| 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 pp 02/19/2016 |

| 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<br><br>A recertification survey was conducted in conjunction with a complaint survey by the Office of Healthcare Licensing and Surveys on 2/16/16 through 2/19/16. The survey was prompted by complaint intakes WY00002109, WY00002124, and WY00002195.<br><br>The following common abbreviations are used throughout this document:<br><br>ADL Activities of Daily Living<br>CAA Care Area Assessment<br>CDM Certified Dietary Manager<br>CNA Certified Nurse Aide<br>DON Director of Nursing<br>MDS Minimum Data Set<br>RN Registered Nurse<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F 000 | | |
| F 225 SS=E | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>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.<br><br>The facility must ensure that all alleged violations | F 225 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 3/9/16

RECEIVED
MAR 16 2016
Wyoming Department of Health
Office of Healthcare Licensing and Surveys

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.

3/18/16 @ 8:45 Am POC accepted telephone call with Nathan Hough, Adm, Phone

| 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 02/19/2016 |

| 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 225 | Continued From page 1<br>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).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance 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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on medical record review, review of State survey and certification agency logs, and staff interview, the facility failed to report and investigate 3 of 3 incidents of potential abuse reviewed (resident #27). The findings were:<br><br>1. Review of the 12/12/15 quarterly MDS showed resident #27 had diagnoses that included non-Alzheimer's dementia, was moderately cognitively impaired, and exhibited physical, verbal and other behaviors on 1 to 3 days during the look back period. The following concerns were identified: | F 225 | **F225**<br>**The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriations 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.**<br><br>1. Resident #27 was started on psychotropics on 2/9/16 after non-pharmalogical interventions failed. He has not been involved in any further altercations.<br>2. Resident #27 and all residents will have an IR done and sent to the State and all appropriate agencies within 24 hours of any resident to resident altercation.<br>3. All resident to resident altercations will be added to the facility incident report log. The DON or designee will monitor the log monthly, using an audit tool, for three months. Any incomplete or inaccurate findings will be corrected immediately and education will be done immediately by Administrator. | |

| 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 02/19/2016 |

| 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 225 | Continued From page 2<br>a. Review of the behavior note dated 1/13/16 and timed 2:42 PM showed "Right in front of the nurse's station [resident name] rolled up to a [gender] resident and struck [him/her] in the face causing a superficial abrasion. [Gender] resident did state that abrasion 'burned.' No other injury is noted. [Resident name] was removed from the situation."<br>b. Review of the behavior note dated 2/4/16 and timed 2:08 PM showed "A Kitchen staff came to this author and stated as she was clearing the dining room she saw [resident name] attempting to strike another resident with [his/her] fist. [S/he] did not make a solid connection and was removed from the situation by the kitchen staff."<br>c. Review of the behavior note dated 2/7/16 and timed 5:33 PM showed "A resident was being walked by a CNA when [resident name] rolled beside the resident in [his/her] wheelchair and scratched [him/her] on the right hand. [S/he] did not draw any blood, but did leave a black and blue mark on [him/her]."<br>d. Review of State survey and certification agency logs failed to show any of the three incidents were reported to that agency.<br>e. Interview with the DON on 2/18/16 at 6:37 PM confirmed the 3 incidents were neither reported nor investigated. | F 225 | 4. The results of the audit will be presented to the QAPI committee. Further actions or follow up to be determined by the QAPI committee.<br><br>5. Long-term care management will be in-serviced regulation 483.13 (c), (1)(ii)-(iii), (c) (2)-(4) Investigate-report allegations/individuals to ensure accurate and timely reporting. | 3/25/16 |
| F 272 SS=E | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the | F 272 | | |

| 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 02/19/2016 |

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

pp

| (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 272 | Continued From page 3<br>resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments were completed in a variety of areas for 7 of 11 sample residents (#2, #4, #6, #7, #13, #18, #27) The findings were: | F 272 | **F272**<br>**The facility will conduct comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) as specified by the state.**<br>1. All staff that completes MDS assessments will be educated on proper completion of MDS and CAA's.<br>2. MDSC or designee will monitor all CAAs on a monthly basis for 3 months, using an audit tool, to ensure all CAAs are complete and comprehensive. Any inaccuracies or incomplete CAAs will be corrected immediately and immediate education done by DON.<br>3. Results of the audit will be brought to the QAPI committee.<br>Further actions or follow up to be determined by the QAPI committee. | 3/25/16 |

