DEPARTMENT OF HEALTH AND HUM... SERVI ES
CENTERS FOR MEDICARE & MEDICAID SERVI ES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING ______ B. WING ______	07/09/2009

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop and implement a care plan which delineated provision of care and services for 1 of 12 sample residents (#13). The findings were: Observation on 7/7/09 revealed resident #13 was not checked for incontinence from 7:30 AM until 12 noon. Interview with certified nurse aides (CNAs) #1 and #2 at the time of the observation revealed they thought hospice staff would provide incontinence care that morning. Review of the medical record showed a care plan delineating	F 279	F 279 The facility will use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The care plan for resident #13 was reviewed on 7/27/09 and updated to reflect the need for him/her to be checked for incontinence every 2-3 hours by the facility staff. A hospice care plan was also added to the resident's medical record. An in-service was held with the staff on 7/31/09 to discuss the duties of hospice and the duties of the facility staff. C.N.A. assignment sheets have been modified to reflect the needs of the residents according to their care plans. Charge nurse, DON, and/or DSD will monitor this area for compliance on daily compliance rounds completed by charge nurse. The DON and DSD will complete compliance rounds at random twice per week for the next three months and as needed thereafter, to ensure that the care plans are being followed. They will report any concerns to the QA committee at least quarterly.	7/31/2009

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: ADMINISTRATOR
(X6) DATE: 7/29/09

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
Wyoming Dept of Health
AUG 01 2009
Office of Healthcare

Accepted on 8/4/09 @ 930 w/ Nancy [illegible] NHO.
DOC 8/14/09
8/4/09

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F 279	Continued From page 1 specific responsibilities for hospice staff v as missing. On 7/7/09 at 5:10 PM the directc of nursing (DON) retrieved a care plan from ıer office which she said she had developed /ithout input from hospice staff. On 7/9/09 at 8:4 AM the DON stated she had no idea how long thr care plan for hospice had been in her office. S e confirmed the CNAs did not have access o the plan and that it did not specifically define ıe tasks hospice staff would complete.	F 279		
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of qua ly. This REQUIREMENT is not met as evid ıced by: Based on medical record review and staf interview, the facility failed to ensure nutr ion assessments were completed by a qualif ıd professional for 4 of 10 sample residents #8, #9, #13, #30) who were assessed as needin a nutrition assessment. The findings were: According to the 2008 Standards of Prac ıce for Registered Dietitians in Nutrition Care, pı ıblished by the American Dietetic Association, Sta ıdard 1: Nutrition Assessment, The registered die tian (RD) uses accurate and relevant data an information to identify nutrition-related pr oblems. Rationale: Nutrition Assessment is the fir t of four steps of the Nutrition Care Process. Nutr ion Assessment is a systematic process of c taining, verifying, and interpreting data in order tc make decisions about the nature and cause of nutrition-related problems. It is initiated b referral and/or screening of individuals ...for nutri on risk factors. ..It provides the foundation for Nı rition	F 281	F281 The facility will ensure that the services provided or arranged by the facility meet professional standards of quality. 1. The registered dietician reviewed and signed the RAP for resident #30 on 7/29/09. 2. The registered dietician reviewed and signed the RAP for resident #8 on 7/29/09. 3. The registered dietician reviewed and signed the RAP for resident #9 on 7/29/09. 4. The registered dietician reviewed and signed the comprehensive assessment for resident #13 on 7/29/09. 5. The CDM will not competed nutrition RAP assessments from this time forward. All RAP assessments will be completed by the RD. The CDM will monitor to ensure the RAP's are being completed by the RD. The CDM will report any concerns to the Quality Assurance Committee at least quarterly.	7/29/2009

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F 281	Continued From page 2	F 281		

Diagnosis, the second step of the Nutritic l Care Process. Further, the 2008 Standards of Practice specifically state: "The RD does not dele iate the nutrition care process, but may assign ce tain tasks for the purpose of providing the RD with needed information (e.g., screens, gathe ng of data and other information) or communic ting with and educating patients."

1. Review of the 3/2/09 significant chang Minimum Data Set (MDS) assessment sl owed resident #30 required an additional evalu tion related to nutrition. Review of the nutritio Resident Assessment Protocol (RAP) sh wed the assessment was completed and signed b / the certified dietary manager (CDM). Further ecord review showed there was no assessmen made by the RD during the MDS assessment timeframe.

