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

PRINTED: 07/25/2011
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 _____	07/14/2011

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 CNA - certified nursing assistant DON - director of nursing MDS - Minimum Data Set IDT - interdisciplinary team ADLs - activities of daily living MAR - medication administration record Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation and medical record review, the facility failed to prevent 2 of 11 residents (#10, #19) observed during medication passes from self-administering their own medications. The findings were: 1. Observation on 7/12/11 showed RN #3 prepared and administered medications, including Milk of Magnesia, at 9:02 AM for resident #10. While the RN observed the resident take the other medications, he just set the Milk of Magnesia on the table then turned and walked away. After reaching the nurses' station, the RN walked to the sink and washed his hands. Both	F 176	F 176 All residents including residents #10 & #19 determined incapable of self-administering/consuming medications will be monitored by the RN/LPN until the medication is consumed. This will be evidenced by the nurses being instructed on proper procedure of self administering/consuming medications. This will be monitored by the DON. A quality indicator has been developed for monthly monitoring and will be reported at the quarterly QI meeting.	8/15/11

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

Interim CEO 8-11-11

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.

This POC created & corrections by phone conversation between Connie Clause, DON & Betty Nelson, WY State Health Survey on 8/22/11 @ 0802

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F 176	Continued From page 1 actions put the resident completely out of the RN's line of sight, and he had no way of knowing if the resident consumed the medication. Review of the assessment for self-administration of medications dated 6/15/11 showed staff determined the resident's cognition was "Not Adequate" to take medications independently due to confusion and dementia. Furthermore, a determination had not been made indicating the resident was capable of independently administering and consuming medication after setup by a licensed nurse. 2. Observation on 7/12/11 showed RN #3 crushed aspirin and Seroquel and mixed them in an individual serving of ice cream before handing it to resident #19 at 9:25 AM. The RN also mixed liquid potassium chloride with juice and handed it to the resident at the same time. At 9:31 AM the RN left the resident to finish consuming the ice cream and medications independently. According to the 4/14/11 MDS assessment, the resident's cognition was severely impaired. Review of the undated self-administration of medications assessment showed that, due to dementia, staff determined the resident's cognition was "Not Adequate" to take medications independently. In addition, the resident was assessed as incapable of independently administering and consuming medication after setup by a licensed nurse.	F 176		
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	F 225		

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CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	719 OAK STREET SUNDANCE, WY 82729

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F 226	Continued From page 2 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 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 review of personnel files and staff interview, the facility failed to screen 1 of 7 current employees (#10) for findings of abuse or neglect prior to resident contact. The findings	F 226	F 226 All employees being hired will have a completed back ground check for abuse and neglect on file before starting employment. This will be evidenced by the DON developing a check list of items needed before the employee starts work. This will be monitored by the DON and Human Resource director for each hire. A quality indicator has been developed for monthly monitoring to be reported at the quarterly QI meetings.	8/4/11

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F 225	Continued From page 3 were: On 7/14/11 at 7:50 AM, the human resources coordinator and surveyor reviewed seven randomly selected personnel files of current employees. This review revealed all seven employees were hired after October 2010. Further review revealed the facility had not completed a background screening for previous findings of abuse or neglect prior to hiring employee #10 on 2/7/11. Interview with the human resources coordinator during review of the employee files confirmed the pre-hire screening for employee #10 was not done until 2/9/11, after the employee already had contact with residents.	F 225		
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 observation, record review and staff and resident interviews, the facility failed to effectively address the behaviors of 2 residents (#14, #19) whose wandering affected the dignity of 4 residents who were interviewed. In addition, the facility failed to provide a dignified dining experience for 2 of 6 sample residents (#15, #21) and 1 non-sample resident (#18) who required dining assistance. The finding were: 1. Interview with four residents on 7/12/11 at 11 AM revealed concerns about two residents (#14,	F 241		

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F 241	Continued From page 4 #19) who frequently wandered in and out of other resident rooms, sometimes using the bathroom or touching personal belongings. The four residents stated that when staff were aware of the wandering behavior, they intervened and redirected the confused residents, but they were not always aware of it. According to the 6/14/11 quarterly MDS assessment, resident #14 was assessed as "wandering" daily. According to the 4/15/11 quarterly MDS assessment, resident #19's daily behaviors included rummaging and wandering. Observation on 7/11/11 at 2 PM revealed resident #19 walked into another resident's room and began to move books, linen, and personal items on the bedside stand, overbed table, and bed. This activity was observed for five minutes; then s/he departed without evidence that staff were aware of it. On 7/12/11 at 8:25 AM, the resident was again observed wandering in other resident rooms without staff awareness. Interview with the DON on 7/14/11 at 8:40 AM revealed staff were aware of the problems associated with the residents' wandering; however, they had not considered implementing environmental changes, door guards, or similar devices to deter the residents. 2. A 26-minute meal observation on 7/11/11 from 5:10 PM to 5:46 PM showed resident #21 sat at the dining room table without cueing or assistance to eat. On a single occasion, CNA #1 told the resident to "Eat your cookie." The cookie was the only food item the resident consumed at this meal. 3. Observation on 7/11/11 at 6:20 PM showed resident #15 slept at the dining room table; the	F 241	~~F 241~~ The facility will promote care for residents that maintains or enhances each residents dignity and respect. This will be evidenced by STOP signs being applied to all resident doors/doorways to help deter residents #14 & #19 from wandering into other residents rooms. Residents who are alert and oriented were instructed to call for help if another resident wanders into their room. Staff have been instructed to shut doors on unattended rooms to help divert the wandering residents. ~~This will be~~ And the facility will ensure all residents who require assistance with dining, including residents #15, #21, #18 will have assistance, cueing, and set-up as needed and indicated in their POC. Kitchen staff will not serve until nursing staff are available in the dining room to assist the residents. The residents will be assisted within 5 minutes of being served their meals. This includes food preparation, cuing and assistance with feeding. This will be evidenced by all staff will be in serviced on monitoring and redirecting wandering residents and assisting residents at meal times as stated above. The charge nurse, DON, and SSD will monitor for effectiveness on a daily basis to be discussed weekly at the IDT meeting.	

