Reprinted corrected by facility fax 4/28/05 @ 15:45 BL

PRINTED: 04/14/2005
FORM APPROVED
OMB NO. 0938-0391

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
---	535013	A. BUILDING _____ B. WING _____	C 03/31/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=B	483.20(b) RESIDENT ASSESSMENT 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	F 272	Disclaimer "This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." F272/B 1. Residents #5, ~~#56, and #59~~ comprehensive assessments have been completed. 2. All resident charts have been audited for Comprehensive assessments. Any missing assessments will be reprinted and signed or reprinted, completed, and signed. 3. A new Utilization Coordinator has been hired. Medical Records will audit monthly all resident charts who required an assessment during the month to ensure complete assessment is signed appropriately and in medical record. Executive Director is responsible for overall compliance. 4. Results of the audits will be brought to the monthly Performance Improvement Committee meeting for review, comments, and recommendations. 5. Compliance Date: May 2, 2005	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lyrecia Patterson, NHA — TITLE: Executive Director — (X6) DATE: 4/25/05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

POC accepted & all changes + corrections on 4/28/05 @ 1640 by Betty Nelson RN & Lyrecia Patterson Adm per phone conversation

PRINTED: 04/14/2005
FORM APPROVED
OMB NO. 0938-0391

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
	535013	A. BUILDING _____ B. WING _____	C 03/31/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 820[illegible]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 1	F 272		

the additional assessment performed through the resident assessment protocols; and

Documentation of participation in assessment

This REQUIREMENT is not met as evidenced by:
Based on medical record review, staff interview, and observation, the facility failed to assure comprehensive assessments were completed for three of eight sample residents (#56, #59, #80) who were identified with concerns. The findings were:

1. According to the face sheet, resident #80, who resided on the third floor, was admitted to the facility with diagnoses which included a recent hip replacement. Review of the 12/14/04 Minimum Data Set (MDS) assessment revealed staff identified the resident as at risk for falls, but a comprehensive fall assessment was lacking. Further review showed comprehensive assessments for all identified concerns were missing from the record. Interview with the administrator on 3/29/05 at 2:45 PM confirmed the comprehensive assessment for falls was not completed.

2. Review of the 10/8/04 initial and the 12/29/04 quarterly MDS assessment for resident #56 revealed section V of the Resident Assessment Protocol (RAP) Summary was not completed. Additionally, no comprehensive assessments were completed for areas of concern.

3. Review of the 10/20/04 significant change and the 1/11/05 quarterly MDS assessments for resident #59 revealed section V of the RAP Summary was not completed. Additionally, no

PRINTED: 04/14/2005
FORM APPROVED
OMB NO. 0938-0391

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
	535013	A. BUILDING _____ B. WING _____	C 03/31/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 820

(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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 2 comprehensive assessments were completed. 4. During the interview on 3/29/05 at 2:45 PM, the administrator stated that the Resident Assessment Protocols (RAPs, comprehensive assessments) which were to be completed by the nursing staff were not finished for most of the residents in the facility. In addition, she stated the areas completed by social services were not done for the residents who resided on the third floor. Observation during the interview showed a table in the administrator's office covered with various RAPs for most of the residents; the administrator stated they included residents #56, #59, and #80.	F 272	Disclaimer "This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." F314/G 1. Resident #56's pressure wounds and stasis ulcers have been assessed and appropriate intervention put in place. 2. All residents with limited mobility and score high on Braden Scale will be considered at risk and will have head to toe skin assessments completed. 3. Skin assessments will be completed by licensed nurses weekly on all residents and skin checks by Certified Nursing Assistants with every bath/shower. A weekly wound team meeting will be held to review all residents with pressure and non pressure wounds and other residents at risk. Charge nurses will be educated on proper positioning and random audits will be completed. Licensed nurses will be inserviced on the difference between pressure and non pressure wounds. Director of Nursing is responsible for overall compliance. 4. Results of weekly skin assessments, wound team meeting, and wound log will be brought to the monthly Performance Improvement Committee meeting for review, comments, and recommendations. 5. Compliance Date: May 2, 2005	
F 314	483.25(c) QUALITY OF CARE 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, staff interview, and medical record review, the facility failed to assure assessment and treatment occurred for one (#56) of four sample residents with a history of pressure sores. The findings were: Review of the 9/26/04 physician's order sheet revealed resident #56 was admitted with diagnoses including decubiti, arthritis,			

