POC accepted 9/1/11 Janice Cordi, OHL

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

PRINTED: 08/22/2011
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
	535038	A. BUILDING _____ B. WING _____	07/14/2011

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 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: CAA- Care Area Assessment CDM- Certified Dietary Manager CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
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 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	F 279	F 279 The facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The care plan for resident #6 was revised to accurately reflect the resident's need for incontinence care related to his/her functional incontinence on 8/2/2011. A new bowel and bladder assessment was completed and the care plan for resident #8 was reviewed and revised to accurately reflect the resident's toileting schedule, the type of incontinence, and indications for use of incontinence products, including when incontinence products are needed and type of incontinence product to be used.	8/4/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 8-29-2011

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.

POC accepted - Carol & Nancy Brust, Admin. on 9/1/11

JC 9/1/11

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F 279	Continued From page 1 by: Based on medical record review, observation and staff interview, the facility failed to develop a comprehensive care plan with individualized interventions for 2 of 9 sample residents (#6, #8). The findings were: 1. Review of the admission MDS assessment dated 6/13/11 showed resident #6 was occasionally incontinent of urine. Review of the CAA showed his/her type of incontinence was functional (unable to get to the toilet in time due to physical disability, external obstacles or problems thinking or communicating). Further, it stated the resident needed assistance to the restroom and wore an incontinence pad/brief. Review of the care plan showed the approach to be used by staff for the resident's incontinence was as follows: "determine type of incontinence and place on toileting plan which best meets needs." Further, the "proper size" of incontinence pads/liners was to be placed on him/her. The care plan did not specify a toileting plan, the type of incontinence pad to be worn, or the type of incontinence the resident had. 2. Review of the admission MDS assessment dated 1/16/11 showed resident #8 was occasionally incontinent of urine. The quarterly MDS assessment dated 5/8/11 showed the resident was always continent. Observation on 7/13/11 at 10:05 AM showed the resident was wearing an incontinence pad and was incontinent of urine. Review of the CAA showed the resident was only incontinent when s/he could not get to the restroom in adequate time. S/he had functional incontinence and needed assistance using the restroom and was unable to get up by	F 279	1. When CAA is completed, the MDS Coordinator will ensure incontinence care plan includes proper toileting plan, the type of incontinence products to be used, and the type of incontinence the resident has. Assessments will continue to be completed upon admission, quarterly, and as needed. Using these assessments, the care plans will be reviewed to assure they are accurate and coincide with assessments. 2. MDS coordinator will review all incontinence care plans on quarterly review to ensure the care plans are individualized and include all aspects of a resident's incontinence care. 3. In-service will be conducted with staff members who participate in care planning process on 8/4/11 to help promote communication of resident's care plans and to ensure the CAAs and care plans reflect an accurate picture of the resident's plan of care. 4. Each resident will be reviewed at least quarterly by IDT team to ensure accuracy of care plans. Any concerns regarding care plans will be reported to the QA committee.	

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F 279	Continued From page 2 him/herself. The care plan showed the approach to be used by staff for his/her incontinence was to toilet as scheduled and as needed, incontinence care as needed and briefs/pads as needed. The care plan did not address what the toileting schedule was, the type of incontinence or the indications for the use of incontinence pads. 3. Interview with the infection control nurse and social services director on 7/14/11 at 10 AM revealed the care plans for incontinence care should be individualized.	F 279	F 318 The facility must ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and or prevent further decrease in range of motion:	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure 1 of 4 sample residents (#36) with range of motion (ROM) limitations received the care needed to prevent further decrease in range of motion. The findings were: Review of the 5/5/11 admission MDS assessment showed resident #36 had ROM impairments of the upper and lower extremities. The assessment showed these impairments affected both sides of the resident's body. Observation on 7/12/11 at	F 318	1. Resident #36 was evaluated by nursing staff on 7/13/11 and a treatment plan was started, which included placing something in his/her hand during day. 2. New doctor order received on 7/15/11 for resident #36 to have physical therapy evaluation. 3. Resident #36 received treatments in physical therapy after initial evaluation. It was determined to put him/her on a restorative program to help prevent further decline in range of motion. Restorative plan was started on 7/29/11. 4. DON will continue to evaluate once per month the appropriateness of restorative therapy services and monitor progress of the residents receiving restorative services. All residents, upon admission, will be evaluated for the potential need for a therapy evaluation and/or initiation of restorative therapy program. DON will report any concerns to the QA committee quarterly.	9/1/11