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F 241	Continued From page 5 evening meal had been uncovered and placed on the table in front of him/her. The resident continued to sleep until observation ceased at 5:48 PM. During this 28 minute time period, staff made no attempt to awaken and assist or encourage the resident to eat. 4. Review of the 6/16/11 revised care plan for resident #21 showed "...needs cueing at meal time." Review of the 5/20/11 revised care plan for resident #15 showed s/he needed encouragement and set up assistance with meals. Review of the care plan dated 4/27/11 revealed resident #18 required assistance with eating. The following concerns regarding the dining experiences for the three residents were noted on 7/12/11: a. Observation showed residents #15, #21 and #18 were positioned at the table at 7:40 AM, waiting to be served. At that time, staff placed glasses of water and other beverages in front of the residents and departed without providing assistance or cueing. At 8 AM the untouched glasses of beverages were moved aside to allow room for the meal trays. b. At 8:20 AM RN #3 moved about between the three residents for ten minutes and gave them sips of fluids. After RN #3 departed, the residents sat and stared at their food until 8:30 AM when CNAs #9 and #4 sat beside the residents and began to provide cueing and assistance as needed. Continued observation revealed the three residents consumed less than half of the meal. c. Interview with CNAs #9 and #5 on 7/14/11 at 8:45 AM revealed residents #21, #15 and #18 ate better when staff provided the assistance the residents needed in a timely manner.	F 241	A quality indicator has been developed for monthly monitoring and quarterly reporting at the QI meeting.	8/30/11

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F 241	Continued From page 6 5. On 7/12/11 at 9:15 AM resident #2 stated "...It bothers me..." when residents are left sitting in the dining room with their food in front of them waiting for staff assistance. Interview on 7/12/11 at 11 AM with four residents revealed they had been told that the facility had addressed the problems of prolonged waiting for dining assistance by employing feeding assistants. The residents stated they thought the feeding assistants were coming last week, but they had not seen them.	F 241		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE 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 resident assessment instrument (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;	F 272		

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F 272	Continued From page 7 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide comprehensive assessments in various areas for 3 of 9 sample residents (#2, #27, #28) whose MDS assessments triggered the need for comprehensive assessments. The findings were: 1. Review of the 1/18/11 admission MDS assessment showed resident #2 required comprehensive assessments for ADLs, pressure ulcers, urinary incontinence, and psychotropic medications. Review of the information designated as the comprehensive assessment for each area showed the causes and contributing factors were not identified. Nor was the impact on the resident's ability to function identified and evaluated. 2. Review of the annual MDS assessment dated 5/31/11 showed resident #27 triggered for comprehensive assessments in communication,	F 272	F 272 Comprehensive Assessments will be accurately completed on all residents including residents #2, #27, #28. All MDS's will be reviewed weekly at the IDT meeting for completeness. This will be monitored by the IDT members weekly. A quality indicator has been developed for monthly monitoring and quarterly reporting at the QI meeting.	8/30/11

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F 272	Continued From page 8 cognition, behaviors, ADLs, urinary incontinence, falls, and psychosocial well-being. Further review showed the assessment information was located in the care area assessments (CAAs), but review showed each CAA failed to included the causes and contributing factors, as well as the impact upon the resident. In addition, several of the CAAs lacked an analysis of the data. 3. According to the 5/18/11 admission MDS assessment, resident #28 required comprehensive assessments for bowel and bladder incontinence, falls, dehydration, and psychotropic medications. Review of the documentation identified as containing that information showed neither the causes nor the contributing factors were determined. In addition, the facility failed to determine how the triggered areas impacted the resident's functional abilities and psychosocial well-being. All except the CAA for dehydration repeated information already in the MDS, including diagnoses and medications. The dehydration CAA lacked data analysis. 4. During an interview on 7/14/11 at 8:10 AM the MDS coordinator confirmed the assessments were not comprehensive.	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	F 274		

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F 274	Continued From page 9 itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a significant change assessment for 1 of 1 sample residents (#27) who required that type of assessment. The findings were: According to the medical record, resident #27 elected to receive hospice benefits on 6/27/11. Review of the entire medical record showed a significant change assessment after that date was lacking. Interview with the MDS coordinator on 7/14/11 at 8:10 AM confirmed the assessment had not been completed. The coordinator stated she was unaware a significant change assessment was needed.	F 274	F 274 The facility will conduct a comprehensive assessment within 14 days of the facility determining there is a significant change in condition on any resident, including resident #27. The MDS coordinator has been educated on significant changes being completed in 14 days of determining there is a change in condition for a resident. The IDT members will monitor weekly for any resident qualifying for a significant change in condition to assure the comprehensive assessment is completed within 14 days. A quality indicator has been developed for monthly monitoring and will be reported at the quarterly QI meetings.	7/30/11
F 278 SS=D	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.	F 278		

