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WY Dept of Health
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Healthcare Licensing

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	C 08/27/2014

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 000	INITIAL COMMENTS RN - Registered Nurse LPN - Licensed Practical Nurse MDS - Minimum Data Set CNA - Certified Nursing Assistant ADON - Assistant Director of Nursing DON - Director of Nursing ADL - Activities of Daily Living	F 000	F202 Crook County Medical Services District strives to ensure that all residents have appropriate documentation in their charts upon discharge/transfer. 1) Resident # 31 is no longer living here. Referrals were in place upon discharge. The family refused them. The Physician responsible for this documentation is no longer employed at CCMSD. Attempts to obtain documentation from said Physician have been unsuccessful. 2) All residents will have admission and discharge summaries conducted by the physician and documented in the chart. 3) Staff will be educated by the DON /ADON to ensure that documentation requirements are understood. 4)The nursing staff will track all Physician documentation for admission, discharge/transfers monthly for 6 months using an audit tool to ensure documentation is completed and in the chart.	
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure discharge documentation was completed by the physician for 1 of 2 sample residents (#31). The findings were: Review of the medical record showed resident #31 was discharged from the facility on 4/4/14. Review of the medical record revealed no discharge summary had been completed by the physician that included the reason for discharge, the resident's discharge disposition, or referrals for post discharge care. During an interview with	F 202		10/27/14

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

10/15/14

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.

10/27/14 11AM POC accepted voicemail left for administrator Kim Archer. A Chapman-RN

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F 202	Continued From page 1 the social worker on 8/27/14 at 6:50 PM this surveyor requested the physician's discharge order and discharge summary. The social worker produced a handwritten progress note that was dated 4/4/14 stating, "resident discharged into care of spouse voluntarily. Medications provided per physician order..." which was signed by an RN and the administrator, however, the physician had not signed the note. In addition, the social worker was unable to find a documented physician's discharge summary.	F 202	5)The ADON/DON will monitor the audit results monthly for 6 months and report quarterly at the QAPI meeting. Further follow up actions will be initiated by the QI team.	10/10/2014
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 privacy was maintained for 1 observed non-sample resident (#9) who required an indwelling urinary catheter. In addition, the facility failed to ensure assistive devices were kept clean for 1 of 4 sample residents (#6) who required assistive devices. The findings were: 1. Review of the medical record showed resident #9 was admitted to the facility on 9/17/12 with diagnoses including dementia. Review of the medical record also identified the resident as requiring an indwelling urinary catheter. Observation on 8/26/14 from 5:20 PM until 6 PM and again at 7 PM revealed the resident was	F 241	F241 Crook County Medical Services District will promote care for residents that maintains each resident's dignity and respect in full recognition of their individuality. This will be accomplished by: 1) Resident #9 will be care planned, with supportive documentation to ensure his right to choose not to cover his catheter bag. Resident #9 refuses to allow staff to consistently cover his bag. Staff will continue to attempt to cover the bag but will respect his right to refuse to have it covered. 2) All other residents with catheter bags will have them covered to promote dignity. 3)Resident #6's lap buddy was cleansed.	10/27/14

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F 241	Continued From page 2 seated in the main dining room eating the evening meal. The resident's indwelling urinary catheter drainage bag was uncovered and half full of urine. The catheter drainage bag remained uncovered throughout the meal. The resident was assisted to his/her room by staff. Observation with the ADON at 7 PM showed the resident was lying in bed, the urinary catheter drainage bag had been emptied, however, the drainage bag remained uncovered and was facing the resident's open door. Interview with the ADON at the time verified the urinary drainage bag should have been covered with a privacy bag. 2. Review of the medical record showed resident #6 had diagnoses including non-Alzheimer's dementia. Review of the most current quarterly MDS assessment dated 8/13/14 revealed the resident was moderately cognitively impaired and utilized a lap buddy (an assistive cushion placed in the front of the wheelchair) for positioning. Observations on 8/26/14 at 5:25 PM and 8/27/14 throughout the day revealed the resident's lap buddy was soiled with food stains and debris. Interview with the ADON and MDS coordinator on 8/27/14 at 2:45 PM revealed the lap buddy was supposed to be cleansed every night. Review of an undated cleaning log showed the lap buddy was not included on the list of assistive devices that were supposed to be cleaned and the ADON was unable to verify the last time the lap buddy had been cleaned but agreed it should have been.	F 241	4) Staff will be inserviced by the DON/ADON on importance of covering catheter bags and cleanliness of lap buddys to promote resident dignity and health. 5) Nursing staff will conduct random monthly observations for 1 month of catheter bags to ensure they are covered and of lap buddys' cleanliness using an audit tool. If a bag is not covered or the lap buddy is not cleaned,immediate in-servicing and corrective action will be taken. DON/ADON will monitor results of this audit and report to the QAPI team. 6) Further follow up actions will be initiated by the QI team.	10/10/14
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		