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F 318	Continued From page 3 8:06 AM showed the resident required total assistance from staff for activities of daily living (ADLs). At that time it was also noted the resident had a contracture of his/her right hand. Interview with the DON on 7/14/11 at 10:30 AM revealed the resident was not receiving any ROM services related to the contracted hand or other ROM limitations.	F 318	F 371 The facility must procure food from sources approved or considered satisfactory by Federal, State, or local authorities and must store, prepare, distribute and serve food under sanitary conditions. This will be achieved by:	
F 371 SS=F	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 and staff interview, the facility failed to ensure food equipment and ceiling vents were maintained in a clean manner. The findings were: 1. Observation on 7/11/11 at 3:25 PM revealed the two ovens in the main kitchen were not clean; there was spilled burnt food in the bottoms and on the interior walls of the ovens. There was also an accumulation of dust and grease visible on seven ceiling air vents that were all located above food preparation /service areas. In addition, there were splatters of dried batter/food on the underside of the arm of the stand mixer.	F 371	1. The two ovens in the main kitchen were cleaned on 8/1/2011 and will be added to a cleaning schedule to be cleaned once per week and as needed when items spill onto the oven. 2. The ceiling vents were cleaned with a de-greaser by the CDM on 8/1/2011. They will be added to a cleaning schedule to be cleaned once per month at a time when food is not being prepared or served. 3. The stand mixer was cleaned on 7/13/2011 to remove the dried batter/ food on the underside of the arm of the mixer. This will be cleaned after every use to ensure no food debris is left behind. 4. The CDM will discuss with dietary staff on or before 8/5/2011 the need to keep kitchen equipment cleaned and the need to follow cleaning schedules. 5. The CDM will monitor cleanliness of kitchen/kitchen equipment weekly for four weeks and dietician will continue to inspect kitchen for cleanliness once per quarter and as needed. Any concerns will be reported to QA committee.	8/1/11

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F 371	Continued From page 4 Observation on 7/13/11 at 10:20 AM revealed the equipment remained in an unclean state. Interview with the CDM on 7/13/11 at 10:30 AM verified the equipment was in need of routine cleaning. 2. Observation of the activity kitchen on 7/11/11 at 3:58 PM and on 7/13/11 at 11 AM revealed the conventional oven and the microwave oven were dirty with left over/burnt food debris. Interview with the activity director on 7/13/11 at 11 AM revealed her department was responsible for the cleaning and there was not any set schedule. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371	1. The ovens (conventional and microwave) in the activity room were cleaned on 7/13/2011 by the activity staff. 2. The ovens will be placed on a cleaning schedule for the activity staff to ensure they are being cleaned thoroughly and routinely. They will be checked daily and cleaned if needed. Staff was also reminded on 7/15/11 at in-service to clean up when something spills over. The activity staff were in-serviced on 7/29/11 regarding the new schedule to maintain cleanliness of equipment. 3. Activity director will monitor compliance with cleaning schedule and will ensure kitchen equipment in the activity room is kept clean. Equipment will be checked every day for cleanliness. Any concerns will be reported to the QA committee.	
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.	F 428		8/1/11

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F 428	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure irregularities identified by the pharmacist were acted upon for 1 of 9 sample residents (#24). The findings were: Review of a pharmacist to physician communication for resident #24, dated 5/25/11, showed the pharmacist wrote "Use of ASA [aspirin] + Celebrex + Fosomax: The use of these meds together is additive for GI and kidney toxicity, and less than expected bone mineral stabilization from the Fosomax. Please monitor!" Further review showed on 6/20/11, the physician wrote the following new orders on the communication form: "Take 81 mg ASA at bedtime. Take Celebrex in am, only as needed. Hold both ASA and Celebrex on day of Fosamax dosing weekly." However, review of the July 2011 medication administration record (MAR) showed the aspirin was administered at noon, and the Celebrex was given routinely every morning. In addition, neither medication was held on the day Fosomax was given. During an interview on 7/13/11 at 3:16 PM, the DON stated that pharmacist reports with physician orders were given to him. However, when shown the pharmacist report for this resident, the DON stated he had not seen that report. Therefore, the physician orders had not been carried out.	F 428	F 428 The drug regimen of each resident must be reviewed at least once per 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. 1. Resident #24's pharmacy recommendations were noted and drug regimen changes were made according to physician orders on 7/13/11. 2. A new process was implemented on 7/25/11 to assure all documentation coming from pharmacy recommendations and/or physicians is noted and acted upon by the nursing department prior to being filed in the medical record. 3. Monthly audits will be conducted by the medical records department to ensure recommendations are being noted and acted upon by a licensed nurse. Any concerns will be reported to the QA committee at least quarterly.	
F 431 S9=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	F 431 Drugs and biological used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date when applicable.	8/1/11

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F 431	Continued From page 6 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure open multidose vials stored in 1 of 2 medication carts were dated when opened. The findings were: Observation on 7/12/11 at 3:45 PM showed the	F 431	1. The medication vials without time and date were destroyed on 7/13/2011. 2. In-service to licensed nursing staff on 7/15/11 and 7/29/11 regarding the need to time, date, and initial any mulit-dose vials when they are opened. 3. Medication carts will be checked weekly for any expired or unlabeled medications by nursing administration. Any concerns will be corrected immediately and reported to the QA committee.	

