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

PRINTED: 03/07/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/24/2017

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 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Healthcare Licensing and Surveys on 2/21/17 through 2/24/17. The following common abbreviations are used throughout this document: ADLs- Activities of daily living CNA- Certified nurse aide DON- Director of nursing services MAR- Medication administration record MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	F253 The broken plastic binder holder was removed from the wall and replaced with a new one. The call light cover in the shower room was replaced. The handrail to the left of Room 211 was secured to the wall. The upholstered stool with a rip in the vinyl was thrown away. A systematic inspection and repair of all doors/frames and walls/trim to be conducted by the Maintenance staff to ensure that all doors/frames and walls/trim are clean and in good repair within 30 days. Door/frames and walls/trim will be inspected monthly during Maintenance rounds with findings corrected within 30 days. Monthly inspections will be conducted by Maintenance staff as well as general staff and documented on inspection form and used to report any areas in need of repair. Repairs are logged in the Maintenance repair log and will be reviewed at QAPI meeting Monthly for 3 months, further action to be determined by QAPI committee.	04/05/2017
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 3 of 3 resident areas (short hall, long hall, and the dining area) were clean and in good repair. The findings were: 1. Concerns identified on the short hall: a. Observation on 2/23/17 at 10:06 AM in room 201 showed below the door handle on the bathroom door were two damaged areas which measured 20 inches by 1/4 inch. The damage exposed underlying material. The short walls by the bathroom and hallway showed a 2 inch by 1 inch section of damaged drywall, a 1/2 inch by 1/2	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 3/13/17

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
MAR 13 2017
Healthcare Licensing and Surveys

PoC accepted with changes
3/14/17

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F 253	Continued From page 1	F 253		

exposed section of damaged drywall above the wall trim, and an area 29 inches above the wall trim from the base board that had a damaged section that measured 14 inches by 1/4 inch. In addition, the hall door to room 201 had chipped wood on the lower edges that was rough to the touch and could not be cleaned effectively.

b. Observation on 2/23/17 at 10:14 AM showed the main entrance doors to the nursing home had 2 scraped areas that exposed underlying material. These areas measured: 33 inch by 1 inch and 35 inch by 1/2 inch.

c. Observation on 2/23/17 at 10:17 AM showed a broken plastic binder holder affixed to the wall by the bulletin board.

d. Observation on 2/23/17 at 10:20 AM in room 202 showed a 27 inch long area of damage on the wall at a height of 4 inches from the baseboard that could not be cleaned effectively. The room entrance door frame had areas that extended to 7 inches on both sides where the paint was chipped away, which exposed underlying material. The door on the hinge side had 24 inches by 1/2 inch of chipped-off wood that could not be cleaned effectively.

e. Observation on 2/23/17 at 10:25 AM showed the chapel door frame had an area of damage 10 inches from the floor with exposed underlying material that could not be cleaned effectively.

f. Observation on 2/23/17 at 10:29 AM showed the wall to the left of the dining room entrance by the chapel door had a 9 1/2 inch by 13 inch area of wall trim which was loose from the wall and could not be cleaned effectively.

g. Observation on 2/23/17 at 10:32 AM in room 204 showed the lower 10 inches of the door frame on both sides was scraped and exposed underlying material that could not be cleaned

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F 253	Continued From page 2 effectively. To the left of the door there was 12 inches of wall trim loose from the wall that could not be cleaned effectively. h. Observation on 2/23/17 at 10:52 AM in the shower room showed a missing cover over a call light. The bathroom door frame had areas of damage extending to 23 inches on both sides of the frame near the floor that exposed underlying material. The lower 10 inches of the main door frame to the shower room showed exposed underlying material that could not be cleaned effectively. g. Observation on 2/23/17 at 10:57 AM of the beauty salon room door frame showed the lower 10 inches had scraped paint which exposed the underlying material on both sides, and could not be cleaned effectively. 2. Concerns in the dining area: a. Observation on 2/23/17 at 11:02 AM showed an upholstered stool which had a split measuring 12 inches by 2 inches across the seat. The padded portion was not secure to the frame exposing underlying material that could not be cleaned effectively. b. Observation on 2/23/17 at 11:09 AM showed, in the hall to the right of the large entrance of the dining area, there were 7 inches of loose trim, a 1 inch hole in the wall 6 inches up from the floor that exposed underlying material and could not be cleaned effectively. 3. Concerns in the long hall: a. Observation on 2/23/17 at 11:14 AM showed by the room 205 doorway there was 97 inches of the trim that was loose and could not be cleaned. b. Observation on 2/23/17 at 11:15 AM showed the door frame of room 210 had an area	F 253		