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F 278	Continued From page 10 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: Based on observation, record review and staff interview, the facility failed to accurately assess 2 of 9 sample residents (#2, #19). The findings were: 1. Review of the 1/18/11 admission MDS assessment for resident #2 showed the resident required limited assistance with bed mobility, transfers, walking, dressing, and toilet use. Further review showed the resident ate and performed personal hygiene care independently and weighed 147 pounds. Review of the functional status section of the MDS assessment showed the resident's walking was steady at all times with an assistive device, and s/he was able to move from a sitting to standing position, and on and off the toilet, without human assistance.	F 278	F 278 The facility will accurately assess all residents including residents #2 & #19. This will be evidenced by assessments for residents #2&#19 and all residents being completed correctly by the MDS coordinator to reflect the residents current level of functioning. This will be monitored by the IDT members at weekly IDT meetings. A quality indicator has been developed for monthly monitoring for quarterly reporting at the QI meetings.	8/30/11

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F 278	Continued From page 11 Review of the 4/18/11 quarterly MDS assessment showed the following discrepancies: a. The resident required extensive assistance with transfers, dressing and toilet use. b. Review of the functional status section of this MDS assessment showed the resident was unable to walk c. The resident required human assistance to move from a sitting to standing position and on and off the toilet. d. Walking, "did not occur", personal hygiene care was done with limited assistance, and weight had increased to 187 pounds. e. Entries for Item I2300, Urinary Tract Infections (UTI) were blank for both assessments, indicating the resident had not had a UTI within 30 days of either reference date. However, a detailed review of the resident's medical record revealed s/he had a series of UTIs beginning 1/15/11 and continuing through 5/5/11. Laboratory results dated 1/15/11, 1/29/11, 2/5/11, 2/23/11, 3/23/11, 4/8/11, and 5/3/11 all reported positive culture findings for urine samples submitted by the resident; these laboratory data coincided with physician and nursing notes describing the resident as symptomatic for possible UTIs. The DON acknowledged in interview on 7/14/11 at 9:50 AM the medical record and laboratory reports should have resulted in MDS coding for UTIs for the resident. Review of the care plan showed the following interventions: requires limited assistance with all ADLs, toilet every two hours with assistance and assist with transfers due to "does not ambulate". On 7/11/11 at 5:40 PM CNA #1 was observed assisting the resident to the bathroom and providing personal hygiene care. At that time the	F 278		

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F 278	Continued From page 12 CNA said the resident had required assistance with all activities of daily living since admission. During an interview on 7/14/11 at 9:55 AM, the MDS coordinator stated the resident had periodic changes in functional ability due to illness and diagnosis, but the inconsistent information between the two MDS assessments was primarily due to inaccuracies in the 1/18/11 MDS assessment. 2. Review of the 1/13/11 and 4/14/11 quarterly MDS assessment for resident #19 showed the following changes in mood and behaviors in the two week reference period: a. Mood changed from being short tempered two to six days to having trouble sleeping, poor appetite, trouble concentrating and being short tempered seven to eleven days. b Behavioral symptoms changed from resists care one to three days to daily episodes of physical and verbal symptoms directed at others and daily resisting care. c. The 1/13/11 assessment showed continence of bowel and bladder. However, the 4/14/11 assessment showed bowel incontinence. Interview with the MDS coordinator on 7/13/11 at 3:10 PM revealed the inconsistent information between the two MDS assessments was due to inaccuracies in the 1/13/11 MDS assessment.	F 278		
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	F 279		

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	535029	A. BUILDING _____ B. WING _____	07/14/2011

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F 279	Continued From page 13 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: Based on observation, medical record review, and staff interview, the facility failed to develop and implement a care plan that included all identified problems for 2 of 9 sample residents (#2, #27). The findings were: 1. Observation on 7/12/11 at 7:40 AM revealed a sign posted on the door of resident #2's room that directed staff to use the appropriate personal protective equipment for respiratory precautions. Interview with RN #3 on 7/13/11 at 2:40 PM and review of the physician's orders dated 7/11/11 revealed the respiratory precautions for the resident were started on 7/12/11. Review of the care plan on 7/14/11 showed information regarding the precautions had not been added to the care plan. On 7/14/11 at 9:55 AM the DON stated the information should have been added to the care plan.	F 279	F 279 The facility will update the residents plan of care in a timely manner to reflect the residents current level of care to include resident #2 and resident #27. All nurses will be inserviced on updating care plans and this will be monitored by the IDT members. A quality indicator has been developed for monthly monitoring and quarterly reporting at the QI meeting.	8/30/1

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F 279	Continued From page 14 2. Review of the medical record showed resident #27 elected to receive hospice benefits on 6/27/11. Review of the care plan showed hospice services were not addressed, thus the care and services to be provided by hospice versus those to be provided by the facility were not delineated. Review of the 3/15/10 agreement between the facility and the hospice program showed hospice would provide a copy of the plan of care. On 7/12/11 at 6 PM the DON stated the facility had never had an IDT meeting with hospice concerning care and services to be provided to hospice residents. She confirmed a care plan integrating hospice and facility services was lacking.	F 279		
F 281 SS=D	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, and staff interview, the facility failed to ensure staff maintained professional standards of practice related to post-fall assessments and medication administration. These failures affected 1 of 3 sample residents (#27) reviewed for falls and 1 non-sample resident (#24) observed during administration of medications. The findings were: 1. Review of the medical record showed resident #27 fell on 7/2/11 and sustained a head laceration that required evaluation and treatment at a local emergency department. Prior to transfer, vital signs were taken and documented,	F 281		

