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

PRINTED: 08/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X3) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	C 08/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	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 A complaint survey was conducted by Healthcare Licensing and Surveys from 8/1/15 to 8/2/15. The survey was prompted by complaint intakes WY00002032 and WY00002036. F 225 483.13(c)(1)(ii)-(iii), (e)(2) - (4) SS=D INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 000 F 225	Crook County Medical Services District (CCMSD) will ensure that results of all abuse investigations are reported to the administrator and other officials in accordance with State law (including the State Survey/ Certification agency) within 5 working days of the incident. CCMSD has developed a checklist (Abuse Notification Checklist) included in the abuse reporting process to include appropriate and timely notification of all appropriate parties. This Abuse Notification Checklist will be used with every abuse allegation/report investigation. Abuse allegation/reports will be monitored monthly by the Director of Nursing to ensure appropriate use/ compliance of the Abuse	09/21/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: _____ TITLE: Admin (9/23/15) (X6) DATE: 9/23/15

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.

POC accepted. Spoke to Bob Brainard, NHA on 11/18/15 @ 8:55 AM

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: O10311 Facility ID: WY00002036 If continuation sheet Page 1 of 2

Janice Cox 10/21/15

RECEIVED
WY Dept of Health
SEP 23 2015
Healthcare Licensing and Surveys

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2015
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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 08/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

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F 225	Continued From page 1 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 1 of 2 abuse allegations reviewed were reported to the state survey agency. The findings were: Review of the medical record for resident #9 showed on 5/28/15 at 9:35 PM the resident's family displayed abusive verbal behavior to the resident's roommate (#13). The note showed the supervisor was notified and interventions were put into place to protect the residents. Review of an administrative note on 5/29/15 at 8:58 AM showed the family member was not allowed to visit the facility until the conclusion of an investigation. Also this note showed the state survey agency was to be notified of the investigation along with other agencies. Further review showed no evidence the state survey agency was notified of the allegation or of the investigation results. Interview with the long term care manager and the director of nursing on 9/1/15 at 4:50 PM verified the abuse allegation and investigation results were not reported to the state agency.	F 225	Notification Checklist. Results of the monitoring will be recorded on an audit tool and reported to the QAPI committee quarterly for 3 months. Further followup to be determined by QAPI committee.	09/21/15