STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING _____ B. WING _____	C 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 6/3/19 through 6/6/19. Also reviewed in the course of the survey was complaint intake WY00002842. The following common abbreviations are used throughout this document. ADON: Assistant Director of Nursing BIMS: Brief Interview for Mental Status CDM: Certified Dietary Manager CNA: Certified Nursing Assistant DON: Director of Nursing RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		6/27/19

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

Electronically Signed | 06/27/2019

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F 600	Continued From page 1 by: Based on staff interview and medical record review, the facility failed to ensure 1 of 4 sample residents (#42) identified in reported allegations of resident to resident abuse was free from abuse. This failure resulted in recurrent incidents of resident #13 punching and kicking resident #42. The findings were: Review of the 3/12/19 annual MDS assessment showed resident #13 had a BIMS score of 12/15 (moderate cognitive impairment) and diagnoses that included Alzheimer's Disease. Further review showed the resident required extensive assistance with bed mobility, dressing, and transfers. Review of the care plan, last updated 4/24/19, showed the resident could self propel his/her wheelchair independently and staff were to set firm limits on behaviors. Review of the 4/29/19 quarterly MDS assessment for resident #42 showed s/he had a BIMS score of 1/15 (severe cognitive impairment); diagnoses included dementia; and s/he required extensive assistance with activities of daily living. The following concerns were identified: a. Review of incident/accident investigations showed resident #13 "punched" resident #42 on 4/22/19. This review showed both residents were in their wheelchairs in the hallway and the incident occurred before staff who were present at that time could prevent it. Interview on 6/6/19 at 9:20 AM with the administrator revealed no major injuries resulted from the incident; and staff determined they would prevent close contact between the residents. Review of the investigation documentation showed the incident was reported to all appropriate agencies, family, and physician in timely manner.	F 600	Care plans for resident #13 and resident #42 were updated to include keeping the residents away from each other. Staff were informed of the changes in care plan via the standard communication methods of the facility. A note was created in the CNA documentation system to have staff acknowledge that residents #13 & #42 are to be kept apart. Education was provided to staff on 6/10/19 regarding the issues between resident #13 and resident #42. Staff were instructed that any new employees, clinical instructors, or clinical participants will receive verbal report on this issue and similar issues when beginning work at the facility. Administrator or designee will audit resident to resident incidents for six weeks and as needed thereafter to ensure proper care plan updates and proper communication is taking place. Any issues will be reported to the QAPI committee.	

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F 600	Continued From page 2 b. Review of incident/accident investigations showed resident #13 "kicked" resident #42 on 5/14/19 in the dining room and no serious injuries resulted from this. Further review showed at the time of the incident, the nursing school instructor was wheeling resident #42 and did not know she should not move the resident in an area close to resident #13. Review of the investigation documentation showed the incident was reported to all appropriate agencies, family, and physician in timely manner. c. Review of the 5/31/19 updated care plan for resident #13, and the 4/29/19 updated care plan for resident #42 showed neither included information about preventing close contact between the residents. d. Interview on 6/6/19 at 9:20 AM with the administrator revealed the best thing to do to prevent recurrent incidents was to keep the two residents apart. She further stated their system for letting staff know to keep the two residents apart was to document this information on the daily staff information sheet. She further stated they could use the CNA electronic documentation system, "Care Tracker" to disseminate this information, but they had not done this or implemented additional systems for ensuring everyone who assisted residents were aware of the need to prevent resident to resident interactions between the two residents.	F 600		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		7/3/19

