Reviewed & approved w changes on pages 3 to 10, 12 & 13. All changes were made over phone per permission of WHITSON. 11/2/05 10PM Linda Brown RN

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

PRINTED: 10/05/2005
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
	535038	A. BUILDING _____ B. WING _____	09/22/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 167 SS=B	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on staff interview and document review, the facility failed to ensure 3 of 3 survey results were posted for public review. The findings were: During facility tour on 9/20/05 at 11 AM, review of posted survey results revealed the complaint surveys dated 03/02/05, 05/06/05, and 8/15/05 were not available for public review. Interview with a registered nurse on 9/20/05 at 3 PM revealed she was not aware of the complaint survey results. Tour on 9/22/05 at 9 AM revealed the surveys still were not available. Interview with the general manager on 9/22/05 at 5 PM revealed he was unaware complaint survey results were to be available for public review.	F 167	F167 A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This will be accomplished by: 1. Survey results date 03/02/05, 05/06/05 and 08/15/05 have been placed properly in a convenient location where residents and have access to read all survey results, 2, A notice has been posted telling of their availability to all interested parties. 3. This will be monitored by the general manager. 4. All steps will be monitored by the QA committee.	10/13/05 10/13/05 10/13/05 10/13/05
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Roland Peek
TITLE: General Manager
(X6) DATE: 10-14-05

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.

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 _____	09/22/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 248	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, resident, and staff interview the facility failed to offer scheduled and meaningful activities on one of two living units, and failed to provide a variety of activities on Sundays to meet all resident's interests. The findings were: 1. The following concerns were noted concerning activities in the special care unit (SCU) on 9/21/05 between 12:40 PM and 2:40 PM: a. Observation revealed three residents (#38, #24, #16) were seated at the table in the day room, CNA #5 did not offer or engage the residents in any activity throughout the entire observation. b. Review of the September 2005 activity unit calendar showed that an activity titled ball toss was scheduled at 1:30 PM. This activity was not offered to any residents in the SCU. c. At 1:50 PM in the SCU an announcement was heard over the loud speaker saying an activity titled grandma's apple pie was starting. No offer was made to any residents in the SCU to participate in this activity. Interview with the quality of life coordinator on 9/22/05 at 9:15 AM confirmed that all scheduled activities should be offered. She further stated she expected that games, activity boxes, and movies would be offered to provide meaningful activity for residents in the SCU.	F 248	F248 The facility will ensure that an ongoing program of activities that meet the interests and physical, mental and psychosocial well-being of the residents. This will be accomplished by: 1. The Activity Director will in-service nursing, activity and restorative staff on the activity program and their level of involvement in the programs that are scheduled for all residents including but not limited to #38, #24 and #16. They will also be in-serviced on the leisure material available in the unit to help nursing staff assist with residents' leisure time. 2. Activities will be offered in the secured unit that will fill their time and address their needs. These activities will give attention to the special need of those that can't leave the secured unit. 3. Resident's concern about Sunday's activities will be addressed in the next activity planning meeting on October 17th, 2005 at 11:15 a.m. At this time activity has schedule two chef's breakfast one of which took place on October 2nd and one that will take place on October 16th. Residents #11, #30, #33, #28, #7, #3 and #10 will be asked and given the opportunity for their ideas for Sunday activities in future	10/14/05 10/14/05 10/17/05

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 _____	09/22/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 248	Continued From page 2 2. The following concerns were noted concerning Sunday activities: a. Review of the September 2005 activity calendars revealed that on Sundays only two activities were scheduled: 10 AM movie time, and 4:30 PM Latter Day Saints (LDS) service (a denominational church service). b. Resident interviews on 9/21/05 at 10 AM revealed 7 (#11, #30, #33, #28, #7, #3, #10) out of 7 residents wanted more activities offered on Sundays. Three of the seven expressed that Sunday church services for resident's who were not members of the LDS church should be offered. Interview with the quality of life coordinator on 9/22/05 at 9:15 AM revealed she was aware that residents wanted more Sunday activities because, "it came out of the last resident council meeting."	F 248	planning. 4. From November forward activity schedule will include Sunday activity as residents plan for them in activity planning. 5. Will be monitored by QA. 6. Bible study for Lutheran provided Mondays @ 10:30. Catholic church provides communion every week. another Lutheran church provides services on Sunday but somewhat sporadically. Are continuing to work on getting more denominations involved.	11/01/05
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure tub cleaning was performed to ensure prevention of infection during one of one observations of tub cleaning. The findings were:	F 253	F253 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. This will be accomplished by: 1. The DON in serviced all staff on the policy and procedure for proper and appropriate cleaning of the bath tub. 2. The DON will do random checks with the staff on cleaning of the tub to ensure compliance. 3. DON will present results of the audits to QA Committee for ongoing compliance.	10/14/05 10/14/05 10/14/05