PRINTED: 04/14/2005
FORM APPROVED
OMB NO. 0938-0391

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
	535013	A. BUILDING _____ B. WING _____	C 03/31/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIV CHEYENNE, WY 820 -1

(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 (EACH CORREC CROSS-REFEREN C	LAN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 3 osteoporosis, anemia, and dementia. Review of the 12/29/04 quarterly Minimum Data Set (MDS) assessment revealed the resident required total dependence of two or more staff for bed mobility and transfer. In addition, review of the MDS revealed the resident had one stage I, one stage II, and three stage III pressure sores. Observation on 3/30/05 at 1:45 PM revealed the resident's left foot was contracted and rested on the medial aspect of the right foot. Observation further revealed staff had to force the feet apart to place an egg crate bootie on the feet. On 3/30/05 at 2:10 PM, observation with the registered nurse (RN) caring for this resident revealed the resident had an open area on the medial aspect of the left foot. The RN stated the open area looked like a stage II pressure sore. She further stated she was unaware of the sore and that it should be treated and dressed. Review of the wound and skin records revealed no documentation regarding the open area on the medial aspect of the left foot. Interview with the wound care RN on 3/31/05 at 10:15 AM revealed the last notation in the wound log regarding this area of the foot was on 3/5/05 and documented the wound as 0.6 centimeter (cm) by 0.7 cm and scabbed. She stated she did not know if the wound had healed at some point after 3/5/05. The wound RN further stated facility practice was that all new pressure sores were documented on the 24 hour shift report. Interview with the administrator and DON at the same time confirmed the protocol was to document pressure sores on the 24 hour shift report. The wound RN and the administrator both stated there was no documentation of this pressure sore on the shift reports and they were unaware of the pressure sore. Observation of the wound and interview on	F 314	recommendations. Treatment protocol in place & approved by Med. Director. Duties the following for this resident's pressure sores. 5. Compliance: May 2, 2005	

PRINTED: 04/14/2005
FORM APPROVED
OMB NO. 0938-0391

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
	535013	A. BUILDING _____ B. WING _____	C 03/31/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 820[illegible]

(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 4 3/31/05 at 1:15 PM with the wound RN and the physical therapist revealed a wound they stated was a stage IV because they were unable to tell what was underneath the area. Interview again confirmed neither the wound RN or the physical therapist were aware of the pressure sore.	F 314	Disclaimer "This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	
F 353 SS=E	483.30(a)(1)&(2) NURSING SERVICES The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans; Except when waived under paragraph (c) of this section, licensed nurses; and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident and family interview, staff interview, and medical record review, the facility failed to ensure regularly scheduled bathing was provided for three (#56, #69, #86) of 8 sample residents and seven (#35,	F 353	F353/E 1. Residents #5[illegible], #69, #86, #35, #52, #73, #83, #8[illegible] #87, and #111 will have two bath/showers per week as required. 2. All residents have the potential to be affected. 3. Bath audits will be completed weekly to ensure all residents are being offered two baths per week. Director of Nursing is responsible for overall compliance. 4. Results of audits will be brought to the monthly Performance Improvement Committee meeting for review, comments, and recommendations. 5. Compliance Date: May 2, 2005 6. Ads running in newspaper & on internet for open positions. Also recruiting from CNA class. Tuition pmt. & reimbursement in place. Bath aide program to be put in place on all floors. CNA duties being evaluated. Results monitored through P.I.	

PRINTED: 04/14/2005
FORM APPROVED
OMB NO. 0938-0391

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
	535013	A. BUILDING _____ B. WING _____	C 03/31/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 820[illegible]

(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 353	Continued From page 5	F 353		

#52, #73, #83, #84, #87, #111) non sample residents. The findings were:

1. Review of the 12/29/04 quarterly MDS assessment for resident #56 revealed he/she required total help with his/her bath. Review of the March 2005 bath records and the CNA flowsheets revealed the resident required two baths per week. Further review of the bath records and CNA flowsheets revealed the resident received baths on 3/24/05 and 3/28/05; two of the nine scheduled.

2. Review of the admission MDS assessment dated 11/16/04 and the quarter MDS assessment dated 2/16/05 for resident #69 revealed he/she required assistance with part of the bath. Review of the March 2005 bath records and the CNA flowsheets revealed this resident required two baths per week which were scheduled for 3/3, 3/7, 3/10, 3/14, 3/17, 3/21, 3/24, 3/28, 3/31. Further review of the bath records and CNA flowsheets revealed the resident received baths on 3/10, 3/14, 3/17, and 3/21; the resident received four of the scheduled nine baths during March 2005. During an interview on 3/30/05 at 11:30 AM, the resident stated he/she quite often did not get a bath. The resident further stated that "things around here are really in an uproar".