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F 684	Continued From page 3 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure needed care and services that met each resident's highest practicable physical, mental, and psychosocial well-being were provided for 1 of 24 sample residents (#198). The findings were: Review of the 5/8/19 care plan for resident #198 showed the following: The interventions for impaired ability to participate included encourage simple activities and attempt simple interactions. The interventions for pressure ulcers included staff will assist with toileting and peri-care. The interventions for function and rehab included use wheelchair for locomotion. The following concerns were identified: a. Intermittent observation on 6/4/19 showed the resident remained in bed, in the same supine position from 8:55 AM until end of observations at 3:53 PM. Extended observation of the resident on 6/5/19 from 12:40 PM to 4:50 PM showed the only staff to enter the room during this time period was a dietary aide to leave and pick up meal tray. The resident was in bed, in supine position with the covers up. b. During an interview on 6/5/19 at 11:32 AM RN #2 revealed she was unable to access the resident's care plan in the computer but knew the resident was on palliative care, stayed in bed all of the time, and that toileting was done "as we	F 684	Resident #198 expired on 6/13/2019 due to natural causes. Any resident who is bedbound will receive new facility protocol to be repositioned every two hours unless contraindicated. A turning/positioning schedule has been implemented for staff to follow. The turning schedule will be included in resident care plan. Any resident who is bedbound will be the subject of a random audit by CNA coordinator or designee for four weeks and as needed thereafter. Education with staff was provided to CNAs and nursing staff on 6/25/19. Education was added to new hire procedures and will be revisited on at least an annual basis. Findings of audits will be reviewed with QAPI committee.	

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F 684	Continued From page 4 can." c. During an interview on 6/6/19 at 9:15 AM CNA #1 revealed the expectation was for direct care staff to check and change bed-bound residents every two hours. d. During an interview on 6/6/19 at 9:35 AM, the ADON revealed the facility expectation was to check and change the bed-bound resident for incontinence every two hours.	F 684		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview and medical record review, the facility failed to implement effective pain management for 1 of 1 sample resident (#9) reviewed for pain management. The findings were: Review of the 2/27/19 quarterly MDS assessment for resident #9 showed s/he had a BIMS score of 14/15 (cognitively Intact) and required extensive assistance with activities of daily living. This review also showed the resident had hemiplegia due to a stroke and frequent pain. Review of the 2019 May recapitulation of physician orders showed the physician ordered Norco (pain medication) 5/325 mg, 1 pill to be given every four hours as needed. Interview on 6/4/19 at 2:15 PM with the resident revealed s/he had a lot of pain and sometimes the pain pills helped and	F 697	Resident #9's BIMS was conducted on 6/26/19. Resident was found to have a score of 7/15 (severe impairment). Resident #9 was examined by physician on 6/27/19. Resident reports to MD that pain is well controlled on current regimen and that he/she pain is much better after taking medication. MD discussed FACES scale with resident #9 and resident rated pain at the equivalent to a 4 on the FACES scale. MD recommends that resident have consult with pain clinic. Will follow recommendations of pain clinic for additional interventions. Offered resident #9 a visit with neurology specialist. Resident and POA declined this neurology consultation.	7/3/19

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F 697	Continued From page 5 sometimes they did not provide complete relief. The resident further stated his/her left leg hurt "a lot" and lower back "hurts too." On 6/6/19 at 9:45 AM, the pain medication administration record for May 2019 was reviewed with RN #1. This review showed the pain medication was administered on 5/14/19, 5/20/19, 5/21/19, 5/22/19, 5/27/19, and 5/29/19. Further review showed an assessment prior to the medication administration or an assessment after the medication was administered was not done or neither was completed for the above dates. Interview with the DON on 6/6/19 at 10:15 AM revealed staff were aware of the resident's pain and had tried various interventions to address his/her pain. The DON further stated the resident's pain was hard to assess.	F 697	MDS coordinator audit conducted for any residents who consistently rate pain at or above 5. Residents found to be scoring at this level will be assessed by physician and offered alternatives. Education provided for nursing staff on 6/25/19 regarding pain assessment prior to and after administration of pain meds. Staff instructed to document assessment using FACES scale with resident #9 due to physician recommendation and severely impaired cognition. Resident #9 care plan updated to reflect use of FACES scale. DON or designee to audit multiple residents and multiple shifts of pain documentation for four weeks and as needed thereafter. Audit will include complete documentation of pre and post medication assessment. Any issues identified during audit will be discussed with QAPI committee.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		7/10/19