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F 431	Continued From page 7 medication cart used for residents located in corridors 1 and 2 had a vial of Humulin-R, one third full, which was not labeled and initialed to show when it was opened. In addition, one vial of Humulin-N, one fourth full, was opened and did not show when it was opened. Both vials were available for use. Interview with RN #1 at the time of the observation confirmed the medications should have been labeled with the date opened. According to Smith, Duell and Martin in "Clinical Nursing Skills Basic to Advanced Skills"seventh addition, 2008, page 605, If multi-use vials are opened, they should be marked with the date and time the container is entered and nurse's initials."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (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.	F 441	F 441 The facility must establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1. The facility has obtained individually wrapped germicidal wipes that will be kept in the med cart where they are easily accessible. These are effective against Hepatitis B, Hepatitis C, and HIV/AIDS. These will be used to cleanse the glucometer between uses.	8/1/11

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F 441	Continued From page 8 (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. (g) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 of 2 blood glucose monitors (glucometers) were properly cleaned after resident use. In addition, the facility failed to ensure staff followed appropriate infection control practices regarding hand hygiene during 1 of 3 medication passes. The findings were: 1. Observation on 7/12/11 at 11:25 AM showed licensed practical nurse (LPN) #1 cleansed the glucometer with alcohol after obtaining blood glucose results for resident #16. Interview with the infection control nurse on 7/14/11 at 8:30 AM revealed she was not aware alcohol was not a recommended product to use for cleaning the meters. According to recently released guidance by the Food and Drug Administration (FDA) at www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/InVitroDiagnostics/ucm227935.htm (accessed 7/20/11) for cleaning and disinfecting	F 441	2. In-service was held on 7/13/11 and 7/29/11 to educate staff regarding use of germicidal wipes instead of alcohol wipes for disinfecting medical equipment. This topic will be added to the yearly blood borne pathogens in-service. In addition, staff was educated regarding the need to cleanse hands between interactions with each resident, with special emphasis on med pass and meal times. 3. Nursing administration to observe blood sugar checks once per week for one month and as needed thereafter. Any concerns will be reported to QA committee.	

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F 441	Continued From page 9 of blood glucose meters, "...The disinfection solvent you choose should be effective against HIV, Hepatitis C, and Hepatitis B virus." Further, "Please note the 70% ethanol solutions are not effective against viral bloodborne pathogens." Further interview with the infection control nurse on 7/14/11 at 8:40 AM revealed she was not involved in any training related to the cleaning of the glucometers. 2. Observation on 7/11/11 at 5:45 PM showed LPN #2 administered medication to residents #27, #19, and #23. The LPN touched each resident, inanimate objects surrounding each of the residents and the medication cups after each resident had handled them. She did not cleanse her hands after each contact and before preparing medication for the next resident. Interview with the infection control nurse on 7/14/11 at 8:30 AM revealed the nursing staff are to wash their hands between residents during medication pass.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure kitchen equipment was maintained in a sanitary and safe working	F 465	F 465 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1. The stainless steel two compartment sink was detached from the wall and sent to be welded by an outside contractor on 7/27/11. Welding was completed and sink was re-installed on 8/2/11. 2. The area under the sink was cleaned and disinfected by kitchen staff on 7/27/11. 3. The area under the sink was put on a cleaning schedule to be mopped once per day.	8/2/11

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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 _____	07/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - EVANSTON	478 YELLOW CREEK ROAD EVANSTON, WY 82930

(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 465	Continued From page 10 condition. The findings were: 1. Observation on 7/11/11 at 3:25 PM and on 7/13/11 at 10:20 AM showed there was a two compartment sink equipped with a garbage disposal on one side. Underneath the sink there was a puddle of standing water and a large amount of a slimy grayish sludge. Interview with cook #1 on 7/14/11 at 11:15 AM revealed the garbage disposal leaked and this had been going on for a while. She verified the sink and disposal were still being used on a regular basis. Interview with the CDM on 7/13/11 at 10:30 AM verified the sink/disposal had been leaking for a "couple of months", and she tried to clean up the mess at least once a week. The CDM stated the maintenance department was aware and they were trying to find someone to make the needed repairs. 2. Observations of the walk-in-freezer on 7/11/11 at 3:25 PM and on 7/13/11 at 10:20 AM revealed there was a leak from the condenser unit. The water from the leak was being caught in a pan which had become full, and the water had leaked onto the floor and formed an eight inch mound of ice. There were also smaller spots of ice on the main area of the walk-in floor. Interview with the maintenance director and the CDM on 7/14/11 at 11:45 AM revealed they had not communicated about this leak. The CDM revealed it was a slow small leak that had been continuous for the past year. The maintenance director was not aware of the leak.	F 465	1. A contractor was contacted on 8/1/11 regarding the walk-in freezer. Contractor repaired broken drain line in freezer on 8/2/11. 2. Maintenance staff will ensure proper operation of walk-in freezer by checking for ice build-up once per month. 3. Kitchen staff will notify maintenance staff of any issues immediately. Any concerns will be reported to the QA committee on a quarterly basis.	