10/27/14 da

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F 278	Continued From page 3 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. 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 medical record review and staff interview the facility failed to ensure resident assessments accurately reflected resident status for 1 of 6 sample residents (#31). The findings were: Review of the medical record showed resident #31 was admitted to the facility with diagnoses including dementia. Review of the admission MDS assessment dated 12/10/14 and the most	F 278	F278 CCMSD will ensure that assessments accurately reflect the resident's status. 1) Resident #31 is no longer a resident in this facility. 2) All staff participating in the MDS process will be in-serviced on section E of the MDS using the MDS 3.0 Manual and the importance of accurate assessment of a resident's status. 3) Audits will be conducted using an audit tool by ADON/DON/MDS coordinator monthly for 3 months to ensure that section E is done accurately. Audits will be reviewed by ADON/DON monthly and reported to QAPI quarterly. 4) Further follow up actions will be initiated by the QAPI team. 10/27/14	10/10/2014

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F 278	Continued From page 4 recent quarterly MDS assessment dated 3/12/14 identified the resident as having no behaviors. However, review of the medical record progress notes dated 12/3/14 through the resident's discharge on 4/4/14 revealed 33 documented entries by various staff of resident behaviors including wandering, yelling, and sexually inappropriate comments. Interview with the social worker on 8/27/14 at 7:05 PM verified the resident had displayed numerous increasing behaviors.	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. 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:	F 279	F 279 CCMSD will develop a comprehensive care plan for each care area assessment that is identified in the comprehensive assessment. 1) Resident #11's Care plan was corrected. 2) All staff participating in the MDS/Care planning process will be in-serviced on Care Area Assessments and resulting care plan development to ensure all triggered areas have a resulting Care plan item to address each resident's needs. 3) Care plans will be audited monthly for 3 months by the DON/ADON/MDSC,using and audit tool, to ensure that they are complete. Audit results will be reported to QAPI team quarterly.	10/27/14

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F 279	Continued From page 5 Based on medical record review and staff interview, the facility failed to ensure comprehensive care plans were completed to include all the individualized needs for 1 non-sample resident (#11) reviewed for ADLs. The findings were: Review of the medical record showed resident #11 was admitted to the facility on 7/3/14 with diagnoses including senile dementia and diabetes mellitus. Review of the admission MDS assessment dated 7/11/14 identified the resident as being moderately cognitively impaired and requiring limited to extensive assistance with ADLs including transferring, bathing, hygiene, and dressing.Review of the care area assessment indicated the resident should have had a care plan developed related to assistance with completing ADLs. Review of the resident's care plan dated 7/11/14 revealed no care plan for ADLs had been completed. Interview with CNA #1 on 8/27/14 at 1:25 PM verified the resident required assistance with completing ADLs such as transferring, dressing and bathing. CNA #1 was unsure where to find documentation on the level of assistance she was supposed to provide for the resident's she assisted. She said that it was passed along by other staff members.	F 279	4) Further follow up action will be initiated by the QI team.	10/10/2014
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview,	F 281	F281 CCMSD will provide services that meet or exceed professional standards. 1. Resident #7's wound is currently closed with no open skin areas. 2. All residents with open skin areas will be assessed, measured and documented (per WOCN nurses	10/27/14