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 _____	09/22/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 253	Continued From page 3 1. Observation of tub cleaning on 9/20/05 at 7:20 AM revealed CNA #4 sprayed the bathtub with 1/2 strength bleach and water. She scrubbed and rinsed the tub two minutes later. She then began filling the tub for resident #31 who was next on the bath schedule. 2. Review of the facility's policy and procedure on bath tub cleaning revealed "the 1/2 strength bleach and water or HDQ will be allowed to stand at least 10 minutes. Once the 1/2 strength bleach and water or HDQ has stood for 10 minutes the bath tub will be scrubbed down. [The] bathtub will then be rinsed out." 3. Interview with the infection control nurse on 9/22/05 at 11 AM revealed staff were expected to follow infection control policies and procedures and that the CNA should have waited 10 minutes prior to scrubbing and rinsing the tub.	F 253		
F 272 SS=D	483.20, 483.20(b) 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 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;	F 272		

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 _____	09/22/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSO 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 272	Continued From page 4 Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to perform a comprehensive assessment for 2 (#39, #32) of 11 sample residents who required further review of nutritional status. The findings were: 1. Review of section V of the 8/1/05 significant change Minimum Data Set (MDS) assessment for resident #32 showed that nutritional status was a problem area that required comprehensive assessment. A RAP (resident assessment protocol) module was identified as the assessment documentation. Review of the medical record revealed there was no evidence the nutritional status RAP module or any nutritional status assessment was performed.	F 272	F272 The facility will ensure that a comprehensive, accurate standardized reproducible assessment of each residents' functional capacity. This will be accomplished by: 1. The facility will ensure that a comprehensive assessment of a resident within 14 days of admission using the RAI specified by the state. 2. The DON held an in-service to the team on completion of the comprehensive assessment; instructed on all parts of MDS, RAPS and care plans, timeliness and completions dates. 3. Residents #39 and #32 have nutritional RAPs completed and placed in chart. 4. The DON and MDS Coordinator will do random chart audits quarterly for completion of all parts of comprehensive assessments. 5. Results of these audits will be reviewed quarterly by the QA Committee meeting to ensure compliance.	10/14/05 10/10/05 10/14/05 10/14/05 10/14/05

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 _____	09/22/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 272	Continued From page 5 2. Review of section V of the 4/9/05 annual MDS assessment for resident #39 revealed nutritional status was a problem area that required comprehensive assessment. However, the column for location and date of the RAP assessment documentation was blank. Review of the entire medical record revealed there was no nutritional status assessment completed. Interview with the director of nursing on 9/22/05 at 11:35 AM revealed nutritional status assessments should have been done. Further, she was unable to find a documented assessment for either resident.	F 272		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an 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:	F 315		

