STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 170 SS=B	483.10(i)(1) MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interviews with residents and staff, the facility failed to ensure all mail was routinely delivered on Saturdays. The resident census at the time of survey was 43. The findings were: A group interview with residents on 11/7/06 at 3:30 PM revealed two of five residents (#6 and #24) did not routinely receive their mail on Saturdays. They further stated they were told mail delivery on Saturdays was the responsibility of the manager on duty. Interview with the facility administrator on 11/9/06 at 1:35 PM revealed some mail (e.g. business mail or benefits statements from Medicare/Medicaid) was not delivered on Saturdays. She further stated the local community did receive mail on Saturdays and confirmed the role of the manager on duty to pick up mail from the post office on weekends.	F 170	F170 This facility strives to maintain the residents right to privacy including the right to sent and promptly receive unopened mail. All Department Managers have been inserviced on their role & responsibility to obtain the mail on Saturdays and ensure it is delivered to residents according to the wishes of themselves an or their legal representative. An audit is being done to determine how each resident's business mail will be delivered. A list will be compiled and given to the managers on duty, as well as to the Business Office. Social Services Director will ask resident council monthly to assure mail is delivered on Saturday. Results with corrective action will be discussed at monthly Quality Assurance meeting	11/10/06 12/15/06 ~~10/8/06~~
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by:	F 221	F221 This facility strives to ensue residents have a right to be free from physical restraints.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pat Miller — TITLE: NHA — (X6) DATE: 12/4/06