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F 281	Continued From page 15 but neurological checks were not initiated. On 7/14/11 at 7:35 AM the DON reviewed the medical record and confirmed neurological checks were not conducted. She stated the facility had neurological flow sheets that should have been completed. According to Smith, Buell and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," Seventh Edition, 2008; the level of consciousness, determined by a neurological assessment, "...is the most sensitive and reliable index of cerebral function. 2. Observation on 7/13/11 showed RN #6 prepared and administered medications for resident #24 at 8:55 AM. While preparing the medications, the RN removed an ampule of Refresh Tears and a Lidocaine Patch from the medication cart. Prior to administering them, the RN verified their time of administration with RN #3 and found neither should be administered at that time. The RN replaced both, but failed to complete a medication error report of the near misses. Interview with the DON on 7/14/11 confirmed the errors should have been, but were not, reported. According to the facility's policy and procedure, "Medication Errors", last revised 9/11/09, near misses "will be logged in 'Near Miss Log' book" and tracked by pharmacy.	F 281	F 281 The facility will maintain professional standards of quality. This will be evidenced by the appropriate post fall neurological assessment to be completed with a head injury, including resident #27. Medication error reports will be completed on all near miss medication errors including resident #24. All nurses will be inserviced on the post fall policy to include neuro checks, and review of medication error policy. The DON will monitor. A quality indicator has been developed for monthly monitoring for quarterly reporting at QI meeting.	8/30/11
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.	F 309		

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F 309	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the hospice agreement, the facility failed to ensure coordination and integration of hospice services for 1 of 1 sample (#27) and 1 non-sample (#1) resident receiving those services. The findings were: 1. According to the medical record, resident #27 elected to receive hospice services on 6/27/11. Further review of the record showed a care plan had not been developed. Refer to F279 for additional information. Detailed review of the hospice notes showed they contained minimal information and that the space designated "Coordination/Plan" was left blank on each note. Furthermore, the notes lacked evidence the hospice RN conducted the visits as planned by the hospice interdisciplinary group, thoroughly assessed the resident, or determined if the goals and interventions were appropriate. According to the 3/15/10 agreement between the facility and hospice, "Long Term Care Facility shall institute, maintain and conduct administrative procedures and patient care protocols...,(b) consistent with those procedures and protocols of a hospice program, and (c) as may be reasonable and necessary to implement the provisions of this agreement." Further review showed hospice will "...perform periodic reviews of the Plan of Care and conduct interdisciplinary Group meetings and conferences as necessary to coordinate provision of Hospital Services...Hospice shall provide assistance as may be reasonable and necessary to Long Term	F 309	F 309 The Hospice/Home Health Supervisor and nurse have been terminated on 8/02/11. It is the decision of CCMSD that the Hospice Program be discontinued. 2 of the 3 patients have since died and the 1 remaining has declined a transfer of services to another Hospice provider. Hospice was discontinued and the patient will remain on our Long Term Care Unit. 8/8/11 Any new residents on hospice services will be monitored for integration of services & the results will be sent to QA quarterly.	

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F 309	Continued From page 17 Care Facility to satisfy its responsibilities to implement the provisions of the agreement." 2. On 7/12/11 at 6 PM the DON stated that resident #1 was also receiving hospice services. She confirmed that hospice care plans were lacking for both residents. Furthermore, the DON stated the facility had never had an IDT meeting with hospice for any resident receiving that service.	F 309	F 312 All residents who are unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene including residents #15, #21 & #18. This will be evidenced by nursing staff assisting residents with food preparation, cuing, and set up as needed and indicated in their POC. Kitchen staff will not serve until nursing staff are available in the dining room to assist the residents. The residents will be assisted within 5 minutes of being served their meals. This includes food preparation, cuing and assistance with feeding. All staff will be inserviced on providing assistance as needed to all residents in a timely manner during meal times. It will be monitored by the charge nurse and DON daily. A quality indicator has been developed for monthly monitoring and quarterly reporting at the QI meeting.	8/30/11
F 312 SS=D	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: Based on observation, medical record review and staff and resident interview, the facility failed to provide dining assistance in a timely manner for 2 of 6 sample residents (#15, #21) and 1 non-sample resident (#18) who required assistance. The findings were: Refer to F241 for information regarding staff's failure to provide dining assist in a timely manner for residents #15, #18 and #21.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315		

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F 315	Continued From page 18 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview; the facility failed to ensure 1 of 6 sample residents (#27) reviewed for incontinence received the necessary treatment and services to promote dryness and prevent urinary incontinence. The findings were: Observation showed resident #27 was not toileted or checked for incontinence from 7:40 AM through 11 AM on 7/12/11. At 10:15 AM that day, CNAs #7 and #4 stated they had changed the resident's incontinence brief before breakfast (before 7:40 AM) but had not provided any care since that time. They stated the resident had a shower scheduled that day and would be gotten up and changed then. At 11 AM the resident was awakened and taken into the bathing area. CNAs #1 and #6 stated the resident was incontinent when they got him/her up. According to the "CNA ADL Reference Sheet", the resident's toileting schedule was every two hours and PRN. Underneath that schedule, those instructions were defined as,"Upon rising, before & after meals, HS [bedtime], & as needed." Per the 8/1/11 care plan, staff were to assist the resident to the bathroom instead of just checking and changing the disposable brief.	F 315	F315 All residents with scheduled toileting plans including resident #27 will be toileted as per their plan of care to promote dryness and prevent incontinence. All staff will be inserviced on the importance of incontinence care and following the plan of care. This will be monitored by the charge nurses and DON. A quality indicator has been developed for monthly monitoring and quarterly reporting at the QI meeting.	8/30/11

