveyor requested temperatures be taken of the pureed hot dog mixture, the pureed potato salad, and the regular texture potato salad. The following temperatures were measured: a. The first reading of the pureed hot dog mixture was taken by the dietary manager using an infrared-style thermometer (measures the surface temperature) the reading showed 111 degrees Fahrenheit (F). At that time the surveyor requested an internal temperature reading. The dietary manager used a different thermometer and the internal reading showed 120 degrees F. b. The cold pureed potato salad showed an internal temperature reading of 60 degrees F. c. The regular potato salad showed an internal temperature of 50 degrees F. According to Food Code 2013, U.S. Public Health Service: 3-501.16 "(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, potentially hazardous food (time/temperature control for safety food)	F 371		

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F 371	Continued From page 34 shall be maintained: (1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54°C (130oF) or above; or (2) At 5°C (41°F) or less." 3. Observation on 11/4/13 at 5 PM and on 11/6/13 at 4:30 PM showed the following equipment was identified as requiring additional cleaning: a. The right-side oven had black burned-on food that was crumbling and flaking on the floor of the oven. b. The electric slicer had a build-up of food and grime on and around the power switch. c. The wall under the exhaust hood unit, behind the oven/range unit had a black dusty looking substance along the edge which was 6 feet in length. d. The wall behind the sprayer in the dish room had a build-up of a black substance 10 inches in length by three inches in height. e. Eight plastic beverage pitches were stored on a clean dish rack. Each of the pitchers had left-over paper and adhesive attached to the outsides. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 4. Interview with the dietary manager on 11/7/13 at 10:20 AM revealed a hand washing inservice education had been provided in May 2013. Review of the 5/31/13 inservice sign-in sheet	F 371		

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F 371	Continued From page 35 showed the dietary manager and cook #1 were not listed among the attendees. The dietary manager further revealed there was no planned or documented cleaning schedule for kitchen equipment. During a previous interview with the dietary manager on 11/4/13 at 5 PM, she revealed she was enrolled in a certified dietary managers course through the University of North Dakota. The manager stated she had completed about 50% of the course, and found it difficult to devote time to the assignments and study.	F 371	F 441 1-A policy and procedure for IV care was implemented on 11/20/13. The policy includes instruction regarding PICC line dressing changes. The policy was reviewed by the facility medical director and DON. All nursing staff was in-serviced on the proper procedure for PICC line dressing changes on 12/2/13. This procedure will be added to nursing staff's annual skills day and will be added to the skills check for new hires. 2-Nursing staff was in-serviced on hand hygiene during resident cares on 12/13/13. Random audits will be conducted by DON or designee at least once per week for six weeks or until hand hygiene compliance is achieved to ensure proper hand hygiene during resident care. 3-Nursing staff was in-serviced on proper procedure for providing injections, including that the injections are not to be given in the dining room, on 12/13/13. Staff was also instructed on the proper disposal or sharps into a sharps disposal container.	12/31/13
F 441 SS=E	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	F 441		

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F 441	Continued From page 36 direct contact will transmit the disease. (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 observation, staff interview and current recommendations for standards of practice the facility failed to ensure infection control guidelines were followed for 1 of 1 sample residents (#24) observed for a dressing change of a peripherally inserted central catheter (PICC). In addition, infection control issues were identified for 1 of 3 sample residents (#11) observed for perineal care, and 1 non-sample resident (#36) administered insulin. The findings were: 1. Review of the medical record for resident #24 showed the resident was admitted to the facility on 10/22/13 with diagnoses including post operative knee infection, intravenous (IV) antibiotic therapy and PICC line. Review of the admission MDS assessment showed the resident was cognitively intact. Review of the care plan dated 10/31/13 did not identify the resident as having an actual infection or the potential for an infection. The care plan identified the resident was at risk for dehydration related to wound infection and IV therapy. There were no interventions listed related to the resident's PICC	F 441	Audits will be conducted by DON or designee for six weeks to ensure proper procedure for injections and for disposal of sharps. Any concerns will be corrected immediately and will be addressed by the QA committee.	

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F 441	Continued From page 37 line. Review of the nursing notes and treatment administration record showed no documentation the PICC line dressing had been changed, the exit site assessed, or the exposed PICC line catheter had been measured. The following concerns were identified: a. Observation on 11/5/13 at 9:00 AM revealed the resident had a dual-lumen PICC line in the right upper arm. The dressing had a handwritten date of 10/29/13. The PICC line exit site was covered with 2 inch by 2 inch gauze and was not visible. Interview with the resident at the time of the observation revealed the dressing had been changed on 10/29/13 and was due to be changed that day. Observation of the PICC line dressing change performed by RN #1 at 10:15 AM revealed the old gauze that was removed from the exit site was damp and had a small amount of dark red drainage. The Stat-Lock (a disposable device that is taped to the skin and secures the PICC line) remained intact and was not changed. The injections caps were not changed. Interview with RN #1 at the time of the observation verified the PICC line dressing should have been changed within 48 hours because the exit site was covered with gauze. RN #1 also revealed s/he did not want to remove the Stat-Lock for fear of dislodging the PICC line. RN #1 revealed the caps would be changed that afternoon. b. Interview with RN #1 on 11/7/13 at 1:15 PM revealed she is responsible for infection control in the facility. The interview further revealed a new policy and procedure for performing PICC line dressing changes had been submitted to the facility's corporate office, however, the policy had not yet been approved. c. Review of the Centers for Disease Control (CDC) Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011	F 441		