Reviewed + Changes made w/ approval of Pat Miller NHA

DEC 05 2006

DOC changed to 12/15/06 due to changes. Accepted on 12/11/06 by Lori Russell RD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 221	Continued From page 1 Based on observation, staff interview, and medical record review, the facility failed to consider an alarming seat belt as an intermittent restraint for one (#43) of one sample residents utilizing that device. The findings were: According to the 5/25/06 annual and 11/2/06 quarterly Minimum Data Set (MDS) assessments, resident #43 had moderately impaired cognition and required cues and supervision. Further review of those MDS assessments showed the resident did not use a restraint. Observation on 11/8/06 at 7:15 AM showed the resident self-propelled a wheelchair with an alarming, self-releasing seat belt fastened loosely across the thighs. The resident was unable to release the belt upon request, and s/he did not answer when questioned. On 11/8/06 at 1:50 PM, the new director of nursing (DON) stated the resident could remove the belt at times. However, interview with licensed practical nurse #11 immediately after that conversation revealed the resident was unable to remove the belt during periods of increased confusion. Review of all the information related to the alarming belt showed the facility had not considered it as a restraint. Observation with the DON that same day at 3:15 PM showed the resident was again unable to release the seat belt on demand.	F 221	Resident #43 was reassessed by therapy and the Restraint Committee as to the need for use of seat belt and the resident's ability to self-release. If found that a belt is warranted with consideration of the resident's past history of falls, the MDS will be updated to reflect a restraint & the Care Plan will reflect the restraint. Staff was inserviced on proper application of the restraint so it is secure across the body This will be completed by December 8, 2006 and monitored by the Director of Nursing and the Interdisciplinary team. All Residents with safety devices will be reassessed with corrective action and care plans revised as needed. All resident with safety devices are reassessed at least quarterly or with significant change of condition. Restraint Committee will monitor compliance weekly for one month and monthly thereafter. Quality Assurance Committee will review monthly and make recommendations.	12/15/06 12/8/06 physical restraints 12/8/06 12/8/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 223 SS=D	483.13(b), 483.13(b)(1)(i) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, review of policies and procedures, and review of internal investigations, the facility failed to protect two (#34, #38) of two female residents from the sexual advances of resident #14. In addition, measures to assure the safety of other female residents were not implemented. The findings were: Review of completed internal investigations showed reports of "Resident to Resident, Inappropriate Sexual Behavior" against resident #34 on 9/16/06 and "Resident-to-Resident Assault" against resident #38 on 10/21/06. Both instances were reports of completed investigations faxed to the State Survey and Certification Agency and involved resident #14 as the perpetrator. Review of the 9/21/06 admission Minimum Data Set (MDS) assessment revealed resident #14 had moderately impaired cognition and required cues and supervision. Review of faxed reports showed the physician was notified of the resident's involvement in sexual activities with female residents on 9/13/06, 9/16/06, 9/20/06, and 10/22/06. According to the facility's undated policy and procedure entitled "Abuse and Neglect	F 223	F223 It is the practice of this facility to ensure that each resident is free from mistreatment, neglect, and misappropriation of property On 11-09-06, a complete mood and behavior assessment with appropriate Care Plan was completed on Resident #14. The facility will assess the Admission policies and make changes as needed to ensure every attempt is made to thoroughly screen new referrals. On 11-13-06, the Admission team was inseviced on the importance of thorough pre-admission screening. The Administrator and Admission Team to monitor all new admissions Quality Assurance Committee to review the process and make corrections as needed.	12/15/06 12/8/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 223	Continued From page 3 Prohibition Policy", "Each resident has the right to be free from...abuse." Further review showed "The facility will screen for potentially abusive residents." In addition, the policy and procedure instructed the facility to "protect residents from harm..." Review of the medical record showed no evidence the resident was screened for abusive behavior. Interview with the social worker on 11/9/06 at 8:07 AM confirmed the resident was not screened for potential abuse prior to or after his admission. Review of the care plan showed it lacked a comprehensive plan to assure the safety of female residents and protect them from sexual advances. Interview with the administrator, social worker, corporate nurse, and business office manager on 11/9/06 at 8:15 AM revealed the facility had not provided additional training to staff on how to manage the resident's behaviors, nor had they developed and implemented specific measures to protect the female residents.	F 223	F223 All staff was inserviced on 11-22-06 on the techniques to implement whenever Resident #14 or any other resident becomes sexually or physically abusive towards others. Staff were also inserviced on the policies and procedures for Identifying, reporting, documenting and investigating and follow-up of those investigations. The facility will implement the "Guardian Angel" program where Department Managers will be assigned a new resident admission to monitor for specific needs. Issues will be discussed during Morning Briefing meeting and followed up as needed. Administrator to monitor for compliance. Quality Assurance Committee to review results of any allegation of abuse.	12/15/06 12/8/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS 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 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	F 225	F225 The facility strives to ensure that any alleged violations of Resident Rights is investigated and reported appropriately. An assessment was completed on Res. # 14 on 11-09-06. A Care Plan was devised to reflect resident's needs and behaviors. All staff, including department managers, and nurses were inserviced on the importance of reporting all cases of alleged abuse on 11-22-06. Thorough investigations with follow-up will be completed on all alleged abuse cases. Administrator /Social Services Director to monitor for compliance. Quality Assurance Committee to review results of any allegation of abuse or violations of Resident Rights.	12/15/06 12/6/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 225	Continued From page 5 by: Based on medical record review, staff interview, review of policies and procedures, and review of completed internal investigations, the facility failed to adequately investigate two of two allegations of sexual abuse by resident #14. The findings were: Review of completed internal investigations showed reports of "Resident to Resident, Inappropriate Sexual Behavior" on 9/16/06 and "Resident-to-Resident Assault" on 10/21/06. Both reports were completed investigations faxed to the State Survey and Certification Agency and involved resident #14 as the male perpetrator. Review of the 9/21/06 admission Minimum Data Set (MDS) assessment revealed the resident had moderately impaired cognition and required cues and supervision. Review of faxed reports showed the physician was notified of the resident's involvement in sexual activities with female residents on 9/13/06, 9/16/06, 9/20/06, and 10/22/06. According to the facility's undated policy and procedure entitled "Abuse Prevention Policy", "The administration of this facility will be responsible for investigating all reports of abuse or suspected abuse." On 11/9/06 at 8:15 AM, interview with the social worker, administrator, corporate nurse, and business office manager revealed they did not consider the incidents as abuse, even though they were reported as such to the State Survey and Certification Agency, and therefore, they did not conduct a thorough investigation of either incident.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interviews, the facility failed to provide needed social services for one (#33) of one sample residents. An audiology appointment arranged prior to admission was not kept or rescheduled for this resident. The findings were: According to the admission face sheet, resident #33 was admitted to the facility on 8/30/06. Review of the 8/30/06 discharge summary from the sending facility showed the resident was hard of hearing, wore a hearing aid, and had a follow-up appointment with the audiologist scheduled for 9/5/06; the sending facility recommended the receiving facility keep that appointment. Observations of the resident on 11/6/06 at 5:45 PM and 11/7/06 at 11:30 AM showed the resident was not wearing a hearing aid. Interview with licensed practical nurse (LPN) #20 on 11/7/06 at 2:50 PM revealed she was unaware of the appointment, but she stated the social worker would know about it. On 11/7/06 at 4:30 PM the social worker confirmed she was responsible for making appointments. However, she stated she missed reading about the scheduled audiology appointment and did not make arrangements to keep it or change it to the facility's audiologist. During an interview on	F 250	F250 The facility strives to provide medically-related social services to attain or maintain the highest practicable physical, mental, & psychosocial well-being of each resident. Social Services Director has scheduled an appointment for Resident #33 with the audiologist. Social Service Director has been inserviced on the importance of doing a timely assessment and reviewing all pertinent information for each new admission. Social Services Director reviewed hearing status of all residents to identify if any other resident was in need of an audiology appointment. Action will be taken as needed. The Admission Team will review all information with each referral and ensure it is distributed to the appropriate entity.	12/15/06 12/5/06 12/8/06 12/8/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 250	Continued From page 7 11/9/06 at 9:55 AM the resident confirmed s/he did not have a hearing aid but stated "I would like to hear as good as I could."	F 250	Social Services Director/Administrator to monitor any concerns with corrective action discussed at Quality Assurance Committee meeting monthly.	12/15/06 12/8/06
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 maintain an environment that was clean, free of unpleasant odors, and in good repair for residents. The resident census at the time of survey was 43. The findings were: 1. Observations during the initial tour of the facility on 11/6/06 revealed the walls in one of six hallways (F Hall) were partially unpainted above the handrails and several areas had paint chipped from the walls. The same hallway had wooden handrails, some of which were worn to the point that the surface of the wood was not protected by a cleanable finish. Baseboard heater covers in two of six hallways (E and F Halls) were fashioned from wooden boards, several of which were scratched, marred, and gouged below the finished surface of the wood. Interview with housekeeping staff on 11/7/06 at 10:45 AM confirmed the worn areas on the handrails and the condition of the boards covering the baseboard heaters in the E and F halls. The facility also had a malodorous smell, with a particularly strong urine-like smell emanating from	F 253	F253 This facility strives to provide services to maintain a sanitary, orderly, and comfortable interior. The wall in hall F will be painted. Handrails and wooden baseboard covers have been assessed and repaired on 11-29-06. Handrails were repaired 11-21-06. Maintenance Supervisor will monitor all areas for paint and repair on his daily rounds and repair as needed. Administrator and Maintenance Supervisor to make rounds together on a monthly basis to identify any additional painting or repairs needed. Quality Assurance Committee to review any trends with corrective action.	12/15/06 12/8/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 8 the vicinity of room 29. Interview with the director of nursing (DON) and facility administrator on 11/8/06 at 4:30 PM confirmed the smell. 2. Observation on 11/7/06 at 9:20 AM showed the bathroom door in room 29 was closed. When opened, the room smelled so strongly of urine that the surveyor's eyes stung. The surveyor's shoe stuck slightly to the floor when she tried to take a step. Further observation on 11/9/06 at 10:10 AM revealed the room still smelled of urine after being cleaned.	