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	535025	A. BUILDING _____ B. WING _____	C. 01/06/2012

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F 000	INITIAL COMMENTS CAA- Care Area Assessment CNA- certified nursing assistant DON- director of nursing LPN- licensed practical nurse MDS- Minimum Data Set RN- registered nurse	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan of correction serves as the facility's allegation of compliance.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure the dignity and respect for 1 of 4 sample residents (#51) observed during dining. The findings were: Review of the 12/22/11 quarterly MDS assessment for resident #51 showed s/he needed limited assistance with eating. Further, the 9/23/11 admission MDS assessment CAA for ADL function/rehabilitation potential showed the resident had a cerebral vascular accident and left hemiparesis (paralysis). Observation on 1/3/12 at 5:40 PM showed the resident sitting at the dining room table with a filled water pitcher in the center	F 241	F TAG 241 DIGNITY- CORRECTIVE ACTION: Resident #51 is being offered fluids when she arrives to the dining room. ID OF OTHERS: The NHA made observations of several meals to observe for residents needing assist with beverages. No other opportunities were identified. SYSTEMS MEASURES: Staff will be educated by the Staff	2/28/12

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

Jennifer Reaume — N.H.A — 3-8-12

RECEIVED
WY Dept Of Health
MAR 12 2012
Healthcare Licensing and Surveys
Event ID: YRDT11 Facility ID: WY0005

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F 241	Continued From page 1 of the table. The resident turned his/her water glass upright, then brought the empty glass to her/her lips. On two occasions, the resident then pounded the empty glass on the table and raised the glass over his/her head. During the observation, the dining room staff and nursing staff were assisting other residents and did not acknowledge the resident. After 10 minutes (at 5:50 PM) the resident pulled the tablecloth towards him/her but was still unable to reach the water pitcher. At 6 PM (20 minutes later), the dining room staff poured water for the resident. During an interview with the DON on 1/5/12 at 11 AM, she acknowledged the 20 minute time frame to recognize the resident's gestures for assistance with fluids was too long.	F 241	Development Coordinator (SDC) on or before 2/28/12 regarding dignity and specifically offering fluids to residents when in the dining room. Dietary Manager or designee will perform 3-5 random observations of dining room for offering fluids timely per week for 1 month. Meal Monitors will report to NHA any dining room observations any findings of non-compliance with timeliness of offering fluids. MONITOR: Dietary Manager or designee will track and trend audits and report findings to the QA&A committee. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and implemented additional interventions as needed to ensure continued compliance for 3 months. Date of Compliance:	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		2/28/12

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F 279	Continued From page 2 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 medical record review and staff interview, the facility failed to to develop a comprehensive care plan for 1 of 1 sample resident (# 98) who required a care plan for fluid restriction. The findings were: Review of the face sheet for resident #98 showed s/he had diagnoses including chronic kidney disease and morbid obesity. Review of the 11/16/11 physician's progress notes showed the resident was receiving dialysis for chronic renal failure. According to the 11/16/11 physician's admission orders the resident required a 2000 cc fluid restriction. However, an interview with the DON on 1/5/12 at 11 AM confirmed the fluid restriction was not on the care plan, and needed to be due to the resident's fluid restriction.	F 279	F TAG 279 CORRECTIVE ACTION: Resident #98 discharged on 12/5/2011. ID OF OTHERS: An audit was conducted for residents with fluid restriction orders. Any found will have care plans updated. SYSTEMS MEASURES: RCD/designee to educate the interdisciplinary team on documentation of all pertinent information on the care plans. DON/Designee will review care plans for all residents on a fluid restriction weekly during Care Management Risk Review. DON/designee to conduct random weekly audits of care plans to ensure all pertinent information is on the care plan x 4 weeks and then random audits. MONITORING: The DON or designee will track and trend and report findings to the	

