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Office of Healthcare Licensing and Surveys

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

PRINTED: 11/03/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	R 10/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET SUNDANCE, WY 82729

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The following common abbreviations are used throughout this document: RN - registered nurse DON - director of nursing MDS - Minimum Data Set assessment CNA - certified nursing assistant PoC - Plan of correction DoC - Date of compliance Less commonly used abbreviations will be annotated in each deficiency where used.	{F 000}		
{F 221} SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Interview with the administrator on 10/18/10 at 1:18 PM revealed the facility was not in compliance with their PoC. The administrator stated they had just started to implement parts of the plan on 10/15/10. During an interview on 10/19/10 at 9:55 AM, the DON confirmed the facility had not met their stated compliance date for the 7/1/10 survey and that monitoring had not been implemented by 8/15/10. She also stated safety assessments had not yet been completed for the three residents who utilized siderails.	{F 221}	F221 The facility will meet this requirement by residents #4, 5 and 19 having a comprehensive assessment completed. All residents receiving an order for restraints will have a comprehensive assessment completed. The assessment will define each resident's medical symptoms, determine the least restrictive restraint and identify safety protection and improved quality of life each resident will gain. Restraint use will be appropriately care planned. This requirement will be maintained by inservicing nursing staff, families and physicians on facility protocol for restraint use and removal, and restraint assessment. A quality indicator has been developed and will be monitored by IDT monthly through QA/QI program.	11/24/10
{F 244} SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the	{F 244}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

X Debbie Brown — X CEO/Administrator — X11/4/10

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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{F 244}	Continued From page 1 grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on family and staff interviews and interview with the board of trustees, the facility failed to complete the actions stated in their PoC to address grievances voiced by residents. The findings were: Interview with the administrator on 10/18/10 at 1:18 PM revealed the facility was not in compliance with their PoC. The administrator stated they had just started to implement portions of the plan on 10/15/10. During an interview on 10/19/10 at 9:55 AM, the DON confirmed the facility had not met their stated compliance date for the 7/1/10 survey and that monitoring had not yet been implemented. A member of the board of trustees (trustee #2) stated in interview on 10/19/10 at 1:20 PM that s/he was only recently made aware families had complained about the long-term care facility. A meeting held "...about two weeks ago..." was his/her first indication that complaints and grievances were unresolved. During a confidential interview on 10/19/10 at 18:30 PM, a family member stated a concern that the administrator and previous DON did not listen to residents' complaints. S/he acknowledged the facility recently hired a new DON, but had yet to see "...a change in attitude..."	{F 244}	F244 The facility will meet this requirement by attempting to resolve complaints/concerns until no further options can be identified. This requirement will be maintained by inservicing staff on facility procedure for filing, follow-up and resolution to resident and family complaints/concerns. A quality indicator has been developed and will be monitored on a monthly basis by Social Services through the QA/QI program.	11/24/10
{F 272}	483.20, 483.20(b) COMPREHENSIVE	{F 272}		

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{F 272} SS=E	Continued From page 2 ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Interview with the administrator on 10/18/10 at 1:18 PM revealed the facility was not in compliance with their PoC. The administrator stated they had just started to implement parts of	{F 272}	F272 The facility will meet this requirement by conducting initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. MDS 3.0 training was provided in September 2010 and again in October 2010 for the MDS Coordinator and DON. The facility will maintain this requirement through a quality indicator that will be monitored monthly by IDT and reported to QA/QI committee.	11/24/10

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{F 272}	Continued From page 3 the plan on 10/15/10. During an interview on 10/19/10 at 9:55 AM, the DON confirmed the facility had not met their stated compliance date for the survey of 7/1/10. The DON confirmed all assessments had not been completed per the plan of correction and stated they were "working on it." She further stated monitoring had not yet occurred as planned. Furthermore, interview with the unit secretary on 10/19/10 at 1:15 PM verified the facility was not ready to implement MDS 3.0 by 10/1/10.	{F 272}		
{F 274} SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE 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: Interview with the administrator on 10/18/10 at 1:18 PM revealed the facility was not in compliance with their PoC. The administrator stated they had just started to implement portions of the plan on 10/15/10. During an interview on 10/19/10 at 9:55 AM, the DON confirmed the facility had not met their stated compliance date	{F 274}	F274 The facility will meet this requirement by all residents who meet the criteria to initiate the significant change of status assessment will have an assessment completed within 14 days after facility determines there has been a significant change in status. The MDS/care plan will be reviewed upon completion at weekly care plan meetings by the MDS Coordinator and the IDT to ensure accurate data has been recorded. This requirement will be maintained by a quality indicator and will be monitored by IDT monthly through QA/QI program.	11/24/10