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 _____	09/22/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 315	Continued From page 6 Based on observation, staff interview, and medical record review, the facility failed to provide care to minimize infection risk for one (#9) of two sample and one (#30) non-sample residents who had a urinary catheter. The findings were: 1. Observation of resident #9 on 9/20/05 at 6:40 AM revealed he/she required the assistance of two certified nurse aides (CNAs) for transfer from the bed to the wheelchair utilizing a mechanical lift. The observation revealed the resident had an indwelling urinary catheter. During the observation, CNA #3 placed the catheter bag above the resident's bladder on the resident's abdomen during the transfer. Observation revealed urine flowed back into the bladder. 2. Observation on 9/20/05 at 7:17 AM revealed certified nurse aide (CNA) #2 and #3 transferred non sample resident #30 with a mechanical lift from bed into his/her wheelchair. During this transfer, CNA #2 placed the catheter bag on the resident's upper thighs near the stomach. Further observation revealed urine flowed back up the tubing to the resident. 3. Interview with the director of nursing on 9/22/05 at 4:50 PM revealed that when handling a catheter bag, it should not be placed where urine can flow back up the tubing. 4. Review of the facility's reference regarding catheter care entitled "Skills and Techniques for The New Nursing Assistant Textbook", 7th edition by Gillogly and Conley, copyright 2004, revealed the following information. "To keep a free-flowing system going, the catheter drainage tubing and collection bag or container must be properly placed. The collection bag or container must	F 315	F315 The facility must ensure that a resident who enters the facility who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal function as possible. This will be accomplished by: 1. Residents #9, and #30 wil be observed for signs and symptoms of UTI and treat as needed. 2. The DON in-serviced all nursing staff on appropriate foley catheter care when transferring a resident with a hoyer to wheelchair. They were instructed that the catheter must always be lower than the bladder to prevent infection. 3. The Quality Care Manager and the RN staff trainer/infection control nurse/MDS Coordinator will do random monitoring with CNA's on appropriate care of residents with foley catheters. 4. Mentoring program will be provided for all new CAN's for appropriate techniques of foley catheter care. 5. All steps will be monitored by QA quarterly for ongoing compliance.	10/11/05 10/14/05 10/14/05 10/14/05 10/14/05

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 _____	09/22/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 315	Continued From page 7 always be below the level of the bladder to allow the urine to drain. ..... Germs and bacteria grow very quickly in urine. If urine is allowed to pool or if the collection container is above the level of the bladder, these germs and bacteria can travel back into the body to cause illness."	F 315		
F 371 SS=F	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must 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 facility policies and procedures, the facility failed to assure expired nutritional beverages were not available to give to residents. In addition, the facility failed to assure eaten food items and dirty dishes were not stored with clean dishes. The census was 47. The findings were: 1. Observation of the pantry of the nursing unit on 9/22/05 at 10:30 AM revealed the following concerns: a. There was one can of Ensure Plus that had an expiration date of 11/1/04. b. There were five cans of Magnacal Renal drinks that had an expiration date of 6/1/05. c. There were two cans of choice dm nutritional beverages with an expiration date of 11/1/04, and one additional can with an expiration date of 6/1/05. 2. Interview with licensed practical nurse #1 on 9/22/05 at 1:15 AM revealed she was unaware of the expired drinks in the cupboard and that they	F 371	F371 The facility will ensure policies and procedures are followed on expired nutritional beverages and not given to residents. Also eaten food items and dirty dishes are taken care of properly. This will be accomplished by: 1. All employees will be in-serviced on proper rotation and throwing away of out dated items. — 10/14/05 2. All drinks held in the fridge at the nursing area will be checked daily by nurses handing the drinks out to residents to ensure no resident gets and expired drink. — 10/14/05 3. All drinks have been checked and disposed of with expired dates. — 10/14/05 4. Drinks will be checked weekly for expired dates. — 10/14/05 5. An in-service will be done by DON to all staff to educate each employee as to the many concerns this inappropriate action causes residents. — 10/14/05 6. A training class for CNA's working the SCU to how proper technique for handling return trays with dirty items on them and placed on the return cart to go back to the kitchen. — 10/14/05 7. This will be monitored by the QA Committee. — 10/14/05	