2. Review of the 4/24/09 annual MDS assessment for resident #8 showed nutri onal status triggered, which required an asses ment. Review of the attached RAP summary fo nutritional status showed it was complete l by the CDM, and not an RD. Further review sho ved no assessment completed by an RD during ie MDS assessment timeframe.

3. Review of the 5/18/09 annual MDS assessment for resident #9 showed nutri onal status triggered, requiring an assessmen Review of the attached RAP summary fo nutritional status showed it was complete l by the CDM, and not an RD. Further review sho ved no assessment completed by an RD during ie MDS assessment timeframe.

4. According to the 11/28/08 annual MDS

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F 281	Continued From page 3 assessment, resident #13 required a comprehensive assessment of his/her nu ritional status. Review of that assessment show it was completed by the CDM. Further review s owed no assessment completed by the RD dur ng the assessment timeframe. 5. Interview with the CDM on 7/8/09 at 1: 25 PM revealed she had always completed the utrition RAP assessments, and was not aware th ey needed to be completed by the RD.	F 281	F 282 The facility will ensure that the services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. 1. The care plan was reviewed and updated on 7/27/09 to include seizure precautions for resident #8. The care plan includes the need for him/her to have a mattress or pad by his/her bedside when in bed. This was added to the C.N.A. assignment sheet to remind the staff to put the mattress/pad next to the resident's bed. An in-service was held on 7/31/09 with the staff to discuss how care plans should be used to address specific needs of the residents. C.N.A. assignment sheets were modified to reflect the needs of the residents and the objectives of the resident care plan. Charge nurse will monitor this area for compliance by conducting daily compliance rounds. DON and DSD will conduct random compliance checks twice a week for three months on those residents who require special equipment (according to the care plan). Any concerns will be reported to the Quality Assurance (QA) committee at least quarterly. 2. The care plan was reviewed and updated for resident #13 on 7/27/09 with regards to checking and changing the resident for incontinence of bowel or bladder. It is the responsibility of the facility staff to check and change a resident for incontinence of bowel or bladder.	7/31/2009
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CAR PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written p an of care. This REQUIREMENT is not met as evid nced by: Based on observation, medical record re iew and staff interview, the facility failed to provid care in accordance with the written plan of care or 3 of 11 sample residents (#8, #13, #30). The indings were: 1. Refer to F323 for details regarding not following the plan of care related to seizu e precautions for resident #8. 2. Refer to F309 for details regarding not following the care plan related to bowel incontinence for resident #13. In addition refer to F315 for details regarding not following t e care	F 282		

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F 282	Continued From page 4 plan related to bladder incontinence. 3. Refer to F315 for details regarding not following the care plan related to bladder incontinence for resident #30. In addition refer to F309 related to bowel incontinence and F 323 related to safety precautions not being implemented according to the care plan.	F 282	An in-service was held on 7/31/09 with the staff to discuss how care plans should be used to address the specific needs of the residents and also to discuss the role of hospice for our residents and their care. C.N.A. assignment sheets were modified to reflect the needs of the residents according to the care plan.	
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facili must provide the necessary care and services b attain or maintain the highest practicable physi al, mental, and psychosocial well-being, in accordance with the comprehensive ass ssment and plan of care. This REQUIREMENT is not met as evid noed by: Based on observation, review of medical ecords, and resident, staff, and physician intervie vs, the facility failed to provide necessary care a id services to meet the individual needs of of 11 sample residents (#13, #30, #36). Resid ht #36 was not thoroughly evaluated and treate to effectively control pain, and residents #1: and #30 did not receive care to promote bow l continence. The findings were: 1. During an interview on 7/7/09 at 1:15 I M, resident #36 stated his/her feet were "kill ng me." The resident rated his/her pain at "9" or 0" on a scale of "0 to 10" (0, no pain; 10, worst p in), and stated s/he had been in the facility for 3 onths "without pain relief." The resident stated /he had not seen his/her physician since admissi n in May 2009. The resident also stated s/he just ts "in	F 309	Charge nurse, DON, and DSD will monitor this area for compliance by conducting daily compliance rounds and random checks twice per week for the next three months. Any concerns will be reported to the QA committee at least quarterly. 3. The care plan relating to bladder incontinence was reviewed and updated for resident #30 on 7/27/09. An in-service was held on 7/31/09 to discuss how care plans should be used to address the specific needs of the residents and also to discuss safety precautions in resident care plans. Charge nurse, DON, and DSD will monitor this area for compliance by conducting daily compliance rounds and random checks twice per week for the next three months. They will report any concerns to the QA committee at least quarterly.	

