PRINTED: 01/22/2015
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	01/08/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set mg- milligrams RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	F 157 Resident #28: Physician was notified on 1/26/15 of resident's edema in October 2014, and that resident is free from edema at this time. Nursing staff will be educated 1/30/15 regarding process to follow for changes of condition notifications. Nurses will note change of condition in record and place resident on a "hot watch", to be monitored closely. Nurses to contact physician within 24 hours of any change of condition, and note such communication in resident record. DON or designee will monitor shift change reports and 24 hour reports to ensure appropriate action has been taken. Unit Manager to monitor all new orders with triple check system. Medical Records will audit 10% of resident charts for past changes of condition and physician follow up, and convey findings to DON. This process will be included in monthly QA meetings to monitor effectiveness and identify trends. Process will be adjusted as needed. Completion date: 2/13/15	2/13/15
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Allison Miller — TITLE: ADMINISTRATOR — (X6) DATE: 1/26/15

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
JAN 26 2015
WY Dept of Health
Healthcare Licensing and Surveys

Accepted by Lori Ruesman 1/28/15. DOC = 2/13/15
Spoke w/ Allison Miller 1/28/15 3:30pm

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to notify the physician of a change in condition for 1 of 9 sample residents (#28). The findings were: Review of nursing notes dated 10/24/14, timed at 8:51 PM, showed resident #28 experienced the onset of bilateral lower leg edema. Further review failed to show evidence the resident's physician was notified of this change in condition. Interview with the DON on 1/8/15 at 11:43 AM revealed no documentation was available to show the resident's physician had been notified of the change in condition. Further, the DON revealed the facility had contacted the physician's office on 1/8/15 to obtain any records of communication between the physician and the facility about this change in condition, and the physician's office was unable to provide any.	F 157		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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F 282	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to ensure care was provided in accordance with the care plan for 3 of 9 sample residents (#18, #22, #28). The findings were: 1. Review of the current care plan, revised 11/20/14, for resident #18 revealed staff were instructed to use the gait belt provided in the room for transfers and ambulation. However, observation on 1/6/15 at 11:40 AM revealed CNA #1 and CNA#2 transferred the resident from bed to the wheelchair, and from the wheelchair to the toilet, without using the gait belt. During an interview on 1/7/15 at 5:16 PM the DON and RN Resident Assessment Coordinator stated staff should be using the gait belt for transfers and ambulation. 2. Review of the care plan for falls, initiated 12/15/14, showed staff were instructed to encourage resident #22 to wear "appropriate footwear." Review of the 5/22/14 Care Area Assessment (CAA) for falls and the 12/10/14 fall risk assessment revealed the resident was supposed to wear non-slip (gripper soled) socks. The following concerns were identified: a. Observation on 1/6/15 at 12:05 PM, 1/6/15 at 12:30 PM, 1/6/15 at 1:45 PM, 1/7/15 at 12:20 PM revealed the resident ambulated in the hallway wearing regular socks (no gripper soles). b. During an interview on 1/7/15 at 5:21 PM, the DON and RN Resident Assessment Coordinator stated the resident should wear non-slip socks. They stated the resident dressed him/herself, therefore they had asked family	F 282	F282 CNA and Nursing staff will be educated on 1/30/15 regarding adherence to care plans. Staff will be educated on fall risk assessment, prevention and interventions. Staff also educated on proper use of gait belts and transfers including 1:1 and 2:1 assistance. MDS coordinator will also show CNA's how to find specific care plans. Completion date: 2/13/15 1. Resident #18: Use of gait belt has been discontinued by physician's order, and removed from care plan. Family has provided resident with appropriate footwear for her safety. Resident continues to be assisted with transfers by staff. 2. Resident #22: Resident teaching done regarding fall risk, safety, and appropriate footwear. Resident's family educated about appropriate footwear and encouraged to remove regular socks and replace with gripper-soled socks. Staff educated on importance of checking her socks to ensure she wears gripper-soled socks when out of bed.	2/13/15

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F 282	Continued From page 3 members to remove all socks except for the non-slip ones; however, regular socks must have shown up in the drawers again. They further stated that staff should be monitoring the footwear of the resident. c. During an interview on 1/8/15 at 9:21 AM the resident stated s/he did not like to wear shoes. The resident stated s/he didn't mind the non-slip socks. d. On 1/8/15 at 10:10 AM CNA #3 stated she did not ensure the resident was wearing non-slip socks because the resident "is pretty steady," but stated "maybe I should, because it would be safer." 3. Observation of a transfer on 1/6/15 at 11 AM showed resident #28 was transferred by two staff members, CNA #4 and CNA #5, who placed their arms under the resident's arms and lifted the resident up without use of an assistive device. The staff members pivoted the resident and sat him/her in the wheelchair. Review of the care plan started on 10/3/14 revealed the resident required staff to "Use the Hoyer lift [mechanical] and at least 2 staff for all transfers." Review of active physician orders revealed the resident had a physician order dated 9/26/13 that stated "full body Hoyer for all x-fers [transfers]." Interview with the unit manager on 1/7/15 at 9:15 AM confirmed the resident was "to be transferred with a full body lift for all transfers."	F 282	3. Resident #28: Resident's orders and care plan changed to 2:1 assist with transfers. Staff has been educated on use of full body hoyer for transfers, and 2:1 assist for transfers. Staff educated on where to find and verify care plan to ensure they are following orders. MDS coordinator to review care plans quarterly to ensure they are current and accurate for staff to follow. MDS coordinator will review quarterly to ensure care plans are accurate and reflective of current physician orders. Monthly random audits of 10% of residents will be conducted by DON or designee to ensure staff is following care plans. This will be reviewed monthly in QA meetings. Completion date: 2/13/15	2/13/15
F 309 SS=D	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	F 309		

