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 12/02/2010

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 LPN - licensed practical nurse DON - director of nursing MDS - Minimum Data Set CNA - certified nurse aide ADL - activities of daily living Less commonly used abbreviations will be annotated in each deficiency where used.	{F 000}		
{F 280} SS=D	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:	{F 280}		12/20/10

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

Bruce Bruce | Board Chairman | 12/20/10

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 280}	Continued From page 1 Based on medical record review, family and staff interviews, and review of incident reports, the facility failed to revise the care plan for 1 of 6 sample residents (#10) in order to meet the resident's current needs. In addition, the facility failed to inform the resident's family of the resident's current status or to include the family's input in the care planning process. The findings were: According to the 10/30/10 quarterly MDS assessment, resident #10 displayed physical and verbal behavioral symptoms directed towards others and rejected care 4 to 6 days a week. These behaviors were defined as "hitting, kicking...grabbing, abusing others sexually," as well as threatening, screaming, cursing at others, and refusing medications and/or ADL assistance. Review of the nurses' notes and incident reports showed these behaviors had been occurring over the past several months. Review of the resident's behavioral care plan, last reviewed by the facility on 8/10/10, showed no revisions or specific interventions had been developed that addressed reducing or eliminating the resident's behaviors. Furthermore, the care plan showed no revisions in the goals or interventions Interviews with family members on 12/1/10 at 12 PM and 2:08 PM revealed they had not been notified of the resident's behaviors and had not been involved in revising the care plan. They stated they were unable to attend the last two care conferences due to physical limitations, but the facility made no attempt to reschedule the meeting or have the family members attend per telephone conference. On 12/1/10 at 3:10 PM the social worker stated the family had not been informed of the resident's behaviors as they were directed	{F 280}	The facility has met this requirement as evidenced by all resident care plans have been reviewed and updated in a timely manner and as significant changes indicate. Care plan for resident #10, was revised and updated regarding dealing with behaviors, effective interventions and helping to reduce/eliminate inappropriate behaviors. Furthermore, all resident care plans have been reviewed and updated by IDT to ensure accuracy and appropriateness. Nursing staff will update all care plans to reflect any changes made, including discontinuing use of items or new orders/interventions to be initiated. A quality indicator has been developed and will be monitored by IDT through QA/QI program.	

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{F 280}	Continued From page 2 towards staff. She confirmed the family had not been present at the last two care conferences and that the care plan had not been revised.	{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: Based on observation, medical record review, resident and staff interviews, and review of policies and procedures, the facility failed to ensure staff followed professional standards of practice related to medication administration for 1 of 4 residents (#12). In addition, 1 of 2 medication passes was not completed in a timely manner. The findings were: 1. Observation on 12/1/10 showed LPN #8 prepared morning medications for resident #12 after the resident had eaten breakfast. Even though the label on the unit dose package instructed that Synthroid should be taken on an empty stomach, it was included with the other medications. At 9:11 AM, after preparing the medications, interview with the LPN revealed she was unaware of the instructions on the front of the package. She stated Synthroid was always given with the 8 AM medications. Review of the package and the medication administration records showed the resident received five doses from that specific package. At 9:15 AM that morning, the resident confirmed s/he routinely received Synthroid with the rest of the morning medications. According to Smith, Duell, Martin in "Clinical Nursing Skills Basic to Advanced Skills"	{F 281}	The facility has met this requirement as evidenced by resident #12 having Synthroid administered on an empty stomach as directed to ensure intended therapeutic effect. All nurses will be inserviced on safe medication practices, the six rights. Medications will be administered correctly to all residents. Each resident, requiring pill a cutter will be provided individual pill cutters, to prevent cross contamination. To ensure timely medication pass, colored dots were applied to all medication bottles to correspond with times on the medication record. In addition, two nurses will be responsible for the am medication pass to ensure timely pass. 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.	12/20/10

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{F 281}	Continued From page 3 Seventh Edition, 2008, page 569: "The Six Rights" of medication administration includes giving the medication at the right time. 2. Observation on 12/1/10 at 9:11 AM during preparation of the medications showed the LPN had to cut a pill in half to obtain the correct dosage of a medication. However, the pill cutter had white powder in all corners and on the blade that the LPN did not remove until after completing the task. At that time she confirmed the pill cutter was not clean when she used it. 3. Observation at 10:15 AM showed LPN #8 was closing the medication cart. At that time the LPN stated she had just completed administering the last of the medications scheduled for 8 AM . She confirmed this exceeded the allowed timeline of one hour before or after the routinely scheduled time. According to Smith, Duell, Martin in "Clinical Nursing Skills Basic to Advanced Skills," Seventh Edition, 2008, page 569: "The Six Rights" of medication administration includes giving the medication at the right time. For medication administration in long term care, the right time is defined as one hour before or after the scheduled time.	{F 281}		
{F 309} SS=G	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.	{F 309}		12/9/10