F 253	Room 29 has been thoroughly cleaned including the heat register in the bathroom. Caulking was replaced around the commode. Housekeeping staff was inserviced on the need to mop that room first thing in the AM, after breakfast, after lunch and before the end of the shift. Housekeeping Supervisor to monitor for compliance. Maintenance Supervisor and Housekeeping Supervisor to monitor Room 29 and any other areas of concern on daily rounds and clean as needed. Certified Nursing Assistants on evenings and nights inserviced on need to mop bathroom floor. Resident in room 29 has been placed on a toileting assessment to determine a toileting program so as to have help from staff when toileting. Director of Nursing /Charge Nurses to monitor. Quality Assurance Committee to review any trends with corrective action	12/15/06 11/29/06 11/29/06 12/5/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 SS=E	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; 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 observation, medical record review, and family and staff interviews, the facility failed to ensure thorough assessments in various areas for four (#14, #35, #39, and #43) of eleven	F 272	The clinical team reassessed resident #14's mood and behavior on 11-09-6. His care plan was reviewed to assure it reflected his current treatment plan. The clinical team reassessed resident #35 for the use of Geodon. After completing a mood and behavior assessment, a recommendation was discussed with the resident's attending physician. Care plan was reviewed and revised as indicated. An appropriate diagnosis will be obtained to reflect the use of the medication. On resident #39 a new head to toe skin assessment was completed and care plan reflects findings. The staff has been inserviced on the need for head to toe skin assessments for all new admissions and if a skin ulcer is found will document to the findings including measurements of the site and obtain physician's order for treatment. Staff has also been inserviced on the staging of wounds with eschar at the highest stage.	12/5/06 12/8/06 12/8/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 10 sample residents. The findings were: 1. Review of the 9/21/06 admission Minimum Data Set (MDS) assessment showed resident #14 triggered for comprehensive assessment of physically abusive and socially inappropriate behaviors which were exhibited daily and not easily altered. Review of the documentation listed as the assessment information in Section V of that MDS revealed a comprehensive assessment was lacking. Interview with the social services director on 11/9/06 at 8:07 AM confirmed no other assessment information was available. 2. According to the 4/27/06 admission MDS assessment, resident #35 required a comprehensive assessment for antipsychotic and antidepressant medications. However, review of the assessment information showed the resident was on them for "depression and hypotention [hypotension, low blood pressure]." Review of the medical record and interview with the director of nursing on 11/8/06 1:10 PM revealed she was unable to find any further assessment information related to psychotropic medications. 3. Observation of resident #39 on 11/7/06 at 9:21 AM revealed a physical therapist (PT) provided wound care to the resident's heels and to the toes on the left foot. Interview with the PT at that time revealed the left heel pressure sore was healing and had been debrided in June or July of 2006 to a stage III. Further interview revealed the PT thought the left heel sore had started in the facility, but stated the right heel sore had started during one of the resident's most recent hospitalizations. Interview with a family member of the resident on 11/7/06 at 8:15 PM confirmed	F 272	Resident #43 will be reassessed for use of safety device. Care plan will be reviewed and revised to reflect current plan of care. All residents with a safety device will be reassessed and corrective action and care plan reviewed/revised as indicated. The nurses and Social Services Director were inserviced on 11-10-06 on the policies and procedures of completing a physical restraint and mood/behavior assessment Clinical team will be inserviced on restraint protocol with emphasis on assessment, order, care plan and application process. Director of Nursing will monitor daily for a week, weekly for a month and at least monthly thereafter. Director of Nursing will report any concerns with corrective action to Quality Assessment committee.	12/5/06 12/8/06 12/8/06 12/8/06 12/8/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 11 all the resident's pressure sores developed at the hospital. The following concerns were found related to assessment of the resident's left heel pressure sore at the time of his/her re-admission to the facility: a. Medical record review failed to reveal an admission assessment for the left heel pressure sore upon the resident's re-admission to the facility. An MDS tracking form documented the resident re-entered the facility on 7/20/06. A facility form titled "Resident Assessment Summary", dated for 7/20/06 and signed as completed on 8/3/06, failed to document any skin issues except for the condition of the resident's left hip incision. The facility's first notation of the resident's left heel pressure sore was on 7/24/06 in which a form titled "Skilled Documentation" stated "CNA reported black mushy L (left) heel while doing bedbath...." The resident's left heel pressure sore was first measured and staged at the facility on 8/12/06. At that time, the measurement graph showed the resident had a 5 cm (centimeter) by 3 cm stage II pressure ulcer and a separate smaller area documented as eschar "on the outer heel." The staging of the left heel was documented as a "stage II" and not staged to highest level of the eschar, which was unstageable until debrided. b. Medical record review and interview with the director of nursing (DON) on 11/8/06 at 10:56 AM showed the resident did have pressure sores at the time of his/her re-admittance to the facility in July 2006. The DON stated the pressure sore was not assessed or documented by the facility until four days after the resident's return. The DON stated the expectation for staff was to do a full skin assessment at the time of resident admission.	F 272	The Social Services Director will monitor at least weekly to assure mood and behavior assessments are completed timely. The MDS coordinator will monitor weekly to assure physical restraint assessments are completed timely. The Director of Nursing will monitor weekly to assure skin and wound assessments are completed timely. Any concerns with corrective action will be discussed at the Quality Assurance committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 12 c. Further medical record review with the DON on 11/8/06 at 10:56 AM revealed nursing note copies from the hospital which documented the resident's pressure sore was present prior to re-admission in July 2006. 4. According to the 5/25/06 annual and 11/2/06 quarterly Minimum Data Set (MDS) assessments, resident #43 had moderately impaired cognition and required cues and supervision. Further review of those MDS assessments showed the resident did not use a restraint. Observation on 11/8/06 at 7:15 AM showed the resident self-propelled a wheelchair with an alarming, self-releasing seat belt fastened loosely across the thighs. The resident was unable to release the belt upon request, and s/he did not answer when questioned. On 11/8/06 at 1:50 PM, the new director of nursing (DON) stated the resident could remove the belt at times. However, interview with licensed practical nurse #11 immediately after that conversation revealed the resident was unable to remove the belt during periods of increased confusion. Review of all the information related to the alarming belt showed the facility had not considered it as a restraint. Observation with the DON that same day at 3:15 PM showed the resident was again unable to release the seat belt on demand.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED 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 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 staff interview and medical record review, the facility failed to ensure one (#39) of two sample residents who required a significant change assessment received that assessment. The findings were: Review of the medical record for resident #39 revealed a quarterly Minimum Data Set (MDS) assessment dated 8/3/06. When compared to the previous quarterly MDS assessment dated 5/11/06, the review revealed the resident had declined in the following areas: a. From independent for locomotion on the unit to extensive assistance required. b. From limited assistance for locomotion off the unit to extensive assistance required. c. From requiring extensive assistance with toileting to requiring total staff assistance with toileting.	F 274	F274 The facility strives to complete assessments and determine change of condition in the resident's physical or mental condition. The MDS for Resident #39 has been updated to reflect her current status. The MDS coordinator and the Interdisciplinary Team reviewed the conditions for change of condition and follow up inservicing has been done. The team will review residents who may be considered for change of condition at morning briefing meeting.	12/15/06 12/5/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 274	Continued From page 14 d. From having no pressure sore areas to having a stage IV pressure sore. Interview with the MDS coordinator on 11/8/06 at 12:42 PM revealed a significant change assessment should have been completed.	F 274	~~Prior to the survey and ongoing~~, all residents receive an assessment upon ~~admission, with a significant change~~ of condition, and at least quarterly. Their comprehensive care plans are reviewed and revised as indicated to reflect their current plan of care. The clinical team will monitor weekly to discuss the status of every resident to determine if there has been a change in status in order to determine a need for a reassessment. Care plans reviewed and revised as indicated to reflect current treatment plan. The MDS coordinator will monitor change of conditions. This is completed by 12/08/06. QA Committee to Review any trends with Corrective action.	12/15/06 12/8/06 12/8/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT 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. 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 record review and staff interview, the facility failed to accurately document the status of one of 11 sample residents (#33) and one supplemental resident (#40). The findings were: 1. Review of Section W of the 9/12/06 admission Minimum Data Set (MDS) assessment for	F 278	F278 The facility strives to ensure that all assessments are done accurately and timely to reflect the resident status.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 278	Continued From page 16 resident #33 showed sections for pneumococcal vaccination were incomplete. Interview with the MDS coordinator on 11/8/06 at 2:45 PM revealed she had entered "N/A" (not applicable) in both sections; that resulted in dashes on the completed assessment. According to the 2006 instructions from the Centers for Medicare and Medicaid Services, the section for pneumococcal immunization must indicate that the resident either received the vaccination or did not receive it due to medical contraindication or refusal; N/A is not an option. 2. Review of the medical record for resident #40 revealed a quarterly MDS assessment completed on 2/2/06 in which the resident was assessed in Section I, Infections, as free of all infections; all other areas in this section were left blank (unmarked). Further review of the resident's medical record revealed s/he was diagnosed with a urinary tract infection with a positive culture report listing two microorganisms, methicillin-resistant Staphylococcus aureus (MRSA) and Citrobacter freundii, dated 1/12/06. The urinary tract infection was within 30 days of the quarterly assessment completion date. The Long-Term Care Facility Resident Assessment Instrument User's Manual, version 2.0, December 2002 (revised August 2005), states that Section I is to include chronic and acute symptomatic urinary tract infections in the 30 day period prior to the assessment.	F 278	Modification of the inaccurate MDS of Resident #40 and #33 will be completed. Care plans will be revised to reflect current care. Resident #40 chart was reviewed and a new MDS completed to reflect the status of infections. The MDS coordinator will review all medical records so as to reflect current accurate information. Physician orders will be reviewed on a daily basis to note any antibiotic orders. It will be monitored by the Director of Nurses. The Interdisciplinary team will review the assessments completed during the past quarter to identify any inaccuracies in coding the MDS. If found, a modification of the MDS will be completed. The Interdisciplinary team was inserviced on the coding and double-checking the MDS for accuracy prior to sealing and transmitting the MDS to the State database.	12/15/06 12/8/06 12/6/06 12/8/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 279 SS=D	483.20(d), 483.20(k)(1) 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 by: Based on observation, review of medical records and facility policies, and staff interview, the facility failed to develop a care plan for one of one residents (#40) who required transmission-based isolation when infected with a multi-drug resistant organism (MDRO). The findings were: During initial tour of the facility on 11/6/06, a red warning sign labeled "Isolation" was observed posted at the doorway to room 34. Interview with the director of nursing (DON), who also served as the facility infection control nurse, on 11/7/06 at 2:30 PM revealed resident #40 lived in room 34	~~F 279~~ 278	The Interdisciplinary team will carefully review the MDSs weekly. Any concerns with corrective action will be discussed at the Quality Assurance Committee meeting. F 279 The facility strives to ensure accurate assessments are completed with a comprehensive plan of care. The care plan for Resident #40 was reviewed and revised to reflect plans and approaches for contact isolation. Director of Nursing to monitor for need for change. Director of Nursing to inservice all nurses on importance of timely completion of care plans for all residents. Director of Nursing to audit monthly. Quality Assurance Committee to review.	