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F 309	Continued From page 4 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy and procedure review, and resident and staff interview, the facility failed to provide effective pain management for 1 of 9 sample residents (#28) identified as having pain. The findings were: Review of the annual MDS assessment dated 10/10/14 showed resident #28 had diagnoses that included pain in limb and peripheral enthesopathy (a disorder of the bone attachments), and had severe pain almost constantly that interfered with sleep and day-to-day activities. Review of a pain assessment dated 10/7/14 showed the resident experienced daily, constant pain, and had an acceptable pain level of 4 on a scale of 1 to 10 with 10 being the worst pain. The following concerns were identified: 1. Observation on 1/6/15 at 9:35 AM showed the resident was lying in bed in a darkened room. Interview with the resident at that time revealed s/he was experiencing pain. Interview with the social services director at 9:40 AM revealed the resident had received a scheduled dose of Tylenol 650 mg at 8 AM that morning. Review of medication administration records showed the resident received a dose of Norco 5/325 mg (an opiod pain medication) at 9:41 AM. The initial pain level was reported as an 8 out of 10. The medication was documented as being effective,	F 309	F309 Resident #28: Called physician on 1/8/15 pain medication orders changed and resident monitored for improvement. Called physician on 1/23/15 to update that pain slowly improving. Physician ordered to continue medication. Will continue to monitor for pain and adjust plan of care as needed. Educated nursing staff on 1/30/15 regarding pain management, including pain scale, pain assessment, and follow up. MDS coordinator to assess pain with quarterly MDS to ensure pain goals are being met and pain is being addresses as necessary. Bi-monthly audits of pain medication effectiveness will be done by DON or designee. Audits will be reviewed in monthly QA meetings Completion date: 2/13/15	2/13/15

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F 309	Continued From page 5 however, the follow up pain level was reported as a 5 out of 10. 2. Interview with the resident on 1/6/15 at 11:40 AM revealed s/he was in pain at that time, stating "I wish they would hurry up with my pill!" 3. Review of medication administration records for the month of December 2014 showed Norco 5/325 mg was administered to the resident 47 times during the month. Each of these times the medication was documented as having been effective in treating the resident's pain, however, 32 of the 47 times (68%), the follow-up pain assessment was recorded as being greater than 4 (the resident's documented acceptable pain level). 4. Review of the facility's policy and procedure on the subject of pain management, last revised 10/2009, showed residents would be "assessed for any persistent or worsening pain" and "documentation of physician notification of the resident's non-response to pain medication and any changes in the pain medication regimen shall be noted on the nursing notes." 5. Review of nursing notes and physician orders failed to show efforts to engage the resident's physician in managing the resident's pain at a level acceptable to him/her. 6. Interview with RN #1 on 1/7/15 at 4:10 PM revealed there had been no change in the resident's pain regimen for at least 7 months. 7. Interview with the DON on 1/8/15 at 10:45 AM revealed the facility had not contacted the resident's physician recently about the resident's	F 309		

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F 309	Continued From page 6 persistent pain.	F 309	F312 CNA and nursing staff educated on 1/30/15 regarding cueing residents at meals and assisting residents with meals. Bi-monthly audits will be done by DON or designee for 6 months, then monthly by direct observation during meals to ensure staff is cueing or assisting residents as appropriate. These audits will be reviewed in monthly QA meetings. Skin and weight team will be advised of this POC, and will continue to monitor residents' weights and meal intake, weekly. MDS coordinator will care plan appropriate needs and communicate plan to staff. Completion date: 2/13/15	2/13/15
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 provide necessary services to maintain good nutrition for 1 of 1 sample residents (#32) who required extensive assistance with eating. The findings were: Review of the quarterly MDS assessment dated 11/17/14 showed resident #32 had diagnoses that included non-Alzheimer's dementia and malnutrition. Further review of the assessment showed the resident required the extensive assistance of 1 person with eating. Review of the nutrition assessment dated 11/4/14 showed the resident's self-feeding ability as "3-Fed by staff or tube fed." The following concerns were identified: 1. Observation of the mid-day meal on 1/6/15 beginning at 12:04 PM showed the resident was seated at the feeding assistance table in the facility dining room. Continuous observation until 12:48 PM showed CNA #6 was at the table, but provided neither physical assistance with eating nor cueing/encouragement to the resident to feed him/herself. At 12:37 PM the resident was	F 312	1. Resident #32: Resident's diet was changed on 1/19/15 from regular to puree diet, and is receiving assistance with eating. Since implementing puree diet, resident has consumed 50% or more of meals. Skin and weight team will continue to monitor this weekly. Completion date: 2/13/15	2/13/15

