STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	C 07/01/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES	BOX 517 SUNDANCE, WY 82729

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a significant change Minimum Data Set (MDS) assessment as required for 1 of 1 sample residents (#1) who was identified as having significant changes. The findings were: According to the December 2002, Centers for Medicare & Medicaid Services (CMS) Revised Long-Term Care Resident Assessment Instrument (RAI) User's Manual, Version 2.0, Chapter 2, page 2-8: Decline in two or more of the following areas constitutes a significant change in resident status: "Any decline in an ADL physical functioning are where a resident is newly coded as 3, 4, or 8...the resident's incontinence pattern changes from 0 or 1 to 2, 3 or 4...Overall deterioration or resident's condition; resident receives more support (e.g., in ADLs or	F 274	F274 Facility completed MDS with significant change of status for resident #1. Facility has provided MDS training to the interdisciplinary team, including RN staff. Assessments will be reviewed and updated annually, quarterly, with any significant change in status and as needed. Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings. by the DON	7/3/09 7/9/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dessie Brown — TITLE: Administrator — (X6) DATE: 7/15/09

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

This POC accepted on 7/15/09 with agreed to changes between the Administrator (DeeAnn Brown) and

JUL 15 2009
Office of Healthcare Licensing and Surveys

7/15/09

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 274	Continued From page 1 decision-making) (Item Q2=2)." The following areas were identified as being areas of decline for resident #1 when the 2/24/09 annual MDS assessment and the 5/25/09 quarterly MDS assessment were compared: a. The area for bed mobility G1a showed decline from needing supervision (1) to requiring extensive assistance (3). b. The areas G1b and G1c for walking in the room and the corridor both showed decline from being limited assistance (2) to extensive assistance (3). c. In the area of bladder continence H1b the resident declined from being continent (0) to occasionally incontinent (2). d. The overall change in care needs (Q2) showed the resident had deteriorated and received more support. Interview with the director of nursing on 7/1/09 at 10:50 PM revealed the resident had shown decline in these areas and was receiving additional care, she stated a significant change MDS assessment should have been completed.	F 274		
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.	F 279		

7/15/09

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F 279	Continued From page 2 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, staff interview and medical record review, the facility failed to ensure the care plan was revised to reflect the current care needs related to dining for 1 of 1 sample residents (#1). The findings were: Review of the care plan last reviewed on 5/27/09 showed the resident was "able to feed self just needs guidance." Observation on 6/30/09 at 12:30 PM and at 5:02 PM revealed the resident was provided total assistance with eating for the lunch and evening meals. Interview with the restorative certified nurse aide (CNA) #1 and the director of nursing (DON) on 7/1/09 at 10:50 AM revealed the resident had not been attempting to self feed for the past two weeks. At that time the DON stated the care plan should have been updated to reflect this change.	F 279	F279 The facility completed updated care plan for resident #1. All care plans will be reviewed and updated annually, quarterly, with any significant change in status and as needed. Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings.	7/7/09

by Hope LTC Dons

7/15/09 AM