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FORM APPROVED
OMB NO. 0938-0391

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

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 _____	C 03/09/2017

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 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 3/6/17 through 3/9/17. Also reviewed in the course of the survey were complaint intakes WY00002350 and WY00002361. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing MAR- Medication Administration Record MDS- Minimum Data Set mg- milligrams RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 167 SS=B	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made	F 167	F 167 A cover notice was added to facility survey binder in front lobby indicating that preceding three years of survey results are available upon request for review. The binder will be spot checked by the Administrator or designee over the next quarter to ensure the notice is present. Any concerns found will be brought to the bi-monthly QA committee meeting.	3/27/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 4/19/17

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.

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APR 19 2017
Healthcare Licensing and Surveys

POC accepted. Message left for Nancy Lusot, WHA on 4/20/17 @ 1:17pm. Jennifer C

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F 167	Continued From page 1 respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to publicly display the availability of facility surveys, certifications and complaint investigations for the previous 3 years during 4 of 4 days of the survey. The findings were: 1. Observation from 3/6/17 to 3/9/17 showed the facility entrance lobby had a wall-mounted display with a binder which contained the 2016 survey results and plan of correction. However, there was no notice displayed that indicated the availability of the facility surveys, certifications and complaint investigations for all of the preceding three years. 2. Interview on 3/9/17 at 9:48 PM revealed the DON was not aware of the requirement for the facility to prominently post a notice regarding the availability of facility surveys, certifications and complaint investigations for the preceding three years.	F 167		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must-	F 225		

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F 225	Continued From page 2 (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities 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. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 225	F 225 A thorough investigation was completed regarding the incident with resident #25's family member, including attempts to interview resident #25. Notification was made to HLS on 3/8/17. Final reports were faxed to all entities on 3/14/17. Any allegations of abuse/mistreatment will be reported to all required agencies (HLS, APS, and Ombudsman) within the required timeframe and per facility policy. Administrator or designee will ensure reporting is taking place timely and appropriately. In-services regarding abuse reporting are held annually (at a minimum) and education is provided on hire to new employees regarding their responsibilities to report allegations of abuse. Any concerns will be reported to the QA committee in the bimonthly meeting.	3/27/17

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F 225	Continued From page 3 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policies and procedures and facility abuse investigations, the facility failed to investigate and report an allegation of abuse to Healthcare Licensing and Surveys (HLS) for an allegation of abuse involving 1 of 1 sample residents (#25). The findings were: 1. Review of progress notes dated 2/28/17 showed a family member of resident #25 yelled at the resident during the meal, and then force-fed the resident a bite of food, causing the resident's lip to bleed. Another note dated 2/28/17 revealed a CNA reported that the resident's family member told the resident "If we weren't here I would hit you." A progress note dated 3/3/17 showed when	F 225		