12/15/06 12/5/06 12/15/06 12/5/06 12/5/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 279	Continued From page 18 and was under contact precautions and isolation because s/he had a wound infection. Review of the resident's medical record and current care plan failed to reveal measurable goals and specific care approaches appropriate for his/her contact isolation. Interview with the DON on 11/8/06 at 1:25 PM confirmed a care plan had not been developed for the resident to accurately reflect contact precautions and isolation.	F 279		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS 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 assure staff maintained accepted standards of practice related to clarification of physician orders and medication administration for one sample (#43) and two non-sample (#18, #41) residents. The findings were: According to the sixth edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, "If a written order is illegible or questionable for any reason, the physician must be notified for clarification." The following concerns with failure to clarify physician orders were identified: a. Observation on 11/7/06 at 5:05 PM showed registered nurse (RN) #23 prepared and administered medications, including Quinine Sulfate and Colace, to resident #41.	F 281	F281 The facility strives to meet professional standards of quality. Clarification orders were obtained for the medication orders for resident #41, #18 & #43. All medication orders were reviewed. Any discrepancies on the medication administration records were clarified with the attending physician.	12/15/06 12/8/06 12/8/06 12/8/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 281	Continued From page 19 Reconciliation of the medication pass with the orders showed both medications were ordered on 10/30/06, and both were to be administered at "HS" (hour of sleep or bedtime). Review of the November 2006 medication administration record (MAR) showed the Quinine was scheduled for 5 PM, but the Colace had been scheduled for 8 PM; however, 8 PM was crossed off and 5 PM was written below it. Interview with the RN on 11/7/06 at 5:52 PM revealed she did not know why the medications were not given at bed time. Review of all orders since 10/30/06 showed the physician was not contacted for clarification of the time of administration. b. Observation on 11/8/06 at 7:42 AM showed licensed practical nurse (LPN) #16 prepared and administered 1/2 tablet of Atenolol (antihypertensive) to resident #18. Reconciliation of the medication pass revealed the 10/5/06 order was for 1/2 tablet of Atenolol; however, the physician did not specify an amount so the dose of 1/2 tablet was unknown. Interview with the director of nursing on 11/8/06 at 8:20 AM confirmed that the amount of Atenolol to be given was unknown c. Review of the current orders for resident #43 showed s/he was to receive Pepcid 1/2 tablet twice a day. However, the physician failed to specify an amount so the dose of 1/2 tablet was unknown. Further review of the record showed a clarification order was not obtained.	F 281	On 11-22-06, the nurses were inserviced on the medication order verification policy and procedures. All orders inputted into the computer by the Health Information Manager will be double-checked by a nurse. The Director of Nurses or designee will audit the new orders, MARs and compare the medication labels monthly to assure accuracy. Any concerns with corrective action will be discussed at the Quality Assurance committee meeting.	12/15/06 12/15/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING 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, staff interview, and review of policies and procedures, the facility failed to assure staff provided appropriate perineal (incontinence) care for one (#19) of three residents who were dependent on staff for assistance. The findings were: Observation on 11/7/06 at 10:30 AM showed certified nurse aides (CNAs) #21 and #28 transferred resident #19 from the wheelchair to the toilet. The resident was incontinent of urine prior to the transfer. When providing incontinence care, the CNAs cleansed the residents thighs and buttocks, but failed to cleanse the penis and scrotum, areas that were also in contact with urine. According to the facility's undated policy and procedure entitled "Providing Perineal Care" # 119-14, the penis and scrotum should be cleansed each time perineal care is provided. During the exit interview on 11/9/06 at 5:05 PM, the director of nursing stated her expectation was that staff would thoroughly cleanse incontinent residents of urine.	F 312 all	F312 The facility strives to ensure Resident #19 + residents receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. All nursing staff will be inserviced on proper peri-care for all residents. Skills check list for peri-care will be completed on all Certified Nursing Assistants. Charge nurse to monitor by Randomly spot checking Certified Nursing Assistants at least one time weekly for one month and monthly thereafter. Director of Nursing to monitor for compliance. Quality Assurance Committee to review results.	12/15/06 12/8/06 12/8/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, family interview, and staff interview, the facility failed to ensure that one (#39) of one sample residents admitted with pressure sores received care and services for the pressure sores at the time of admission. The findings were: Observation of resident #39 on 11/7/06 at 9:21 AM revealed a physical therapist (PT) provided wound care to the resident's heels and to the toes on the left foot. Interview with the PT at that time revealed the left heel pressure sore was healing and had been debrided in June or July of 2006 to a stage III. Currently, the PT stated it resembled a stage II to III. The PT stated the right heel was presently unstageable due to eschar. Further interview revealed the PT thought the left heel sore had started in the facility, but stated the right heel sore had started during one of the resident's most recent hospitalizations. Interview with a family member of the resident on 11/7/06 at 8:15 PM revealed all the resident's pressure sores had started at the hospital. The following concerns related to a delay in care and services for the resident's left heel pressure sore upon his/her	F 314	F314 The facility strives to assess all residents' skin status at the time of admission to assure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Resident #39 expired 12/8/06 Although resident #39's wounds are being evaluated during treatment and a more detailed description with measurements are completed weekly the by the physical therapist and licensed nurse, the status of the wounds and treatment plan were reassessed by the Director of Nurses and physical therapist on 11-09-06. The dietician assessed the resident #39's nutritional status 11-07-06. The resident's wound and skin risk care plan was reviewed to assure it reflects the current plan of care. The skin/weight/hydration committee reviews the status of resident #39's wounds and discusses the current treatment plan during the weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 314	Continued From page 22 re-admission to the facility were identified: a. Review of the medical record failed to reveal an admission assessment or treatment orders for the left heel pressure sore at the time of the resident's re-admission to the facility. A Minimum Data Set (MDS) tracking form documented the resident re-entered the facility on 7/20/06. A facility form titled "Resident Assessment Summary", dated for 7/20/06 and signed as completed on 8/3/06, failed to document any skin issues except for the condition of the resident's left hip incision. The first documentation of the resident's left heel pressure sore was on 7/24/06 in which a form titled "Skilled Documentation" stated "CNA reported black mushy L (left) heel while doing bedbath...." The first measurement of the resident's left heel pressure sore was on 8/12/06. At that time, the measurement graph showed the resident had a 5 cm (centimeter) by 3 cm stage II pressure ulcer and a separate smaller area documented as eschar "on the outer heel." b. Medical record review and interview with the director of nursing (DON) on 11/8/06 at 10:56 AM revealed hospital copies of the nursing notes from the resident's hospitalization in July 2006. The notes documented the resident's left heel pressure sore developed while in the hospital. Interview with the DON revealed the resident did have pressure sores at the time of his/her re-admittance to the facility from the hospital. The DON stated the pressure sore was not assessed or documented by the facility until four days after the resident's return. The DON stated the expectation was for staff to do a full skin assessment at the time of admission.	F 314	committee meeting. The care plan is revised as indicated to reflect the current treatment plan. A weekly head to toe skin evaluation is completed for all residents. All residents at risk for skin breakdown have been identified and their skin risk care plan reviewed and revised as indicated to assure appropriate interventions had been established and implemented to assist in preventing skin breakdown. ~~Prior to the survey and ongoing,~~ The nurses complete the skin risk assessment upon admission, weekly for the first month after admission, with a significant change of condition, and at least quarterly. If the resident is at risk for skin breakdown, a skin risk care plan is established and implemented. If the resident has a wound, and an assessment is completed and documented at least weekly. The status of any wound and treatment plan is reviewed by the skin/weight/hydration committee at lest weekly. The care plan is revised as indicated. The physician and legal representative is notified of any change in status.	12/8/06 12/8/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of policies and procedures, the facility failed to assure staff checked for proper placement of a gastrostomy tube prior to an enteral (tube) feeding for one (#15) of one sample residents with a gastrostomy tube. The findings were: Observation on 11/7/06 at 2 PM showed registered nurse (RN) #23 prepared and administered Simethicone (anti-gas medication) per gastrostomy tube for resident #15. Prior to and after administering the medication, the RN flushed the tube but did not check for residual stomach contents or placement of the tube. The RN then hung 250 milliliters of Nutren 1.5 (enteral feeding). When questioned immediately after hanging the feeding, the RN stated she only checked for residual stomach contents and placement of the tube once a shift, as ordered, and that was at 10 AM. However, observation of the 10 AM procedure revealed the RN did check for residual and placement at that time. Medical record review revealed the physician's order was only to check for residual stomach contents once per shift. On 11/9/06 at 9:54 AM the director of	F322 314	Nursing Staff The nurses who were responsible for the care of resident #39 from the date of readmission on 7-24-06, until the day the heel wound as identified Insured received counseling and training on their responsibilities in completing a thorough head to toe skin evaluation at the time a resident is admitted or readmitted to the facility. F322 The facility strives to ensure that Resident #15 and all resident fed by feeding tube receives appropriate treatment and services. The facility policy will be reviewed and all nurses will be inserviced on the policy and procedures for checking for proper placement for gastrostomy tube. Director of Nursing or designee will complete a skills check on all nurses and will monitor weekly for one month and then monthly and PRN. Results will be reviewed by the Quality Assurance Committee.	12/8/06 12/8/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 322	Continued From page 24 nursing stated her expectation was that staff would check for placement of the tube before giving medications, enteral feedings, or water. According to the facility's undated policy and procedure, "Tube Feeding", staff should "Assure tube patency and position before administering feeding." According to Elkin, Perry, and Potter, "Nursing Interventions and Clinical Skills" copyright 2000, placement of feeding tubes is always checked prior to administration of feedings and medications.	F 322		
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation and medical record review, the facility failed to assure the environment for 2 (#33, #43) of 10 sample residents remained free of accident hazards. The findings were: 1. On 11/7/06 at 3:45 PM, a member of the housekeeping staff was observed in the process of mopping the dining room floor. There were no signs or barriers in place to restrict entry into the dining room or to indicate potential accident risks while the floors were wet. Resident #33 was observed to enter the dining room and walk on the wet floor. The housekeeper in the dining room looked in the vicinity of resident #33 as s/he entered the room, then returned to her work; no	F 323	F323 The facility will ensure the resident environment remains free of accident hazards as is possible. Res. # 33 is monitored and encouraged to use his walker when up and about. All staff including housekeepers were inserviced on 11-22-06 on the importance of monitoring residents on wet floors and redirecting them. The housekeeping Supervisor and staff were also inserviced on the need to use wet floor signs appropriately and to be more aware of their surroundings and resident whereabouts. Housekeeping Supervisor to monitor staff weekly. Quality Assurance Committee to review results monthly.	12/8/06 12/8/06