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F 279	Continued From page 3	F 279	QA&A committee. The QA&A will evaluate the effectiveness of the plan based on trends identified and implement any additional interventions as needed to ensure continued compliance for 3 months. Date of compliance:	
F 309 SS=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 medical record review and staff interview, the facility failed to provide the necessary care to maintain the highest practicable level of physical well-being for 1 of 5 sample residents (#98) who were at risk for dehydration and 1 of 4 residents (#98) who were at risk for respiratory complications. The findings were: Review of the face sheet for resident #98 showed s/he was admitted on 11/16/11 with diagnoses including chronic kidney disease, morbid obesity and obstructive sleep apnea. Review of the 10/27/11 consultation note from an out-of-state hospital showed the resident had gastric surgery in June 2011, respiratory failure in July 2011, and a pulmonary embolus in October 2011. Review of	F 309	F TAG 309 CORRECTIVE ACTION: Resident #98 was discharged on 12/5/11. Identification of Others: An audit of nursing notes for the last 30 days has been conducted for residents with signs and symptoms of nausea, vomiting, shortness of breath, respiratory distress, to ensure signs and symptoms were addressed. An audit of residents receiving nebulizer treatments or orders for nebulizer treatments has been conducted to	2/28/12

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F 309	Continued From page 4 the 12/5/11 Resident Transfer Form and Change of Condition form, completed by the facility, revealed the resident was transferred from the facility to a local hospital (nineteen days after admission to the facility) due to hydration needs, confusion, lethargy and nausea with vomiting. The following concerns were identified regarding the facility's failure to provide the care the resident needed during his/her nineteen day stay at the facility prior to the hospital transfer: Related to assessment and monitoring of fluid intake and output: a. Review of the 11/16/11 physician's progress notes showed the resident was receiving dialysis for chronic renal failure. Review of the medical record showed the 11/16/11 physician admission orders included: a 2000 cc daily fluid restriction and phenergan 12.5 mg every 8 hours as needed for nausea. Review of the Nursing Daily Skilled Summary dated 12/5/11 at 11 AM showed the resident had nausea and " light brown mucous vomit " with decreased appetite. Interview with RN #1 on 1/4/12 at 2:50 PM, who had written the nurses note, revealed she did not medicate the resident for vomiting on 12/5/11. She stated she did not administer the phenergan after isolated episodes of vomiting, only if there was more than one episode of vomiting. The RN further stated the resident had periodic episodes of vomiting and decreased appetite throughout the time s/he resided at the facility. During an interview on 1/4/12 at 3:25 PM CNA #1 stated the resident had episodes of vomiting and "dry heaves." The CNA did not know the number of episodes of vomiting. An interview with physical therapist #1 on 1/5/12 at 10:25 AM revealed the resident had complaints of nausea	F 309	determine need and usage in the past 30 days. An audit of residents receiving Hemodialysis was conducted to review current plan of care. An audit was conducted for residents at hydration risk which includes history of treatment for dehydration, new conditions that increase fluid needs for example, fever, diarrhea, and any recent changes of condition. System Measures: SDC/Designee will provide education to the nursing staff on or before 2/28/12 to include administering prn medications when symptoms exist, documenting results and effectiveness of prn medications, hydration risks including signs and symptoms of dehydration (not limited to but may include fever, sunken eyes, increased thirst), assessment prior to and after nebulizer treatments as well as signs and symptoms of respiratory distress (not limited to but may include shortness of breath, adventitious lung sounds, wheezing, decreased air exchange or decreased lung sounds, increased anxiousness). DON/Designee will complete weekly Medication Administration Record Audits x four weeks then random Medication Administration Records monthly for three months. Nurses will be re-educated as needed.	