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F 309	Continued From page 5 here [his/her room] in pain" and that the ylenol provided for complaints of breakthrough ain was ineffective. The resident reported being nable to attend activities due to the pain. Intervie with the director of nursing (DON) on 7/8/09 at 1: 50 PM revealed, and medical record review cor irmed, the resident was not ambulating upon ac nission. Observation showed the resident ambul ted independently while pushing a wheelcha on 7/7/09, 7/8/09, and 7/9/09. Medical record review showed the n sident was admitted on 5/11/09 with diagnoses ncluding depression with psychosis, neuropathic ain, and cerebrovascular accident (CVA). The re cord also showed that the resident was under the are of a psychiatrist, and had a designated prima y care physician (PCP). Interview with the psyc iatrist on 7/8/09 at 1:05 PM revealed the resident vas obsessive/compulsive and that the resic nt's CVA occurred in an area of the brain tha : increased this problem. Review of the p in assessment completed on 5/11/09 shov ed the resident complained of constant pain in oth legs and feet. The resident identified his/her acceptable level of pain as "3" on a scal of "0 to 10." At that time, the resident's treatmer for pain was Ultram 50 milligrams (mg) every 6 ours. Review of the daily pain check for J ne 2009 showed the resident rated his/her pain ove the acceptable level of "3" on 25 of 30 days on 15 of those days days, the documented rating was "8" or above (severe pain). Comparison of le medication administration record (MAR with the pain checks showed the resident receiv d Tylenol on 13 of the 25 days s/he complained o pain; 9 of those days were times the resident rate l the pain as "8" or above. Review of the pain che ks from 7/1/09 through 7/9/09 showed all days ere above the identified acceptable pain lev l. Tylenol	F 309	F309 The facility will provide and ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1. a. Resident #36 was reviewed by the DON on 7/8/09 and the PCP on 7/10/09. A new pain assessment was completed on this resident on 7/8/09. Order received from MD for topical pain relief medication on 7/8/09. Nursing staff will complete a pain assessment on all new admissions. The assessment will include interventions that have provided pain relief for the resident prior to admission. The charge nurse will also monitor pain control daily and will document pain control/interventions in the treatment book. The MDS coordinator will review residents for effective pain management at the time of the MDS assessment. If residents are expressing pain at a level 5 or greater, they will be added to the 24-hour report as a change in condition. An acute temporary care plan will be initiated and physician will be notified when residents complain of pain at a level of 5 or greater. The acute temporary care plan will help the nursing staff to assist with pain	7/31/2009

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F 309	Continued From page 6 was given on three of those days. Furthe review showed the MARs lacked documentatior as to the effectiveness of the Tylenol. The follc ving concerns with the facility's treatment plar for this resident's pain were identified: a. Staff failed to identify interventions on the pain assessment, which, during the inter lew on 7/7/09, the resident stated had previousl provided some relief. The resident speci cally identified Lyrica, amitriptyline, and acupu ncture. Interview with the DON on 7/8/09 at 12:5) PM confirmed that none of those interventio s had been attempted. In addition, the DON st ted topical medications had not been tried. b. The resident's Ultram was discon nued on 5/12/09 and Klonopin 1 mg was increas d to three times daily. On 5/22/09 the psychi trist increased the resident's Neurontin to 60 mg three times a day. However, these were ordered routinely and Tylenol 650 mg every four hours as needed for breakthrough pain was not o dered until 6/9/09. Although it was documente the resident continued to complain of breakt rough pain, no further medication changes wer s made after 6/9/09. c. Medical record review showed nc evidence the PCP had seen the resident since s/h s was admitted on 5/11/09. Further review faili d to show evidence the psychiatrist and PCP communicated in any manner. On 7/8/0 at 10:42 AM the PCP stated he had never seen t ie resident and had not consulted with the psychiatrist. 2. Observation on 7/7/09 showed reside it #13 was not checked for incontinence nor c anged from 7:30 AM until 12 noon. According t the 6/12/09 care plan, staff were to check a d	F 309	management and the use of alternative pain relief methods in addition to pain relieving medications. The facility policy regarding pain and the management of pain has been revised to reflect the need to address resident pain appropriately and in a timely manner. The policy also makes reference to non-pharmacological interventions that can and should be tried to relieve resident pain. The nursing staff will be in-serviced on the appropriate ways to control pain as well as alternative interventions to help manage pain on 7/31/09. Nursing Administration (DON, DSD) will monitor pain control twice per week for the next three months and as needed thereafter. Any concerns will be addressed immediately and will be reported to the QA committee at least quarterly. b. Aspirin 81mg was ordered by resident's PCP on 7/10/09. Neurontin dose was increased by PCP on 7/10/09. MD order received on 7/8/09 to check resident blood pressure when he/she complains of 10/10 pain. PCP also gave order to encourage ambulation to help with pain management on 7/10/09.	