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{F 274}	Continued From page 4 of 10/1/10. The DON confirmed all assessments and monitoring had not been completed per the PoC. The DON stated the facility was "working on it"	{F 274}		
{F 278} SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Interview with the administrator on 10/18/10 at	{F 278}	F278 The facility will meet this requirement as evidenced by all residents MDS will be reviewed for accuracy. The MDS/care plans will be reviewed upon completion at weekly care plan meetings, by the MDS Coordinator and the interdisciplinary team members to ensure accurate data has been recorded. This requirement will be maintained by training staff involved on the MDS process. A quality indicator has been developed and will be monitored by IDT monthly through QA/QI program.	11/15/10

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{F 278}	Continued From page 5 1:18 PM revealed the facility was not in compliance with their PoC. The administrator stated they had just started to implement parts of the plan on 10/15/10. During an interview on 10/19/10 at 9:55 AM, the DON confirmed the facility had not met their stated compliance date of 10/1/10. The DON stated the assessments had not been completed per the plan of correction and that monitoring was not yet in place. She further stated the facility was "working on it."	{F 278}	F279 The facility will meet this requirement as evidenced by all residents care plan will be reviewed and updated as indicated.	11/24/10
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP 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: Interview with the administrator on 10/18/10 at 1:18 PM revealed the facility was not in	{F 279}	Care plans will include psychotropic medications side effects and other non-medication behavioral interventions or individual resident specific techniques for behavioral modifications. The MDS/care plan will be reviewed upon completion at weekly care plan meeting by the MDS Coordinator and the IDT members to ensure accurate data has been recorded and care plan updated. Care plan changes will be communicated to staff after the care plan meeting and at stand-up meetings. This requirement will be maintained by a quality indicator and will be monitored	

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{F 279}	Continued From page 6 compliance with their PoC. The administrator stated they had just started to implement parts of the plan on 10/15/10. During an interview on 10/19/10 at 9:55 AM, the DON confirmed the facility had not met their stated compliance date for the 7/1/10 survey. On 10/19/10 at 9:20 AM RN #1 stated resident care plans had not been completed and that they were in the process of evaluating new care plan forms.	{F 279}	by IDT through QA/QI program.	
{F 280} SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Interview with the administrator on 10/18/10 at 1:18 PM revealed the facility was not in compliance with their PoC. The administrator	{F 280}	F280 The facility will meet this requirement as evidenced by all residents care plans will be reviewed and updated in a timely manner or as significant change indicates. Nursing staff will update all care plans to reflect any changes made including discontinuing use of items or new orders/interventions to be initiated. This requirement will be maintained by in-servicing nursing staff on these procedures. Nursing staff will also be in-serviced on proper notification of non-nursing disciplines when new orders are received. A quality indicator has been developed and will be monitored by IDT through QA/QI program.	11/24/10

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{F 280}	Continued From page 7 stated they had just started to implement parts of the plan on 10/15/10. During an interview on 10/19/10 at 9:55 AM, the DON confirmed the facility had not met their stated compliance date of 10/1/10. On 10/19/10 at 9:20 AM RN #1 stated all resident care plans had not been revised and that they were in the process of evaluating new care plan forms.	{F 280}		
{F 281} SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Interview with the administrator on 10/18/10 at 1:18 PM revealed the facility was not in compliance with their PoC. The administrator stated they had just started to implement parts of the plan on 10/15/10. During an interview on 10/19/10 at 9:55 AM, the DON stated the facility had not met their compliance date of 10/1/10. She further stated that timing of medication passes had "improved significantly" but confirmed it was still an issue. Observation on 10/19/10 showed RN #2 administered medications, including Synthroid, to resident #27 at 9:35 AM. Reconciliation of the medication pass showed Synthroid was scheduled to be given at 7 AM. Interview with the RN immediately after the medication pass revealed he was "quite often" late with medications. According to the facility's policy "LTC-Meds-22", medications should be administered "...within 30 minutes before of after prescribed time to ensure intended therapeutic effect."	{F 281}	F281 The facility will meet this requirement as evidenced by resident #27 will have medication administered within the prescribed time to ensure intended therapeutic effect. All nurses will be inserviced on safe medication practices. Medications will be administered correctly to all residents. This requirement will be maintained weekly by observing and reviewing medication passes and monitored by Treatment Nurse under direction of DON through QA/QI program.	11/26/10