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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: Based on observation, medical record review, staff interview, and review of manufacturer's instructions, the facility failed to maintain a medication error rate under 5 percent (%). Out of 48 opportunities for errors, 6 errors were committed, resulting in an error rate of 12.5%. The residents affected by the errors were sample resident #19 and non-sample residents #7 and #13. The findings were: 1. Observation on 7/12/11 showed RN #3 crushed two medications and mixed them with an individual serving of ice cream. The RN also added liquid potassium chloride to a cup containing a small amount of juice. At 9:25 AM the RN handed the ice cream containing the crushed medications and the cup of juice mixed with potassium chloride to resident #19. The resident set the cup of potassium and juice on the arm of the recliner in which s/he was sitting and started to eat the ice cream. The RN left at 9:31 AM and returned at 9:36 AM. During that interval, the resident never touched the juice/potassium mixture, stopped eating the ice cream, and set it beside the cup containing potassium and juice. Upon returning, the RN picked up and discarded both containers without speaking to the resident or encouraging him/her to consume either medication. Review of 1/20/11 laboratory test	F 332	F 332 The facility will be free of medication error rates of 5% or greater. This includes resident #19, #7, #13. This will be evidencedby:AllNurses assisting/monitoring/encouraging all residents who have been deemed incompetent to self consume medications in taking their medications in a safe timely manner including resident #19. When the medication is mixed in a food product the resident will be monitored within the nurses line of vision until the medication is consumed or discarded. If the resident does not consume the medication, the nurse will dispose of it and document in the clinical record accordingly. All nurses will ensure that residents taking multiple inhaled medications including resident #13, will wait at least 1 minute between all inhalations. All nurses administering Miralax will make sure it is mixed with 8 ounces of water or juice. 8 ounce blue glasses have been purchased for nursing to utilize specifically for Miralax administration. All nurses RN and LPN will be in-serviced on medication error prevention. Medication pass will be monitored	

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F 332	Continued From page 20 results showed the resident's potassium level was low. On 7/13/11 at 2:30 PM the DON confirmed the RN should have attempted to get the resident to take the medications. Three errors occurred with this medication pass. 2. On 7/12/11 at 9:09 AM RN #3 was observed to hand resident #13 two medications to inhale. The resident inhaled Advair correctly then, without waiting, picked up the next container and inhaled a dose of Albuterol. Ten seconds later, the resident repeated a second inhalation of Albuterol. The RN watched the resident without instructing him/her to wait at least a minute between the two medications or between the two inhalations of Albuterol. On 7/13/11 at 2:30 PM, the DON acknowledged that the RN should have instructed the resident to wait between all inhalations. She also stated the facility did not have any evidence the resident was previously taught this but was noncompliant with the instructions. According to the manufacturer's instructions, one should wait a minute between inhalations of Albuterol and shake the inhaler again. Furthermore, the instructions for Advair were to rinse the mouth out thoroughly after inhaling the medication. Two timing errors occurred with these medications. 3. Observation on 7/12/11 at 8:07 AM showed LPN #2 handed resident #7 a cup with Miralax mixed with four ounces of water. Reconciliation of the medication pass with the July 2011 recapitulation of orders showed the physician ordered eight ounces of water to be mixed with the medication. Review of the July 2011 MAR showed specific instructions to mix the medication with eight ounces of water. Interview	F 332	weekly by the DON for accuracy/reporting. A quality indicator has been developed for monthly monitoring for quarterly reporting at QI meeting.	8/30/11

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F 332	Continued From page 21 with the LPN immediately after the medication pass confirmed the cup did not contain eight ounces of water. One error occurred with this medication pass.	F 332	F 371 The facility will ensure that all drink preparations in the facility will be performed in a sanitary manner. This will be evidenced by: 2-5 gallon water coolers being purchased, dietary will fill one in the morning utilizing their food preparation sink and a clean dispensing area has been determined in LTC unit for proper dispensing of water. In the late afternoon or when needed the coolers will be changed out, sanitized and refilled by kitchen staff. Nursing staff will wear gloves when preparing the water glasses for the residents and have been in serviced on cross contamination and maintain sanitary conditions. This will be monitored daily by the nursing staff to ensure sanitation is maintained. All nursing staff have been in serviced on proper dispensing of drinking water and no drink preparation from the sink at the nurses station. It is for hand washing only. A quality indicator has been developed for monthly monitoring and quarterly reporting at the QI meeting. The cooling paddle will be stored on the designated wire rack when not in use. The juice dispenser will be cleaned and the catch pan emptied after every meal and as needed.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to ensure drink preparation was performed in a sanitary manner for 1 of 1 observations. The facility further failed to clean and maintain the juice dispenser and properly store the rapid cooling paddle. The findings were: 1. CNA #7 was observed on 7/12/11 from 10:35 to 10:57 AM preparing ice water for distribution to resident rooms. During the 22 minute observation, the CNA repeatedly touched contaminated surfaces while filling plastic cups from the faucet at a hand washing sink. Twice during the observation period, other staff interrupted the CNA's routine to use the same sink to wash their hands. The CNA was further observed to use her dirty hands to press lids onto	F 371		