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F 309	Continued From page 7 change the resident every 2 to 3 hours a d as needed. When certified nurse aides (CN a) #1 and #2 changed the resident's incontine e brief at 12 PM on 7/7/09, the resident was inc ntinent of bowel. The CNAs stated they had not hanged the resident as they thought hospice wo d do so that morning. 3. Observation of resident #30 on 7/7/09 from 7 AM to 9:50 AM revealed the resident wa not provided toileting care during the 2 hour nd 50 minute period. Observation on 7/7/09 at :50 AM showed the resident was incontinent of l owel. During the observation, CNAs #1 and #2 stated incontinence briefs were to be dated and timed when changed. They stated that, accord ng to the date and time on the brief, the resident as last changed at 6:15 AM that morning. Acco ling to the 6/11/09 care plan, the goal for incon nence care was to keep the resident as clean a d dry as possible. The approaches instructed sta to provide incontinence care as needed. In erview with CNA #3 on 7/9/09 at 3:55 PM revea ed the resident needed to be checked and cha ged for toileting needs at least every two hours.	F 309	c. The resident's primary care physician (PCP) came to see the resident on 7/10/09. The PCP and the psychiatrist also had a discussion about this resident and his/her treatment plan going forward. 2. The care plan for resident #13 was reviewed on 7/27/09. A hospice plan of care was added to this resident's record. C.N.A. assignment sheets were modified to include those residents that need to be checked and changed according to their care plans. This is the responsibility of the facility staff. The nursing staff was in-serviced regarding the role of hospice in the facility as well as regarding the proper following of resident care plans on 7/31/2009. Charge nurse, DON, and DSD will monitor this area for compliance by completing daily compliance rounds and random checks twice per week over the next three months. They will report any concerns to the QA Committee at least quarterly.	
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LI NG A resident who is unable to carry out ac vities of daily living receives the necessary servi es to maintain good nutrition, grooming, and p ersonal and oral hygiene. This REQUIREMENT is not met as evi enced by: Based on observation and staff intervie , the facility failed to ensure staff provided in ontinence	F 312	3. The care plan for resident #30 addressing bowel continence was reviewed on 7/27/09. C.N.A. assignment sheets were modified to include those residents that need to be checked and changed according to their care plans. An in-service was held with C.N.A. and nursing staff on 7/31/09 to educate on the importance of following resident care plans.	