3. Review of the 10/18/04 annual and the 1/14/05 quarterly MDS assessments for resident #86 revealed he/she required staff help with part of his/her bath. Review of the March 2005 bath records and CNA flowsheets revealed the resident had baths scheduled for 3/2, 3/5, 3/9, 3/12, 3/16, 3/19, 3/22, 3/26, and 3/29. Further review of bath records and CNA flowsheets revealed the resident received baths on 3/9 and

PRINTED: 04/14/2005
FORM APPROVED
OMB NO. 0938-0391

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
	535013	A. BUILDING _____ B. WING _____	C 03/31/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 820 1

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 6	F 353		

3/23; the resident received two of nine scheduled baths during March 2005. Family interview on 3/29/05 at 10:15 AM revealed the resident was not always bathed as scheduled.

4. Review of the 2/25/05 admission Minimum Data Set (MDS) assessment for resident #35 revealed he/she required help with part of his/her bath. Review of the March 2005 bath records and certified nurse aide (CNA) flowsheets revealed this resident required two baths per week which were scheduled for 3/1, 3/4, 3/8, 3/11, 3/15, 3/18, 3/22, 3/25, and 3/29. Further review of the bath records and CNA flowsheets revealed the resident received baths on 3/1, 3/4, 3/11, 3/18 and 3/25; the resident received only five of the scheduled nine baths during March 2005.

5. Review of the 1/28/05 quarterly MDS assessment for resident #52 revealed he/she required total help with his/her bath. Review of the March 2005 bath records and CNA flowsheets revealed this resident required two baths per week which were scheduled for 3/2, 3/6, 3/9, 3/13, 3/16, 3/20, 3/23, 3/27, and 3/30. Further review of the bath records and CNA flowsheets revealed the resident received baths on 3/16 and 3/22; the resident received only two of nine scheduled baths during March 2005. Interview with the resident on 3/30/05 at 2 PM revealed baths were not always given as scheduled, but that he/she wanted baths at the scheduled times.

6. Review of the 7/14/04 initial MDS assessment and the 1/3/05 quarterly MDS assessment for resident #73 revealed he/she required assistance with transfer for a bath. Review of the March 2005 bath records and CNA flowsheets revealed this resident required two baths which were

PRINTED: 04/14/2005
FORM APPROVED
OMB NO. 0938-0391

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
	535013	A. BUILDING _____ B. WING _____	C 03/31/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3138 BOXELDER DRIVE CHEYENNE, WY 820

(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 353	Continued From page 7	F 353		

scheduled for 3/1, 3/4, 3/8, 3/11, 3/15, 3/18, 3/22, 3/25, and 3/29. Further review of the bath records and CNA flowsheets revealed the resident received baths on 3/2, 3/9, 3/14, and 3/20; the resident received four of the scheduled nine baths during March 2005.

7. Review of the 2/16/05 annual MDS assessment for resident #83 revealed he/she required assistance with part of his/her bath. Review of the March 2005 bath records and CNA flowsheets revealed this resident required two baths per week which were scheduled for 3/1, 3/4, 3/8, 3/11, 3/15, 3/18, 3/22, 3/25, and 3/29. Further review of the bath records and CNA flowsheets revealed the resident received baths on 3/4, 3/8, 3/11, and 3/25; the resident received four of nine scheduled baths for the month of March 2005.

8. Review of the 2/16/05 quarterly MDS assessment for resident #84 revealed he/she required staff assistance with part of his/her bath. Review of the March 2005 bath records and CNA flowsheets revealed the resident required two baths per week which were scheduled for 3/2, 3/5, 3/9, 3/12, 3/16, 3/19, 3/22, 3/26, and 3/29. Review revealed the resident received baths on 3/2, 3/9, 3/23, and 3/26; four of nine scheduled baths.