| 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 02/19/2016 |

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

| (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 272 | Continued From page 4<br>1. Review of the 10/9/15 annual MDS assessment for resident #2 showed the following areas triggered and required a comprehensive assessment: cognitive loss, urinary incontinence, psychosocial well-being, mood state, behavioral symptoms, activities, falls, nutritional status, pressure ulcers, and psychotropic drug use. Review of the CAAs showed an analysis of data to support the care plan decision was lacking for the following triggered areas: cognitive loss, urinary incontinence, psychosocial well-being, and mood state.<br><br>2. Review of the 9/8/15 admission MDS assessment for resident #4 showed the following areas triggered and required a comprehensive assessment: communication, cognitive loss, urinary incontinence, psychosocial well-being, activities, falls, nutritional status, and pressure ulcers. Review of the CAAs showed an analysis of data to support the care plan decision was lacking for the following triggered areas: cognitive loss, and nutritional status.<br><br>3. Review of the 7/11/15 annual MDS assessment for resident #6 showed the following areas triggered and required a comprehensive assessment: cognitive loss, urinary incontinence, psychosocial well-being, mood state, activities, falls, nutritional status, pressure ulcers, and psychotropic drug use. Review of the CAAs showed an analysis of data to support the care plan decision was lacking for the following triggered areas: cognitive loss, activities, and psychotropic drug use.<br><br>4. Review of the 10/11/15 significant change MDS assessment for resident #7 showed the following areas triggered and required a comprehensive | F 272 | | |

| 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 02/19/2016 |

| 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 272 | Continued From page 5<br>assessment: delirium, communication, cognitive loss, urinary incontinence, psychosocial well-being, mood state, behavioral symptoms, activities, falls, nutritional status, and pressure ulcers. Review of the CAAs showed an analysis of data to support the care plan decision was lacking for the following triggered areas: delirium, communication, cognitive loss, urinary incontinence, psychosocial well-being, mood state, behavioral symptoms, and activities.<br><br>5. Review of the 8/20/15 annual MDS assessment for resident #13 showed s/he triggered for further assessment in the following areas: cognitive loss/dementia, communication, urinary incontinence and indwelling catheter, psychosocial well-being, mood state, behavioral symptoms, activities, falls, nutritional status, dental care, pressure ulcer, psychotropic drug use, and pain. The following concerns were identified:<br>a. Review of the CAA for psychosocial well-being failed to show any analysis of the resident's psychosocial needs.<br>b. Review of the CAA for dental care failed to address the resident's broken teeth.<br><br>6. Review of the 6/18/15 admission MDS assessment for resident #18 showed s/he triggered for further assessment in the following areas: visual function, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, nutritional status, dehydration, and pressure ulcer. The following concerns were identified:<br>a. Review of the CAA for dehydration failed to show any analysis of the resident's needs in this area. | F 272 | | |

| 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 02/19/2016 |

| 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 272 | Continued From page 6<br>7. Review of the 9/1/15 admission MDS assessment for resident #27 showed s/he triggered for further assessment in the following areas: cognitive loss/dementia, communication, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, psychosocial well-being, activities, falls, nutritional status, and pressure ulcer. The following concerns were identified:<br>a. Review of the CAAs for cognitive loss/dementia, communication, psychosocial well-being and activities failed to show any analysis of resident needs for these areas.<br><br>8. During an interview with MDS coordinator on 2/18/16 at 4:10 PM she verified the CAAs were incomplete or analysis data to support the care plan decision for the triggered areas was lacking. | F 272 | | |
| F 312 SS=E | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to ensure assistance with activities of daily living were provided in a timely manner for 3 of 6 residents (#2, #6, #21) who required toileting assistance. The findings were:<br><br>1. Review of the 1/9/16 quarterly MDS | F 312 | | |