8/4/10

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F 312	Continued From page 8 (perineal) care for 1 of 4 residents (#20) observed during provision of that care. The findings were: Observation on 7/7/09 at 7:13 AM showed resident #20 was assisted into the bathroom. When the resident was unable to urinate certified nurse aide (CNA) #4 checked the resident's brief and commented that it would have to be changed as it was wet. While changing the resident's incontinence brief, the CNA stated the resident had recently developed an extremely red groin, which was much better today. However, the CNA failed to cleanse the resident's perineal area. At 7:38 AM that day, the CNA confirmed she had forgotten to provide perineal care.	F 312	Charge nurse, DON and DSD will monitor this area for compliance and to ensure resident care plans are being followed. The charge nurse will conduct daily compliance rounds and the DON and DSD will conduct random checks twice per week for the next three months and as needed thereafter. They will report any concerns to the QA committee at least quarterly. F312 The facility will ensure that a resident who is unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This will be accomplished by: The care plan for resident #20 was reviewed on 7/27/09. The C.N.A. assignment sheet for Resident #20 was revised to include the need for peri care with every incontinent episode and also to reflect the need to toilet the resident every 2-3 hours. An in-service was held on 7/31/09 to discuss the importance of providing proper peri care to residents. The C.N.A. assignment sheets were modified to remind the C.N.A. staff to perform peri care on those residents who need assistance.	7/31/2009
F 315 SS=D	483.25(d) URINARY INCONTINENCE 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. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure staff provided 2 of 9 sample residents (#13, #30) with necessary treatment and services to promote dryness and prevent skin breakdown. The findings were: 1. Observation on 7/7/09 showed resident #13	F 315		

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F 315	Continued From page 9 was not checked for incontinence from 7 30 AM until 12 noon, 4.5 hours later. The reside t's incontinence brief was wet when change l at noon, and the resident's skin was red wi h a darker area on the left buttock. At the tin e of the observation, CNAs #1 and #2 stated the thought hospice staff changed the resident's bri earlier that day. CNA #2 also identified the dark r area on the resident's buttock as an old press re ulcer site. Review of the incontinence care pla), last updated on 5/12/09, showed staff were t check and change the resident every two to th e hours and as needed. 2. Observation of resident #30 on 7/7/09 from 7 AM to 9:50 AM revealed the resident wa not provided toileting care during the two ho r and 50 minute period. Observation on 7/7/09 at 9:50 AM showed the resident was incontinent of ladder. During the observation, CNAs #1 and #2 stated incontinence briefs were to be dated an timed when changed. They stated that, accord ng to the date and time on the brief, the resident was last changed at 6:15 AM that morning. Acco ding to the 6/11/09 care plan, the goal for incon nence care was to keep the resident as clean nd dry as possible. The approaches instructed sta f to provide incontinence care as needed. In erview with CNA #3 on 7/9/09 at 3:55 PM revea ed the resident needed to be checked and cha ged for toileting needs at least every two hours.	F 315	Charge nurse, DON, and DSD will monitor this area for compliance to ensure that proper peri care is being performed. The charge nurse will complete daily compliance rounds and the DON and DSD will complete random checks twice per week over the next three months to ensure that care plans for peri care are being followed. Any concerns will be reported to the QA committee at least quarterly. F315 The facility will ensure that 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. 1. The care plan was reviewed and updated for resident #13 on 7/27/09 with regards to checking and changing the resident for incontinence of bowel or bladder. It is the role of the facility staff to perform these checks. An in-service was held on 7/31/09 with the staff to discuss how care plans should be used to address the specific needs of the residents and also to discuss the role of hospice for our residents and their care. C.N.A. assignment sheets were modified to reflect the needs of the residents according to the care plan and to remind them that they are to be checking and changing all residents according to his/her care plan, regardless of if they are on hospice service.	7/31/2009
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVI ION The facility must ensure that the resider : environment remains as free of acciden hazards as is possible; and each resident receiv s adequate supervision and assistance d vices to prevent accidents.	F 323		

8/4/11/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM ER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535020	A. BUILDING _____ B. WING _____	07/09/2009