9. Review of the 10/18/04 annual and the 1/14/05 quarterly MDS assessments for resident #87 revealed he/she required staff assistance with part of his/her bath. Review of the March 2005 bath records and CNA flowsheets revealed the resident required two baths per week which were scheduled for 3/2, 3/5, 3/9, 3/12, 3/16, 3/19, 3/22, 3/26, and 3/29. Further review of the bath records

PRINTED: 04/14/2005
FORM APPROVED
OMB NO. 0938-0391

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
	535013	A. BUILDING _____ B. WING _____	C 03/31/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 8200

(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 353	Continued From page 8 and CNA flowsheets revealed baths were given on 3/9, 3/13, 3/16, 3/23,and 3/26; the resident received five of the nine scheduled baths. 10. Review of the 2/25/05 quarterly MDS assessment for resident #111 revealed he/she required staff assistance with part of his/her bath. Review of the March 2005 bath records and CNA flowsheets revealed the resident required two baths per week. Further review of the bath records and CNA flowsheets revealed the resident received a bath on 3/4, 3/8, and 3/22; the resident received three of nine scheduled baths.	F 353		
	11. Confidential interview with five different CNAs on 3/29/05 at 11:55 AM, 2:15 PM, 2:25 PM, 2:30 PM, 2:40 PM, and with three additional CNAs on 3/30 at 1:10 PM, 1:55 PM, and 2:05 PM revealed they were short staffed on some days. Each CNA further stated baths were not done on days they were short staffed. 12. Interview with the DON on 3/31/05 at 1:38 PM confirmed there had been days when there was not enough staff.			
F 465 SS=B	483.70(h) PHYSICAL ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a clean and sanitary environment in one of two shower rooms on the second floor and in one of two shower rooms on	F 465		

PRINTED: 04/14/2005
FORM APPROVED
OMB NO. 0938-0391

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
	535013	A. BUILDING _____ B. WING _____	C 03/31/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 8200

(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 465	Continued From page 9 the third floor. In addition, dirt and debris buildup, and soiled furniture was observed throughout the facility. The findings were: A tour of the facility on 3/29/05 from 8:50 AM to 10 AM revealed the following concerns: a. At 9:10 AM a tour of the shower rooms on second and third floors was made with the director of nursing (DON). Observation of the third floor shower room, located on the right of the elevator as you face it from the nursing station, revealed a brown substance underneath the sink. When the surveyor asked the DON to identify the brown substance, she stated it was "BM" (bowel movement). Further observation revealed a bucket of unlabeled liquid located in the left corner of the shower stall in this same room. Interview with the DON revealed she did not know the identity of the liquid. Observation of the second floor shower room, with the duck decorative wall covering, revealed a brown substance on the floor in the middle of the room. Interview with the DON revealed she believed it was "BM." b. At 8:50 AM observation of the shower room on first floor revealed the bathtub contained a blanket, an assortment of linen, a mirror, and a wall decoration. Interview with certified nurse aide (CNA) #1 at 2 PM on 3/29/05 revealed there was only one shower/tub room on first floor and if a resident needed a bath, staff would remove the items stored in the tub. Further observation of the tub revealed a scum buildup and dust in the corners. Observation revealed items of clothing were stored in the tubs on the second and third floors. Interview with the DON at 9:10 AM revealed the tubs were used for resident baths. c. Observation from 8:50 AM to 10 AM revealed a buildup of dirt and debris around the	F 465	Disclaimer "This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." F465/B 1. No individual resident was identified in this deficiency; therefore, no individual plan of correction can be addressed. 2. All residents have the potential to be affected by this practice. 3. Executive Director, Director of Nursing, and Unit Managers or designees will make rounds two times per day to check shower rooms for cleanliness and inappropriate storage of items. The chair identified in the day room on 3rd floor has been removed. Executive Director or designee will monitor for uncleanable surfaces on furniture during rounds. The mattress in room 218 will be replaced and an audit completed of all mattresses to determine need for replacement. Executive Director is responsible for overall compliance. 4. Results of rounds and audits will be brought to monthly Performance Improvement Committee meeting for review, corrections, and recommendations. 5. Compliance date: May 1, 2005	

PRINTED: 04/14/2005
FORM APPROVED
OMB NO. 0938-0391

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
	535013	A. BUILDING _____ B. WING _____	C 03/31/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(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 465	Continued From page 10 soiled utility room doors on third floor and in front of the elevators on each floor. d. Observation revealed a chair with plastic floral covering located in the day room on third floor was stained and had an approximately seven-inch tear in the middle of the seat. e. Observation on 3/30/05 at 1:45 PM revealed a strong urine odor in room #218. Interview with a certified nurse aide (CNA) on 3/30/05 at 1:45 PM revealed the odor was due to one of the residents living in this room being incontinent of urine and repeatedly saturating the mattress. The CNA further stated staff had tried a number of cleaners to remove the odor, but nothing had worked.	F 465	5. Cleaning schedule in place for Health Services Group q nursing 6. Staff will be inserviced on proper cleaning.	