DEPARTMENT OF HEALTH AND HUMA ERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 323	Continued From page 25 attempt was made to stop the resident from entering the dining room, to caution the resident about the accident hazard, or to redirect him/her away from the area. 2. According to the 5/25/06 annual and 11/2/06 quarterly Minimum Data Set (MDS) assessment, resident #43 had moderately impaired cognition and required cues and supervision. Further review of those MDS assessments showed the resident did not use a restraint. Observations on 11/7/06 at 5:10 PM and 11/8/06 at 7:15 AM showed the resident self-propelled a wheelchair with a self-releasing seat belt fastened loosely across the thighs. The seat belt was attached underneath the wheelchair cushion so it could only fasten across the resident's thighs, an arrangement which could allow the resident to attempt to stand or to slide underneath the belt. Review of the entire medical record failed to show a safety assessment for the seat belt or a rationale as to why it was fastened so loosely.	F 323	Resident #43 was reassessed by therapy for the use of a seat belt & ability to self release. If the resident's past history of falls warrants a seat belt, the MDS will be updated to reflect a restraint and care plan will reflect same. Staff will also be inserviced on proper application of restraint so it is secure across the body. This will be completed by 12-08-06 and monitored by the Director of Nursing and Interdisciplinary team.	12/8/06
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure two (#39, #35) of ten sample residents who were at risk for falls had devices and interventions in place to prevent falls. The findings were:	F 324	F324 The facility strives to ensure each residents at risk for falls have devices and interventions in place to prevent falls	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 324	Continued From page 26 1. Review of the 4/27/06 admission Minimum Data Set (MDS) assessment revealed resident #35 was at risk for falls, and review of the 10/12/06 quarterly MDS assessment revealed the resident had fallen in the past 31 to 180 days. According to the care plan, a motion monitor (alarm which alerts staff when a resident gets up) while the resident was in the wheelchair was initiated on 6/7/06. Observations on 11/7/06 at 8 AM and at 4:47 PM showed the resident seated in a wheelchair without a motion monitor attached. On 11/8/06 at 1:52 PM the surveyor overheard licensed practical nurse (LPN) #11 informing the resident's spouse that the resident fell approximately 10 minutes ago while getting out of the wheelchair to go to the bathroom. Interview with the LPN immediately after the phone call revealed she did not think the motion monitor was in use at the time of the fall. The LPN opened a file drawer full of monitors and stated the facility had several but no way to attach them to the wheelchairs or beds. At 2 PM on 11/8/06 the LPN stated she verified a motion monitor was not attached to the wheelchair at the time of the fall. 2. Observation of resident #39 on 11/7/06 at 9:20 AM, 10:11 AM, and 3:01 PM revealed the resident was lying in bed. The observation also revealed the resident's water pitcher and glass were approximately three feet away from the bed. At each of these times, the observation revealed the resident was lying on his/her back and bed bolsters (pillows to prevent the resident from falling out of bed) were present. Interview with certified nurse aid #21 on 11/7/06 at 10:23 AM revealed the resident was capable of getting	F 324	all residents @ risk for falls including Res. # 35 will have a new fall risk and restraint assessment completed and care plan will reflect the updated information. If indicated a motion monitor will be attached and all staff will be informed of the need for use. educated on proper use All motion monitors will be evaluated and repaired or replaced as needed. Director of Nursing or designee will monitor. Res. #39 will have a new fall risk completed and care plan will reflect updated information. Staff was inserviced on the need to ensure residents water and personal articles are available and residents safety is considered in placement. Charge Nurses to monitor on daily rounds for safe and available placement of water. Quality Assurance committee to review monthly room audits for compliance.	12/8/06 12/8/06