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{F 282} SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Interview with the administrator on 10/18/10 at 1:18 PM revealed the facility was not in compliance with their PoC. The administrator stated they had just started to implement parts of the plan on 10/15/10. During an interview on 10/19/10 at 9:55 AM, the DON confirmed the facility had not met their stated compliance date of 10/1/10. The DON stated that quality assurance monitoring was not yet in place.	{F 282}	F282 The facility will meet this requirement as evidenced by all resident care plan interventions will be individualized and implemented as written. Nursing staff will be updated as needed regarding care plan interventions at stand-up meetings. The facility will maintain this requirement with weekly resident care observations and will be monitored by IDT with follow up through QA/QI program.	11/24/10
{F 309} SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide 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. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure staff provided care and services to minimize pain for 1 of 1 residents (#18) and manage bowel function for an unidentified number of residents. The findings were:	{F 309}	F309 The facility will meet this requirement as evidenced by resident #18 will be evaluated and have pain assessment completed to minimize pain. Each resident will receive 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.	11/24/10

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{F 309}	Continued From page 9 Interview with the administrator on 10/18/10 at 1:18 PM revealed the facility was not in compliance with their PoC. The administrator stated they had just started to implement parts of the plan on 10/15/10. During an interview on 10/19/10 at 9:55 AM, the DON confirmed the facility had not met their stated compliance date of 10/1/10. Observation on 10/19/10 at 7:17 AM showed resident #18 was being assisted out of bed by CNAs #3 and #4. During the transfer in a sit-to-stand lift, the resident displayed severe facial grimacing, but staff did not comment or appear to recognize that the grimacing might indicate pain. When questioned by the surveyor, the resident did not answer, but the grimacing became worse; the resident looked as if s/he were crying without tears. At 8 AM that morning RN #2 stated the resident's grimacing had not been reported to him. Review of the MAR showed the resident received Tylenol 500 milligrams around 8 AM. However, medical record review showed no current pain assessment or evidence the resident had been evaluated to determine that 8 AM, after s/he was already up, was the most effective time to administer pain medication. Review of the bowel tracking form with the DON on 10/19/10 at 2 PM revealed several instances where residents had gone three days without a bowel movement and the facility's protocol had not been initiated. During the review, the DON verified staff failed to follow the protocol.	{F 309}	Staff will be in-serviced on bowel protocol. Bowel protocol is implemented and will be updated in a timely manner. All residents will have bowel assessments completed on admission, quarterly, annually and/or significant change and the protocol will be implemented as indicated. Assessment and findings will be incorporated into the care plan and will include resident specific interventions The MDS/care plan will be reviewed upon completion at weekly interdisciplinary care plan meeting, by the MDS Coordinator and the IDT members will ensure accurate data has been recorded. A quality indicator has been developed and will be monitored by IDT monthly through QA/QI program.	
{F 323} SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	{F 323}		

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{F 323}	Continued From page 10 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Interview with the administrator on 10/18/10 at 1:18 PM revealed the facility was not in compliance with their PoC. The administrator stated they had just started to implement parts of the plan on 10/15/10. Observation on 10/18/10 at 3:13 PM showed CNA #3 wet a wash cloth, heated it in the microwave for 45 seconds, put it in a ziploc bag, and tossed it from hand to hand as it was "a little too warm." The CNA then placed it on resident #26's back (over the clothes). The resident stated it was "plenty hot." This same scenario was cited during the 8/13/10 Federal survey. During an interview on 10/19/10 at 9:55 AM, the DON stated the facility was "working on..." the corrective action plans but confirmed they had not met their stated compliance date of 10/1/10.	{F 323}	F323 The facility will meet this requirement by resident #26 will be provided an appropriate hot pack when needed, for back pain. All residents will be provided an area as free of potential burn risk as is possible. Staff will be in-serviced on appropriate hot pack use. The facility will maintain this requirement by quality indicators to ensure the environment remains as free of accident hazards as is possible and each resident receives assistance devices, when needed, to prevent accidents. The IDT, DON and maintenance staff will monitor monthly and report to the QA/QI program.	11/24/10
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	{F 329}	F329 The facility will meet this requirement as evidenced by the completion of medication regime review per the IDT quarterly, annually and/or with significant changes in status	11/26/10