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F 253	Continued From page 3 on the lower 10 inches of scraped paint that could not be cleaned effectively. c. Observation on 2/23/17 at 11:17 AM showed the handrail to the left of room 211 was loose from the wall which exposed underlying material that could not be cleaned effectively. d. Observation on 2/23/17 at 11:18 AM showed the door frames of room 212 and 214 had scrapes on the lower 37 inches which exposed underlying material and could not be cleaned effectively. e. Observation on 2/23/17 at 11:20 AM showed the door of room 212, on the lower left edge, had a scrape that measured 7 inches by 1 inch. f. Observation on 2/23/17 at 11:22 AM showed the door frame of room 216 was scraped on the lower 22 inches. g. Observation on 2/23/17 at 11:25 AM showed the door frame in room 215 and 217 were scraped on the lower 23 inches which exposed underlying material and could not be cleaned effectively. h. Observation on 2/23/17 at 11:30 AM showed both sides of the soiled utility room door frame were scraped on the lower 37 inches, which created a surface that could not be cleaned effectively. 4. Interview with the maintenance director on 2/24/17 at 8:30 AM verified these identified areas were in need of repair. He further stated he kept a list, but there was no time frame in place to ensure the repairs.	F 253		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment	F 278		

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F 278	Continued From page 4 must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure MDS assessments were coded accurately for 1 of 9 sample residents (#26). The findings were:	F 278	F278 MDS on resident # 26 was corrected to show that Ambien was coded as a hypnotic. Section N: Medications was reviewed with the MDSC. Competencies were performed to ensure knowledge of medication classes. 100% of MDS assessments were audited to ensure accurate coding of medications. No further corrections were needed. DON or designee will audit all MDS assessments monthly, using an audit tool, for three months to ensure accurate coding of medications. Results will be reported to the QAPI committee. Further action after 3 months will be determined by QAPI committee.	03/10/2017

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F 278	Continued From page 5 Review of the December 2016 MAR showed resident #26 received scheduled Ambien (hypnotic medication used for insomnia) 5 mg at bedtime. The medication was on hold from 12/24/16 to 12/26/16. Review of the quarterly MDS assessment with an assessment reference date (ARD) of 12/22/16 failed to show the use of the hypnotic medication. Interview with the DON on 2/24/17 at 9 AM verified the medication was used and not coded accurately for this resident.	F 278		
F 279 SS=E	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 279	F279 Care plans on residents # 7,20,21,23,26 will be updated to ensure that all Nutrition and Dehydration goals are measurable. CCMSD has hired a new Registered Dietitian. A 100% audit of all care plans, using an audit tool, was performed to ensure that all goals are measurable. All care plans found to be deficient have been updated. A weekly audit will be completed by DON or designee, using an audit tool, for 6 weeks to ensure all goals are measurable. Results of the audit will be reported to QAPI. Further action after two months will be determined by the QAPI Committee.	03/10/2017

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F 279	Continued From page 6 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure comprehensive care plans were developed for 5 of 9 sample residents (#7, #20, #21, #23, #26). The findings were:	F 279		

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F 279	Continued From page 7 1. Review of the 2/14/17 revised nutrition care plan showed resident #26 was at risk for alterations in nutrition. The goal showed "No significant weight changes. BMI [body mass index] will be in the healthy weight range." The care plan failed to show any weight or weight range and failed to include information related to the BMI. In addition, review of the care plan for this resident failed to address the use of hypnotic medications. Review of the active physician orders showed the resident used Ambien 5 mg at bedtime. The order had a start date of 10/11/16 and review of the December 2016 to February 2017 MARs showed the resident received the medication as ordered. Interview with the DON on 2/23/17 at 2:55 PM verified the hypnotic medication use was not included in the care plan and needed to be developed. 2. Review of 9/24/16 the annual MDS assessment showed resident #23 had diagnoses that included dementia, Barrett's esophagus with dysphasia, and rheumatoid arthritis. The resident required total assistance with ADLs, and the assessment triggered for additional assessment of nutritional status. Review of the 6/30/16 care plan related to the risk for dehydration showed the goal was not measurable. The goal was "Resident will be kept comfortable through next review period." The goal failed to identify the resident's hydration needs. 3. Review of the 7/29/16 annual MDS assessment showed resident #20 had diagnoses that included dementia and chronic constipation. The resident required extensive assistance with ADLs and the assessment triggered for additional assessment of nutritional status. Review of the	F 279		

