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

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

NOV 2 4 2010

Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	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	F225 The facility will meet this requirement by documenting, investigating and reporting all abuse and neglect allocations. Resident #20's unwitnessed fall will be investigated and reports will be sent to the Administrator, along with other officials in accordance with Wyoming law. The results of all investigations will be reported to the Administrator or designee and other officials in accordance with Wyoming law within five (5) working days of the incident. If a violation is verified appropriate corrective action will be taken.	11/20/10
{F 225} SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report 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 to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	{F 225}	All staff/volunteers involved in resident care will be in-serviced on the correct procedure for reporting and investigating allegations of abuse and neglect. A review of the procedure will be included in monthly LTC staff in-services. The facility will maintain this requirement with a quality indicator developed and monitored by Social Services	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: x Dana Brown
TITLE: x CEO/Administrator
(X6) DATE: x 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

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{F 225}	Continued From page 1 prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 staff interview and review of investigated incidents, the facility failed to investigate 1 of 1 unwitnessed falls (resident #20) occurring since their proposed DoC of 10/1/10. The findings were: Interview with the social worker on 10/19/10 at 1:30 PM revealed she was responsible for completing investigations of allegations of abuse, neglect, theft, and injuries from an unknown source. During the interview, the social worker stated a resident #20 sustained an unwitnessed fall on 10/4/10 which was not investigated as the injuries were "consistent" with having fallen. Review of the completed investigations revealed an investigation was lacking.	{F 225}	monthly through QA/QI program.	
{F 226} SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	{F 226}	F226 The facility will meet this requirement by revising the policy and procedure that prohibits mistreatment, neglect, and abuse of residents and misappropriation of resident property to include injuries of unknown origin. Investigation	11/10/10

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{F 226}	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on staff interview, review of internal investigations, and review of monitoring activities, the facility failed to revise their policy and procedure, investigate an injury of unknown origin, and conduct monitoring to assure compliance with their PoC by 10/1/10. The findings were: Interview with the social worker on 10/19/10 at 1:30 PM revealed she was responsible for completing investigations of injuries or unknown origin. During the interview, the social worker stated an resident #20 sustained an unwitnessed fall on 10/4/10. She further stated, and review of completed investigations confirmed, this fall was not investigated. During an interview on 10/19/10 at 9:55 AM, the DON stated she did not know if the policies had been revised, but monitoring to ensure compliance was not in place.	{F 226}	will be completed for resident #20's unwitnessed fall. All injuries of unknown origin will be investigated for possible mistreatment, neglect or abuse of residents and reported to the appropriate The facility will in-service staff on the change to policy and procedure. The facility will maintain this requirement through a quality indicator that will be monitored monthly by Social Services and reported to QA/QI committee.	
{F 241} SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on random observation and resident and staff interviews, the facility failed to assure residents were treated with dignity and respect. The findings were: Interview with the administrator on 10/18/10 at	{F 241}		

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{F 241}	Continued From page 3 1:18 PM revealed the facility was not in compliance with their plan of correction (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 throughout the survey revealed multiple instances where nursing staff knocked on resident doors but entered without waiting for permission. Also observed was an instance where resident #18 was tipped back in a geriatric chair after morning care on 10/19/10 at 7:10 AM. The resident was not informed first, and s/he jerked as if startled; staff still did not speak to him/her. Another observation occurred on 10/19/10 at 8:40 AM when resident #19 was served a meal which had been uncovered on the dining room table since 8:10. The CNA serving the meal did not offer to reheat it until the surveyor asked the resident if the egg was cold; the resident replied that it was "cool." In still another observation on 10/19/10 at 8:58 AM, resident #17 was being toileted and the disposable brief was pulled down without any warning or instructions to the resident. The resident looked astonished and grabbed the brief. During the exit conference on 10/19/10 at 4:42 PM, the 10 people in attendance acknowledged the instances showed lack of respect for the residents.	{F 241}	F241 The facility will meet this requirement by training staff on proper staff/resident communication and customer services skills to maintain or enhance each resident's dignity and respect. Residents ~~#18, 19 and 17~~ All will receive care in a manner and environment that maintains or enhances their dignity and respect in full recognition of his or her individuality. This requirement will be maintained by a quality indicator and will be monitored by Social Services and DON monthly through QA/QI program.	11/5/10
{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	{F 274}		

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{F 274}	Continued From page 4 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 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 confirmed all assessments had not been completed per the plan of correction. The DON stated the facility was "working on it."	{F 274}	F274 The facility will meet this requirement as evidenced 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 interdisciplinary team members to ensure accurate data has been recorded.	11/15/10
{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	{F 278}	This requirement will be maintained by in-servicing and training staff involved in the MDS process. A quality indicator has been developed and will be monitored by IDT monthly through QA/QI program.	

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{F 278}	Continued From page 5 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 1:16 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 10/16/10. 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 confirmed the assessments had not been completed per the plan of correction and that monitoring was not yet in place.	{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.	11/26/10
{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	{F 280}		

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(F 280)	Continued From page 6 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 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)	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. A quality indicator has been developed and will be monitored by IDT through QA/QI program.	11/26/10
(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	(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 inserved on safe medication practices.	11/26/10

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{F 281}	Continued From page 7 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 or after prescribed time to ensure intended therapeutic effect."	{F 281}	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.	
{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.	{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.	11/26/10

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{F 309}	Continued From page 8 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 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 4 month time date of 10/1/10. Observation on 10/19/10 at 7:17 AM showed resident #10 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 7 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 311} SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities	{F 311}		