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{F 309}	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to evaluate pain for 1 of 4 sample residents (#18) who were identified as having pain. This failure resulted in avoidable pain for resident #18. The findings were: According to the medical record face sheet, resident #18 was admitted to the facility on 4/22/10 with diagnoses that included osteoarthritis and osteoporosis. Review of the 10/27/10 quarterly MDS assessment showed the resident was unable to speak and unable to make him-/herself understood. The MDS documented indicators of pain for this resident that were observed 3-4 days during a 5 day period. These indicators included non-verbal sounds, facial expressions, and protective body movements or postures. Review of the 10/26/10 quarterly nurses' note showed the resident received Tylenol elixir 500 mg daily for pain control. However, the note documented that the resident's pain could not be assessed, and the effect of the pain medication could not be determined. Further review of the record failed to show an evaluation of staff-identified pain indicators or any plan to address the signs and symptoms of pain. The resident was cited on the previous survey dated 10/19/10 for this same issue. The following concerns were identified: a. During an observation on 12/01/10 at 7:15 AM CNAs #3 and #9 were assisting the resident to the bathroom with a mechanical lift. As the resident was maneuvered and coached by the CNAs to hold onto the lift, the resident displayed facial grimacing.	{F 309}	The facility has met this requirement as evidenced by resident #18 being evaluated and had pain assessment completed to minimize pain. Each resident will receive the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Resident #18 was evaluated by physician and medication was adjusted. Effectiveness of all pain medication will be documented on Pain Assessment Form located with the MAR. Assessment and findings will be incorporated into the care plan and will include resident specific interventions.	

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{F 309}	Continued From page 5 b. Review of an untimed 10/27/10 late entry nursing note showed the "...resident continued to be tearful and was resistant to move limbs when testing range of movement [ROM], as if they were stiff." The nurse communication to the physician dated 10/27/10 showed..."resident continues to be tearful and cry often, could this be from pain, depression, or part of the disease process?" Detailed review of the medical record showed no response from the physician related to this communication. Interview with RN #1 on 12/1/10 at 2:30 PM confirmed the physician had not responded to the 10/27/10 communication. The RN produced some orders received since then, including one dated 11/9/10 for an evaluation of the resident's range of motion (ROM). She verified there were no orders related to pain relief. Review of the ROM evaluation showed it was completed on 11/15/10. However, the evaluation failed to address the resident's pain with movement. According to documentation in the record dated 11/18/10, the resident continued to display indicators of pain. Review of an un-timed nurses note on this date showed the resident was up and "grimaced as if in pain." Interview with the DON on 12/1/10 at 11:59 AM revealed she was unable to find any follow-up after this note that addressed the issue of pain.	{F 309}		
{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.	{F 312}		12/2/10

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{F 312}	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to ensure staff provided appropriate perineal (incontinence) care for 1 of 3 residents (#18) who required staff assistance with personal hygiene. The findings were: During an observation on 12/01/10 at 7:15 AM CNA #3 failed to thoroughly cleanse resident #18 after s/he had been incontinent of urine. Even though the resident's incontinence brief was saturated with urine, the CNA failed to cleanse the anterior perineum, thighs, suprapubic area, and abdomen of the resident. The CNA was asked (at the time of observation) about her failure to cleanse all skin areas that had been in. contact with urine. The only CNA's response was a shoulder shrug. An interview with the DON on 12/2/10 at 8:30 AM revealed the expectation that incontinence care included cleansing all areas of the skin in contact with urine. Review of the facility's policy and procedure for incontinence care, revised on June 17, 2008, showed: "...wash the area that has urine or feces on it very well, removing all waste material from the skin."	{F 312}	The facility will meet this requirement by resident #18 will be provided appropriate incontinent peri care. All residents will be provided appropriate peri care to reduce potential for skin breakdown and risk for infection CNAs had one on one training on proper peri care. The facility will maintain this requirement by quality indicators to ensure the that residents will receive adequate supervision and assistance to prevent accidents/skin breakdown. The IDT and DON will monitor monthly and report to the QA/QI program	
{F 323} SS=D	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.	{F 323}		12/17/10