DEPARTMENT OF HEALTH AND HUM. . SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 324	Continued From page 27 his/her own drink at times and normally did not call for assistance when requiring a drink of water. Review of the medical record revealed a history of fall concerns for the resident. A fax dated 8/21/06 showed nursing notified the physician that the resident "rolled out of bed to [his/her] knees again...." and on 8/23/06 nursing faxed the physician requesting the bed bolsters related to fall prevention. Interview with the director of nursing on 11/8/06 at 3:33 PM revealed she expected staff to ensure a resident's water pitcher was within reach next to the bed.	F 324		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 334	The facility strives to develop policies and procedures to ensure all residents are educated and receive flu and pneumococcal immunizations. Residents #15, #33 and #39 have a signed education and consent form. Nurse responsible for Flu immunizations was inserviced on the education/consent form procedure. An audit will be completed to determine if all resident/and or legal representatives have returned the education form. Results will be assessed and families not replying will be notified again. Responsible nurse and Director of Nursing to monitor for compliance. Concerns will be reviewed by Quality Assurance Committee at monthly meeting	12/8/06 12/8/06 12/8/06 12/8/06

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 334	Continued From page 29 already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to document resident education for three (#15, #33, #39) of five sample residents who received influenza and pneumococcal immunizations. The findings were: Review of medical records for five sample residents revealed residents #15, #33, and #39 received influenza and/or pneumococcal immunization but did not have educational	F 334		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 334	Continued From page 30 documentation in the medical record. Interview with the director of nursing on 11/7/06 at 4:45 PM revealed that if residents or their guardians received educational information, a signed form of receipt would be in each resident's medical record.	F 334		
F 354 SS=D	483.30(b) NURSING SERVICES - REGISTERED NURSE Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of nursing schedules and staff interview, the facility failed to provide the services of a registered nurse (RN) for 8 consecutive hours of the day, 7 days a week. The findings were: Review of the nursing schedules for August, September, October, and November 2006 showed the facility lacked the services of an RN for 8 consecutive hours on the following days:	F 354	F354 This facility strives to ensure that the services of a registered nurse are in place for at least 8 consecutive hours/7 days/week. Director of Nursing has implemented a process for documenting R.N. hours ensuring the required RN Administrator and Director of coverage Nursing to monitor for compliance. 12/8/06 QA committee to monitor & review for trends.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 354	Continued From page 31 a. August 5th, 6th, 16th, 17th, 25th, and 26th. b. September 17th, 29th, and 30th. c. October 1st. Interview with the director of nursing (DON) on 11/8/06 at 2:45 PM revealed the previous DON may have worked some of the shifts in August, but the facility lacked proof of that. The DON further stated she knew there was no RN in the facility on September 29th through October 1st as she was out with pneumonia and the other RN was off.	F 354		
F 371 SS=E	483.35(i)(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 and staff interview, the facility failed to ensure thorough cleansing of food service equipment to minimize the potential for food-borne illness. The findings were: Observation on 11/7/06 at 10:35 AM revealed a bread machine and popcorn popper in the activities storage area at the end of the D Hall. Closer inspection of the bread machine showed it was coated in spots with dried bread residual on the sides of the backing container and around the paddle/mixer at the bottom of the container. The popcorn popper was dirty, with an oily film covering the inside of the sides and door of the	F 371	F371 Facility strives to ensure that equipment is stored under sanitary conditions. The bread maker was removed from the activity rom & cleaned by the Activity Director on 11-08-06.	12/6/06

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1310 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 32 popping machine. There were also popped corn kernels and residual in the inner popping oven and on the floor of the machine. Interview with the activities director on 11/7/06 at 10:50 AM revealed the bread and popcorn machines were periodically used in resident activities. She stated the machines should have been cleared with their last use. The activities director further stated she could not remember when they were last used, indicating it may have been " ...some months ago." A second observation done on 11/8/06 at 10:34 AM revealed the bread machine and popcorn machine remained soiled. The mixing blades of the bread machine were coated with dried on bread. The metal popper in the popcorn machine was coated with grease, popcorn hulls, and pieces of popcorn. The sides of the machine were coated with a grease build-up, and salt with popcorn hulls were visible. Interview with the dietary manager at 10:37 AM on 11/8/06 confirmed the equipment belonged to the activities department, and they were responsible for cleaning the equipment. Interview with the administrator on 11/8/06 at 12:40 PM revealed activity staff did not have a policy for cleaning the equipment.	F 371	A policy & Procedure for cleaning the popcorn machine and breadmaker was ~~given to surveyor~~ developed & Implemented on 11-08-06 ~~afternoon~~. The popcorn maker is not in use at this time. It has been cleaned and removed to storage. Activity Director and Department Managers will be inserviced on the need to clean equipment and properly store equipment after use. Activity Director and Administrator to monitor for compliance. 12/8/06 QA: Committee to monitor & Review as needed.	

DEPARTMENT OF HEALTH AND HUMA.. SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and review of medical records, facility policies and procedures, and professional standards of practice for infection control in healthcare settings, the facility failed to sustain an effective infection control program for two of two residents (#39 and #40) infected with methicillin-resistant Staphylococcus aureus (MRSA). In addition, the facility failed to ensure transmission-based isolation and other appropriate precautions were in place during two of three infectious events when isolation was appropriate. Further, the criteria established in facility policies and professional standards of practice for terminating isolation were not followed for one of one residents (#40) in which contact isolation was implemented. The facility also failed to fully implement their written policy to monitor sick employees in order to minimize the potential for transmitting infections or communicable diseases to residents. The resident census at the time of survey was 43. The findings were:	F 441	F441 The facility strives to establish and maintain an infection control program. Director of Nursing has implemented a tracking program for MRSA, VRE and other infections to insure the infection control policies are followed. Quality Assurance Committee to review monthly. 12/8/06 Director of Nursing will be responsible for completing surveillance of all infections. Multiple drug resistant organisms tracking has been added to current surveillance log. On 11-06-06, all department directors were instructed to complete illness-tracking form and submit to Director of Nursing weekly.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 441	Continued From page 34 1. Review of medical records for residents #39 and #40 revealed each was diagnosed with MRSA infections based on positive cultures reported from the servicing laboratory. Resident #39 had MRSA isolated from his/her left heel and foot (two separate cultures) on 10/23/06, and resident #40 had MRSA isolated from a urine sample on 1/12/06 and a wound on 10/17/06. Further review of the residents' medical record failed to show whether isolation or other appropriate precautions were implemented for either resident while infected with an epidemiologically-significant, multi-drug resistant organism. Interview with the director of nursing (DON), who also served as the infection control nurse (ICN) for the facility, confirmed the residents had not been placed in isolation based on the MRSA-positive infections. 2. Observation on 11/6/06 during the initial tour of the facility revealed room 34 (belonging to resident #40) was posted with a red "Isolation" sign; the sign had been removed when the room was observed on 11/8/06 at 9:35 AM. Interview with the DON on 11/8/06 at 11:30 AM indicated the isolation restrictions were initiated because the resident had copious drainage from a leg wound. The DON further stated the isolation was discontinued on the basis of clinical improvement in the wound infection. The DON stated the resident had not been cleared of MRSA by repeat reculture of the infected site as established in the facility's infection control policies and as recommended by the Association for Professionals in Infection Control and Epidemiology (APIC) in their consensus standard for infection control in healthcare settings. The APIC Text of Infection Control & Epidemiology,	F 441	has expired on 12/8/06 Res. #39 has been assessed and was placed on Linezolid on 11-08-06. Resident has open areas on foot and buttock, none are draining or exhibiting signs of infection. Director of Nursing will monitor for infection. Resident #40 ~~was and is still on~~ Remains on precautions per facility policy. The red sign was only removed from the door jamb and a new sign was placed on resident door which said, "Please see the ~~nurse.~~ Before Entry ~~This was a new element~~ of the precaution policy which was pointed out to us by corporate consultant at the time. This Resident is now in the hospital for debridment of the draining stump wound. Resident will not be removed from precautions until resident has met the infection control guidelines for terminating precautions. 12/8/6	

DEPARTMENT OF HEALTH AND HUMA. . SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535061	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 441	Continued From page 35 2nd edition, January 2006, establish the professional standards for infection control in healthcare facilities. The referenced standards recommend long-term care residents diagnosed by positive cultures for MRSA should be confirmed negative by reculture at the site of infection before precautions are terminated. The recommended practice states precautions should be continued until the patient "...completes antimicrobial therapy and until surveillance cultures are obtained at least 48 hours apart and are culture-negative from the original site of infection. The patient should have completed antibiotic therapy for at least 72 hours before cultures are obtained." Specific reference to culture-negative recommendations is found in Chapter 53, Long-Term Care, pages 53-8 through 53-10, of the 2006 edition of the APIC Text. 3. The facility's infection control policy regarding MRSA required the maintenance of a "...MRSA surveillance Line Listing...for residents known to have had MRSA infection/colonization..." Review of infection control records and logbooks on 11/8/06 at 3:45 PM failed to revealed a line-listing of residents with culture-confirmed infections involving multi-drug resistant organisms (MDROs). As noted it item #1, residents #39 and #40 had each experienced MRSA positive infections over the past 9 months. Interview with the DON on 11/8/06 at 4:15 PM confirmed the absence of an appropriate mechanism to monitor the prevalence or occurrence of MDROs in the facility. 4. Review of infection control records on 11/8/06 at 4:10 PM revealed the DON used a preprinted form to screen employees calling in sick for a	F 441	Director of Nursing has implemented a procedusre for tracking all infection and monitoring resistance to antibiotics. Residents #39 and #40 are being tracked. The nurses will be instructed on responsibility of timely follow-up on cultures with emphasis on appropriate treatment for MRSA and VRE.	12/5/06