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F 812	Continued From page 6 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure food safety requirements were met and sanitary conditions were maintained in the kitchen during 2 of 2 observations of the kitchen. The findings were: 1. Observation of the ice machine in the kitchen on 6/5/19 at 4:30 PM revealed the upper interior area was dirty. At that time the CDM moved a clean cloth across the area and removed a black and brown substance. Interview on 6/06/19 at 9:20 AM with the maintenance supervisor, revealed he was responsible for cleaning the ice machine once a month and last did it on 5/3/19. He further stated he might need to revise the cleaning schedule and perform the task more frequently. 2. Observation on 6/6/19 from 7:20 AM to 8:30 AM showed 3 packaged herb rubbed pre-cooked turkey breasts, one package of sliced ham and a partially thawed 30 ounce container of frozen basil were in a pan on the countertop near the sink. The packaged meats and container of basil sat in the thawing moisture in the pan. At 8:35 AM, the CDM said the turkey was to be prepared for the noon meal and the ham for the supper meal later that day, but staff had not had an opportunity to cut it up. She further stated she did	F 812	1. Ice machine interior will be wiped down daily by the dietary staff with a clean cloth and warm water bleach solution. Deep cleaning will continue in addition to the daily cleaning. Contractor has been hired to perform deep cleaning of machine every 6 months to ensure proper cleaning and proper function of ice machine. CDM or designee will audit ice machine cleanliness for a period of 6 weeks and as needed thereafter to ensure ice machine is being kept clean. Ice machine inspection will also be added to dietician kitchen inspection to ensure cleanliness. Education was provided to dietary staff on 6/20/2019 regarding ice machine cleaning schedule and procedures. Any concerns found during audit will be discussed in QAPI committee. 2. Dietary staff meeting was held on 6/20/2019. Staff were educated on safe thawing of food. Staff were given education from Crandall Corporate Dieticians regarding food thawing and food safety.	

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F 812	Continued From page 7 not know how long the meat had been on the counter and it should have been in the refrigerator until ready for use. Review of the menu directions for the meat showed instructions to "Thaw meat under refrigerator (41° F)." 3. On 6/6/19 at 7:20 AM observation showed 6 shelving units used for storage of dishes, pans, condiments, bread and bananas had lint and dust threads covering the wired structures on all of the two lower shelves of each unit. At 8:35 AM, the CDM observed the shelves and verified they needed to be cleaned. She further stated her staff were responsible for cleaning the shelves and it had been overlooked. 4. According to Food Code 2017, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, (C) Nonfood-contact surfaces of equipment, shall be kept free of accumulation of dust, dirt, food residue, and other debris." 5. According to Food Code 2017, U.S. Public Health Service: 3-501.13 "Except as specified in ¶ (D) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be thawed: (A) Under refrigeration that maintains the FOOD temperature at 5° C [5 degrees centigrade] (41° F) [41 degrees Fahrenheit] or less; or (B) Completely submerged under running water: (1) At water temperature of 21° C (70° F) or below, (2) With sufficient water velocity to agitate and float off loose particles in an overflow, and (3) For a period of time that does not allow thawed portions of READY-TO-EAT FOOD to rise	F 812	CDM or designee will audit thawing technique and procedures for a period of 6 weeks and as needed thereafter to ensure proper thawing procedures are being followed. Dietician will also audit during kitchen inspection to ensure compliance. Any problems will be addressed immediately and discussed with staff immediately. Findings of audits will be discussed with QAPI committee. 3. A deep cleaning of the shelving units in the kitchen will be conducted on 7/10/2019. All items will be removed from shelves and they will be deep cleaned. The shelves will be added to a deep cleaning schedule to be completed twice per year. Staff will wipe dust and debris off shelves on a quarterly basis, or more often if necessary. Audit will be conducted for 6 weeks by CDM or designee to ensure shelving is kept clean and free of dust/debris. Dietician will audit shelving units for cleanliness during kitchen inspection. Any issues found during inspections will be reported to QAPI committee.	

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F 812	Continued From page 8 above 5°C (41° F)..."	F 812		