| 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 02/19/2016 |

| 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 312 | Continued From page 7<br>assessment showed resident #2 was frequently incontinent of bowel and bladder and required extensive assistance with toileting and personal hygiene care. Review of the care plan, revised 2/2/16, showed interventions for incontinence included check and/or toilet resident before and after meals, at bedtime and as needed. The following concerns were identified:<br>a. Observation on 2/19/16 at 8:10 AM revealed the resident sat in the wheelchair in the dining room eating breakfast. After breakfast CNA #1 and #2 wheeled the resident to his/her room, transferred him/her to a recliner chair, and departed without checking or providing toileting assistance.<br>b. Further observation revealed the resident remained in the recliner chair until 11:25 AM (3 hours and 15 minutes), when CNA #1 used a mechanical lift to transfer the resident to the bathroom. At that time the CNA removed the resident's urine- and fecal-soiled disposable brief prior to positioning the resident on the bathroom commode.<br><br>2. Review of the 1/11/16 Quarterly MDS assessment showed resident #6 was frequently incontinent of bowel and bladder and required extensive assistance with toileting and personal hygiene care. Review of the care plan, revised 2/2/16, showed interventions for incontinence included check and/or toilet resident before and after meals, at bedtime and as needed. The following concerns were identified:<br>a. Observation on 2/19/16 at 8:10 AM revealed the resident sat in the wheelchair in the dining room eating breakfast. Continued observation from 8:10 AM until 11:55 AM revealed the resident was wheeled to his/her room for an insulin injection, then positioned in the activity | F 312 | **F312**<br>**The facility will ensure that residents who are unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.**<br>1. Resident #2, 6 and 21, and all residents requiring assistance, will be toileted according to their care plan.<br>2. Long Term Care Staff will be in-serviced on toileting schedules according to the resident's Care Plans.<br>4. An audit will be done monthly for three months, by the DON or designee, using an audit tool, to ensure that resident's toileting schedules according to the care plan are being followed. Any variances found will be corrected immediately and immediate education done by the auditor.<br>5. The results of the audit will be brought to QAPI committee. Further actions or follow up to be determined by the QAPI committee. | 3/25/16 |

| 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 02/19/2016 |

| 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 312 | Continued From page 8<br>room for Bingo, and remained in the activity area thereafter. Further observation revealed staff did not check or toilet the resident during that time.<br>b. At 11:55 AM (3 hours and 45 minutes) CNA #2 wheeled the resident to his/her room and used a sit-to-stand mechanical lift to transfer the resident to the bathroom. The CNA removed the resident's urine- and fecal-soiled disposable brief prior to positioning him/her on the bathroom commode.<br><br>3. Review of the 1/19/16 annual MDS assessment showed resident #21 had frequent urinary incontinence and required extensive assistance with toileting and personal hygiene. Review of the care plan, revised 1/28/16, showed interventions for urinary incontinence included check and/or toilet resident before and after meals, at bedtime and as needed. The following concerns were identified:<br>a. Observation on 2/19/16 at 8:10 AM revealed the resident sat in the wheelchair in the dining room eating breakfast. Continuous observation revealed the resident attended the morning Bingo activity and remained in the activity area after breakfast without receiving toileting assistance.<br>b. At 11:10 AM (3 hours), CNA #3 used a gait belt to transfer the resident from the wheelchair to bathroom. At that time the CNA removed the resident's urine-soiled disposable brief prior to positioning him/her on the bathroom commode.<br><br>4. Interview with the DON on 2/19/16 at 2:35 PM revealed CNAs were expected to provide incontinent care as soon as they can get to it. | F 312 | | |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES | F 314 | | |