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 441	Continued From page 36 scheduled work shift. In an interview on 11/8/06 at 4:20 PM, the DON stated she only monitored employees in nursing services for potentially infectious or communicable diseases. She further stated employees in the ancillary services, such as housekeeping, laundry, maintenance, and dietary, were not routinely tracked for potentially transmissible infections. The DON confirmed, in interview on 11/9/06 at 1:30 PM, that the facility's infection control policy for managing employee infections had not been fully implemented to include facility staff outside nursing services. 5. Observation on 11/6/06 at 6:12 PM revealed the facility failed to ensure staff utilized appropriate hand hygiene practices when assisting residents to eat. CNA #19 was observed to cough into her right hand while assisting resident #14 to eat. During a 16 minute observation period, the CNA handled the resident's sandwich, lifted the resident's glass by placing her right hand over the rim of the glass, and wiped the resident's face. The CNA also assisted three other residents (#13, #26, #43) to eat, and, in the process, touched their utensils, cups, and plates with her hands. At no time during the observation period did the CNA wash her hands or use a hand sanitizer. The Centers for Disease Control and Prevention (CDC) Guideline for Hand Hygiene in Health-Care Settings, published October 25, 2002, specifically requires healthcare workers to practice stringent hand hygiene practices. Further guidance published in the CDC Factsheet for Respiratory Hygiene/Cough Etiquette in Healthcare Settings, published November 4, 2004, specifically advises healthcare workers to "...clean your hands after coughing or sneezing...wash with soap and water	F 441 #4 #5	All managers and staff were inserviced on the new employee illness tracking form. This form will be completed and given to the Director of Nursing to log on the Employee Illness Log. Director of Nursing/Administrator to monitor all managers to ensure compliance. Quality Assurance Committee will review compliance monthly. All staff were inserviced on practicing appropriate hand hygiene. All staff were also given a skills check on washing hands. Certified Nursing Assistants were reminded of hand sanitizing solution availability and inserviced them to use solution at the assistive table. Charge nurse to monitor staff in dining room for compliance.	12/18/06 11/22/06 12/08/06

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 441	Continued From page 37 or clean with an alcohol-based hand cleaner."	F 441		
F 442 SS=E	483.65(b)(1) PREVENTING SPREAD OF INFECTION When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of medical records, facility policies and procedures, and professional standards of practice for infection control in healthcare settings, the facility failed to implement transmission-based isolation and other appropriate precautions for two of three infectious events involving multi-drug resistant organisms (MDROs) for which isolation was appropriate. Further, criteria established in facility policies and recommended in consensus standards for terminating precautions were not implemented for four of four infections involving methicillin-resistant Staphylococcus aureus (MRSA). The findings were: 1. Review of medical records for resident #39 revealed s/he was diagnosed with MRSA from two separate cultures taken from a wound of his/her left heel and from a wound between the 4th and 5th toes of the left foot. The resident was admitted to the local hospital at the time the cultures were collected and submitted to the laboratory. The final microbiology report, dated	F 442	F442 The facility strives to ensure resident needs to prevent the spread of infection. Resident #39 has been assessed. Resident was placed on Linezolid on 11-08-06 and was cleared on 11-16-06. Resident continues to have healing stage 2 open areas which are not draining or showing signs of infection. Director of Nursing continues to monitor all labs and started a tracking form on resident. Director of Nursing will monitor.	12/8/06

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1710 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 442	Continued From page 38 10/23/06, confirmed the presence of MRSA from both culture sites. Interview with the microbiology supervisor at the servicing laboratory on 11/8/06 at 9:35 AM confirmed the laboratory reports specified MRSA. The supervisor further stated a copy of the laboratory reports were sent to the attending physician. The resident reentered the long-term care facility on 10/25/06, two days after the MRSA-positive culture results were reported, and was undergoing antibiotic treatment for MRSA infections when s/he reentered the facility. Further review of the resident's medical record failed to show whether isolation or other appropriate precautions were implemented when the resident returned to the facility with the positive MRSA culture results. Interview with the DON, who also served as the infection control nurse (ICN) for the facility, confirmed the resident had not been placed in isolation upon his/her return to the facility. 2. Review of medical records for resident #40 revealed s/he was diagnosed with MRSA on two occasions from separate anatomic locations. Laboratory reports dated 1/12/06 and 10/17/06 confirmed the presence of MRSA from a urine sample and a wound, respectively. The resident's medical record failed to show that contact isolation or other precautions were implemented for the MRSA infection diagnosed in January 2006. Interview with the DON on 11/9/06 at 11:45 AM confirmed the record failed to document isolation or other appropriate precautions during January 2006. Observation on 11/6/06 during the initial tour of the facility revealed the resident's room was posted with a red "Isolation" sign; the sign was no longer in place when the room was observed on 11/8/06 at 9:35 AM. Interview with	F 442	See Plan of Correction for F441	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 442	Continued From page 39 the DON on 11/8/06 at 11:30 AM indicated the isolation restrictions had been removed on the basis of clinical improvement in the wound infection. The DON stated the resident had not been cleared of MRSA by repeat reculture of the infected sites for either of the two culture-positive MRSA infections. The process of clearing a resident of MRSA based on multiple culture-negative results is the recommendation practice of the Association for Professionals in Infection Control and Epiderniology (APIC) in their consensus standard for infection control in healthcare settings. 4. The facility administrator provided a copy of infection control policy 526, entitled "Methicillin Resistant." The policy stated "...residents known or suspected to have MRSA infection or colonization will be placed on Contact Isolation Precautions." The facility's policy further stated residents would "...remain on Contact Isolation until a clear culture report has been obtained." With regard to this infection control policy, the DON stated in interview on 11/9/06 at 11:40 AM that the established practices had not been followed in the situations involving MRSA for residents #39 and #40. 5. The APIC Text of Infection Control & Epidemiology, 2nd edition, January 2006, established the professional standards for infection control in healthcare facilities. The referenced standards recommend long-term care residents diagnosed by positive cultures for MRSA should be confirmed negative by reculture at the site of infection before precautions are terminated. The recommended practice states precautions should be continued until the patient	F 442 #39 #40	Director of Nursing has implemented a tracking program for MRSA, VRE and other infections to insure the infection control policies are followed. Quality Assurance Committee to review monthly. See Plan of Correction for F441	

DEPARTMENT OF HEALTH AND HUMA ERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 442	Continued From page 40 "...completes antimicrobial therapy and until surveillance cultures are obtained at least 48 hours apart and are culture-negative from the original site of infection. The patient should have completed antibiotic therapy for at least 72 hours before cultures are obtained." Specific reference to culture-negative recommendations is found in Chapter 53, Long-Term Care, pages 53-8 through 53-10, of the 2006 edition of the APIC Text. 6. Interview with the Chief, Emerging Diseases/Health Statistics Section, Wyoming Department of Health, on 10/12/06 at 2:40 PM confirmed the Wyoming Department of Health recommends individuals be considered free of MRSA only after two cultures of the infected body site are negative for MRSA.	F 442		
F 443 SS=E	483.65(b)(2) PREVENTING SPREAD OF INFECTION 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of infection control records and policies and procedures, the facility failed to fully implement a policy for monitoring healthcare workers reporting infections or potentially communicable diseases. Resident census at the time of survey was 43. The findings were:	F 443	The facility strives to ensure resident needs to prevent the spread of infection.	8/