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F 281	Continued From page 6 and current standards for practice the facility failed to ensure wound assessments were completed with descriptions and consistent measurements were recorded for 1 of 2 sample residents (#7) assessed for wounds. The findings were: Review of the medical record showed resident #7 required extensive assistance from staff for ADLs including mobility. Review of nursing documentation showed a nursing note dated 4/2/14 which revealed the resident had a, "sore on [his/her] butt." No description or measurements were included. Further review of wound documentation showed a wound graph dated 4/7/14 which outlined the wound, however, there was no identification of where the wound was located or the appearance or depth of the wound. There were 2 undated wound graphs that outlined wounds on on the graph, one was labeled, left buttock, the other was not labeled with a location, and neither note described the appearance or depth of the wound. Review showed 1 graph dated 5/30/14 which identified the wound was on the left buttocks and described the wound as, "several layers of skin missing." There was no additional wound documentation showing the progression or decline of the wound. Interview with the social worker on 8/27/14 at 7:15 PM showed the wound graphs were kept in a notebook under the residents name and nursing staff were responsible for following wounds. The interview further revealed no additional wound documentation was available. According to recommendations by the WOCN nurses' association publication dated 2010, "Assessment and documentation of wound status which includes comprehensive	F 281	association publication 2010) in the medical record weekly. 3) All Long Term Care nursing staff will be in serviced by ADON/DON on the proper procedure and frequency to assess, measure and document wounds. 4) All residents with compromised skin will be discussed in the weekly Interdisciplinary Team Meeting to ensure interventions are effective and documentation is completed. 5) Audits will be conducted using an audit tool ADON/DON/MDSC to ensure that documentation is complete on a monthly basis for 3 months and will report them to the QAPI team. 4) Further follow up actions will be initiated by the QI team.	10/10/2014 10/27/14 ac

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F 281	Continued From page 7 clinical data demonstrating evidence of progress in healing or failure to heal. Parameters for comprehensive wound assessment include: dimensions and depth; presence, location and depth of any sinus tracts or undermining areas; status of the wound bed (granulating or epithelializing vs. clean but not granulating vs. avascular); volume, color, and odor of exudate; evidence of infection in surrounding tissues (erythema, induration, crepitance); and status of wound edges (closed and nonproliferative vs. open and proliferative). Such data, when sequentially recorded over time, can be used to objectively track the progress of wound healing. The use of wound descriptors to accurately convey the true state of the wound in addition to documenting the stage of the wound."	F 281		
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 review, and staff interview the facility failed to ensure wounds were reported to the physician for 1 of 2 sample residents (#8) who had wounds. The findings were:	F 309	CCMSD will promote care/ services for highest well-being. 1. Resident #8 has pending appointments for cardiology and surgery. Documentation of resident #8's wounds have been initiated and will continue until the wounds are resolved. 2. All residents with open skin areas will be assessed, measured and documented (per WOCN nurses association publication 2010) in the medical record weekly.	10/27/14 CC

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F 309	Continued From page 8 Review of the medical record showed resident #8 was admitted to the facility on 5/13/14 with diagnoses including partial ampuation of the left foot and diabetes. Review of the nursing admission assessment dated 5/13/14 revealed the resident had swelling in the right foot, however, there were no open areas. Review of nursing notes showed a note dated 5/28/14 that the nurse, "noticed resident had a large blood spot on [his/her] sock on the right foot...looked and pinky toe was bloody and looked like the toe nail was missing." There was no documentation the physician was notified. Subsequent review of the medical record showed no documentation of the right pinky toe until a nursing note dated 6/8/14 that the resident's small toe was black and there was an open area between the 4th and 5th toes.The nurse also noted his/her lower leg was very red and swollen. The physician was notified and gave verbal orders for the resident to be sent to the hospital where s/he was admitted for a diagnoses of cellulitis (skin infection) of the right foot. Review of a physician's progress note dated 5/19/14 indicated the resident was supposed to follow-up with podiatry and the physician would continue podiatry involvement in the resident's care due to his/her ongoing foot infections. Review of the medical records showed no documentation the resident was referred to podiatry for follow-up until 7/31/14. According to an interview with the social worker on 8/26/14 at 7:40 PM the podiatry appointment scheduled for 7/31/14 was cancelled by the facility because the resident saw the orthopedic surgeon on 7/30/14, and a recommendation was made by the orthopedic surgeon to perform a partial	F 309	3) All Long Term Care nursing staff will be in serviced on the proper way to assess, measure and document wounds. 4) All residents with compromised skin will be discussed in the weekly Interdisciplinary Team Meeting to ensure interventions are effective and documentation is completed. 5) Audit will be conducted using an audit tool by ADON/DON/MDSC monthly for 3 months to ensure that documentation is complete. Audit results will be reported to the QAPI team quarterly. 4) Further follow up actions will be initiated by the QI team. 10/27/14	10/10/2014