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 This REQUIREMENT is not met as evic nced by: Based on observation, medical record re iew, and staff interview, the facility failed to e sure interventions to prevent accidents were implemented for 2 of 11 sample residen s (#8, #30). The findings were: 1. Review of the admission face sheet s owed resident #8 had a diagnosis of seizure d sorder. Review of physician orders showed the esident was ordered Depakote 500 milligrams (g) twice per day for seizures. In addition, on 4/22 09 the physician ordered a low bed with a matt ess "to prevent injury during seizures from fallir from the bed." Review of the 4/19/09 care pla showed the treatment administration record (TA) was part of the written care plan. Review of ie TARs for June and July 2009 showed a mattr s was to be in place when the resident was in be . However, observation on 7/6/09 at 7:62 PM, 7/7/09 at 1:20 PM, and on 7/8/09 at 3:4 PM revealed the resident was in bed, but a mattress was not on the floor next to the bed. Du ng an interview on 7/9/09 at 8:10 AM, the DOI stated a mattress was supposed to be placed or the floor next to the bed whenever the resident v as in bed. 2. Review of the restraint assessment c ited 6/24/09 showed resident #30 used a la restraint	F 323	Charge nurse, DON, and DSD will monitor this area for compliance. The charge nurse will complete daily compliance rounds to ensure the care plans are being followed and that residents are being checked and changed appropriately in the proper time frame. The DON and DSD will conduct random checks twice per week over the next three months to ensure compliance. They will report any concerns to the QA committee at least quarterly. 2.. The care plan relating to bladder incontinence was reviewed and updated for resident #30 on 7/27/09. An in-service was held on 7/31/09 to discuss how care plans should be used to address the specific needs. The C.N.A. assignment sheets were updated to reflect the needs of the residents according to the care plan. Charge nurses will monitor this area for compliance by completing daily compliance rounds. The DON and DSD will also complete random compliance rounds twice per week over the next three months. They will report any concerns to the QA committee at least quarterly. F323 The facility will ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	7/31/2009

8/4/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING _____ B. WING _____	07/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE EVANSTON	476 YELLOW CREEK ROAD EVANSTON, WY 82930

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 on his/her wheelchair to prevent unassis ed transfers. The care plan dated 6/11/09 s owed the resident was unaware of safety and as at risk for injuries. The care plan further sh wed the restraint was to be used as needed, and released during activities of daily living and during dining. Review of a nursing note dated 6/22/09 t 9:15 AM revealed the resident had a fall in th dining room when the restraint was not in place just after dining. Interview with licensed practical nurse (LPN) #1 at 9:25 AM revealed the restra nt should be in place anytime the resident was up n the wheelchair with the exception of dining. Observation on 7/7/09 at 8:55 AM revealed the resident was seated in his/her wheelchair away from the dining table watching television. The lap restraint had not been placed back onto the chair after dining, and remained off until 9:43 AM, 48 minutes, when CNA #5 noticed and placed it onto the resident's chair	F 323	1. The care plan for resident #8 regarding the use of a mat by his/her bedside was reviewed and updated on 7/27/09. An in-service was held on 7/31/09 to educate on the importance of following resident care plans. The C.N.A. assignment sheets were updated on 7/27/09 to reflect resident care plans and to remind them of any special instructions for a resident. The charge nurse will conduct daily compliance rounds to ensure that care plans are being followed. The DON and DSD will conduct random checks for residents who require a mat at the bedside to ensure that the mattress is in place when the resident is in bed. They will check this twice per week over the next three months. Any concerns will be addressed immediately and will be reported to the QA committee at least quarterly.	
F 356 SS=B	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:	F 356	2. The restraint assessment and the care plan regarding the restraint for resident #30 were both reviewed and updated on 7/27/09. An in-service was held on 7/31/09 for the nursing staff to address the need to follow resident care plans.	

8/4/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER :LIA IDENTIFICATION NUM ER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535088	A. BUILDING _____ B. WING _____	07/09/2009

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

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F 356	Continued From page 12 o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the nurse staffing data as required per regulation. The findings were: Observation from 7/6/09 through 7/8/09 showed the nurse staffing data was posted on a dry erase board by the nurses' station. The data consisted of the names of each employee working that day. During an interview on 7/8/09 at 2:25 PM, licensed practical nurse (LPN) #1 stated she was unaware of any other posted data. At 2:36 PM that day, the director of nursing confirmed the information written on the dry erase board was the only data posted in the facility. The data failed to include the facility name, the date, the total number and actual hours worked by category of staff, and the resident census. In addition, the posted information was not maintained in a format which could be kept for 18 months.	F 356	The DON and DSD will monitor the use of restraints and will hold quarterly restraint review meetings. They will also monitor the following of resident care plans by conducting random compliance checks twice per week for the next three months and as needed thereafter. They will report any concerns to the QA committee at least quarterly. F356 The facility will post the following information on a daily basis: --facility name --current date --total number & actual hours worked by registered nurses, licensed practical nurses, and certified nurse aides --resident census The facility will post this information in a clear and readable format and in a prominent place readily accessible to residents and visitors. The facility will also keep this information on file for a period of 18 months. The Administrator will ensure that this report is being completed daily and will conduct audits, once per month for the next three months, of the reports on file. Any concerns will be reported to the QA committee at least quarterly.	8/1/2009
F 385 SS=D	483.40(a) PHYSICIAN SERVICES A physician must personally approve in writing a recommendation that an individual be admitted to	F 385		