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{F 329}	Continued From page 11 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic 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: Interview with the administrator on 10/18/10 at 1:18 PM revealed the facility was not in compliance with their PoC. The administrator stated they had just started to implement parts of the plan on 10/15/10. Interview with the DON on 10/19/10 at 9:55 AM confirmed the facility had not met their stated compliance date of 10/1/10. The DON stated new indicators had been devised but monitoring was not yet in place.	{F 329}	and as needed with documentation to support use. The physician and pharmacist will be kept abreast of changes and the IDT will seek recommendations as necessary. This requirement will be maintained by monthly monitoring of quality indicator by IDT through QA/QI program. F332 The facility will meet this requirement by: all residents will have a review completed by charge nurse of monthly order sheets and any updated information will be noted. Nursing will review to ensure accuracy of recap before being sent to medical staff and Unit Coordinator will review for changes after the recap has been returned. Nurse administering medication will check each of the 6 rights of medication administration prior to administering a medication.	11/24/10
{F 332} SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Interview with the administrator on 10/18/10 at 1:18 PM revealed the facility was not in compliance with their PoC. The administrator	{F 332}		

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{F 332}	Continued From page 12 stated they had just started to implement portions of the plan on 10/15/10. Interview with the DON on 10/19/10 at 9:55 AM confirmed the facility had not met their stated compliance date of 10/1/10. The DON stated new indicators had been devised but monitoring was not yet in place.	{F 332}	This requirement will be maintained by weekly observation of medication pass and reconciliation with the orders. A quality indicator has been developed and will be monitored by DON and MDS Coordinator through QA/QI program.	
{F 406} SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services, or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Interview with the administrator on 10/18/10 at 1:18 PM revealed the facility was not in compliance with their PoC. The administrator stated they had just started to implement parts of the plan on 10/15/10. Interview with the DON on 10/19/10 at 9:55 AM confirmed the facility had not met their stated compliance date of 10/1/10. The DON stated new indicators had been devised but monitoring was not yet in place.	{F 406}	F406 The facility will meet this requirement by providing for or arranging the provision of specialized rehabilitative services such as PT, OT, Speech and mental illness rehabilitative services, if resident's comprehensive plan of care requires it. This requirement will be maintained and monitored by Restorative Therapy through chart audits and reported monthly through the QA/QI program.	11/24/10
{F 425} SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit	{F 425}	F425 The facility will meet this requirement by all residents will receive ordered	11/26/10

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{F 425}	Continued From page 13 unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Interview with the administrator on 10/18/10 at 1:18 PM revealed the facility was not in compliance with their PoC. The administrator stated they had just started to implement parts of the plan on 10/15/10. Interview with the DON on 10/19/10 at 9:55 AM confirmed the facility had not met their stated compliance date of 10/1/10. The DON stated new indicators had been devised but monitoring was not yet in place.	{F 425}	medications within the acceptable standard of practice timeframe as determined by facility policy. This requirement will be maintained and monitored monthly by nursing staff. A quality indicator has been developed and will be reported through QA/QI program.	
{F 428} SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON 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.	{F 428}	F428 The facility will meet this requirement by all residents will have a monthly drug regimen review. The pharmacist will report any irregularities to the attending physician and the DON. Nursing staff and current pharmacists will be in-serviced on CMS regulations and a communication sheet will be placed in the review book for	11/26/10

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{F 428}	Continued From page 14 This REQUIREMENT is not met as evidenced by: Interview with the administrator on 10/18/10 at 1:18 PM revealed the facility was not in compliance with their PoC. The administrator stated they had just started to implement parts of the plan on 10/15/10. Interview with the DON on 10/19/10 at 9:55 AM confirmed the facility had not met their stated compliance date of 10/1/10. The DON stated new indicators had been devised but monitoring was not yet in place.	{F 428}	the pharmacist to complete upon regimen review. A copy will be faxed to physician and a copy will be given to DON to ensure follow-up on recommendations made. This requirement will be maintained by monthly audits. A quality indicator has been developed and will be monitored by Unit Coordinator through QA/QI program. The facility will meet this	
{F 431} SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	{F 431}	F431 The facility will meet this requirement by all residents will have new labels as orders change. Nursing staff and pharmacist will be inserviced on CMS regulations for updating medication labels when orders are changed by the physician. This requirement will be maintained by monthly audits. A quality indicator has been developed and will be monitored by DON through QA/QI program.	11/24/10