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{F 311}	Continued From page 9 specified in paragraph (a)(1) of this section. 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. Observation of 2 meals during the survey revealed multiple instances where residents were not promptly cued or assisted while dining. These instances involved residents #15, #17, and #19.	{F 311}	F311 The facility will meet this requirement as evidenced by residents #15, #17, and #19 will be promptly cued or assisted while dining. All residents will be cued or assisted as needed in a timely manner for meals. Dietary staff will serve meals to residents and assist with cueing residents when needed. Resident seating during meal times will allow for staff to assist with feeding in an efficient manner. The facility will maintain this requirement with a quality indicator monitored by the Nursing staff or DON monthly through QA/QI program.	11/15/10
{F 312} SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 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. Observations on 10/19/10 at 7:10 AM and 8:58 AM showed incontinence care was provided incorrectly for residents #18 and #17,	{F 312}	F312 The facility will meet this requirement as evidenced by residents #18 and #17 will have proper toileting care provided. All residents who require toileting will have proper toileting care provided.	11/15/10

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{F 312}	Continued From page 10 (back and forth several times with the same area of the wipe for resident #18 and only to the buttocks for resident #17). During an interview on 10/19/10 at 9:55 AM, the DON stated her expectation was that perineal care be provided correctly and to the entire perineal area each time a resident was toileted.	{F 312}	Staff have been inserviced on proper toileting and infection control protocol for residents. The nursing staff and DON will monitor weekly. A quality indicator has been developed and will be reported monthly to QA/QI program.	
{F 323} SS=E	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 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 ziplock 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. Observation throughout the survey showed wheelchair bound residents did not have covered tumblers or holders to secure the tumblers while propelling the wheelchairs. During an interview on 10/19/10 at 9:55 AM, the DON stated the facility was "working on..." the	{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. Wheelchair bound residents who need covered tumblers and holders for their hot drinks, for safety reasons, now have those items in place. 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	11/24/10

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

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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

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{F 323}	Continued From page 11 corrective action plans but confirmed they had not met their stated compliance date of 10/1/10. 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 ziplock 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. Observation throughout the survey showed wheelchair bound residents did not have covered tumblers or holders to secure the tumblers while propelling the wheelchairs. 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}	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.	
{F 353} SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	{F 353}	F353 The facility will meet this requirement by providing adequate staffing to meet the needs of all residents. The facility will monitor staff for	11/24/10

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(F 353)	Continued From page 12 The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. 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. Although staffing had improved, she stated it was still an issue and they were still using agency staff. She further stated monitoring had not yet been implemented.	(F 353)	possible burn-out, frustration and stress. Toby Leser was brought in to facilitate with staff to identify problems and solutions to better identify the needs of staff to prevent burnout and stress. This requirement will be maintained by a quality indicator to monitor appropriate staffing levels to adequately provide care to residents. Social Services will monitor on a monthly basis and report to the QA/QI committee.	
(F 425) SS=E	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 unlicensed personnel to administer drugs if State law permits, but only under the general	(F 425)	F425 The facility will meet this requirement by all residents will receive ordered medications within an	11/24/10

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{F 425}	Continued From page 13 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}		
{F 441} SS=F	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 14 (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}	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. This requirement will be monitored monthly by Infection Control Coordinator with a quality indicator and will be reported to the QA/QI program.	11/15/10

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{F 441}	Continued From page 15 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	{F 441}		

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{F 441}	Continued From page 16 sink. The housekeeper was further observed to wash her hands at 8:21 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." 3. Regarding proper cleaning of areas used for preparing drink and snacks: Observation on 10/19/10 at 8:26 AM showed housekeeper #7 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 9:06 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	{F 441}		

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{F 441}	Continued From page 17 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}	F490 The facility will meet this requirement by administering in such a manner that there will be adequate qualified staff to meet the residents' needs, maintain effective infection control program and provide adequate qualified supervision for the staff. The facility has implemented and will maintain a quality assessment and assurance program to assure the facility identifies issues related to the quality of care and quality of life for every resident in the facility. Quality indicators have been developed and will be monitored by the Administrator to ensure appropriate reporting in a timely manner by all staff involved in the QA/QI program. Results of QA/QI will be reported to the Board of Trustees quarterly.	11/15/10
{F 490} SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 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 490}		
{F 514} SS=F	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	{F 514}		

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{F 514}	Continued From page 18 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 514}	F514 The facility will meet this requirement by all residents medical records will be maintained in an accurate and orderly manner. Staff have been trained on appropriate documentation method to ensure sufficient, accurate and complete clinical records are maintained in accordance with accepted professional standards and practices and will be readily accessible and systematically organized. This requirement will be monitored by IDT and DON with a quality indicator. Each resident's medical record will be reviewed as needed quarterly, annually and/or if a significant change in status is indicated. This will be reported to the QA/QI program.	11/15/10
{F 520} SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET 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.	{F 520}	F520 The facility will meet this requirement by the DON, a physician and three other LTC	11/15/10

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{F 520}	Continued From page 19 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. On 10/19/10 at 9:55 AM, review of the quality assurance program with the DON showed new indicators had been identified, but data for monitoring had not been collected.	{F 520}	staff members attending quarterly QA/QI meetings. If the medical director cannot attend the QA/QI meeting, s/he will designate an alternate physician or 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 Department Heads of LTC and will be reported to the Board of Trustees through the QA/QI program.	

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(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 (	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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0253 Reg. # 483.15(h)(2) LSC	Correction Completed 10/01/2010	ID Prefix F0363 Reg. # 483.35(c) LSC	Correction Completed 10/01/2010	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 10/01/2010
ID Prefix F0467 Reg. # 483.70(h)(2) LSC	Correction Completed 10/01/2010	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** BO 11/3/10	**Date:** 11/2/10	**Signature of Surveyor:** B. Nelson, RN State Health Surveyor	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	

Followup to Survey Completed on: 8/13/10

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