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F 279	Continued From page 8 11/3/16 revised care plan for nutrition showed the goal was not measurable. The goal was "I will maintain adequate nutritional status as evidenced by maintaining weight with 5% in 30 days, 7.5% in 90 days and 10% in 180 days, with daily current interventions through the next review date." The goal failed to identify the resident's weight and nutritional needs. 4. Review of the 2/13/17 revised nutrition care plan showed resident #7 was identified at risk for alterations in nutrition. The goal showed "Resident will experience no further weight loss..." There was no weight or weight range identified to use as a basis for the goal. 5. Review of the 2/19/16 revised nutrition care plan showed resident #21 was at risk for alterations in nutrition. The goal showed "No weight gain through the next period." There was no weight or weight range identified in the care plan to use as a basis for the goal. 6. Interview with the DON on 2/24/17 at 9 AM verified these goals needed to be further developed in order to be measurable.	F 279		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide	F 431	F431 The Policy on Medication storage will be reviewed with each staff member that has access to the Medication cart and Medication room. Medication Cart/Room out dates will be checked and logged by nursing staff weekly. Competency of the staff's knowledge of the policy will be performed by all nursing staff through audits done by the DON or designee and documented on an audit tool. Audits will continue for 6 weeks to ensure knowledge. Any outdated materials or medications found will result in re education of the staff member found to be responsible for the missed, outdated items. Results of the audits will be reported to the QAPI committee. Further action after 2 months will be determined by the QAPI committee.	04/05/2017

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F 431	Continued From page 9 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431		

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F 431	Continued From page 10 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure expired medications and supplies were removed and not available for use in 2 of 3 medication storage areas (the medication cart, medication room). The findings were: Observation in the medication cart on 2/23/17 at 1:45 PM showed 1 tube of triamcinolone acetonide ointment 0.1% was available for use, and had expired on 1/2017. Observation of the medication room on 2/23/17 at 2:18 PM showed 7 packs of 6 inch by 8 inch Mepilex Transfer Ag with Safetac Technology that was available for use, and had expired on 11/2015. Interview on 2/23/17 at 2:20 PM with the CNA-medicaton aide verified the medications and supplies were available for use, despite being past the manufacturer's expiration date.	F 431		
F 465 SS=D	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with	F 465	F465 The wall below the dish washer, the corner near the coffee station and the corner near the 3 compartment sink will be repaired. The ceiling tiles in the kitchen were cleaned. The metal framing for the ceiling tiles in the kitchen will be cleaned/reconditioned to resolve the rust issue. Inspection of ceiling tiles, frames and walls in the kitchen has been added to the monthly Maintenance inspection form. (Cont)	

Cathy Spackman
3/14/17

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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 465	Continued From page 11 applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the walls/ceiling and floors in the kitchen and dish room were maintained in a sanitary manner. The findings were: 1. Observation on 2/23/17 at 11 AM showed the following damaged areas: a. The wall located below the mechanical dish machine was water-damaged and crumbling. The area measured 3 feet by 5 feet. b. The corner of the wall near the coffee station had an area of damage that measured 3 inches by 2 inches and exposed underlying material. c. The corner of the wall near the 3 compartment sink counter had an area of damage that measured 4 inches by 3 inches and exposed underlying material. d. Four ceiling tiles in the kitchen were soiled with splattered debris and the metal framing for the tiles had areas of visible rust. 2. Interview with the maintenance director on 2/24/17 at 8:28 AM verified the dietary manager relayed maintenance issues to him verbally and a list was created. The maintenance director stated the list was completed when there was time, and there was no exact schedule.	F 465	Monthly inspections will be conducted by Maintenance staff as well as general staff and documented on inspection form that is used to report any areas in need of repair. Repairs are logged in the Maintenance repair log and reviewed at QAPI meeting Monthly for 3 months, further action will be determined by the QAPI committee.	04/05/2017

3.14.17