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F 371	Continued From page 22 cups, unwrap drinking straws from their paper cover, and insert the straws into drinking cups with hands and fingers contacting the drinking surface of the straw. The CNA wore a single pair of gloves throughout the observation and did not change gloves or perform hand hygiene. The DON acknowledged in interview on 7/14/11 at 11:25 AM that the CNA's practice failed to meet her expectation for sanitation. In an interview on 7/13/11 at 3:10 PM, the dietary manager stated the observation did not represent acceptable practice for preparing food or drink. 2. The initial tour of the kitchen was performed on 7/11/11 at 1:55 PM. On tour, a rapid cooling paddle was observed on the floor of the walk-in freezer. A subsequent observation and interview with the dietary manager on 7/25/11 at 2:10 PM revealed the paddle was placed into large containers of hot foods, such as soup, to facilitate cooling. The dietary manager stated the cooling paddle should not be on the floor; her expectation was that it be stored on a wire shelf. 3. On 7/11/11 at 2:25 PM a juice dispenser was observed in the kitchen. The drip tray on the dispenser was approximately half full and 2 of the 4 juice nozzles were seen leaking into the tray. There was further evidence of juice splatter on vertical surfaces of the dispenser, leaving a sticky residue. Repeat observations on 7/12/11 at 11:20 AM showed dried juice residue remained on the front of the dispenser. The dietary manager stated in interview on 7/13/11 at 1:20 PM that she was aware the juice dispenser leaked into the drip tray and had directed her staff to put the tray through he dishwasher every night. She further stated her	F 371	The proper storage of the cooling paddle and cleaning of the dietary equipment will be monitored for compliance by a daily checklist. This will be monitored and reported on by the Certified Dietary Manager through the QI process to assure ongoing compliance. The RD will also review the daily checklist and compliance bi-monthly addressing any concerns that arise. Dietary Staff will be educated by the Certified Dietary Manager with assistance from the Registered Dietitian through an in service on sanitation. This education will include appropriate use of gloves and hand washing, the proper use and storage of the cooling paddle, proper cleaning of equipment including the juice dispenser, and work order completion. A quality indicator has been developed for monthly monitoring for quarterly reporting at the QI meeting.	8/30/11

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F 371	Continued From page 23 expectation that the dispenser be cleaned each day of use or more frequently if needed.	F 371		
F 428 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and interview with the consulting pharmacist, the facility failed to ensure the monthly medication regimen reviews (MRRs) for 2 of 10 sample residents (#2, #28) identified potential irregularities. The findings were: 1. Review of the medical record for resident #2 revealed antibiotic therapy was ordered in January, February, March, April, May, June, and July 2011 for upper respiratory or recurrent urinary tract infections. This review showed the antibiotics that were ordered during that time included the following: Macrobid, Vancomycin, Keflex, Ceftin, Doxycycline, trimethoprim and Cipro. This review also showed there were periods when the resident received more than one antibiotic at the same time. Review of the monthly pharmacy reviews showed "no	F 428		

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	535029	A. BUILDING _____ B. WING _____ 8/22/11	07/14/2011

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 428	Continued From page 24 irregularities" were noted by the pharmacist for February, March, May, and June 2011. Pharmacy reviews for January and April 2011 were not done. In interview on 7/20/11 at 3:49 PM, the pharmacist acknowledged she had failed to review the antibiotic therapies for interactions and potential adverse reactions. She also stated she had not reviewed the corresponding laboratory tests that identified antibiotic sensitivities. 2. Review of the admission face sheet showed resident #28 was admitted on 5/5/11. Review of the May 2011 MRR showed it was initialed by the pharmacist on 5/31/11. However, the pharmacist had written "Incomplete" on the form and failed to determine if irregularities were present. After reviewing the record on 7/13/11 at 1:40 PM, the DON confirmed the MRR was incomplete. She stated the resident took "over twenty" different medications (including Ativan, Trazodone, Haldol, and Klonopin) at home and was "oversedated" at the time of admission. The DON also stated the physician discontinued several of the medications. Despite the number of, and changes in, medications, the MRR was not conducted until 26 days after admission. On 7/20/11 at 3:49 PM, the pharmacist stated the reason she wrote "Incomplete" on the MRR form was that not all of the resident's paperwork was available. She confirmed she had not performed a complete review of the resident's medications. She further stated she conducted the monthly MRRs at the end of each month but was not informed when residents were admitted to the facility.	F 428	F 428 The facility in conjunction with the pharmacist will ensure that all medication irregularities on all residents including those on residents #2 and #28 will be reported. The DON will monitor monthly pharmacy reviews with the pharmacist. The monthly reviews will be checked by the DON within 3 days of completion by the pharmacist. A copy of noted irregularities will be forwarded to the physician for notification and noted on the original pharmacy review form. The pharmacist will be notified of any new resident admitted to the LTC unit by the charge nurse or DON. A copy of the orders will be faxed to the pharmacist along with a current H&P to include all medications. A quality indicator has been developed for monthly monitoring and quarterly reporting at QI meeting.	8/30/11
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 26 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 - (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:	F 441	F 441 The facility will ensure that acceptable infection control practices will be maintained on all residents including resident #27, 14, 24,. This will be evidenced by all nursing staff being in serviced on hand hygiene, the need to change gloves every time clean gloves become contaminated (dirty) and perform appropriate hand hygiene. Barriers will be utilized for all dressing changes. A sterile drape will be utilized on the surface before dressing supplies are prepared to prevent contamination. Hand hygiene has been reviewed with all staff to make sure when gloves are contaminated they are changed immediately and the appropriate hand hygiene performed immediately and surfaces disinfected as indicated to prevent the spread of infection. This includes during medication pass and ice water preparation. A daily surveillance has been implemented to monitor hand hygiene. The procedure for proper use of PPE has been reviewed and PPE needed for specific types of isolation , all appropriate PPE will be utilized when entering an isolation room. The shelf in the shower room has been raised so towels are no longer contaminated from touching the floor. When we have a resident on dressing changes or isolation the charge nurse, DON, and IDT will monitor daily for compliance.	