8/4/9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER :IJA IDENTIFICATION NUM ER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING _____ B. WING _____	07/09/2009

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ROCKY MOUNTAIN CARE EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

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F 385	Continued From page 13 a facility. Each resident must remain ur ler the care of a physician. The facility must ensure that the medica care of each resident is supervised by a physiol n; and another physician supervises the medic l care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evi enced by: Based on observation, medical record r view, resident and staff interview, and intervie / with the primary care physician, the facility failed o ensure a physician supervised the medical care of 1 of 12 sample residents (#36). The findings were: During an interview on 7/7/09 at 1:15 PI , resident #13 stated s/he had not seen e her primary care physician (PCP) since adn ssion in May 2009. Review of the medical recor showed documentation the resident's original PC P resigned effective 6/8/09 and that the s vices of a second PCP were arranged by 6/9/09 However, there was no evidence in the ecord that either PCP participated in the resid nt's assessment and care planning, monitor d changes in the resident's medical statu or consulted with other physicians involve in the resident's care. Review of daily pain rat gs for June and July 2009 showed the resider consistently complained of pain above n acceptable level. Refer to F309 related o the facility's failure to control pain at an acc ptable level. Interview with the current PCP on 7/8/09 at 10:42 AM revealed his involvement in t e resident's care was based on faxed inf mation, rumor, and the family's request to provi e care.	F 385	F385 A physician must personally approve in writing a recommendation that an individual be admitted to a facility. each resident must remain under the care of a physician. The facility will ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. Resident #13 was seen in the facility by his/her primary care physician on 7/10/09. The resident's PCP also spoke with the psychiatrist involved in his/her care. The PCP has evaluated the resident and has made some changes regarding his/her pain control. The facility revised the admission audit conducted by medical records to include making sure that residents are seen within the first 30 days of admission. This will be included on the 30 day audit. The facility will also conduct physician visit audits every 30 days for the first 90 days of a residents admission and every 60 days thereafter to ensure that residents are being seen. The facility will notify the physician , when a resident is due to be seen and will monitor to ensure compliance. The medical records worker will monitor this area for compliance monthly. An audit of resident's medical records will be completed monthly to ensure the resident has been seen by his/her physician. The results of the audit will be	7/31/2009

8/4/09

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	535038	A. BUILDING _____ B. WING _____	07/08/2009

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

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F 385	Continued From page 14 The physician stated he had not commu icated with the resident's psychiatrist, evaluater the resident to develop an effective treatmer t regimen for pain, and, in fact, had never seen the resident.	F 385	noted on the MD visit report. The medical records worker will be responsible for conducting the audit and notifying the physician of residents who are due to be seen. The Administrator will conduct random checks once per month over the next three months to ensure that the MD visit report is being completed. Any concerns will be reported to the QA committee at least quarterly.	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHY ICIAN VISITS The resident must be seen by a physicl n at least once every 30 days for the first 90 days ifter admission, and at least once every 60 d ys thereafter. A physician visit is considered timely if i occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evi enced by: Based on observation, medical record r view, resident and staff interview, and intervie v with the resident's physician, the facility failed to ensure 1 of 12 sample residents (#36) was seen y a physician as required. The findings wer : During an interview on 7/7/09 at 1:15 P I, resident #13 stated s/he had not seen a physician since his/her admission in May 2009. A cording to the admission face sheet, the resider t was admitted to the facility on 5/11/09. Furth er review showed no evidence the resident was e er seen by a physician. During an interview on 7 8/09 at 10:42 AM, the resident's current physic an stated he had never seen the resident. Intervie v with the corporate nurse on 7/9/09 at 9:02 AM c nfirmed the resident had never been seen by a hysician since admission.	F 387	F387 The resident must be seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. This will be accomplished by: Resident #13 was seen the in facility by his/her PCP on 7/10/09. The facility revised the admission audit conducted by medical records to include making sure that residents are seen within the first 30 days of admission. This will be included on the 30 day audit. The facility will also conduct physician visit audits every 30 days for the first 90 days of a residents admission and every 60 days thereafter to ensure that residents are being seen. The facility will notify the physician when a resident is due to be seen and will monitor to ensure compliance. The medical records worker and/or the Administrator will monitor this area monthly for compliance and will report any concerns to the QA committee at least quarterly.	7/31/2009
F 428	483.60(c) DRUG REGIMEN REVIEW	F 428		