| 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 02/19/2016 |

| 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 314 | Continued From page 9<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review and staff interview the facility failed to ensure preventive skin measures were implemented for 1 of 6 sample residents (#7) assessed as needing pressure-relieving devices. The findings were:<br><br>According to the 10/11/15 significant change MDS assessment and 1/1/16 quarterly MDS assessment, resident #7 was at risk for developing pressure ulcers and required a pressure-relieving device in the bed and wheelchair. The following concerns were identified:<br>a. Periodic observations of the resident on 2/16/16, 2/17/16, and 2/18/16 showed s/he sat in the wheelchair without a pressure-relieving device.<br>b. During an interview on 2/19/16 at 8:40 AM the DON acknowledged the absent pressure-relieving device in the wheelchair. At that time she stated the pressure-relieving device was in the wheelchair when the resident's family took him/her to an appointment on 2/16/16 and it must not have returned with the resident (3 days | F 314 | **F314**<br>**The facility will 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, presenting infection and prevent new sores from developing.**<br>1. Resident #7 had a cushion placed in her WC.<br>2. All residents who are chairbound will have pressure-relieving devices in their wheel chairs<br>3. Restorative or designee will do monthly audits for three months, using an audit tool, to ensure that all pressure relieving devices are in place. Any device found missing will be corrected immediately and education provided to caregiver assigned.<br>4. Results of audit will be brought to QAPI committee. Further follow up or actions to be determined by QAPI committee. | 3/25/16 |

| 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 pp 02/19/2016 |

| 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 314 | Continued From page 10<br>ago).<br>c. Observation with the DON on 2/19/16 at 9:05 AM revealed the resident had an area of redness around the anus extending to both buttocks. | F 314 | | |
| F 315 SS=E | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>.<br>Based on observation, medical record review, and staff interview, the facility failed to ensure toileting was provided in a timely manner for 3 of 6 residents (#2, #6, #21) who required assistance to restore as much normal bladder function as possible. The findings were:<br><br>1. Review of the 1/9/16 quarterly MDS assessment showed resident #2 was frequently incontinent of bowel and bladder and required extensive assistance with toileting and personal hygiene care. Review of the care plan, revised 2/2/16, showed interventions for incontinence included check and/or toilet resident before and after meals, at bedtime and as needed. The | F 315 | | |

| 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 pp 02/19/2016 |

| 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 315 | Continued From page 11<br>following concerns were identified:<br>a. Observation on 2/19/16 at 8:10 AM revealed the resident sat in the wheelchair in the dining room eating breakfast. After breakfast CNA #1 and #2 wheeled the resident to his/her room, transferred him/her to a recliner chair, and departed without checking or providing toileting assistance.<br>b. Further observation revealed the resident remained in the recliner chair until 11:25 AM (3 hours and 15 minutes), when CNA #1 used a mechanical lift to transfer the resident to the bathroom. At that time the CNA removed the resident's urine- and fecal-soiled disposable brief prior to positioning the resident on the bathroom commode.<br><br>2. Review of the 1/11/16 quarterly MDS assessment showed resident #6 was frequently incontinent of bowel and bladder and required extensive assistance with toileting and personal hygiene care. Review of the care plan, revised 2/2/16, showed interventions for incontinence included check and/or toilet resident before and after meals, at bedtime and as needed. The following concerns were identified:<br>a. Observation on 2/19/16 at 8:10 AM revealed the resident sat in the wheelchair in the dining room eating breakfast. Continued observation from 8:10 AM until 11:55 AM revealed the resident was wheeled to his/her room for an insulin injection, positioned in the activity room for Bingo, and remained in the activity area thereafter. Further observation revealed staff did not check or toilet the resident during that time.<br>b. At 11:55 AM (3 hours and 45 minutes) CNA #2 wheeled the resident to his/her room and used a sit-to-stand mechanical lift to transfer the resident to the bathroom. The CNA removed the | F 315 | **F315**<br>**The facility will ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.**<br>1. Resident #2, 6 and 21, and all residents requiring assistance, will be toileted according to their care plan.<br>2. Long Term Care Staff will be in-serviced on toileting schedules according to the resident's Care Plans.<br>3. An audit will be done monthly for three months, by the DON or designee, using an audit tool, to ensure that resident's toileting schedules according to the care plan are being followed. Any variances found will be corrected immediately and immediate education done by the auditor.<br>4. The results of the audit will be brought to QAPI committee. Further actions or follow up to be determined by the QAPI committee. | 3/25/16 |