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F 225	Continued From page 4 staff walked by the resident's room, the family member's voice was raised and the resident was tearful. The following concerns were identified: a. A social services note dated 3/2/17 showed a referral to Adult Protective Services (APS) was made, and the Ombudsman was notified. However, there lacked evidence HLS was notified. b. Review of the facility's abuse investigations for the past year showed no evidence the incidents involving resident #25 were treated as allegations of abuse. There was no evidence the facility reported the allegation to HLS, nor was there evidence the facility investigated the allegation. c. During an interview on 3/8/17 at 3:24 PM, the administrator confirmed the incidents involving the family member of resident #25 would meet the definition of abuse. She stated the incidents were not reported to HLS, nor had the facility conducted an investigation. She stated she was unsure how to handle it because the resident would ask for the family member to visit. 2. Review of the facility's policy "Abuse-Prevention, Investigating and Reporting" (revised 12/12/16) revealed "Rocky Mountain Care takes steps to prevent abuse of residents. This includes abuse from staff, other residents, families or any person having contact with the resident...Once the Administrator has been notified he/she or designee will immediately ensure the resident's safety and report the incident to: State Survey Agency [HLS]...The Administrator or designee will initiate an investigative process as soon as possible..."	F 225		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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F 241	Continued From page 6 (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide care in a manner that maintained dignity during 1 of 3 meal observations, affecting sample resident #17. The findings were: 1. Observation on 3/9/17 at 8:38 AM showed resident #17 sat in a reclining-type chair at the assistive horseshoe-style table and was fed breakfast by CNA #1. The CNA was leaned over the resident and assisted him/her with a spoon from standing position, which continued for nine minutes until the resident was finished with his/her meal. 2. Interview with the CNA on 3/9/17 at 9:35 AM revealed she was not aware of any specific feeding instructions for resident #17, but stated the resident leaned to the side on occasion, and it was easier sometimes to provide food from a standing position. 3. Interview with the DON on 3/9/17 at 9:47 AM revealed that CNAs received orientation and then yearly training regarding dignity, and that unless it was specified differently in the care plan, staff should be sitting down when feeding residents. She confirmed resident #17 was not a resident with a care plan that allowed assisting the resident with eating while standing.	F 241	F 241 Resident #17's care plan was revised on 3/9/17 to include the need for staff to stand at times to provide meals for the resident to ensure resident safety. CNA and nursing staff were in-serviced on 3/24/17 regarding the need to notify the MDS coordinator or designee when special accommodations need to be made to ensure resident care is provided safely and effectively. Care plans will be implemented to ensure these special accommodations are met. Weekly check will be completed by Unit Manager or designee to ensure staffs are following care plans for residents and that any special accommodations are being addressed in the care plan. Any concerns will be discussed with the QA committee who meets every other month.	3/24/17

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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 4 of 5 resident areas (100 hall, 200 hall, 300 hall, dining room) were clean and in good repair. The findings were: 1. Observation in the 100 hall on 3/8/17 between 10:14 AM and 10:39 AM revealed the following: a. In room #108 the bathroom door frame was scraped to bare metal from the floor to 23 inches high. The bottom right of the closet door had an area of the wood frame that was bare and splintered measuring 3 inches. The storage drawers had three areas of broken veneer which measured 3 inches by 2 inches, 1 1/2 inches by 3/4 inches, and 1/2 inches by 1/2 inches. The wall corner by the closet had 9 inches of exposed metal. The room entrance door frame was scraped to bare metal from the floor to 23 inches high. These surfaces could not be cleaned effectively. b. In room #103 the wall behind the bed near the entrance door had scraped paint measuring 32 inches which exposed drywall. The caulking which surrounded the perimeter of the toilet was broken and soiled with a dark substance. The floor at the bathroom entrance had a 1/2 inch gap between tiles. These surfaces could not be cleaned effectively. 2. Observation in the 200 hall on 3/8/17 between 10:40 AM and 11:04 AM revealed the following: a. The wall near the exit door by room #211	F 253	F 253 Room #108 will be remodeled by 4/5/17 including wall repairs, painting walls, door frames and cabinet refinishing. Room #103 walls will be repaired and repainted by 4/5/17. Toilet caulking will be replaced on 3/28/17. Bids obtained for flooring on 3/15/17. Flooring to be replaced. Room #211 wall covering pulling away will be repaired on 3/28/17. The covering will be glued back to the wall and cleanable plastic corner guard will be added. Room #206 flooring bids obtained 3/15/17. Flooring to be replaced. Room #302 flooring bids obtained 3/15/17. Flooring to be replaced. Room #303 flooring bids obtained 3/15/17. Flooring to be replaced. Hallway outside dining room floor to be stripped and waxed by 4/15/17. Kitchen entrance in dining room floor to be replaced. Bids obtained 3/15/17. Dining room wall will be repaired and repainted by 4/5/17. Dining/day room floor to be replaced. Bids obtained 3/15/17. Door to outside in dining room floor to be replaced. Bids obtained 3/15/17. Door to outside in day room flooring to be replaced. Bids obtained 3/15/17.	