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F 312	Continued From page 7 observed to pick up a piece of cake and take a single bite. At 12:45 PM, the CNA asked the resident if s/he was finished, and then removed the resident from the dining room at 12:48 PM. Review of the meal consumption log showed the resident was recorded as having refused lunch. 2. Observation of the morning meal on 1/8/15 beginning at 8:17 AM showed the resident was seated at the feeding assistance table in the facility dining room. CNA #6 was at the table but provided neither physical assistance with eating nor cueing/encouragement to the resident to feed him/herself. Observation after the resident left the table, at 8:58 AM, showed the resident had consumed less than 25% of the meal. 3. Interview with the DON on 1/8/15 at 10:45 AM confirmed the facility's expectation that the resident would always receive cueing/encouragement to eat, and physical assistance would at least be attempted.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interviews, the facility failed	F 323		

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F 323	Continued From page 8 to consistently implement interventions to prevent falls for 2 of 5 sample residents (#18, #22) who experienced falls. The findings were: 1. Review of the 11/2/14 annual MDS assessment showed resident #18 had fallen while a resident in the facility. Review of nursing notes showed on 2/7/14 the resident slipped from the edge of the bed while a CNA was assisting the resident up from the bed. According to the 2/13/14 falls/safety meeting note, staff were to ensure a gait belt was used. Review of the current care plan, revised 11/20/14, revealed staff were instructed to use the gait belt provided in the room for transfers and ambulation. However, observation on 1/6/15 at 11:40 AM revealed CNA #1 and CNA #2 transferred the resident from bed to the wheelchair, and from the wheelchair to the toilet, without using the gait belt. During an interview on 1/7/15 at 5:16 PM the DON and RN Resident Assessment Coordinator stated staff should be using the gait belt for transfers and ambulation. 2. Review of the 12/10/14 fall risk assessment showed resident #22 was at high risk for falls. Review of nursing notes revealed the resident fell on 4/18/14, 5/22/14, 6/15/14, 8/1/14 and 10/3/14. Further review of the 4/18/14 fall documentation showed the resident was wearing regular socks in the hallway and slipped. Review of the care plan for falls, initiated 12/15/14, showed staff were instructed to encourage the resident to wear "appropriate footwear." Review of the 5/22/14 Care Area Assessment (CAA) for falls and the 12/10/14 fall risk assessment revealed the resident was supposed to wear non-slip (gripper soled) socks. The following concerns were identified:	F 323	F323 CNA and Nursing staff will be educated on 1/30/15 regarding adherence to care plans. Staff will be educated on fall risk assessment, prevention and interventions. Staff also educated on proper use of gait belts and transfers including 1:1 and 2:1 assistance. 1. Resident #18: Use of gait belt has been discontinued by physician's order, and removed from care plan. Family has provided resident with appropriate footwear for her safety. Resident continues to be assisted with transfers by staff. 2. Resident #22: Resident teaching done regarding fall risk, safety, and appropriate footwear. Resident's family educated about appropriate footwear and encouraged to remove regular socks and replace with gripper-soled socks. Staff educated on importance of checking her socks to ensure she wears gripper-soled socks when out of bed.	

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F 323	Continued From page 9 a. Observation on 1/6/15 at 12:05 PM, 1/6/15 at 12:30 PM, 1/6/15 at 1:45 PM, 1/7/15 at 12:20 PM revealed the resident ambulated in the hallway wearing regular socks (no gripper soles). b. During an interview on 1/7/15 at 5:21 PM, the DON and RN Resident Assessment Coordinator stated the resident should wear non-slip socks. They stated the resident dressed him/herself, therefore they had asked family members to remove all socks except for the non-slip ones; however, regular socks must have shown up in the drawers again. They further stated that staff should be monitoring the footwear of the resident. c. During an interview on 1/8/15 at 9:21 AM the resident stated s/he did not like to wear shoes. The resident stated s/he didn't mind the non-slip socks. d. On 1/8/15 at 10:10 AM CNA #3 stated she did not ensure the resident was wearing non-slip socks because the resident "is pretty steady," but stated "maybe I should, because it would be safer."	F 323	Falls and fall risk are reviewed Monday through Friday in morning census meeting attended by Administrator, DON and all available department heads. Trends are identified immediately and interventions are implemented. These are reported to QA committee and reviewed monthly. Completion date 2/13/15	2/13/15