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F 309	Continued From page 5 and vomiting during his/her therapy sessions from the time of his/her admission. The therapist stated she didn't know the number of times the resident complained of nausea and vomiting, but did notify the nursing staff of the complaints. Review of the November and December 2011 MAR showed it was documented the resident only received two doses of phenergan during that time, on 11/21/11 and 11/22/11. b. Review of the physician orders dated 12/4/11 at 3:30 PM showed Imodium (for diarrhea) 4 mg first dose then 2 mg after every loose stool was ordered. Review of the MAR with the DON on 1/4/12 at 3 PM showed the medication was not documented as given. Interview with LPN #1 at that time via telephone revealed the resident was experiencing diarrhea stools, the physician was notified, and the LPN received an order for Imodium. The LPN also stated she gave the first dose as ordered, but was not certain if the medication was effective. Further, the LPN stated she was not sure if she documented the medication was given. Review of the Nursing Daily Skilled Summary dated 12/4/11 showed no documentation related to the amount or frequency of diarrhea. c. Review of the entire care plan for the resident with the DON on 1/5/12 at 11 AM confirmed there was no intervention that addressed hydration/ fluid maintenance. Further review of the 11/18/11 care plan for hemodialysis showed no information regarding the 2000 cc daily fluid restriction as ordered by the physician. The DON also confirmed there was no evidence of a comprehensive assessment for hydration. Interviews with LPN #2 on 1/5/12 at 10:45 AM, and DON on 1/5/12 at 11 AM revealed the facility did not have a system for measuring and	F 309	The IDT (Interdisciplinary Team) will review residents at risk for hydration weekly in Care management risk review (CMRR) meeting to ensure interventions are appropriate. The IDT will review meal intake percentages, supplements, fortified foods and current diet orders. The IDT will review residents at risk for hydration weekly during CMRR and determine if Intake and Output (I&O) is needed as an intervention and notify the physician to obtain an order if warranted. I&O's will be completed as ordered by the physician. The DON/Designee will ensure communication to staff members on any changes in interventions related to hydration status determined by the team. The DON/Designee will review the 24 hour report during the morning business meeting for any changes in condition, notations of nausea, decreased appetite, and symptoms of respiratory distress to ensure appropriate interventions are implemented. The DON/Designee will conduct weekly rounds with the nursing staff to assist with identifying any resident needing early interventions for possible symptoms of decline. Monitor:	

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F 309	Continued From page 6 monitoring the resident's fluid intake and output. Related to the assessment and monitoring of the resident's respiratory status: a. Review of the admission physician orders dated 11/16/11 for the resident showed oxygen was to be administered at 2 liters to keep oxygen saturations above 90 percent. In addition, albuteral nebulizer treatments were to be given every six hours as needed for shortness of breath. b. Review of the 2011 November MAR showed the resident received albuterol four times from 11/23/11-11/26/11. Review of the Nursing Daily Skilled Summary for those dates showed no rationale for the use of the medication. The area for respiratory assessment did not show documentation the resident was short of breath. There was no evidence the resident's respiratory status was assessed before or after the treatment. According to Smith, Duell and Martin in "Clinical Nursing Skills-Basic to Advanced", seventh edition, 2008, page 952: "Documentation for respiratory prevention and maintenance measures include pre and post intervention breath sounds and adventitious sounds." c. An interview with the DON on 1/4/12 at 2:05 PM confirmed the nursing staff was to assess the respiratory status of the resident and document any abnormal findings to include wheezing, shortness of breath or decreased breath sounds. Review of the medical record showed no evidence there was a comprehensive respiratory assessment completed by the nursing staff except during the 11/16/11 admission assessment at which time the lungs were documented to be clear. On 1/4/12 at 3 PM the DON attempted to locate any additional medical	F 309	DON/Designee will track and trend audits and observations and report findings to QA & A Committee. The QA & A Committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance for 3 months. Date of Compliance:	

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F 309	Continued From page 7	F 309		

records for the resident. She later confirmed there were no other records for this resident.

d. Review of the 12/5/11 change of condition documentation completed by RN #2 prior to the resident's transfer to the hospital, showed his/her oxygen saturation rate was 84% on 2 liters of oxygen. Interview with the RN on 1/4/12 at 2:05 PM revealed she did not assess the resident's lungs to determine if there were decreased breath sounds or wheezing prior to the hospital transfer. Review of the hospital admission history and physical dated 12/5/11 revealed an assessment of the lungs. The resident had coarse rhonci (indicates partial airway obstruction) and reduced breath sounds on the right side. A CAT scan of the chest showed right lower lobe pneumonia and empyema (a collection of pus).