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F 253	Continued From page 7 had a wall covering which was pulled away from the wall from the floor to 16 inches high which created a surface that could not be cleaned effectively. b. In room #206 there were four 12 inch by 12 inch tiles with 1/8 inch gaps between the tiles that were soiled with a dark substance and could not be cleaned effectively. 3. Observation in the 300 hall on 3/8/17 between 11:05 AM and 11:15 AM revealed the following: a. In room #302 a 12 inch by 6 inch tile under the entrance door hinge was soiled with a dark substance. b. In room #303 a 12 inch by 6 inch tile under the entrance door hinge was soiled with a dark substance. The bedroom wall had scraped paint which measured 30 inches by 6 inches and created a surface which could not be cleaned effectively. c. The hallway outside of the dining room had three 12 inch by 12 inch tiles with dark stains. 4. Observation in the dining room on 3/8/17 between 10:16 AM and 11:24 AM revealed the following: a. At the kitchen entrance there were ten 12 inch by 12 inch tiles that were soiled with a dark substance. There were four 12 inch by 12 inch cracked tiles and three 12 inch by 3 inch cracked tiles, which created a surface that could not be effectively cleaned. b. Near the door marked "kitchen" was a wall which had scraped paint measuring 11 inches by 2 1/2 inches which exposed drywall and created a surface which could not be cleaned effectively. c. The wide threshold between the dining room section and activity area had flooring with dark stains which measured 160 inches across.	F 253	Upon admit and discharge in a resident room, the room will be inspected to ensure it is in good repair. Inspection will include paint, flooring, doors, and general repairs/cleanliness in the room. Rooms will also be inspected monthly to ensure they are in good repair. Results of the inspection will be documented in online TELS maintenance system. Any concerns will be reported to the QA committee who meet every other month.	4/22/17

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F 253	Continued From page 8 d. The door leading outside in the dining room area had a 1/4 inch gap between the door frame metal and tile which was soiled with a dark substance. e. Near the door leading outside in the activity/lounge area were five cracked tiles which created a surface that could not be cleaned effectively. 5. Interview with the director of facility maintenance on 3/8/17 at 11:47 AM confirmed the areas reviewed were visibly dirty and/or in disrepair and required maintenance.	F 253		
F 283 SS=D	483.21(c)(2)(i)-(iii) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS (c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	F 283	F 283 Nursing staff was in-serviced on the need to ensure resident being discharged receives all needed information on 3/24/17. Nursing administration team to ensure a complete and accurate discharge summary is completed and entered into the resident medical record. The discharge summary will include a recapitulation of the resident's stay as well as information regarding outside services that are needed/have been arranged for discharge. Social Service department will be responsible for making arrangements for outside services and will document those service arrangements and will review those arrangements with resident/resident representative prior to or upon discharge. Medical records department will audit all discharged resident charts for two months to ensure there is a completed, comprehensive discharge summary in the resident chart. Audits will continue per facility schedule after that time. Any concerns will be reported to the QA committee who meets every other month.	3/27/17

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F 283	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a discharge summary and recapitulation of the resident's stay was completed 1 of 1 sample residents (#40) who was discharged from the facility. The findings were: 1. Review of the medical record showed resident #40, was discharged to home on 10/11/16. A nurses note dated 10/11/16 and timed 11:42 AM stated "Resident discharged @ (at) 1130 (11:30 AM). Resident took all belongings, medications and paperwork. Went over discharge and all medications. All questions were asked and answered." The following concerns were identified: a. Review of the discharge paper work showed the last times medications were administered was not addressed. b. Review of the medical record showed no evidence a discharge summary or recapitulation of the resident's stay with all of the required items was completed, including arrangements for outside services. 2. Interview with the DON on 3/9/17 at 9:45 AM revealed that nurses fill out the times medications were taken on the resident's discharge paper work, but the facility did not have a copy of that information for resident #40. The DON confirmed the discharge summary and recapitulation of stay did not contain all of the required items.	F 283		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents.	F 323		

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F 323	Continued From page 10 The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interviews, and review of temperature logs, the facility failed to ensure side rails/enablers were assessed for safety for 2 of 2 sample residents (#13, #32) who utilized such devices. In addition, the facility failed to ensure water in resident sinks did not reach potentially hazardous temperatures in 3 of 3 hallways. The findings were: Related to side rails: 1. Observation on 3/8/17 at 3:51 PM revealed	F 323	F 323 Related to side rails: Resident #32 was assessed on 3/29/17 for safety with use of the side rails on the bed. No concerns were found regarding resident safety. Resident #13 was assessed on 3/29/17 for safety with use of the side rails on the bed. No concerns were found regarding resident safety. Residents requesting/needing side rails will be assessed prior to the side rails being installed. The side rail usage will be assessed quarterly or more often if needed. The assessment will be documented in the resident's medical record. Medical records dept. will audit the resident medical record to ensure the assessment is being completed. Facility maintenance staff will do weekly inspection of rails to ensure there are no gaps that would increase risk of entrapment. Any concerns will be reported in the bi-monthly QA committee.	3/31/17

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F 323	Continued From page 11 resident #32 was in bed. There was one quarter side rails/enablers on each side of the bed, 16 inches from the top of the mattress. Further observation showed the side rails/enablers had openings which measured 7 inches by 4 inches and 4 inches by 3.5 inches. Interview with the resident during the observation revealed s/he used the side rails for bed mobility. Review of the medical record showed no evidence an assessment to ensure the safety of the side rails, including the risk for entrapment, was completed. 2. Observation on 3/8/17 at 3:59 PM revealed the bed of resident #13 had one quarter side rail/enabler on the top of the right side. Further observation revealed the side rail/enabler had openings which measured 13 inches by 4.5 inches and 8 inches by 4.5 inches. Review of the medical record showed no evidence an assessment to ensure the safety of the side rail, including the risk for entrapment, was completed. 3. During an interview on 3/9/17 at 8 AM the DON stated the facility did not complete safety assessments for side rails, including for residents #13 and #32. Related to water temperatures: 1. Observation of the water temperatures in resident areas on 3/8/17 between 10:14 AM and 11:24 AM revealed the following: a. In room 100 the hot water temperature of the bathroom sink measured 123.4 degrees Fahrenheit (F). b. In room 101 the hot water temperature of the bathroom sink measured 118 degrees F.	F 323	Related to water temperatures: Water temperatures were adjusted on 3/8/17 and were set to not exceed 110 degrees Fahrenheit. The following temperatures were recorded after the temperatures were adjusted. a. In room 100 hot water temp of the bathroom sink measured 104.0 F on 3/8/17. b. In room 101 the hot water temp of the bathroom sink measured 104.3 F on 3/8/17. c. In room 200 the hot water temp of the bathroom sink measured 105.2 F on 3/8/17. d. In room 202 the hot water temp of the bathroom sink measured 104.1 F on 3/8/17. e. In room 206 the hot water temp of the bathroom sink measured 105.2 F on 3/8/17. f. In room 209 the hot water temp of the bathroom sink measured 106.3 F on 3/8/17. g. In room 303 the hot water temp of the bathroom sinks measured 105.2 F on 3/8/17. h. In room 308 the hot water temp of the bathroom sink measured 106.5 F on 3/8/17. Facility maintenance staffs were educated on 3/8/17 regarding the regulation that water temperatures are not to exceed 110 degrees F in shower/bath and resident lavatories. Facility maintenance staff will monitor water temps weekly and record results in online preventative maintenance system. Any concerns found will be reported to the QA committee who meets bi-monthly.	

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F 323	Continued From page 12 c. In room 200 the hot water temperature of the bathroom sink measured 127.6 degrees F. d. In room 202 the hot water temperature of the bathroom sink measured 116.8 degrees F. e. In room 206 the hot water temperature of the bathroom sink measured 126.8 degrees F. f. In room 209 the hot water temperature of the bathroom sink measured 118.9 degrees F. g. In room 303 the hot water temperature of the bathroom sink measured 128.1 degrees F. h. In room 308 the hot water temperature of the bathroom sink measured 113.2 degrees F. 2. Review the facility's logbook documentation showed the random hot water temperatures recorded on December 30, 2016 ranged from 105.1 F to 126.6 F. 3. Interview with the director of facility maintenance on 3/8/17 at 11:47 AM verified the water temperatures reviewed during a facility walk through were above 110 degrees F. He also stated he thought the hot water temperatures were supposed to be kept between 110 degrees F and 120 degrees F.	F 323		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making	F 328		

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F 328	Continued From page 13 appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care	F 328	F 328 Resident #25 is no longer in the facility. CNA and nurse staff in-service held on 3/24/17. Staff informed of vital sign ranges and what needs to be reported to nurse. CNA staffs were instructed that a nurse must be notified if a resident is found to have vital signs that are not within generally accepted normal ranges. Nursing staff will follow-up on abnormal vital signs in a timely manner and will document interventions. Nursing admin to conduct monthly audit of resident medical records to ensure any abnormal vital signs are being addressed and that interventions are in place when needed. Any concerns will be reported to the QA committee who meet every other month.	3/27/17

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F 328	Continued From page 14 and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure respiratory orders were followed for, 1 of 6 sample residents (#25) who had orders for oxygen. The findings were: 1. Review of the skilled nursing/rehabilitation admission orders showed resident #25 was admitted to the facility on 2/24/17 with admitting diagnoses of adrenal insufficiency, UTI, muscular dystrophy, and major depression. The resident was ordered to have oxygen delivered through a nasal cannula as needed to maintain a blood oxygen saturation level (SpO2) greater than 90%. Review of the medical record showed the resident had the following oxygen levels below 90%: a. The SpO2 recorded on 3/1/17 at 2:04 PM was 81%. b. The SpO2 recorded on 3/2/17 at 1:42 PM was 88%. c. The SpO2 recorded on 3/3/17 at 9:28 AM was 86%. d. The SpO2 recorded on 3/3/17 at 5:55 PM was 86%. e. The SpO2 recorded on 3/5/17 at 3:12 AM was 89%. f. The SpO2 recorded on 3/5/17 at 10:18 AM was 74%. g. The SpO2 recorded on 3/5/17 at 2:25 PM was 71%.	F 328		

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F 328	Continued From page 15 h. The SpO2 recorded on 3/6/17 at 2:44 PM was 75%. Further review of the medical record failed to show any interventions by nursing staff when the resident's SpO2 fell below 90%. 2. Interview on 1/8/17 at 9:28 AM with CNA #2, who had recorded the oxygen level on 3/5/17 at 10:18 AM, revealed that when oxygen was found to not be within defined limits, the CNA would try different fingers to check for accuracy, and if the results were the same, the nurse was informed. She further stated that CNAs were able to make a note in the "CareTracker" computer charting if there was an irregular vital sign. 3. Interview on 3/8/17 at 9:51 AM with RN #1 revealed that when a low oxygen level was reported to a nurse, the nurse might check to see if the resident's oxygen tank was empty if on oxygen, have the resident take deep breaths then recheck the oxygen level, look at resident's coloration, or per standing order protocol, put the resident on oxygen at 2 liters if the saturation level was below 90%. The nurse would then document their actions or findings. In regard to resident #25 she stated if the resident had an oxygen level less than 90% recorded, there should be documentation of actions taken. When shown the recorded oxygen levels, the RN stated "I'm sure those are false readings." 4. Interview on 3/8/17 at 10:45 AM with the DON revealed she could not find any evidence showing the resident's oxygen levels were rechecked or nursing interventions were taken after the times the resident's oxygen level was recorded as less than 90%. She confirmed it was always the expectation that abnormal vital signs be followed	F 328		

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F 328	Continued From page 16 up on, and the CNA should be telling the nurses so they were aware of the abnormality.	F 328		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used– (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that– (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329	F 329 Resident #13 was discussed in psychotropic drug review meeting on 3/22/17. Committee recommended no change for the Klonopin. Physician will be rounding on resident #13 on 4/6/17 and will review psychotropic committee recommendations at that time. Resident #4 was discussed in psychotropic drug review meeting on 3/22/17. Committee recommended no change for the Risperidone at this time. Physician will be rounding on resident #4 on 4/6/17 and will review psychotropic committee recommendations at that time. Resident #6 was discussed in psychotropic drug review meeting on 3/22/17. The committee recommended no changes in the Risperidone. Physician will be rounding on resident #6 on 4/6/17 and will review psychotropic committee recommendations at that time. Nursing admin staff or designee will monitor psychotropic committee recommendations and will ensure that GDR is attempted when appropriate. Staff will also ensure that physician is addressing the physician documentation portion of the form and that medications are appropriately documented related to lack of GDR. Any concerns will be discussed in the bi-monthly QA committee meeting.	4/6/17

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F 329	Continued From page 17 (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary medications for 3 of 10 sample residents (#4, #6, #13). The findings were: 1. Review of physician's orders showed resident #13 was prescribed Klonopin (benzodiazepine, used to treat anxiety) 0.5 mg twice per day and 1 mg at bedtime for anxiety on 2/23/15. Review of the medical record showed no evidence a gradual dose reduction (GDR) was attempted, nor documentation from the physician stating why a GDR would be contraindicated. Review of the "Psychotropic Drug Review" form dated 1/18/17 showed there was no committee recommendation for the dose of the Klonopin; that section was left blank. The physician signed the form on 2/2/17, but the section for the physician documentation was left blank. During an interview on 3/9/17 at 10:52 AM the DON stated there was no evidence of a GDR and she was unable to find physician documentation related to the lack of a GDR. 2. Review of the 2/13/17 quarterly MDS assessment for resident #4 showed diagnoses that included schizophrenia. Review of the MAR revealed "Risperidone (antipsychotic) 6 mg oral daily" was ordered on 08/10/15. Review of the physician progress notes dated 11/28/16, 02/02/17, and 3/2/17 showed no evidence of documentation concerning rationale for taking	F 329		

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F 329	Continued From page 18 risperidone. Further, review of the physician progress notes showed no evidence a GDR had been attempted. Review of the "Psychotropic Drug Review" dated 12/21/16 showed no evidence of physician documentation concerning the risks and benefits of continuing risperidone. During an interview on 3/9/17 at 10:52 AM the DON stated she was unable to find any additional documentation. 3. Review of the 1/7/2017 quarterly MDS assessment for resident #6 showed diagnoses that included schizophrenia. Review of the MAR revealed "Risperidone (antipsychotic) 4 mg oral daily" was ordered on 12/05/2015. Review of the physician progress notes dated 2/2/17 and 3/2/17 showed no evidence of documentation concerning rationale for taking risperidone. Further review of the physician progress notes showed no evidence a GDR had been attempted. Review of the "Psychotropic Drug Review" dated 11/18/2016 showed no evidence of physician documentation concerning the risks and benefits of continuing risperidone, and no physician signature. During an interview on 3/9/17 at 10:52 AM the DON stated she was unable to find any additional documentation.	F 329		
F 356 SS=B	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.	F 356	F 356 Nurse staffing data posting was revised to include the hours that are schedule for each position per shift. Administrator or designee will audit for one quarter to ensure the posting is accurate and includes the hours scheduled for each shift. Any concerns will be discussed in the bi-monthly QA committee meeting.	3/27/17

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F 356	Continued From page 19 (iii) 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: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. 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. (4) Facility data retention requirements. 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.	F 356		

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F 356	Continued From page 20 This REQUIREMENT is not met as evidenced by; Based on observation and staff interview, the facility failed to ensure that nurse staffing information was posted in a manner that showed actual hours of staffing per shift for 3 of 4 days during the survey. The findings were: 1. Observation from 3/6/17 to 3/8/17 showed a staffing information sheet was posted in the hall near the lobby. The posted sheet listed the hours worked for RNs, LPNs and CNAs per 24 hour day, but did not reflect the hours that were scheduled for each position per shift. 2. Interview with the DON on 3/8/17 at 4:27 PM revealed the facility was not aware it was required to post staffing information on a per shift basis.	F 356		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in	F 371		

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F 371	Continued From page 21 accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the Food Code, the facility failed to ensure staff prepared and served food in accordance with professional standards for food safety during 1 of 1 observations of food preparation and 1 of 2 observations of meal service. In addition, the facility failed to document refrigerator temperatures for 1 of 4 refrigerators and failed to ensure nutritional supplements were not outdated in 1 of 4 refrigerators. The findings were: 1. Observation on 3/8/17 at 12:26 PM revealed cook #1 and dietary aide #1 were in the kitchen at the steam table dishing up resident meals. Both staff members were wearing hairnets; however, the hairnets did not completely cover their hair. The cook's bangs were left loose and unrestrained, and the hairnet for the dietary aide exposed 1.5 inches of her hair above the forehead. Observation during meal preparation on 3/7/17 at 5:13 PM revealed the certified dietary manager (CDM) was assisting cook #2 at the stove. The CDM was wearing a hairnet, but her bangs were loose and not covered by the hairnet. During an interview on 3/8/17 at 4:30 PM the CDM confirmed some staff did not wear hairnets that completely covered their hair. According to Food Code, 2013, by U.S. Public	F 371	F 371 In-service held with dietary staff on 3/24/17. Instructed all staff that hairnets must be worn and must cover hair completely (including bangs). Administrator or designee will conduct audit monthly for next quarter to ensure hair is appropriately covered. Any concerns will be brought to attention of the employee and will be discussed in QA meeting. Health shakes that were identified in the survey were discarded on 3/8/17. Staff were instructed at in-service on 3/24/17 to label the "pull date" on the carton. Administrator or designee will conduct audit monthly for the next quarter to ensure health shakes are appropriately labeled. Any concerns will be addressed immediately and will be brought to the QA committee for discussion. Additional Robot Coupe food processor was put into use on 3/27/17. Staff were instructed at the in-service on 3/24/17 to use a separate container for each food item. If using a separate container is not feasible, staff will put container in dishwasher between food items. Dietary manager or designee will monitor to ensure proper procedure is being followed with the food processor. Any concerns will be addressed immediately and will be reported in the bi-monthly QA committee meeting. A temperature log was added to the refrigerator in the dining room on 3/29/17. Dietary manager or designee will ensure that the temperatures are being recorded. Any concerns will be reported to the QA committee who meets every other month.	3/29/17

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

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OMB NO. 0938-0391

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 _____	C 03/09/2017

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 371	Continued From page 22 Health Service, Food and Drug Administration, 2-402.11 "(A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES." 2. Observation of the walk-in refrigerator on 3/8/17 at 4:21 PM revealed a box containing 14 cartons of Lyons Ready Care healthshakes, which were thawed. On the box, "Pulled 2/16" was written in marker. Further observation of the cartons revealed no other thaw date was marked. According to the instructions on the cartons, the product was good for 14 days after thawing. An interview with the CDM at the time of the observation revealed she could not say when the healthshakes were thawed. 3. Observation on 3/7/17 at 5:13 PM revealed cook #3 pureed coleslaw in the RobotCoupe food processor. She then took the food processor bowl over to the sink and rinsed it off with water. Then, she re-used the bowl to puree peaches. During an interview on 3/8/17 at 4:30 PM the CDM stated the cook should have sanitized the bowl in the dish machine prior to re-using it. According to Food Code, 2013, by U.S. Public Health Service, Food and Drug Administration, 4-702.11 "UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT shall be SANITIZED before use after cleaning." 4. Observation on 3/8/17 at 10:10 AM revealed a	F 371		

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F 371	Continued From page 23 smaller refrigerator on the counter in the dining room. The refrigerator contained yogurt, cream cheese and margarine packets for resident use. There lacked a log with recorded temperatures to ensure the refrigerator was maintained at 41 degrees Fahrenheit (F) or below. Observation of the thermometer inside the refrigerator showed a temperature of 46 degrees F. On 3/8/17 at 4:27 PM the CDM stated that maybe the thermometer was not accurate. She pulled a container of yogurt out of the refrigerator and put a thermometer inside it. That thermometer showed the temperature of the yogurt was 41 degrees. During an interview on 3/8/17 at 4:27 PM the CDM stated there were logs for the other refrigerators in the facility, but not for this one. She stated there was "no reason" why there was no log kept. According to Food Code, 2013, by U.S. Public Health Service, Food and Drug Administration, 3-501.16 "Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained....(2) At 5 degrees C [Celsius] (41 degrees F) or less."	F 371		