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F 441	Continued From page 38 (http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf) retrieved 11/7/13, revealed the following recommendation for PICC line dressing changes: "Replace dressings used on short-term CVC sites every 2 days for gauze dressings." d. Interview with RN #1 on 11/7/13 at 1:15 PM revealed that facility nursing interventions were derived from "Nursing Interventions and Clinical Skills" by Perry, Potter and Elkin. According to Perry, Potter and Elkin, "Nursing Interventions & Clinical Skills" 5th ed. St. Louis, MO: Mosby, 2012, page 671, "Gauze dressings are changed every 48 hours and immediately if integrity is compromised. When gauze is used in conjunction with a transparent dressing, it is considered a gauze dressing and changed every 48 hours." e. According to the StatLock manufacturer, C.R. Bard, Inc., "The StatLock stabilizer device should be replaced every 7 days." (http://www.bardaccess.com/statlock-pcl-picc-plus.php?section=Prescriptive%20Information - retrieved 11/22/13) 2. Observation on 11/6/13 at 2 PM showed CNAs #3 and #2 used a mechanical lift to transfer resident #11 from the wheelchair to bed. The two CNAs then assisted the resident who had been incontinent of bladder and a scant amount of bowel in changing the incontinence brief and provided perineal care. Both CNAs wore disposable gloves while they provided the care. Once the resident was clean and a new incontinence brief was put on, CNA #2 removed the soiled gloves and without any hand hygiene placed an oxygen nasal cannula into the resident's nose. Review of the undated facility "Hand Hygiene	F 441		

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F 441	Continued From page 39 Practice Guidelines" showed "2. The use of gloves does not eliminate the need for hand hygiene. Hand hygiene should be performed before and after taking off gloves." 3. Observation on 11/6/13 at 5:45 PM revealed RN #2 administered insulin in resident #36's abdomen while the resident was seated in the main dining room with other residents. After the insulin was administered RN #2 placed the used needle (contaminated with body fluid and other potentially infectious material) on a high-touch environmental surface where dining was occurring. The sharps container was located on the medication cart at the opposite side of the dining room. Interview with RN #2 at 5:50 PM verified insulin was not supposed to be administered in the dining room. a. Interview with RN #1 on 11/7/13 at 1:15 PM verified insulin administration and finger sticks were not supposed to be performed in the dining room. b. According to the occupational safety and health administration (OSHA) current guidelines code of federal regulations; sharps must be disposed of in sharps disposal container immediately or as soon as feasible after use [1910.1030 (d)(4)(iii)(A)(2)(i)] and sharps containers must be readily accessible and located as close as feasible to the area where the sharps will be used [1910.1030(d)(4)(iii)(A)(1)].	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		

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F 465	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe, comfortable and sanitary environment in the 100 and 200 halls, the staff bathroom, in the kitchen, and in the dish room. The findings were: 1. During a tour of the facility on 11/6/13 from 9:39 AM thru 10:20 AM, the following concerns with the building maintenance were identified: a. The exhaust fans in 200 hallway on both the east and west side of the hall, and the fan in the tub room on the 100 hallway were not functioning. b. The exhaust fan in the bathroom located in the kitchen was not functioning. Interview with the maintenance director at that time revealed he did not have any explanation as to why the fans were not working in the 100 hall tub room and the 200 hallway or when they had stopped working, as he did not check them routinely. He further stated he was aware that the fan in the kitchen bathroom had not worked the past 2 months, but did not have a plan in place for the repair. 2. Observation of the dish room on 11/6/13 at 12:15 PM revealed the wall located in the dish cart wash area was noticebly bowed out, with loose and missing tiles on the baseboard. Black spots were noted at the area where the base board met the floor. Interview with the maintenance director at that time revealed he was aware of the problems with the wall in the dish room. He further stated he had a plan to fix	F 465	F 465 Contractor was called on 11/25/13 and a work order placed for the exhaust fans. Contractor is willing and ready to repair Fans will be repaired or replaced by 12/31/13, weather permitting. Maintenance staff will add the exhaust fans to a monthly check. The wall in the dish room will be repaired by 12/31/13. Any concerns will be reported to the QA committee.	12/31/13

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F 465	Continued From page 41 the wall but no timeline had been determined.	F 465		