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 _____	09/22/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 371	Continued From page 8 should have been discarded. 3. Observation in the special care unit dining room on 9/20/05 at 12:10 PM revealed CNA #5 placed a tray of dirty dishes with partially eaten food on them into a dietary cart containing a clean tray of cups. Observation revealed after placing the tray of dirty items above the clean items, she took the tray with clean cups and placed them in the special care unit cupboard for resident use. Interview with the infection control nurse on 9/22/06 at 1 PM revealed trays of dirty dishes and partially eaten food items should not be placed on a clean dietary cart.	F 371		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure that 1 (#6) of 11 sample residents was seen by a physician as required. The findings were: Review of the medical record revealed resident #6 was re-admitted to the facility on 3/13/05. According to the doctor's progress notes the resident was seen on: 3/30/05, 4/5/05, 4/29/05	F 387	F387 Residents must be seen by a physician 30 days after admission and at least every 60 days thereafter. This will be accomplished by: 1. Residents #6 and all residents will received physician services as required and needed. Medical records and DON will monitor. — 10/14/05 2. A letter will be drafted and sent to all physicians by General Manager to address timeliness of physician visits. Residents will be taken to physician office for appointments as needed by the RTA staff. — 10/14/05 3. Medical records will audit charts monthly and report to General Manager or DON. Physican will be notified of needed visits by medical records. — 10/14/05 4. Audits will be reviewed at least quarterly by QA Committee to ensure ongoing compliance. — 10/14/05	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	09/22/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 387	Continued From page 9 and on 9/15/05. There were no physician visits documented between 4/29/05 and 9/15/05. Interview with the director of nursing on 9/22/05 at 11:35 AM confirmed there was no additional documentation of physician visits for this resident.	F 387		
F 426 SS=E	483.60(a) PHARMACY SERVICES - PROCEDURES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policies and procedures, the facility failed to assure expired medications were not available to administer to residents. The census was 47. The findings were: 1. Observation of the medication storage room and refrigerator on 9/22/05 at 10 AM revealed the following concerns: a. Accuzyme (debriding ointment) ointment for resident #4 had an expiration date of 8/13/05. b. Promethazine (antihistamine) 50 milligrams (mg) 10 ampules for resident 26 had an expiration date of 7/16/05. c. Five prochlorperazine (antipsychotic, antiemetic) 25 mg suppositories for a resident who no longer resided in the facility had an expiration date of 9/17/05. An additional box with two suppositories had an expiration date of	F 426	F426 A facility must provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing and administrering of all drugs and biologicals to meet the needs of each resident. This will be accomplished by: 1. The medication room will be checks weekly for outdates by Don or designee for compliance. 10/14/05 2. The DON held an in-service on Policy and Procedure on expired medications open or unsealed and discontinued medications to dispose of or return to pharmacy. 10/14/05 3. The in-service was held to all nursing staff on proper disposal of outdated medications. 10/14/05 4. DON and General Manager will do weekly checks to ensure compliance. 10/14/05 5, Facility policy will be covered in in-service for all staff members awareness of this area of concern. 10/14/05 6. Will be monitored quarterly by QA Committee. 10/14/05 7. all expired meds were disposed of at the time of the survey LB per DON 11/2/05 10 AM	

LB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	09/22/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 426	Continued From page 10 9/15/05. d. One bag of intravenous solution with vancomycin (antibiotic)1.5 Gram for a resident who no longer resided in the facility had an expiration date of 9/5/05. e. One vial of pneumovax vaccine had an expiration date of 12/1/04. f. One syringe of hepatitis vaccine had an expiration date of 9/25/04. g. Two opened and three unopened vials of influenza virus vaccine had an expiration date of 12/1/04. h. Two one pint bottles of Enulose (laxative) had an expiration dated of 7/6/05. 3. Interview with the director of central supply during the observation revealed these expired items should have been discarded. 4. Interview with the director of nursing on 9/22/05 at 1:30 PM confirmed these items should have been discarded. 5. Review of the facility policy on expired medications, undated, revealed expired medications should be discarded. Review of facility policy #8016 on pharmacy services - management of drugs dated 5/22/98 revealed "Drugs to be destroyed are those which are opened, unsealed, outdated and discontinued."	F 426		
F 454 SS=D	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.	F 454		

