STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING _____ B. WING _____	C 03/02/2005

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

RECEIVED
MAR 29 2005
WYO DEPT OF HEALTH
HEALTH FACILITIES

(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 164 SS=D	483.10(d)(3) FREE CHOICE The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect confidential health information from other residents, family members, and visitors. The findings were: 1. Observation on 3/1/05 at 9:30 AM revealed a certified nurse aide (CNA) #1 documenting care she had performed that day. The CNA was using a computer and the name of resident #48 was visible to the surveyor from the hallway approximately two feet away.	F 164	The facility will ensure personal privacy and confidentiality of each resident, this will be accomplished by: 1. Accounting Clerk will change the Kiosk Care Tracker systems in the hallways to reflect only the resident's first ~~name~~ and last initial. 2. Every new admission into the facility will be entered into the Care Tracker system with the ~~only~~ first ~~name~~ and last initial. 3. The D.O.N. will complete weekly computer checks completing the linen/care tracker checklist for ongoing compliance and the Accounting Clerk will make any necessary adjustments.	~~03/04/05~~ ~~03/07/05~~ 03/28/05

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

Administrator 3/28/05

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. 4/1/05

Plan of correction approved with changes approved by Peggy Duran DON on 3/3/05 at 2:30 PM & 4/1/05 at 8:05 am.

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F 164	Continued From page 1 2. Observation on 3/2/05 at 8:25 AM revealed certified nurse aide (CNA) #1 documenting care she had performed that day. The CNA was using a computer and the name of resident #37 was visible to the surveyor from the hallway approximately three feet away. 3. Observation on 3/2/05 at 8:29 AM revealed CNA #1 documenting care she had performed that day. The CNA was using a computer and the name of resident #39 was visible to the surveyor from the hallway approximately three feet away. 4. Observation on 3/2/05 at 8:32 AM revealed CNA #1 documenting care she had performed that day. The CNA was using a computer and the name of resident #52 was visible to the surveyor from the hallway approximately three feet away. 5. Interview with the administrator and director of nursing on 3/2/05 at 2:40 PM revealed they were unaware the computers did not provide privacy during use.	F 164		
F 254 SS=E	483.15(h)(3) ENVIRONMENT The facility must provide a clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation, and staff and resident interview, the facility failed to ensure wash cloths were available during two of two random observations of the linen closets and the clean utility room. The findings were: On 3/1/05 at 9:10 AM, observation of the clean	F 254	The facility will provide clean bed and bath linens that are in good condition, this will be accomplished by: 1. The Aides will restock linen closets prior to the end of each shift. ~~03/15/05~~ 2. Nursing staff in-service was held to re-educate nurses and aides on the need for available linens in the linen closets for resident use at all times. ~~03/15/05~~	

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F 254	Continued From page 2 utility room, the linen cabinet on the 200 hall, and the linen cabinet on the 300 hall, revealed there were no wash cloths available for use in meeting resident needs. On 3/2/05 at 11 AM, observation of the clean utility room, the linen cabinet on the 200, and the linen cabinet on the 300 hall, revealed there were no wash cloths available. Interview with resident #27 on 3/1/05 at 9:17 AM revealed there frequently were no washcloths available for resident use; he/she stated staff sometimes used paper towels or bath towels in place of a washcloth. The resident further stated it seemed like the nursing home should have enough linen for residents. Interview with certified nurse aide (CNA) #1 on 3/2/05 at 11:30 AM revealed there frequently were no washcloths available. Interview with CNA #2 on 3/2/05 at 1:20 PM revealed washcloths were not always available.	F 254	3. The D.O.N. and nursing staff will be responsible for ongoing compliance by completing weekly spot checks and filling out the linen check sheet.	03/28/05
F 278 SS=D	483.20(g) - (h) 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	F 278	The facility must, by a Registered Nurse, provide an assessment which accurately reflects the resident's status, this will be accomplished by: 1. Minimum data sets for residents #27 and #35 will be recoded and submitted to Medicare as a correction in coding for an admission assessment. 2. The MDS Coordinator will ensure complete and accurate assessments on each ~~resident~~ section she completes with accurate coding on each Minimum Data Set.	03/28/05 ~~03/15/05~~

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F 278	Continued From page 3 resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or 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:	F 278	3. MDS Coordinator and D.O.N. will complete random chart audits~~completing a~~ for completeness & accuracy chart check list. Audits will be reviewed quarterly by the QA Committee to insure ongoing compliance.	~~03/08/05~~
	Based on medical record review, and staff interview, the facility failed to ensure each resident's assessment was accurate for two (#27, #35) of seven sample residents. The findings were: 1. Review of the admission face sheet revealed resident #27 was admitted on 9/1/04. Review further revealed a Minimum Data Set (MDS) assessment dated 9/14/04 was not coded as an admission MDS assessment. 2. Review of the admission face sheet for resident #35 revealed he/she was admitted on 7/19/04. Review further revealed an MDS assessment dated 8/1/04 was not coded as an admission MDS assessment. 3. Interview with the director of nursing and the MDS coordinator on 3/2/5 at 10 AM confirmed the 9/14/05 MDS assessment for resident #27 and the 8/1/04 MDS assessment for resident #35 were coded inaccurately.			
F 279 SS=D	483.20(k) RESIDENT ASSESSMENT	F 279		

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F 279	Continued From page 4 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 following: 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 s483.25; and Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and medical record review, the facility failed to develop an individualized nutritional care plan for one (#27) of seven sample residents. The findings were: Review of the February 2005 physician's order sheet for resident #27 revealed the resident was admitted with diagnoses including cachexia (malnutrition, wasting). Review of the 12/28/04 dietary progress notes revealed the resident had a five percent weight weight loss in the past 90 days. Review of the 12/29/04 significant change Minimum Data Set (MDS) assessment revealed the resident had a weight loss of five percent or more in the past 30 days or 10 percent or more in the past 180 days. Interview with the resident on 3/1/05 at 9:17 AM revealed he/she had lost	F 279	The facility will ensure that a comprehensive care plan for each resident that includes measurable objectives and time tables to meet the resident's nutritional care is completed, this will be accomplished by: 1. Weekly weight meetings with the D.O.N., MDS Coordinator, Dietary Manager and Social Services Designee will be held to identify resident's at risk for nutritional defects. ~~03/08/05~~ 2. Any resident that has weight loss of ~~10%~~ 5% in 30 days will have an individualized nutritional care plan implemented by the Dietary Manager and the Dietician. ~~03/08/05~~ or 10% in 180 days 3. The Dietary Manager and Dietician will be responsible for quarterly chart audits for ongoing compliance. 03/10/05 4. Resident #27 with diagnosis Cachexia identified as weight loss of 10% in the past 180 days has a care plan implemented and placed in the chart. ~~03/03/05~~ 5. Weekly weights will be reviewed by Q.A. Committee quarterly. ~~03/09/05~~	

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F 279	Continued From page 5 weight recently. Review of the medical record revealed there was no care plan to address the resident's weight loss. Interview with the dietary manager on 3/2/05 at 1:15 PM confirmed there was no nutritional care plan developed for the resident and that it must have been an "oversight."	F 279		
F 281 SS=D	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record review, the facility failed to assure staff followed physician's orders for four (#2, #3, #11, #33) of seven sample residents. The findings were: 1. Review of the medical record for resident #2 revealed he/she had diagnoses including constipation. Review of the facility's bowel tracking report for February and March 2005 revealed the resident went from 2/19/05 through 3/1/05 (11 days) without a bowel movement. Review of the February 2005 care plan revealed elimination had been identified as a problem with a goal for the resident to have a bowel movement every two to three days. Further review of the care plan revealed approaches included administering a laxative according to standing orders for no bowel movement in three days. Review of the February 2005 physician's orders revealed an order for medications according to standing orders dated 1/27/04. Review of the standing orders for constipation included Milk of	F 281	The facility must meet professional standards of quality of care by resident assessment, this will be accomplished by: 1. The charge nurse will attain daily information from the Care Tracker System and residents that have not had a BM in the last 9 shifts. The charge nurse will notify the doctor and follow doctor's orders for those residents. 2. D.O.N. held an in-service with all nursing staff to instruct on use of Care Tracker System and how to attain information from the System.	03/15/05 03/15/05

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F 281	Continued From page 6 Magnesia (laxative) 30 cubic centimeters (cc) PRN (as needed) if no bowel movement for three days, bisacodyl (laxative) suppository one daily PRN if no bowel movement for three days, tap water enema (solution to stimulate bowel activity) or Fleets enema PRN if no results from the suppository, and notify the physician for chronic constipation. Review of the Medication Administration Record (MAR) for February and March 2005 revealed no PRN laxatives were administered during the eleven days without a bowel movement. Interview with a registered nurse on 3/1/05 at 5:10 PM confirmed there was no indication the resident had a bowel movement since 2/18/05 and that no PRN laxative had been given from 2/19/05 through 3/1/05. Review of the 9/22/04 significant change Minimum Data Set (MDS) assessment and the quarterly 12/21/04 MDS assessment revealed the resident was continent of bowel. Interview with a registered nurse (RN) on 3/2/05 at 2 PM revealed the resident toileted him/herself independently and exhibited no signs or symptoms of constipation. 2. Review of the facility's bowel tracking report for February and March 2005 revealed resident #3 had not had a bowel movement from 2/23/05 to 3/1/05 (7 days). Review of the February 2005 physician's orders revealed an order dated 8/30/02 for medications according to standing orders. Review of the standing orders for constipation included Milk of Magnesia (laxative) 30 cubic centimeters (cc) PRN (as needed) if no bowel movement for three days, bisacodyl (laxative) suppository one daily PRN if no bowel movement for three days, tap water enema (solution to stimulate bowel activity) or Fleets enema PRN if no results from the suppository,	F 281	3. Residents #2, #3, #11 and #33 were questioned and had BM's without staff knowledge ~~to~~ due to their independence prior to surveyor's departure. Independent residents will be given a tool to help retain independence and allow proper charting in regards to BM's. 4. Aides were in-serviced on questioning independent residents on bowel and bladder daily and documenting on Care Tracker System. 5. Charge nurses will daily check compliance of bowel and bladder and follow up with appropriate interventions. BM's will be audited for compliance by Q.A. Committee.	~~03/02/05~~ 03/15/05 03/15/05 documentation

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F 281	Continued From page 7	F 281		

and notify the physician for chronic constipation. Review of the Medication Administration Record (MAR) for February and March 2005 revealed no PRN laxatives were administered during the seven days without a bowel movement. Interview with a registered nurse on 3/1/05 at 5:10 PM confirmed there was no indication the resident had a bowel movement since 2/22/05 and that no PRN laxative had been given from 2/23/05 through 3/1/05.

Review of the 11/28/04 quarterly MDS assessment revealed the resident was continent of bowel. Interview with an RN on 3/2/05 at 2 PM revealed the resident toileted him/herself independently and exhibited no signs or symptoms of constipation.

3. Review of the facility's bowel tracking report for February and March 2005 revealed resident #11 went from 2/23/05 through 3/1/05 (7 days) without a bowel movement. Review of the February 2005 care plan revealed elimination had been identified as a problem with a goal for the resident to have a bowel movement every two to three days. Further review of the care plan revealed approaches included administering a laxative according to standing orders for no bowel movement in three days. Review of the February 2005 physician's orders revealed an order dated 11/2/03 for medications according to standing orders. Review of the standing orders for constipation included Milk of Magnesia (laxative) 30 cubic centimeters (cc) PRN (as needed) if no bowel movement for three days, bisacodyl (laxative) suppository one daily PRN if no bowel movement for three days, tap water enema (solution to stimulate bowel activity) or Fleets enema PRN if no results from the suppository, and notify the physician for chronic constipation.

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F 281	Continued From page 8 Review of the Medication Administration Record (MAR) for February and March 2005 revealed no PRN laxatives were administered during the seven days without a bowel movement. Interview with a registered nurse on 3/1/05 at 5:10 PM confirmed there was no indication the resident had a bowel movement since 2/22/05 and that no PRN laxative had been given from 2/23/05 through 3/1/05. Review of the 11/24/04 annual MDS assessment revealed the resident was continent of bowel. Interview with an RN on 3/2/05 at 2 PM revealed the resident toileted him/herself independently and exhibited no signs or symptoms of constipation. 4. Review of the facility's bowel tracking report for February and March 2005 revealed resident #33 went from 2/24/05 through 3/1/05 (6 days) without a bowel movement. Review of the February 2005 physician's orders revealed an order dated 6/22/04 for medications according to standing orders. Review of the standing orders for constipation included Milk of Magnesia (laxative) 30 cubic centimeters (cc) PRN (as needed) if no bowel movement for three days, bisacodyl (laxative) suppository one daily PRN if no bowel movement for three days, tap water enema (solution to stimulate bowel activity) or Fleets enema PRN if no results from the suppository, and notify the physician for chronic constipation. Review of the Medication Administration Record (MAR) for February and March 2005 revealed no PRN laxatives were administered between 2/23/05 and 3/1/05. Interview with a registered nurse on 3/1/05 at 5:10 PM confirmed there was no indication the resident had a bowel movement since 2/23/05 and that no PRN laxative had been given from 2/23/05 through 3/1/05.	F 281		

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F 281	Continued From page 9 Review of the 9/22/04 significant change and the 12/21/04 quarterly MDS assessments revealed the resident was continent of bowel. Interview with an RN on 3/2/05 at 2 PM revealed the resident toileted him/herself independently and exhibited no signs or symptoms of constipation.	F 281		
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, staff interview, and review of the facility's staffing, job descriptions, employee report, and personnel records, the facility failed to follow accepted standards of nursing practice related to certification requirements for nursing assistants/nurse aides. In addition, professional staff failed to follow accepted standards of nursing practice related to delegation of basic nursing functions to non certified staff. The findings were: 1. According to the Wyoming "Nursing Practice Act and Administrative Rules and Regulations", November 2003, section 4, pages 7-3, all nurse aides, regardless of title or care setting, shall be required to hold a current, valid CNA (certified nurse aide) certificate within four months (120 days) from the first date of hire. Review of the "Employee Seniority Report", and the facility	F 492	The facility will follow accepted standards of nursing practice related to certification requirements for nursing assistants and nurse's aides. This will be accomplished by: 1. NA #1, #2 and #3 were put on a leave of absence from the Universal Worker role and personal resident care until C.N.A. licensure is presented to the facility. 2. The D.O.N. held an in-service to nursing staff regarding N.A.'s roles at the facility and the 120 days to provide to the facility the C.N.A. licensure.	~~03/03/05~~ ~~03/15/05~~

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F 492	Continued From page 10 staffing schedule for the month of February 2005 revealed three staff were assigned to work with residents as nurse aides (NA) who did not have a CNA certificate. Upon review of the personnel files for these three nurse aides, the following concerns were identified: a. NA #1 was hired on 7/7/04. As of 3/1/05 (117 days past the required four month (120 days) rule) she did not have a valid CNA certificate. The NA worked 19 days in February 2005. The dates were February 1, 2, 3, 5, 6, 8, 10, 11, 12, 14, 15, 16, 19, 20, 21, 22, 24, 25, and 27. b. NA #2 was hired on 8/24/04. As of 3/1/05 (69 days beyond the required four month rule), she did not have a valid CNA certificate. The NA worked 15 days in February 2005. The dates were February 3,6,7,11,13,14,15,16,17,20,21,23,24,25, and 28. c. NA #3 was hired on 10/5/04. As of 3/1/05 (27 days past the four month rule), she did not have a valid CNA certificate. The NA worked 17 days in February 2005. The dates were February 5,7,8,9,11,12,13,14,16,17,18,21,22,23,24,25, and 28. Observation on 3/1/05 revealed NA#2 and NA#3 worked on the nursing unit. Confidential interview with three CNAs on 3/2/05 at 1 PM, 1:15 PM, and 1:20 PM confirmed NAs regularly worked the nursing unit and performed direct personal care functions. Interview with a registered nurse on 3/2/05 at 1:05 PM confirmed the NAs performed direct personal care functions. 2. Interview with the administrator on 3/1/05 at 8:30 AM revealed nurse aides (NAs) who were not yet eligible for a valid certified nurse aide (CNA) certificate and who had worked past 120 days were reclassified as "universal workers".	F 492	3. The Administrator or DON or Quality Care Manager will in-service all new N.A.'s on 120 days to work in the facility without licensure. If licensure is not attained at that time the N.A. will be put on a leave of absence until licensure is attained and given to the facility. 4. Administrator, D.O.N. and Quality Care Manager will evaluate each NA's length of time for certification as ongoing compliance. Compliance will be monitored quarterly through the Q.A. Committee. Nurse aides will be actively participating in a CNA course on the day of hire. The CNA course will be approved by the WY Board of Nursing. The Nurse aides will perform only those delegated tasks in which they	~~03/03/05~~ ~~03/03/05~~ 4/1/05

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING _____ B. WING _____	C 03/02/2005

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

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F 492	Continued From page 11 Review of the job description for a universal worker revealed the following "Personal Nursing Care Functions", page 2, were included as NA tasks: assist residents with nail care including clipping, trimming, and cleaning the finger/toenails, maintain intake and output records, weigh and measure residents, ensure that residents who are unable to call for help are checked frequently, check each resident routinely to ensure that his/her personal care needs are met, provide residents with reality orientation , and assist with feeding residents. According to the "Nursing Practice Act and Administrative Rules and Regulations" dated November 2003, section 6, page 7-4 the delegating nurse must verify the nurse aide's competence to perform any nursing tasks prior to delegation; according to section 8, pages 7-5 through 7-7, the following nursing functions, tasks, and skills may be delegated to a certified nurse aide: measuring and recording height, weight, intake and output, assisting with eating including proper feeding technique, and nail care. The following concerns were identified: a. Interview with the staff member responsible for personnel records on 3/1/05 at 2:15 PM revealed NA #1 was unable to pass the CNA class so was reclassified as a universal worker. Interview further revealed this NA had not had inservice training on nail care, maintaining intake and output records, weighing and measuring residents, or providing care with consideration of the resident's cognitive level of functioning. b. Interview with the staff member responsible for personnel records on 3/1/05 at 2:15 PM revealed NA #2 completed her CNA class at the end of June 2004 and is scheduled to take the CNA test on 3/19/05. Further interview	F 492	have demonstrated competency by that WY Board of Nursing instructor.	

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F 492	Continued From page 12 revealed this NA had not attended inservice training on nail care, maintaining intake and output records, weight and measuring residents, how to ensure resident personal care needs were met, providing residents with reality orientation, and feeding techniques. c. Interview with the staff member responsible for personnel records on 3/1/05 at 2:15 PM revealed NA #3 started the CNA class in February 2005 with an anticipated completion date of 3/4/05. Interview further revealed she had not attended inservice training on nail care, maintaining intake and output records, weighing and measuring residents, how to ensure resident personal care needs were met, providing residents with reality orientation, and feeding techniques.	F 492		