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F 309	Continued From page 9 amputation of the right foot. Observation of the wound on the resident's right foot on 8/27/14 at 8:45 AM revealed the resident had an extensive wound with two exit sites on the top and bottom of the right foot, the wound had a slight foul odor and yellowish/green drainage. The resident was alert and oriented and verified s/he was supposed to have part of the right foot removed after the cardiologist cleared him/her for surgery.	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. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure residents who required extensive assistance performing ADLs received assistance with hygiene for 2 of 4 sample residents, (#5, #6) and 2 non-sample resident's (#9, #10) identified as requiring extensive assistance. The findings were: 1. Review of the medical record showed resident #5 had diagnoses including Alzheimer's disease. Review of the most recent MDS assessment dated 8/14/14 identified the resident as being severely cognitively impaired and requiring	F 312	F312 CCMSD will ensure ADL cares are provided for dependent residents 1. Resident #6 and #5,#10s' nails were cleaned and trimmed. Resident #9 had his beard trimmed, hair combed and nails cleaned and trimmed. 2. All LTC nursing and activity staff will be in-serviced on the importance and proper way to conduct nail care. 3. All residents will receive weekly nail care from nursing on their bath day or the activity department in a Nail Salon Activity. All residents will have their nails inspected and cleaned daily and PRN. 4. Beard and hair combing/brushing will be done once daily and PRN 5. Nursing staff will conduct random monthly observations of fingernail cleanliness and condition using an audit tool for one month.	10/27/14

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F 312	Continued From page 10 extensive assistance from staff to complete ADLs including hygiene and bathing. Review of the care plan revised 1/24/14 revealed the resident had an ADL self care performance deficit related to confusion, impaired balance, and dementia. Interventions included staff checking nail length, trimming, and cleaning fingernails on bath days. Observations on 8/26/14 at 5:25 PM and 8/27/14 at 5:30 PM showed the resident had long, jagged fingernails encrusted with brown matter. 2. Review of the medical record showed resident #6 had diagnoses including non-Alzheimer's dementia. Review of the most current quarterly MDS assessment dated 8/13/14 revealed the resident was moderately cognitively impaired and required extensive total assistance from staff to complete bathing and hygiene. Review of the care plan updated on 1/17/14 showed the resident had an ADL self care performance deficit and interventions identified the resident as requiring total assistance from staff to complete personal cares. Observations on 8/26/14 at 5:35 PM and 8/27/14 at 5:45 PM revealed the resident had uneven fingernails encrusted with brown matter. Observations further showed the resident was using his/her hands to eat during the evening meals. 3. Review of the most recent quarterly MDS assessment dated 6/18/14 identified resident #9 as being severely cognitively impaired and requiring extensive assistance with bathing. The care plan updated on 7/2/14 revealed the resident had an ADL self care performance deficit and interventions included staff participation with personal hygiene and bathing. Observations on 8/26/14 at 5:20 PM and 8/27/14 at 5:30 PM showed the resident was in the main dining room	F 312	If nails are found to be unkempt or dirty, immediate in-servicing will be conducted immediately and the situation rectified. Results of audits will be reported to the QAPI team. 6. Further follow up actions will be initiated by the QAPI team.	10/10/2014 10/27/14 QC

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	C 08/27/2014

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

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F 312	Continued From page 11 eating the evening meal. The resident's fingernails were long, jagged, and nailbeds were encrusted with thick brown matter. The resident's hair was unkempt and his/her beard was untrimmed. 4. Review of the most recent quarterly MDS assessment dated 6/11/14 showed resident #10 was severely cognitively impaired and required extensive assistance from staff to complete bathing and hygiene. Review of the care plan updated 3/30/14 revealed the resident had an ADL self care performance deficit and interventions identified the resident was totally dependent on staff for bathing. Observations on 8/26/14 at 5:30 PM and 8/27/14 at 5:20 PM showed the resident had long fingernails that were encrusted with thick brown matter. Interview with the ADON on 8/27/14 at 1:30 PM verified CNA's were supposed to assess resident fingernails during baths. She further revealed the CNA's were supposed to trim and clean the resident's fingernails as needed.	F 312	10/27/14	