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F 441	Continued From page 26 Based on observation, staff interview, and nationally recognized standards for infection control activities, the facility failed to ensure acceptable hand hygiene practices for 2 of 3 observations of wound care, 1 of 3 staff administering medications, and 1 of 1 observations of staff preparing drinking water for residents. Staff also failed to use personal protective equipment (PPE) on 1 of 4 occasions when entering a resident room with posted infection control precautions requiring the use of PPE. In addition, staff failed to maintain clean linens to prevent contamination in 1 of 1 shower rooms. The findings were: a. With regard to hand hygiene: 1. Observation on 7/12/11 at 9:45 AM showed RN #3 prepared to change a dressing on resident #27's left arm. Without cleaning the bedside table or establishing an aseptic field, the RN placed a tube of ointment, the wound dressing, and an applicator (long stick tipped with cotton) directly onto the resident's bedside table. The ointment and dressing were in sterile packages, but the applicator had been removed from its package and was placed directly on the high-touch and potentially contaminated surface. After removing the old dressing from the resident's arm, the RN used the contaminated applicator to apply ointment to the resident's wound. The RN was not observed to clean or disinfect the bedside table before leaving the resident's room. 2. On 7/12/11 RN #3 was observed completing a dressing change for resident #14 at 10 AM. The resident had recently undergone an amputation for osteomyelitis (infection in a bone).	F 441	A quality indicator has been developed for monthly monitoring and quarterly reporting at the QI meeting.	8/30/11

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F 441	Continued From page 27 After donning non-sterile gloves, the RN removed the old dressing, then, while wearing the gloves, moved the trash can closer to the resident. Without changing gloves, the RN picked up the spray can of wound cleanser and cleansed the entire area with normal saline soaked gauze. He then handled the opened dry dressing before passing it to LPN #2 to complete the dressing change. 3. While preparing medication for resident #24 on 7/13/11, RN #6 was observed to drop the lid from an individual dose medication container ("blister pack") onto the floor at 8:50 AM. The RN retrieved the lid from the floor and, without performing hand hygiene, continued to prepare medications; she administered them to the resident at 8:55 AM. When administering the medications at 9:55 that morning, the RN donned gloves and placed each pill into the resident's mouth, touching the resident's lips and tongue in the process. While wearing these same gloves, the RN returned to the medication cart and reviewed the MAR to determine if eye drops should also be administered. During this process, the RN touched the top of the medication cart, the cover of the MAR, and several pages in the MAR before arriving at the correct location. The RN was not observed to perform hand hygiene or clean the items she touched on the medication cart or the MAR. 4. Observation on 7/12/11 at 10:35 AM revealed an absence of hand hygiene by CNA #7 while preparing ice water for residents (refer to F371 for details). Reference: The Centers for Disease Control & Prevention	F 441		

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F 441	Continued From page 28 (CDC) Guideline for Hand Hygiene in Health-Care Settings, published in Mortality & Morbidity Weekly Report, RR-16, October 25, 2002, pp 32-33, strongly recommends healthcare workers perform hand hygiene after contact with patients [residents], after contacting environmental surfaces in the vicinity of the patient, before and after potential contact with non-intact skin [such as a wound], and after removing gloves. Reference: Facility policy #IC017, Infection Control Hand Washing and Hygiene, revision signed 11/9/10, was reviewed on 7/12/11 at 11:15 AM. The facility's policy reiterated the CDC recommendations for hand hygiene and required staff compliance to the recommended practices. b. With regard to PPE use: Observation on 7/12/11 at 7:45 AM revealed a sign posted on resident #2's door that instructed all who entered to use PPE, located outside the room, prior to close contact with the resident. Observation on 7/12/11 at 8:06 AM revealed the social services director entered the resident's room and talked with the resident for eight minutes without donning PPE. Interview with the social services director on 7/14/11 at 1:55 PM revealed she wasn't aware of the posted sign. c. With regard to linens: A plastic shelving unit holding bath towels was observed during the initial tour of the shower room on 7/11/11 at 4:05 PM. The lowest shelf sat directly on the floor and held 6 bath towels at the initial observation. Subsequent observations	F 441		

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F 441	Continued From page 29 revealed the practice of storing towels on the lowest shelf continued on 7/12/11 and 7/13/11. On 7/12/11 at 11:38 AM, housekeeper #8 was observed cleaning the shower room. She mopped the floor around the shelves, a process that brought the mop head into contact with the bath towels on the lowest shelf. The maintenance director (also housekeeping supervisor) was shown the linen storage area in the shower room on 7/13/11 at 10:25 AM. He stated at that time that storing clean towels on the lowest shelf would not effectively prevent them from inadvertent contamination by the housekeeping staff. He further stated the storage shelf should not be sitting directly on the floor, but should be elevated several inches above the floor surface. Interview with the infection control nurse on 7/13/11 at 2:05 PM confirmed the bath linens should be stored above floor-level to prevent contamination when the shower floor was cleaned. Reference: The Centers for Disease Control & Prevention (CDC) Guideline for Hand Hygiene in Health-Care Settings, published in Mortality & Morbidity Weekly Report, RR-16, October 25, 2002, pp 32-33, strongly recommends healthcare workers perform hand hygiene after contact with patients [residents], after contacting environmental surfaces in the vicinity of the patient, before and after potential contact with non-intact skin [such as a wound], and after removing gloves. Reference: Facility policy #IC017, Infection Control Hand Washing and Hygiene, revision signed 11/9/10,	F 441		