8/4/09

DEPARTMENT OF HEALTH AND HUMAN SERV CES
CENTERS FOR MEDICARE & MEDICAID SERVI ES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING _____ B. WING _____	07/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428 SS=E	Continued From page 15 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to ensure the attending physician acted upon the pharmacist's reports for 5 of 12 sample residents (#9, #28, #35, #36, #48). The findings were: 1. Medical record review and review of the following pharmacist reports of potential irregularities showed no evidence the physician acted upon the reports: a. Review of the pharmacist's May and June 2009 medication regimen reviews for resident #36 showed the pharmacist identified a drug-to-drug interaction. There was no evidence in the medical record that the physician acted on the pharmacist's reports. Interview with the resident's physician on 7/8/09 at 10:42 AM revealed he received the faxed recommendation. The physician stated the medications were ordered by the psychiatrist and he was "not inclined to change" any medications started by her. On 7/8/09 at 1:05 PM the psychiatrist stated she had not been notified of the pharmacist's	F 428	F428 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. the pharmacist must report any irregularities to the attending physician and the director of nursing, and these reports must be acted upon. This will be accomplished by: 1. The facility will begin the use of a new tracking form that will be sent to physicians to make them aware of the pharmacist recommendations. This form will have a place for the physician to indicate what he/she would like to do in response to the pharmacy recommendation. The facility will put a tracking system in place to ensure that we are receiving these forms back from physicians. a. Resident #36 was reviewed by the DON on 7/27/09. The PCP was notified of the drug-to-drug interaction on 7/8/09. The PCP discontinued use of the drug in question on the pharmacy consult report on 7/8/09. Any recommendations made by the consultant pharmacist will be communicated to the PCP and to the psychiatrist (where applicable) for review and advisement. b. Medications were reviewed for resident #9 by the DON on 7/27/09. The physician was contacted regarding the pharmacist recommendation and documentation of the physician's response was indicated in the resident's medical record.	8/14/2009

8/4/10

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F 428	Continued From page 16 recommendation. b. In May 2009, the pharmacist noted that Razadyne is not effective with severe intellectual impairment and recommended the medication be discontinued for resident #9. c. In April and May 2009, the pharmacist noted Exelon was not effective with severe intellectual impairment and recommend the medication be discontinued for resident #28. In addition, the pharmacist noted that the resident's blood sugars were high in the morning. d. In February 2009, the pharmacist recommended a urio acid level for resident #48, because s/he received Allopurinol 300 milligrams (mg) daily. e. Review of the May 2009 pharmacy medication review for resident #36 showed the pharmacist questioned the extra folic acid the resident was receiving. 2. During an interview on 7/8/09, the director of nursing (DON) stated it was the responsibility of the charge nurses to call or fax the physician with the pharmacist's reports of potential irregularities. The DON stated there was no evidence the physician acted upon the reports, unless there were new orders. She stated "something we don't get anything back."	F 428	c. Medications were reviewed for resident #28 by the DON on 7/27/09. d. Resident #48 is deceased. The facility will implement the use of a new form to communicate pharmacist recommendations to the physician. e. Resident #35's PCP was contacted regarding the pharmacist recommendation on 7/27/09 questioning the use of the extra folic acid that the resident was receiving. Documentation of the PCP response was added to the resident's medical record. 2. The facility will implement the use of a new form that will be sent to the physician indicating the pharmacist recommendations. There will be a place for the physician to indicate how he/she would like to proceed given the pharmacist recommendation. The DON or DSD will be given the responsibility to follow-up and ensure that we are receiving response from the physician. Any concerns will be reported to the QA committee at least quarterly.	

8/4/10