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
	535025	A. BUILDING _____ B. WING _____	C 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000	**Date of Compliance** **Preparation and/or execution of the response and 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. For the purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance.**	7/18/2012
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 and family interview, the facility failed to ensure 1 of 5 sample residents (#6) was groomed in a manner to promote dignity. The findings were: Medical record review showed a 2/16/12 quarterly MDS assessment that revealed resident #6 needed extensive assistance with dressing and hygiene. Interview on 6/6/12 at 12:05 PM with the resident's spouse revealed that when the resident was independent, the resident's routine was to shave every morning. The following concerns were noted: a. Observation on 6/6/12 at 10:35 AM revealed the resident was in a wheelchair in the hallway working with the occupational therapist.	F 241	**F241** **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 identity.** **Corrective Action:** **Resident # 6 is assisted with shaving daily and clothing is monitored for soiling and resident is assisted with clean clothing as needed throughout the day.** **ID of Others:** **An audit of resident's requiring extensive assistance with dressing and hygiene needs will be conducted to determine those that are at risk.** **System Measure:** **Staff will be educated by the Staff Development Coordinator (SDC) on or before July 18, 2012 regarding dignity and respect to include timely replacement of soiled clothing and hygiene needs. DON or Designee will round facility 5-7 times per week to view dignity and care of residents weekly for four weeks then randomly monthly for three months.** **Monitor:** **Data obtained by way of audits conducted to be reviewed and analyzed for patterns and trends and reported monthly to the facility QAA committee by Director of Nursing/Designee. The QAA committee will evaluate the effectiveness of the plan based on trends identified and implemented additional interventions as needed to ensure continued compliance monthly for three months.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Reaume — TITLE: NHA — (X6) DATE: 6/29/12

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.

This POC approved on 7/16/12 between Shelley Cotton DON and Tony Madden - Health Surveyor with agreed to changes

7/16/12

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F 241	Continued From page 1 The resident was wearing sweat pants with dried food on them and was unshaven. b. Further observation that day showed the resident remained unshaven and was wearing the soiled sweat pants at 12:05 PM while in the dining room with his/her spouse for lunch. Interview with the resident's spouse at that time confirmed the resident had on soiled clothes and was unshaven. The spouse stated the resident's clothes probably wouldn't be changed unless the resident was wet. The spouse further commented, "[S/he] looks pretty scruffy." Continued observation throughout the day until 5 PM confirmed the resident remained unshaven and was wearing the soiled sweat pants. c. Interview on 6/7/12 at 10:30 AM with the DON revealed the expectation was that residents were shaved on their shower days (twice a week) and in between if they needed it. Interview on 6/7/12 at 1:30 PM with CNA #2 revealed residents' clothes were to be kept clean.	F 241	**Date of Compliance** 7/18/2012 **F 250** **The facility must provide medically- related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.** **Corrective Action:** **Resident #3's care plan to address s/sx of depression was placed in chart on 6/7/2012. On 6/7/12 physician was notified of resident # 3's s/sx of depression. On 6/7/12 facility obtained an order for services with psychology group: POA was contacted on 6/7/12 and notified of s/sx of depression. Facility was denied permission to from POA to obtain psychological services for resident #3.** **ID of Others:** **An audit has been completed of resident's displaying s/sx of depression as evidence by the PHQ-9 score.** **System Measures:** **RCD or designee will conduct an in-service with Social Service Director and Social Service Assistant on or before 7/18/2012 regarding resident showing s/sx of depression and proper follow-up to ensure psychosocial needs are being met. Residents will be assessed on admit, quarterly, annually, and with significant changes to ensure that psychosocial needs are met. Any residents with s/sx of depression will be further assessed and physician and family notified for further interventions. Social Services notes will be reviewed randomly on a monthly basis to ensure adequate documentation is provided for resident's psychosocial needs.** **Monitoring:** **DON/Designee will track and trend the results of chart reviews and interviews and report findings to the QAA committee monthly. The QAA committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x3 months, then reassess the need for continued monitoring based on compliance.**	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE 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 medical record review and staff interview, the facility failed to provide social service interventions for 1 of 1 sample resident (#3) identified with a social service need. The findings were:	F 250		