| 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 02/19/2016 |

| 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 315 | Continued From page 12<br>resident's urine and fecal soiled disposable brief prior to positioning him/her on the bathroom commode.<br><br>3. Review of the 1/19/16 annual MDS assessment showed resident #21 had frequent urinary incontinence and required extensive assistance with toileting and personal hygiene. Review of the care plan, revised 1/28/16, showed interventions for urinary incontinence included check and/or toilet resident before and after meals, at bedtime and as needed. The following concerns were identified:<br>a. Observation on 2/19/16 at 8:10 AM revealed the resident sat in the wheelchair in the dining room eating breakfast. Continuous observation revealed the resident attended the morning Bingo activity and remained in the activity area after breakfast without receiving toileting assistance.<br>b. At 11:10 AM (3 hours), CNA #3 used a gait belt to transfer the resident from the wheelchair to bathroom. At that time the CNA removed the resident's urine soiled disposable brief prior to positioning him/her on the bathroom commode.<br><br>4. Interview with the DON on 2/19/16 at 2:35 PM revealed the CNAs were expected to provide incontinent care as soon as they can get to it. | F 315 | | |
| F 332 SS=D | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>The facility must ensure that it is free of medication error rates of five percent or greater.<br><br>This REQUIREMENT is not met as evidenced | F 332 | | |

| 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 02/19/2016 |

| 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 332 | Continued From page 13<br>by:<br>Based on observation, medical record review and staff interview, the facility failed to ensure a medication error rate of less than five percent. Errors were observed on 3 of 30 medication administrations (residents #6, #13), resulting in an error rate of 10 percent. The findings were:<br><br>1. Observation on 2/18/16 at 5:16 PM showed hydrocodone-acetominophen 10/325 mg was administered to resident #13. Review of physician's orders showed a 10/13/15 order for hydrocodone-acetominophen 10/325 mg 1 tablet to be given orally with meals three times daily for chronic pain. Observation at the time of the medication administration showed the resident was in bed, and did not have a meal. Observation at 6:06 PM showed the resident was being fed the evening meal, and interview with the DON at that time revealed the resident's meal had arrived at approximately 5:50 PM. Interview with the DON on 2/19/16 at 12 PM confirmed the medication was supposed to be given with a meal, and was not.<br><br>2. Observation on 2/19/16 at 8:22 AM showed levothyroxine sodium 50 mcg was administered to resident #6 along with 7 other medications. Review of physician's orders showed a 7/3/14 order for for levothyroxine sodium 50 mcg to be administered by mouth once daily. According to the PDR Nurse's Drug Handbook, 2013 Edition, levothyroxine sodium should be administered 30 minutes to one hour before breakfast on an empty stomach. Review of the resident's January 2016 MAR showed the medication was scheduled to be administered at 7 AM. Interview with RN #1 at 10:06 AM confirmed the medication had been given late. | F 332 | **F332**<br>**The facility will ensure that it is free of medication error rates of five percent or greater.**<br>1. Resident #6 & 13, and all residents, will have their medications administered correctly.<br>2. DON or designee will educate Long Term Staff on correct administration of medications in Long Term Care.<br>3. DON or designee will do monthly medication pass audit for three months, using an audit tool. Any variances will be corrected immediately and immediate education done by auditor.<br>4. Results of audit will be brought to the QAPI committee. Further actions or follow up to be determined by the QAPI committee. | 03/25/2016 |

| 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 PP 02/19/2016 |

| 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 332 | Continued From page 14<br><br>3. Observation on 2/19/16 at 8:22 AM showed losartan potassium 25 mg was administered to resident #6. Review of physician's orders showed a 9/4/14 order for losartan potassium 25 mg to be administered by mouth once daily. Further review of the physician's order showed the medication was to be held if the resident's systolic blood pressure was lower than 110 mm Hg. Review of the medical record showed the resident's systolic blood pressure that morning had been measured at 96 mm Hg. Interview with RN #1 at 10:06 AM confirmed the medication should have been held because the resident's blood pressure was outside of physician-ordered parameters. | F 332 | | |
| F 364 SS=E | 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP<br><br>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and resident interview, and review of council meeting minutes, the facility failed to ensure food was maintained at a temperature considered palatable. The census was 32. The findings were:<br><br>1. Review of the resident council minutes showed food temperature was brought up as a concern for the month of February 2016. During a group interview of 7 residents on 2/17/16 at 11 AM, the residents revealed the temperature of the food | F 364 | | |

| 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 pp 02/19/2016 |

| 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 364 | Continued From page 15<br>served was too cold for their liking.<br><br>2. Interview with resident #31 on 2/16/15 at 6:15 PM revealed the steamed cabbage s/he had for supper was "not good, it was cold." Interview with resident #12 on 2/17/16 at 3 PM revealed sometimes the food was "not as hot as it could be."<br><br>3. Observation on 2/17/16 of the supper meal preparation and service showed the menu included potatoes, green beans, noodles and turkey croquettes. At 5:10 PM after checking the food temperatures, the cook began to serve food from the steamtable in the kitchen. The covered foods on the trays were placed on a food tray delivery cart for transport to the dining room. At 5:30 PM the cart was wheeled to the dining room and service to the residents began at 5:33 PM (23 minutes after the food was dished from the steamtable). During the meal service, the cook and CDM tested the food temperatures of a sample tray that had sat covered for 20 minutes. The test revealed the following temperatures: the potatoes were 113 degrees Fahrenheit (F), green beans were 105 degrees F, noodles were 89 degrees F, and turkey croquettes were 109 degrees F.<br><br>4. Interview with the CDM on 2/17/16 at 5:50 PM revealed in the past the residents were served directly from the steamtable in the dining room, but this was changed to prevent moving the steamtable from the kitchen to the dining room. The CDM acknowledge the current procedure for transporting the food trays to the dining room caused the prepared food trays to sit for over twenty minutes before being served to the residents. | F 364 | **F364**<br>**The facility will ensure that each resident receives and is provided food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive and the at the proper temperature.**<br>1. Crook County Medical Services have changed the process of how we are serving residents in the dining room. The new process includes serving residents off of the steam table in our dining room.<br>2. The temperatures will be taken immediately prior to serving our residents and tracked on the temperature log. Any variances will be addressed and corrected immediately.<br>3. An audit will be done monthly by the dietary supervisor or designee for three months, using an audit tool, and brought to QAPI committee. Further follow up or actions will be determined by the QAPI committee. | 03/25/16 |

| 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 PP 02/19/2016 |

| 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 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, manufacturer's recommendations, and review of dish machine logs, the facility failed to maintain effective sanitation concentration levels for the dish machine. The census was 32. The findings were:<br><br>Review of the February 2016 dish machine logs showed staff were to check for effective sanitization twice daily, using the manufacturer-recommended test strips. Review of the label on the test strips showed effective sanitation concentration levels were confirmed with results of 50 or higher parts per million (ppm) hypochlorite. According to the February 2016 dish machine logs, 24 of 34 test strip results were below 50 ppm. The dietary aide was observed checking the sanitation concentration level of the dish machine on 2/17/16 at 4:30 PM. The results were 45 ppm. At that time the dietary aide stated he did not know the acceptable concentration level. He further stated he was unable to consistently check the levels twice daily because all staff were working extra hard until additional | F 371 | **F371**<br>**The facility will procure food from sources approved or considered satisfactory by Federal, State or local authorities and store, prepare, distribute and serve food under sanitary conditions.**<br>1. The dishwasher will be checked by dietary supervisor or designee once day during the rinse cycle to ensure that it is at 50PPM. Results will be recorded on a log.<br>2. Staff will be educated the importance of the dishwasher rinse cycle being at 50PPM.<br>3. The dietary supervisor or designee will audit the log monthly for three months using an audit tool. If any variances are found, they will be addressed and corrected immediately and immediate education provided to staff that recorded the variance.<br>4. The audit results will be brought to the QAPI committee. Any further actions or follow up will be determined by the QAPI committee. | 3/25/16 |

| 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 4P 02/19/2016 |

| 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 371 | Continued From page 17<br>staff were hired. Interview with the CDM on 2/17/16 at 5 PM revealed she was not aware of problems with the sanitation concentration levels and she had not noted the recorded tests on the logs.<br><br>According to Food Code 2013, U.S. Public Health Services, 4-204.117 Warewashing Machines, Automatic Dispensing of Detergents and Sanitizers. The presence of adequate detergents and sanitizers is necessary to effect clean and sanitized utensils and equipment. The automatic dispensing of these chemical agents, plus a method such as a flow indicator, flashing light, buzzer, or visible open air delivery system that alerts the operator that the chemicals are no longer being dispensed, ensures that utensils are subjected to an efficacious cleaning and sanitizing regimen.<br><br>According to Food Code 2013, U.S. Public Health Services,4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration. The effectiveness of chemical sanitizers is determined primarily by the concentration and pH of the sanitizer solution. Therefore, a test kit is necessary to accurately determine the concentration of the chemical sanitizer solution. | F 371 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program | F 441 | | |

| 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 02/19/2016 |

| 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 441 | Continued From page 18<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, policy and procedure review, and staff interview the facility failed to ensure blood glucose meters were cleaned and disinfected between uses for 2 of 2 observations of blood glucose meter use (resident #6, #18). The findings were: | F 441 | **F441**<br>**The facility will 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.**<br>1. Residents #6 and 18, and all residents receiving finger-stick glucose monitoring, will have the blood glucose meter cleaned/disinfected between uses.<br>2. Staff will be in-serviced on proper disinfection/cleaning of the blood glucose meter in accordance with facility policy.<br>3. Audits will be conducted by LTC supervisor or designee monthly for three months, using an audit tool. Any variance from policy will be corrected immediately and education provided to the staff involved.<br>4. Results of the audits will be brought to the QAPI committee. Further follow up or actions will be determined by the QAPI committee. | 3/25/16 |

| 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 02/19/2016 |

| 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 441 | Continued From page 19<br>1. Observation on 2/18/16 at 4:52 PM showed LPN #1 used a blood glucose meter to obtain a blood glucose level on resident #18. After obtaining the result, the nurse failed to perform any cleaning or disinfection of the blood glucose meter, and placed the meter in a tray that contained other blood glucose monitoring supplies such as lancets and alcohol swabs.<br><br>2. Observation on 2/18/16 at 4:58 PM showed LPN #1 used the same blood glucose meter to obtain a blood glucose level on resident #6. After obtaining the result, the nurse did not clean or disinfect the blood glucose meter, placed the meter into a tray that also contained other blood glucose monitoring supplies such as lancets and alcohol swabs, and then placed the tray in the top drawer of the medication cart.<br><br>3. Review of the facility's policy and procedure entitled, "Blood Glucose Testing, Cleaning & Quality Control With Glucometer" last revised 12/26/13 showed "...17. To clean the glucometer put on clean gloves, wrap the machine in a germicidal disposable wipe and let it sit for 20 minutes. If the glucometer is visible (sic) soiled with blood, use germicidal disposable wipe upfront to wipe off the machine..."<br><br>4. Review of "CDC - Infection Prevention during Blood Glucose Monitoring and Insulin Administration" (2012, May 2) retrieved from http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html on 3/2/16 showed "... Unsafe practices during assisted monitoring of blood glucose and insulin administration that have contributed to transmission of HBV [hepatitis B virus] or have put persons at risk for infection include:...Using a blood glucose meter for more | F 441 | | |

| 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 pp 02/19/2016 |

| 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 441 | Continued From page 20<br>than one person without cleaning and disinfecting it in between uses..."<br><br>5. Interview on 2/19/16 at 12:30 PM with the DON revealed it was the expectation that all staff disinfect the glucometer after use because they had all received training on how to do this. | F 441 | | |