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 04/14/2016

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 A complaint survey was conducted by Healthcare Licensing and Surveys on 4/12/16 through 4/14/16. Complaints reviewed in the course of this survey was complaint intake WY000002226 and WY00002205. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse RN: Registered Nurse MDS: Minimum Data Set ADON: Assistant Director of Nursing Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 323 SS=E	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 medical record review, staff interview, fall follow-up review, and policy and procedure review, the facility failed to ensure interventions	F 323	Crook County Medical Services District strives to ensure that residents receive adequate supervision and assistance to prevent accidents. Resident 7 now has a lap belt for trunk support while in wheelchair. Resident #7 and #21 have had no further falls. Resident #13 "fell" since 04/13/2016. New interventions were implemented post fall in attempts to prevent further falls and to resident care plan. A chart audit will be performed of all residents with falls occurring in March and April 2016 to insure interventions were added/noted in Care Plan. All residents at high risk for falls will receive low beds as they become available to the facility. A Post Fall Investigation template has been developed and deployed to ensure that all falls are thoroughly investigated and appropriate, new interventions are implemented and added to Care Plan. All falls and their investigations will be written on the Incident Log, reviewed by the Interdisciplinary Team weekly, and audited by the Director of Nursing to ensure appropriate follow-up and intervention. Results of the audit will be reported at QAPI monthly for 3 months. Further follow-up/resolution of this monitoring will be determined by the QAPI Committee.	05/05/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 5/5/16

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
MAY 09 2016
WDS Cheyenne

Healthcare Licensing and Surveys

5/5/16 - POC accepted per Tim Cozad. Corrected copy reviewed & accepted 5/11/16. J VanDyke, RN

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F 323	Continued From page 1	F 323		

were implemented/developed to prevent and minimize falls for 3 of 5 sample residents (#7, #13, #21) who had falls. The findings were:

1. Review of the "actual fall" care plan revised on 10/19/15 showed resident #7 had unsteady gait, poor balance, and poor communication and comprehension. Review of the interventions showed "fall risk assessment to be completed quarterly, assist with all transfers using a gait belt and walker, half-siderails for positioning and support, non slip footwear on at all times, call light within reach at all times, alarm in bed and chair, frequent checks, encourage activities, provide activities that promote exercise and strength building where possible, and provide 1 to 1 activities." Review of progress notes between 2/19/16 and 4/6/16 showed the resident had falls on 2/19/16, 2/22/16, 3/11/16, 3/16/16, and 4/6/16. The following concerns were identified:

a. Review of a progress note dated 2/19/16 and timed between 1:17 PM and 5:34 PM showed the resident was in the dining room and staff observed the resident fall out of his/her chair. There were no other residents or staff around at that time. The resident received a laceration to his/her head and was taken to the emergency room for sutures. The resident's daughter came to the facility, inspected the resident's hand, and requested an x-ray.

b. Review of a radiology report dated 2/19/16 and timed 5:01 PM showed an acute fracture involving the mid shaft of the fifth metacarpal was mildly displaced.

c. Review of the "fall follow up" note dated 2/20/16 and untimed showed there were no Interdisciplinary Team (IDT) recommendations and no evidence that new interventions were implemented related to the 2/19/16 fall.

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F 323	Continued From page 2 d. Review of the "fall follow up" note dated 2/23/16 and untimed showed there was no injury to the resident and "appropriate follow up was done." There were no IDT recommendations and no evidence that new interventions were implemented related to the 2/22/16 fall. e. Review of the "fall follow up" note dated 3/3/16 and timed 2 PM showed there was no injury to the resident. There were no IDT recommendations or evidence that new interventions were implemented related to the 3/11/16 fall. f. Review of the "fall follow up" note dated 3/16/16 and timed 10 AM showed the resident received a skin tear to the left elbow. There were no IDT recommendations and no evidence that new interventions were implemented related to the 3/3/16 fall. g. Review of the "fall follow up" note dated 4/6/16 and untimed showed there was no injury to the resident and "Interventions in place to prevent [him/her] from injuring [him/herself]. They have been effective." Further, there were no IDT recommendations and no evidence that new interventions were implemented related to the 4/6/16 fall. 2. Review of the "fall" care plan revised on 2/11/16 showed resident #21 was "at risk" for falls related to incontinence, gait and balance problems, and deconditioning. Review of the interventions showed the facility was to "anticipate the resident's needs, ensure the call light was within reach and encourage the resident to use it for assistance as needed, respond promptly to all resident's requests, encourage the resident to participate in activities that promote exercise, ensure the resident is wearing nonslip footwear when ambulating or mobilizing in	F 323		

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F 323	Continued From page 3 wheelchair, complete a fall risk score quarterly and after each fall, follow the fall protocol, and have physical therapy evaluate and treat as ordered or as needed." The following concerns were identified: a. Review of the "fall follow up" note dated 3/11/16 and untimed showed the resident had a fall on 3/10/16 at 3 PM that resulted in a skin tear to the "right little finger." There were no IDT recommendations and no evidence that new interventions were implemented related to the 3/10/16 fall. 3. Review of the "actual falls" care plan revised on 2/17/16 showed resident #13 had confusion, impulsive behavior, and used psychotropic medication. Review of the interventions showed the facility was to anticipate the resident's needs, place a mat at bedside to minimize injury from falls, make sure water was within reach, ensure the call light was within reach and encourage the resident to use it for assistance, promptly respond to resident requests for assistance, apply a bolster pillow for boundary identification, complete a fall risk score quarterly, "monitor/document/report to Nurse/MD" signs and symptoms of depression, and "monitor/record/report to MD" as needed risk for harming others. The following concerns were identified: a. Review of the "fall follow up" note dated 3/14/16 and untimed showed there was no injury to the resident and "interventions successful." Further, the IDT recommendation was to "anticipate further episodes like this one." There was no evidence that new interventions were implemented related to the 3/11/16 fall. 4. Interview with the DON on 4/13/16 at 4:30 PM	F 323		

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F 323	Continued From page 4 confirmed that no new interventions were implemented after the falls. 5. Review of the "Falls and Fall Risk" policy revised April 2013 showed "...Treatment/Management 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and address risks of serious consequences of falling...2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation...Monitoring and Follow up...2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling...4. If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions..."	F 323		