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{F 431}	Continued From page 15 have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Interview with the administrator on 10/18/10 at 1:18 PM revealed the facility was not in compliance with their PoC. The administrator stated they had just started to implement parts of the plan on 10/15/10. Interview with the DON on 10/19/10 at 9:55 AM confirmed the facility had not met their stated compliance date of 10/1/10. The DON stated new indicators had been devised but monitoring was not yet in place. She further stated they were still having trouble getting labels from some of the pharmacies	{F 431}	F441 The facility will meet this requirement by inservicing and training all staff associated with LTC on proper hand washing technique. LTC staff, including housekeeping, will be inserviced on PPE, equipment disinfecting, infection transmission prevention and proper linen handling, storage and transport.	11/15/10
{F 441} SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	{F 441}		

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{F 441}	Continued From page 16 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to enforce acceptable infection control practices among staff. Failures were evident in 3 areas: a. Facility staff failed to use proper hand washing technique on 3 of 4 random observations. b. Facility staff failed to comply with requirements to keep food and drink out of areas	{F 441}	This requirement will be monitored monthly by Infection Control Coordinator with a quality indicator and will be reported to the QA/QI program.	

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{F 441}	Continued From page 17	{F 441}		

with the potential for contamination.

c. Facility staff failed to properly clean 1 of 2 countertops used to prepare resident drinks and snacks.

The findings were:

1. Regarding hand hygiene: Observation on 10/19/10 revealed 3 of 4 staff members failed to use proper handwashing technique when randomly observed at the facility's hand washing station.

a. At 7:40 AM RN #1 was observed to use her hands to turn off the faucets after washing instead of using paper towels, thus recontaminating her hands. The RN proceeded to enter information into resident medical records and delivered linen to the tub/shower room. When interviewed at 7:51 AM, the RN described proper hand washing steps; she was unable to explain why she did not follow the steps correctly.

b. At 8:01 AM environmental aide #5 was observed to reach for paper towels with her right hand, but used her left hand to turn off the faucets, thus recontaminating her hand. The aide then prepared ice water for resident hydration handling cups, the ice scoop, and using both hands to seal the lids on plastic drinking cups. When interviewed at 8:09 AM, the aide was able to correctly recite the properly steps in washing her hands; she was not aware she performed the sequence incorrectly.

c. At 8.11 AM housekeeper #6 was observed to wear gloves while emptying 2 trash cans in the vicinity of the nurses station, one of which had previously been used by staff to throw away tissues used to wipe a resident's nose and mouth. Still wearing the same gloves, the housekeeper opened a package of paper towels and replenished the dispenser over the hand washing

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{F 441}	Continued From page 18 sink. The housekeeper was further observed to wash her hands at 3:21 AM, then use her hands to turn off the faucets, thus recontaminating her hands. 2. Regarding drinks in potentially contaminated areas: Observation on 10/19/10 from 8:24 AM to 8:46 AM (22 minutes) showed 2 housekeepers (#6 and #7) kept their drink containers (a coffee cup and a soda bottle) on the housekeeping cart. The cart was located in a resident hallway and the housekeepers were cleaning contact surfaces and emptying trash cans The housekeepers were observed to spray disinfectant on to a cleaning cloth held 12-14 inches above the drinks. Both housekeepers were seen to drink from their drink containers intermittently; no hand hygiene was performed by either housekeeper during the observation period. When asked about facility policies on food and drink in areas with a potential for contamination, housekeeper #7 stated "It [coffee cup] probably shouldn't be here, but no one ever says anything about it." Observation while touring with the infection control nurse on 10/19/10 at 1:45 PM showed an uncovered coffee cup, about 3/4 full, sitting adjacent to the hand washing sink. When asked, the infection control nurse stated staff should not have food and drink in any area where it could be contaminated, "...they know better, we just talked about it..." The infection control nurse acknowledged drink containers should not be on the housekeeping cart or areas immediately adjacent to the hand washing sink. 3. Regarding proper cleaning of areas used for preparing drink and snacks: Observation on 10/19/10 at 8:26 AM showed housekeeper #7	{F 441}		

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{F 441}	Continued From page 19 cleaned the hand washing sink with disinfectant sprayed on a cleaning cloth. She then used the same cloth from the hand washing sink to clean an adjacent countertop surface. Staff were observed at 9:05 AM to use the countertop when preparing resident drinks and as a location to hold several packages of snack crackers. 4. The infection control nurse stated in interview on 10/19/10 at 2:20 PM that staff received in-service training on proper hand washing and she recently began monitoring compliance with the techniques covered in training. She acknowledge she did not routinely monitor non-nursing staff for hand hygiene compliance or cleaning techniques.	{F 441}		
{F 496} SS=C	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.	{F 496}	F496 The facility will meet this requirement by verifying, receiving and maintaining a copy of the state registry information on all CNA's. This copy will be retained in the personnel file in Human Resources and will be made available upon request. A quality indicator has been developed and will be monitored by Human Resources monthly through QA/QI program.	8/15/10 11-19-10 Completed 11:50 AM 11-19-10 with Donna Rowan