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 _____	09/22/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 454	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the kitchen and tub room floors and a door into the tub room were maintained. The findings were: 1. Observation on 9/20/05 at 10:20 AM and on 9/22/05 at 10:10 AM revealed a white and green build up on the floor underneath and behind the ice machine that was located in the kitchen. Additionally behind the steamer and the ovens, there were burnt crumbs of food, and a dark brown accumulation on the floor. Interview with the dietary manager on 9/21/05 at 2 PM revealed the white and green build up consisted of "hard water spots." The dietary manager stated the floor under the ice machine and behind the ovens and steamer should be cleaned monthly. However, was unaware of the last time this was done. 2. Observation of the tub room on 9/20/05 at 7:15 AM revealed 7 broken tiles underneath the bath tub. Interview with the director of maintenance on 9/22/05 at 8:15 AM revealed he was aware of the broken tiles, but was not planning to fix them until a new bath tub was installed. When asked how soon that would be, he stated he did not know. 3. Observation of the shower room on 9/20/05 at 10:30 AM revealed a washcloth wrapped around the flexible tubing of the shower wand at the outlet in the wall. Interview with certified nurse aide (CNA) #1 on 9/20/05 at 10:30 AM revealed there was a leak, and she stated that she had told maintenance "several weeks ago." During interview with the director of maintenance on 9/22/05 at 8:15 AM he stated he was unaware of	F 454	F454 The facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. This will be accomplished by: 1. Dietary staff will have a cleaning schedule for deep cleaning areas in kitchen. This will be done monthly or a needed. 2. Maintenance will replace pipe on back of steamer so that water from steamer goes down drain and not onto the floor causing lime build up. 3. The white and green build up was hard water build up that has been removed with proper cleaning techniques. 4. Dietary manager created and list and will monitor monthly. 5. Monthly findings from the monitoring will be presented to QA quarterly to ensure ongoing compliance. 6. Broken tiles will be replace. in the Tub room 7. Shower hose and wand will be replaced. in the shower room 8. All bath aides and CNA's have been informed to check commode after each resident leaves the shower room. This will ensure that each resident goes into a clean shower room. 9. Tub room will be inspected bi-monthly by Maintenance director and General Manager. Findings will be reported to QA to ensure ongoing compliance.	10/14/05 10/14/05 10/14/05 10/14/05 10/14/05 10/21/05 pen 10/21/05 10/21/05 pen 11/2/05 10/14/05 10/14/05

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 _____	09/22/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 454	Continued From page 12 the leak. 4. Observation of the shower room on 9/20/05 at 10:30 AM revealed a commode was filled with approximately 4 inches of a yellow tinged liquid. Interview with CNA #1 on 9/20/05 at 10:30 AM revealed she thought it was urine diluted with shower water. She stated the commode should have been emptied and cleaned after the resident's shower was given.	F 454		
F 502 SS=D	483.75()(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, and medical record review, the facility failed to obtain laboratory services to meet the needs of 2 (#1, #14) of 11 sample residents. The findings were: 1. Review of the September 2005 physician's orders for resident #1 revealed an order dated 8/3/04 for a thyroid panel to be performed annually. Review of the laboratory reports revealed no evidence this test was done. Interview with the director of nursing (DON) on 9/21/05 at 1:30 PM confirmed this test was not completed as ordered. 2. Review of September 2005 physician's orders for resident #14 revealed an order for vitamin B12 and folate laboratory tests to be completed annually in August. Review of the laboratory	F 502	F502 The facility must provide or obtain lab services to meet the needs of its residents. This will be accomplished by: 1. Residents #1, #14 and all residents will receive ordered lab services in a timely manner. This will be monitored by DON and Medical Records. 2. Lab tracking sheet will be developed by DON and Medical Records to insure labs ar ordered in the month they are due. Medical records will verify that all results are obtained from hospital and place in charts. 3. New admissions to facility will receive lab work as ordered. Routine non emergency labs will be drawn at the next schedule weekly lab draw. DON will monitor for compliance. 4. Lab spreadsheets will be monitored quarterly by QA Committee for ongoing compliance.	10/14/05 10/14/05 10/14/05 10/14/05

Resident #14 had B12 & folate done & results received on 9/27/05.

Resident #1 had thyroid panel done - results were received on 9/27/05

per DON 11/2/05 @ 10AM

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 _____	09/22/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 502	Continued From page 13 reports revealed no evidence these tests were done. Interview with the DON on 9/21/05 at 1:30 PM confirmed these tests were not completed as ordered.	F 502		