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{F 323}	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure 1 of 1 sample residents (#18) transferred with a mechanical lift was capable of completing the transfer safely. The findings were: During an observation on 12/01/10 at 7:15 AM, CNAs #3 and #9 were assisting resident #18 to the bathroom with a sit-to-stand mechanical lift. In order to stand, the resident was required to hold onto the lift without the use of security devices. During the transfer, the resident made facial grimaces, and resident's wide open eyes gave the appearance of fear while s/he held onto the lift with out-stretched arms. Review of the 11/15/10 physical therapy range of motion evaluation showed the use of mechanical lifts were not addressed. The evaluation documented that the resident required the assistance of two staff for transfers and bed mobility. Further review of the medial record failed to show the mechanical lift was determined to be a safe method of transfer for this resident.	{F 323}	The facility has met this requirement as evidenced by resident #18 has been evaluated by the physician. The physician assessed resident for appropriate use of sit to stand lift for safe transfers. Each resident will be evaluated, by the IDT, on admission, quarterly and upon significant change, for appropriateness of safety devices. Assessment and finding will be incorporated into the care plan and will include resident specific interventions. A quality indicator has been developed and will be monitored by IDT monthly through QA/QI program.	
{F 490} SS=E	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: Based on observation, medical record review, interviews with residents, staff, and board	{F 490}	The facility has met this requirement by addressing problems in tags from	12/20/10

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{F 490}	Continued From page 8 members, and review of policies and procedures and incident reports, the administrator failed to ensure the facility was administered in a manner which resulted in correction of all previously cited deficiencies. The findings were: 1. Refer to F280 for information related to failure to develop and revise care plans to meet a resident's needs. 2. Refer to F281 for details regarding staff failure to follow professional standards of practice. 3. Refer to F309 for information related to failure to assess and treat pain. 4. Refer to F312 for details regarding lack of appropriate care for dependent residents. 5. Refer to F520 regarding failure to develop and implement an effective, sustainable quality assurance program. 6. Interview with 3 of 3 board members revealed the administrator had not informed them of the severity of the consequences if the facility failed to meet their date of compliance for correction of all deficiencies.	{F 490}	previous surveys. All board members have been notified of facility deficiencies and failure to comply with CMS guidelines (completed 12/4/10). Contingency plan has been initiated in the event the facility loses its certification. Refer to specific tagged sections for plan of correction (F280, F281, F309, F312, F520) with regards to QA/QI.	
{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.	{F 520}		12/15/10

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{F 520}	Continued From page 9 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: Based on review of the quality assurance (QA) program information, staff interview, medical record review, and observation, the facility failed to fully implement an effective QA program with action plans to correct previously identified deficiencies. The findings were: Interview with RN #7 and medical records staff member #2 revealed the QA program lacked a coordinator. The medical records staff member stated she was "filling in" and was responsible to input the monthly data into the computer. She did not consider herself as overseeing or coordinating the program. During the 10 /19/10 revisit survey, the QA program was identified as deficient. Although data had been collected since September 2010, the action plans were not evaluated by the quality committee to ensure their effectiveness in resolving issues or sustaining	{F 520}	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 Furthermore a QA/QI Coordinator has been designated to oversee the completion, implementation and effectiveness of the program.	

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{F 520}	Continued From page 10 improvement. Review of the QA worksheets for 2010 showed multiple monitoring results below 90%, the minimum baseline selected by the facility for successful performance. In the case of chart audits for accuracy and completion, unsuccessful performance was found for two consecutive months (September and October 2010). There was no evidence to show the facility recognized the unsuccessful performance, investigated the problem, or developed interventions to improve performance. On the basis of present survey findings, it was determined the QA program had not effectively addressed deficiencies first cited on the recertification survey originally completed on July 1, 2010. Failure of the committee to evaluate action plans and provide adequate oversight contributed to the facility's failure to correct the following deficiencies: F 280, F281, F309, F312, F323, F 431, F490, F520. Refer to each federal citation for additional information.	{F 520}	This will be monitored by DON, Administration 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	12/02/2010

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 F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4 LSC	Correction Completed 11/20/2010	ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 11/10/2010	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 11/15/2010
ID Prefix F0274 Reg. # 483.20(b)(2)(ii) LSC	Correction Completed 11/15/2010	ID Prefix F0278 Reg. # 483.20(g) - (i) LSC	Correction Completed 11/26/2010	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 11/15/2010
ID Prefix F0353 Reg. # 483.30(a) LSC	Correction Completed 11/24/2010	ID Prefix F0425 Reg. # 483.60(a),(b) LSC	Correction Completed 11/26/2010	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 11/15/2010
ID Prefix F0514 Reg. # 483.75(l)(1) LSC	Correction Completed 11/15/2010	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

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:		Date:
		12/6/10	D Dickson, RD State Surveyor		
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**		

Followup to Survey Completed on: 8/13/10

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