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{F 496}	Continued From page 20 If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Interview with the administrator on 10/18/10 at 1:30 PM revealed the facility had not achieved the quality assurance actions stated in their PoC for this deficiency. According to the administrator, the facility had just begun to implement portions of the PoC on 10/15/10.	{F 496}	F498 The facility will meet this requirement by completing competency forms for any agency personnel within the first week of starting work. The charge nurse will readily observe and record the agency personnel's competency. The DON will also ensure that the facility staff be evaluated upon completion of orientation and annually. This requirement will be monitored by implementing a quality indicator and will be monitored by DON monthly through QA/QI program.	11/24/10
{F 498} SS=E	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Interview with the administrator on 10/18/10 at 1:30 PM revealed the facility had not completed the actions stated in their PoC for this deficiency. According to the administrator, the facility had just begun to implement portions of the PoC on 10/15/10.	{F 498}		
{F 520} SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	{F 520}		

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{F 520}	Continued From page 21 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Interview with the administrator on 10/18/10 at 1:30 PM revealed the facility had not completed the actions stated in their PoC for this deficiency. According to the administrator, the facility had just begun to implement portions of the PoC on 10/15/10. Review of the revised indicators revealed data had not been collected for monitoring by the compliance date of 10/1/10.	{F 520}	F520 The facility will meet this requirement by the DON, a physician and three other LTC staff members attending quarterly QA/QI meetings. If the medical director cannot attend the QA/QI meeting, s/he will designate an alternate provider to attend in their place. The appropriate personnel will implement plans of action to correct all quality problems identified in the survey process and by the committee. Implementation will include tracking/monitoring plans of action with identification of the root cause, and solutions to implementing plan of action to include deficiencies cited by the survey team in this survey. Acceptable standard levels will be identified to meet the goals of the plans and will be reported to the committee at each meeting. This will be monitored by DON, Administration and will be reported to the Board of Trustees through the QA/QI program.	11/15/10

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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
	535029	A. BUILDING _____ B. WING _____	C 10/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET SUNDANCE, WY 82729

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to complete the actions stated in their PoC to address grievances voiced by residents. The findings were: Interview with residents #11 and #12 on 10/18/10 and again on 10/19/10 revealed the facility had not completed actions to address a grievance concerning residents' access to a coffee and cappuccino machine. These residents stated the current location of the machine was not accessible to residents in wheelchairs. The residents further stated the administrator and previous DON did not "...seem to care..." if, or when, the problem was fixed. The administrator stated in interview on 10/19/10 at 3:45 PM that the facility was working to improve access to the coffee and cappuccino machine, but had not fully resolved limitations that prevented wheelchair-bound residents from independently accessing it. She further stated a table of the correct height had been ordered, but had not arrived.	F 244	F244 The facility will meet this requirement by residents #11 and #12 having proper access to coffee and cappuccino drinks. All residents will have access to the coffee and cappuccino drinks. A table has been placed for coffee, cappuccino and other hydration drink containers, allowing all residents easy access, including those wheelchair bound. All drink containers are covered. Dietary staff will replenish containers every six hours and as needed throughout the day, Activity staff will replenish prior to leaving the facility in the evening and night CNA will replenish after midnight. The table is located in the dining area to improve access for residents. This requirement will be maintained by Dietary personnel. A quality indicator has been developed and will be monitored by CDM weekly and reported to QA/QI program.	11/9/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Doris Brown — TITLE: CEO/Administrator — (X6) DATE: 11/15/10

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.

Department of Health and Human Services
Centers For Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535029	A. Building B. Wing	10/19/2010

Name of Facility	Street Address, City, State, Zip Code
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM C	713 OAK STREET SUNDANCE, WY 82729

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0253 Reg. # 483.15(h)(2) LSC	10/01/2010	ID Prefix F0503 Reg. # 483.75(j)(1)(i-iv) LSC	08/15/2010	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By 10/3/10	Date: 11/2/10	Signature of Surveyor: S. Nelson, RN State Medicaid Surveyor	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	

Followup to Survey Completed on: 07/01/2010 (State)

X Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO