EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

10/20/11

PRINTED: 10/12/2011
FORM APPROVED
OMB NO. 0938-0391

FEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 09/29/2011

IE OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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
'000	INITIAL COMMENTS The following common abbreviations and acronyms are used throughout this document: DON- director of nursing PRN- as needed MAR- medication administration record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
309 S=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record review, the facility failed to ensure a comprehensive musculoskeletal assessment was performed after a fall for 1 of 6 sample residents (#76) who had falls. This lack of a comprehensive assessment may have contributed to a delay in diagnosis of a hip fracture. In addition, the facility failed to ensure all necessary assessments and monitoring were implemented for preventive pain management for 1 of 5 sample residents (#70) who had pain. The findings were: 1. Review of the nursing notes for resident #76	F 309	F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1) Resident # 76 no longer resides at the facility. 2) Following a fall the nurse will document a complete musculoskeletal assessment of the resident. 3) Proper and complete pain assessments will be performed and documented for resident #70. 4) The Director of Nursing will provide re-education to all nurses on or before November 16, 2011 regarding completion of a thorough musculoskeletal assessment following a resident fall, and the performance and completion of a pain assessment for patients who have pain. The education will also include evaluation for effectiveness of pain relieving method whether pharmacological or alternative methods.	11-16-11 11/12/11

11/15/4

TORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Tonya M — ED — 10-21-11

iency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that eguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 wing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued participation.

RECEIVED
Wyoming Dept of Health
OCT 21
Office of Healthcare Licensing and Surveys

Accepted w/ changes. Spoke w/ Tonya M Brown on 10/28/11. Date of Compliance = 11/16/11

11/15/11 Per ED request (Tonya) DOC was changed to 11/13/11 SH

10/21/11

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F 309	Continued From page 1 written on 6/12/11 at 11:15 PM showed s/he was found on the floor in the activity room. Review of the nursing assessment notes written at 11:15 PM on 6/12/11 showed the resident complained of a sore left hip but there was no redness or discoloration, and the vitals signs included a blood pressure of 161/52, pulse of 69, respirations 20, and temperature 96.7 degrees Fahrenheit. Review of the 6/12/11 nursing assessment performed at 11:15 PM showed no evidence a musculoskeletal assessment was performed, only that the skin was not red or discolored. Review of the 6/13/11 nursing notes written at 12:45 PM showed no evidence a musculoskeletal assessment was performed. Review of the nursing notes on 6/14/11 written at 4:30 AM revealed the resident complained of pain in the left hip and left knee and was administered Tylenol. Again, no musculoskeletal assessment was performed. Review of the 6/15/11 nursing notes written at 5 AM showed the resident screamed with pain and grabbed his/her thigh during staff provision of morning care. At that time, the physician was contacted and ordered the resident to be transported to the emergency department for evaluation. Review of the 6/15/11 radiology report showed the resident had a displaced fractured left hip. Interview with the DON on 9/29/11 at 2:20 PM revealed the nurse should have done a more thorough assessment. 2. Review of the September 2011 physician's recapitulation of orders for resident #70 showed s/he was admitted after surgical repair of a broken left hip. Review of the physician's orders showed an order for Hydrocodone/APAP 5/500 milligrams (mg) every four hours as needed for pain. Review of the nursing notes, MAR, and pain	F 309	5) Members of the Performance Improvement Committee will use a quality assurance- monitoring tool to perform random weekly audits of documentation of thorough musculoskeletal assessments following resident falls. The tool will also be used to perform random weekly audits of documentation of pain assessments prior to administration of pain relieving methods and to perform random weekly audits of documentation of effectiveness following pain-relieving methods. The audits will include resident #70. If non-compliance is noted immediate re-education and/or corrective action will occur. 6) The results of the audits will be reported at the monthly Performance Improvement Meeting for a minimum of three months and until substantial compliance is achieved.	

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F 309	Continued From page 2 flow sheet for September 2011 revealed the resident received sixteen PRN medications for pain. Continued review showed no evidence an assessment of the resident's pain as to intensity or description was performed five of the sixteen times (31%). Additionally, there was no evidence a re-assessment to determine the effectiveness of the pain medication was performed seven of the sixteen times (44%). Interview with the resident on 9/29/11 at 1:40 PM revealed the pain medications helped most of the time but not always. Interview with the DON on 9/29/11 at 2:20 PM revealed nurses should re-assess a resident's pain after administration of medications to determine if it was effective.	F 309		
F 325 S=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the medical record, the facility failed to ensure nutritional needs were met for 1 of 1 sample residents (#75) who required tube feedings. The findings were:	F 325	F325 MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident, 1) maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and 2) receives a therapeutic diet when there is a nutritional problem. 1) Resident #75 no longer resides at this facility. 2) When there is a resident residing in the facility that has an order for tube feedings, audits will be conducted to ensure that all feedings are given as prescribed as evidenced by complete documentation of administering the feedings. 3) The Director of Nursing will re-educate the nurses about the importance of providing tube feedings as prescribed and about documenting the administration of all tube feedings. The re-education will be conducted on or before November 16, 2011.	

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325	Continued From page 3 Review of the 5/12/11 hospital history and physical for resident #75 showed s/he had diagnoses including dysphagia, failure to thrive, and generalized weakness. Further review showed the resident underwent PEG (percutaneous endoscopic gastrostomy) tube placement secondary to dysphagia. Upon admission to the facility on 6/27/11, the resident received Jevity tube feedings for nutrition. Review of the speech therapist evaluation performed on 6/29/11, showed the resident had weakness involving the pharyngeal wall muscles and required swallowing therapy. The following concerns were identified: a. Review of the 8/19/11 physician's orders showed an order for two cans of Jevity 1.2 four times per day through the PEG tube. Review of the treatment record for August 2011 showed on 8/25/11 at 9 AM, and on 8/29/11 at 9 AM and 1:30 PM, the resident was not administered the Jevity because the 1.2 was unavailable. Interview with the DON on 9/29/11 at 2:20 PM revealed Jevity 1.2 was unavailable because the orders were changed and the facility still had the previous order of Jevity 1.5. She said the nurse should have called the physician and asked to continue with the Jevity 1.5 while waiting on the arrival of the Jevity 1.2 instead of holding the Jevity feedings entirely. The DON further said she talked with the nurse involved and that nurse verified she had not given the Jevity feedings on those dates. b. Review of the September 2011 MAR showed no evidence the resident was provided the prescribed Jevity tube feedings on 9/4/11 at 4 PM or 8 PM. Further review of the document revealed no explanation as to why the two	F 325	4) Members of the Performance Improvement Committee will use a quality assurance tool to conduct random weekly audits of any resident having orders for tube feedings to ensure that feedings are administered as prescribed and that documentation about the administration of feedings is complete. If non-compliance is noted there will immediate re-education and/or corrective action conducted. 5) Results of the audit will be reported at the Performance Improvement Meeting for a minimum of three months and until substantial compliance has been achieved. 11-14-11 11/13/11 SM 11/15/11	

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325	Continued From page 4 feedings were not administered. Interview with the DON on 9/29/11 at 2:20 PM revealed she was unsure why the Jevity tube feeding had not been given.	F 325		
502 S=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure laboratory tests were performed as ordered for 1 of 6 sample residents (#75). The findings were: Review of the 7/13/11 physician's orders for resident #75 showed a pre-albumin laboratory test was ordered to be drawn weekly beginning on 7/14/11 to monitor the adequacy of his/her tube feedings. However, review of the entire medical record revealed the weekly test was not performed as ordered on 7/21/11, 7/28/11, 8/11/11, 8/18/11, and 9/1/11. Interview with the DON on 9/29/11 at 2:20 PM verified the laboratory tests were not performed as ordered and she was unsure why.	F 502	F502 ADMINISTRATION The facility will provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. 1) Resident #75 no longer resides at the facility. 2) Random weekly audits of laboratory orders will be conducted to ensure that labs are being obtained per physician order. 3) The Director of Nursing will re-educate nurses about the importance of obtaining labs per physician orders. The education will be conducted on or before November 16, 2011. 4) Members of the Performance Improvement Committee will use a quality assurance tool to conduct audits to ensure labs are obtained per physician orders. If non-compliance is noted immediate re-education and/or corrective action will occur. 5) Results of the audits will be reported for a minimum of three months and until substantial compliance is achieved.	11-16-11 11/13/11 SH 11/15/11