7/19/12

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F 250	Continued From page 2 Review of the medical record for resident #3 showed s/he had diagnoses which included senile delusions, dementia, and depression. Review of the 5/16/12 admission MDS assessment showed the resident was coded for depression. Review of a 5/31/12 nurses note showed the resident "refuses cares, refuses meals, and refuses meds." In addition, the resident made statements to staff that included "Leave me alone," and "I just want to die." The following concerns were noted: a. Review of the care plan showed depression was not addressed. b. Interview with the unit manager on 6/6/12 at 4 PM verified the facility had not addressed the resident's depression. c. Review of the medical record showed the physician had not been notified concerning the resident's negative statements until after the surveyor interviewed the unit manager on 6/6/12. On 6/7/12 the physician ordered a consult with a consulting psychology group. d. Review of the social services documentation showed the resident's depression was not addressed until 6/7/12, when social services staff contacted the power of attorney concerning the physician's order for consultation with a psychology group.	F 250		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280	**Date of Compliance** **F 280** **The resident has the right unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care in treatment or changes in care and treatment.** **A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse within responsibility for the resident and other appropriate staff in disciplines as determined by the resident's needs and to the extent of practicable, the participation of the resident, resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.** **Corrective Action:** **Resident #3's Care plan has been revised to include status of depression as well as interventions and acceptance of those interventions.** **Resident #3's Care plan has been revised to include resident's requirement for oxygen administration and/or oxygen saturation monitoring.** **ID of Others:** **An audit of resident's medical record with s/sx of depression and or DX of depression will be conducted to identify others to ensure that a care plan for depression and interventions is in place.** **An audit of resident's medical record with oxygen and or respiratory status condition will be conducted to identify others to ensure that a care plan for Respiratory Status and interventions is in place.** **System Measure:** **DON/ Designee to educate interdisciplinary team on documentation of all pertinent information on the care plans on or before 7/18/12. 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.**	7/18/2012

7/16/12

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F 280	Continued From page 3	F 280	**The DON/Designee will review the 24 hour report and telephone orders daily Monday through Friday for changes in condition, for example symptoms of Depression and changes in orders for example, Oxygen to ensure a plan of care is in place to address the changes.** **Monitor:** **Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility's QA& A committee by Director of Nursing/ Designee. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months.**	

within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to ensure a care plan was developed for 1 of 6 sample residents (#3). The findings were:

1. Review of the 5/16/12 admission MDS assessment showed resident #3 was coded for depression. Review of a 5/31/12 nurses note showed the resident "refuses cares, refuses meals, and refuses meds." In addition, the resident made statements to staff that included "Leave me alone," and "I just want to die." Review of the care plan showed the facility failed to initiate a plan to address the resident's depression. Interview with the unit manager on 6/6/12 at 4 PM verified the facility failed to initiate a plan of care to address the resident's depression.

2. Review of the physician's orders for resident #3 showed a 5/11/12 order for oxygen as needed to

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F 280	Continued From page 4 keep his/her oxygen saturation above eighty-eight percent. Review of the 5/11/12 nurses' notes showed the resident had an oxygen saturation of eighty-four percent and required supplemental oxygen at that time. Review of the resident's nurses' notes showed the resident had an oxygen saturation of above ninety percent each day after the 5/11/12 decline. Review of the care plan showed the facility failed to initiate a plan to address the resident's required oxygen saturation monitoring and oxygen administration as needed. Interview with the unit manager on 6/6/12 at 4 PM verified the facility failed to initiate a plan of care to address the resident's requirement for oxygen saturation monitoring and oxygen administration as needed.	F 280	**Date of Compliance** **7/18/2012** **F312** **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.** **Corrective Action:** **SDC provided re-education to C.N.A.'s regarding providing proper perineal care to incontinent residents for resident #6 on 6/7/2012.** **ID of Others:** **An audit of resident's requiring extensive assistance with dressing and hygiene needs will be conducted to determine those that are at risk..** **System Measure:** **SDC will provide re-education on or before ~~6/18/2012~~ 7/18/12 to the C.N.A.'s regarding proper pericare for incontinent residents including areas that need to be cleaned and proper manner to wipe/clean residents.** **Randome weekly audits of pericare will be completed by the sdc/designee to ensure pericare is completed correctly.** **~~All newly hired C.N.A.'s will be educated on pericare during orientation by the SDC/Designee.~~** **Unit Manager/Designee will randomly observe pericare of resident's on a weekly basis x4, then monthly x2, then quarterly.** **Monitor:** **The DON or designee will track and trend results of the pericare audits and report findings to QAA committee monthly, the QAA committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x3 months then reassess the need for continued monitoring based on compliance.**	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 medical record review, observation, and staff interview, the facility failed to ensure the staff provided appropriate care to 1 of 5 sample residents (#6) who needed assistance with personal care. The findings were: Medical record review for resident #6 revealed a quarterly MDS assessment with an assessment reference date of 2/6/12. The assessment showed the resident was incontinent of bowel and	F 312		

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F 312	Continued From page 5	F 312		

bladder and needed extensive assistance with personal hygiene. The following concerns were noted:

a. Observation on 6/6/12 at 11:30 AM showed CNA #4 and CNA #3 transferred the resident from a wheelchair into bed. CNA #3 stated the resident's incontinent brief was wet. Continued observation showed CNA #3 cleaned the resident's lower abdomen and anterior perineal area with a back and forth, side to side motion. She did this several times without changing the area of the wipe being used.

b. Observation on 6/7/12 at 8:10 AM showed CNA #4 was assisting the resident with morning care. The CNA confirmed the resident's incontinent brief was wet. Again, the CNA used a back and forth, side to side motion to clean the resident's anterior perineal area. Also, the CNA placed a dry incontinent brief on the resident without cleaning the resident's lower abdomen, thighs or buttocks.

c. Interview on 6/7/12 at 11:30 AM with the DON confirmed incontinence care included cleaning the lower abdomen, perineal area, upper thighs, and buttocks wiping from front to back.