DEPARTMENT OF HEALTH AND HUMA[illegible] SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 443	Continued From page 41 Review of infection control policy 614, entitled "Management and Reporting of Employee Infection", revealed the established facility standard stated as "...when an employee is absent from duty with complaints of signs and symptoms of an infection, the employee's immediate supervisor must fill out and complete an infection report." The policy further directed the "...immediate supervisor must provide the infection control coordinator with a copy of the completed report." The policy summarized the infection control coordinator's responsibility to evaluate the potential transmissibility of the employee's infection, provide guidance regarding limited duty assignments, and monitor the physician's return to work release. In reviewing the implementation of this facility policy, the following concern was noted: a. Review of infection control records on 11/8/06 at 4:10 PM revealed a form used by the infection control nurse (ICN) to screen employees calling in sick for a scheduled work shift. The completed forms only included nursing personnel responsible for direct resident care. The director of nursing (DON), who also served as the facility ICN, stated in interview on 11/8/06 at 4:20 PM she only monitored employees in nursing services for potentially infectious or communicable diseases. She further stated she did not routinely monitor ancillary services, such as housekeeping, laundry, maintenance, and dietary, for potentially transmissible infections. The DON/ICN confirmed in interview on 11/9/06 at 1:30 PM the infection control policy for managing employee infections had not been fully implemented to include facility staff outside nursing services.	F 443	See Plan of Correction F441 pg 36 & 37	

DEPARTMENT OF HEALTH AND HUM/ SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policy and procedures, infection control records, and professional standards of practice, the facility failed to ensure staff utilized appropriate hand hygiene practices on two occasions involving resident care and assistance. The findings were: 1. Interview with the director of nursing (DON), who also served as the facility infection control nurse (ICN), on 11/8/06 at 4:10 PM revealed an expectation that staff assisting residents to eat would follow facility guidelines for hand hygiene; those guidelines included washing hands before providing assistance with dinning and after coughing onto their hand. Facility infection control policy 304, entitled, "Handwashing", required all personnel to follow established handwashing procedures to prevent the spread of infections. In addition, the Centers for Disease Control and Prevention (CDC) published recommended standards and professional practices for healthcare personnel in the United States. The CDC Guideline for Hand Hygiene in Health-Care Settings, published October 25, 2002, requires healthcare workers to practice stringent hand hygiene practices and specifically recommends hand decontamination "...before and after contact with food or food products. ." The CDC Factsheet	F 444 F-444 #1	The facility strives to ensure all staff wash hands after each direct resident contact. See Plan of Correction for F441 #5 Pg. 37	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 444	Continued From page 43 for Respiratory Hygiene/Cough Etiquette in Healthcare Settings, published November 4, 2004, specifically recommends healthcare workers perform "...hand hygiene...after having contact with respiratory secretions...". The CDC further advises healthcare workers to "...clean your hands after coughing or sneezing...wash with soap and water or clean with an alcohol-based hand cleaner " The following concern with staff failure to practice hand hygiene were observed: a. On 11/6/06 at 6:12 PM CNA #19 was observed to cough into her right hand while seated at an assisted dining table in the facility dining room. She was not wearing gloves at the time of the observation. She continued to assist resident #14 to eat by holding a sandwich in her right hand, lifting a glass by placing her right hand over the rim of the glass, and using both hands to wipe the resident's face with his/her clothing protector. During a 16 minute observation, from 6:12 PM to 6:28 PM, the CNA also assisted residents #13, #26, and #43 to eat, and, in the process, touched their utensils, cups, and plates with her hands. At 6:21 PM, CNA #19 left the table to get a spoon from the serving window across the dinning room; while walking to the serving area she touched her hair and rubbed her face with her right hand. At no time during the observation period did the CNA wash her hands or use hand sanitizer. 2. Observation of resident #39 on 11/7/06 at 9:21 AM revealed a physical therapist (PT) provided wound care to the resident's heels and the toes on the left foot. After finishing at 9:37 AM, the PT removed her gloves and picked up the dressing container, then without washing her hands, left	F 444	The Physical Therapist was inserviced on 11-02-06 on proper handwashing. Director of Nursing to monitor for compliance. 12/8/06 QA committee to review and monitor monthly	

...ENT OF HEALTH AND HUMAN SERVICES
...S FOR MEDICARE & MEDICAID SERVICES

...ENT OF DEFICIENCIES ...AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 444	Continued From page 44 the resident's room. The PT then went to the nurses' charting room and documented care. Observation of the chart room revealed it did not contain a sink. At 9:55 AM, the PT left the chart room and went to the physical therapy room. No handwashing was observed. Interview with the director of nursing on 11/8/06 at 3:33 PM revealed staff were expected to wash their hands after patient contact, which included after a dressing change.	F 444		
F 468 SS=B	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure handrails in all hallways. Sections of handrails were missing in two of six resident hallways. The findings were: Observation on 11/8/06 at 6:38 PM revealed two sections of handrails missing in the "B" hallway near the lounge. One section was approximately three feet long, and the other was approximately five and a half feet long. Further observation revealed a missing section approximately six feet long in the "A" hall outside of the business office. Interview with the administrator on 11/9/06 at 2:11 PM comfirmed the rails were missing.	F 468	F468 The facility strives to maintain secure hand rails on each side. Hand rails were installed on 11-29-06. Maintenance Supervisor to monitor for missing hand rails on daily rounds and repair as needed. Maintenance Supervisor to monitor. Quality Assurance and Safety Committee will review compliance monthly.	12/6/06

F HEALTH AND HUMAN SERVICES
MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LLS MANOR	210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff performed tasks as allowed within their scope of practice. One random observation of sample resident #1 revealed his/her oxygen was adjusted by certified nurse aides (CNAs); however, the liter flow rate was not posted as required by the Wyoming State Board of Nursing. The findings were: Observation of resident #1 on 11/7/06 at 4:55 PM revealed the resident's oxygen liter flow rate was at "0". The observation showed CNA #19 switched the resident's empty tank out for a full portable tank in front of the oxygen tank room. The CNA then adjusted the resident's liter flow rate from "0" to "2" liters. The observation revealed no posting as to the liter flow rate prescribed for the resident. Interview at that time with the CNA revealed she knew the liter flow rate because it was on the resident's oxygen concentrator in his/her room. According to the May 2001 decision by the Wyoming Board of Nursing (BON), a CNA may be delegated the task of adjusting the oxygen liter flow rate if it is clearly marked by the nurse on the concentrator and/or oxygen tank. Interview with the director of nursing (DON) on 11/8/06 at 3:33 PM revealed she was aware	F 492	The facility strives to ensure compliance with all regulations and accepted professional standards that apply to professional providing services in facility. Res #19 has been assessed for liter flow. The 02 bottle has been marked with liter flow to ensure ~~the~~ Certified Nursing Assistants can clearly know th liter flow. All 02 tanks will be assessed and liter flow will be clearly written. Charge Nurses to monitor daily on rounds. All nursing staff will be inserviced on proper labeling of 02 liter flow and the Certified Nursing Assistants responsiblility to inform nurses if the liter flow label is missing Director of Nursing to do weekly audit for one month and then quarterly. Results will be reviewed by Quality Assurance Committee.	12/8/06

and that CNA's to only adjust if liter flow is clearly marked

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 492	Continued From page 46 the Wyoming BON decision. The DON stated all the portable tank bags should be labeled with each resident's oxygen flow rate.	F 492		