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F 441	Continued From page 30 was reviewed on 7/12/11 at 11:16 AM. The facility's policy reiterated the CDC recommendations for hand hygiene and required staff compliance to the recommended practices.	F 441		
F 514 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure clinical records were complete and accurate for 2 of 9 sample residents (#19, #28). The findings were: 1. Review of the physician's orders for resident #19 revealed an order for a laboratory test to be done on 6/7/11. Clarification of the order was written on 6/9/11. Review of the medical record failed to show evidence that the test was done or information regarding why it wasn't done. Interview with the DON on 7/13/11 at 4:15 PM revealed the resident physically refused to allow the blood to be drawn; there was a discussion	F 514		

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F 514	Continued From page 31 with the family about not doing the test, and the physician was notified. The DON also verified that this information was not documented in the clinical record, but she stated it should have been. Review of the medical record showed resident #28 was admitted on 6/5/11. Further review failed to show evidence that a physician reviewed the resident's total program of care as required per regulation. On 7/14/11 the DON produced notes from the physician dated 6/8/11. At noon that day, the DON stated the notes were found in the Health Information Management office; she confirmed they had not been filed in the resident's clinical record.	F 514	F 514 All residents clinical records will have complete and accurate information including residents #19 and #28. This will be evidenced by all nurses being inserviced on complete and accurate charting. A charting competency has been developed for documentation. Medical Records will ensure all physician visit notes are sent to LTC 24 hours after dictation. This will be monitored by the charge nurse, DON, and medical records weekly.	
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	F 520	A quality indicator has been developed for monthly monitoring for quarterly reporting at the QI meeting.	8/30/11

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F 520	Continued From page 32 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 staff interview and review of the Quality Assurance (QA) program, the facility failed to maintain an effective QA program capable of identifying, evaluating, and resolving deficient practice issues. In addition, the facility failed to demonstrate sustainability of past actions implemented to resolve prior deficiencies. Finally, the facility failed to ensure the QA committee included a designated physician who attended all quarterly meetings. The findings were: The QA program was reviewed with the coordinator on 7/14/11 at 8:35 AM. Many of the projects showed no evidence indicators were clearly defined or that a goal (benchmark) had been established. In addition, the manner in which results were determined and reported was inconsistent. Furthermore, there was no evidence results had been evaluated and action plans revised and implemented for those projects showing poor results. Finally, evidence was lacking that the committee was actually involved in selecting projects, evaluating the results of a plan of action, and revising that plan if necessary. The minutes indicated that each department manager decided what to do and how to do it without oversight from the QA committee. The QA coordinator stated the committee met monthly but identified the quarterly meetings as those held	F 520		

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

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CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	718 OAK STREET SUNDANCE, WY 82729

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F 520	Continued From page 33 in February, May, August, and November. Review of the minutes revealed the designated physician was not in attendance for the quarterly meetings in 2011. After reviewing the attendance list, the QA coordinator confirmed the absence of the physician. Failure to identify quality of care deficiencies prior to the survey were noted as follows: a. Refer to F309 for details related to hospice services. This deficiency was cited in two of the last 4 (2/4) surveys. b. Refer to F312 for information related to lack of appropriate assistance with ADLs. This deficiency was cited in the Federal survey in 2010. c. Refer to F315 for detailed information related to urinary incontinence. d. Refer to F332 for information related to medication errors, cited in 2/4 previous surveys. Deficiencies demonstrating lack of sustained QA resolutions and monitoring included the following: a. F226, cited in the 2010 Federal survey. b. F241, cited in the 2010 Federal survey. c. F272, cited in 4/4 of the last surveys. d. F274, cited in the 2010 State and Federal surveys. e. F278, cited in the 2010 State and Federal surveys. f. F279, cited in 2/4 of the last surveys. g. F281, cited in 3/4 of the previous surveys and in the 2010 Federal survey. h. F371, cited in the 2010 Federal survey. i. F428, cited in 4/4 of the last surveys. j. F441, cited in 3/4 of the previous surveys and in the 2010 Federal survey. k. F514, cited in the 2010 Federal survey.	F 520 F 520	The facility will meet this requirement by the DON, a physician and three other staff members attending quarterly QI meeting. The Long Term Care Unit will be conducting daily tracking for weekly review of QI at the IDT meeting to assure the appropriate implementation and monitoring is being done for Tags F176, F225, F241, F272, F274, F278, F279, F281, F309, F312, F315, F332, F371, F428, F441, F514, F520. The plan will be revised as needed with continued monitoring by the IDT members. The committee will consist of the DON, Social Services Director, Dietary Manager, Activities Director, MDS RN and Restorative Aide when available. All QI will be monitored monthly for quarterly reporting to the QI committee. To be forwarded to the Board of Directors quarterly. The Physician will be at the August 24, 2011 meeting and again at the September 2011 meeting to put physician monitoring back on the quarterly rotation.	8/30/11

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F 520	Continued From page 34 I. F620, cited in 2/4 of the last surveys and in the 2010 Federal survey.	F 520		