PoC rec'd 8/24/12 via FAX

PRINTED: 08/14/2012
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
	535040	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

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F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and observation, the facility failed to act upon a resident council grievance related to late dining service from one (4/26/12) of six resident council meetings. After three subsequent resident council meetings to the 4/26/12 meeting, a response was not provided. The findings included: Resident Council Meeting Minutes The resident council meeting minutes for 1/26/12 were reviewed. The new business noted under dietary was a concern about timing of meals being served. When the residents were still waiting for their meals the residents are already finished and leaving the dining room. The facility response on 2/1/12 was reviewed. The residents were to be served at the tables as they arrived verus waiting for their tablemates. The resident council meeting minutes for 4/26/12 were reviewed. The new business noted under dietary was a concern about the amount of time it takes to serve the residents. The resident council meeting minutes for 5/31/12.	F 244	F244 The facility will listen to the views and act upon the grievances and recommendations of residents and familiars concerning proposed policy and operational decisions affecting resident care and life in the facility. All residents will receive meals on time. We have initiated open dining. For the main dining room serving times for breakfast is from 6:30 AM-7:15 AM; room trays are served after that. Then the Alzheimer unit is served at 7:30 AM. Lunch for the Alzheimer's unit trays are started at 11:30 AM so that they are there by noon. The main dining room is then served at 12 noon and room trays as soon as the main dining room is done. Dinner trays for the unit are started at 4:30 so they are ready by 5 PM, the main dining room is then done at 5 PM and room trays are done as soon as the main dining room is done. Tables in the main dining room are served as residents arrive and room trays can be done as we are waiting for more residents to come into the dining room. Department heads are helping serve all three meals.	X

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

X [signature] X [illegible] X 8/24/12

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.

PoC accepted by Ken Allison on 8/27/12

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F 244	Continued From page 1 6/28/12, and 7/26/12 were reviewed. There was not a response recorded to the resident concern of 4/26/12. Interviews During the entrance conference on 7/30/12 at 3:00 PM with the administrator, the meal times were requested. The meal times provided identified lunch at 11:45 AM and dinner at 4:45 PM. The administrator was interviewed on 8/1/12 at 3:35 PM. The administrator stated the correct time for lunch is 12:00 PM and for dinner is 5:00 PM. Staff A, the noon cook, was interviewed on 8/2/12 at 12:40 PM. Staff A stated the meal service usually takes a half an hour to complete and a new cook was training today. The activities director was interviewed on 8/2/12 at 1:20 PM. The activities director confirmed there was not a response to the resident concern about dietary after the 4/26/12 resident council meeting but had responded to late meals at a previous resident council meeting. The activities director returned with the meeting minutes for the 1/26/12 resident council and stated that this is the meeting where the residents identified an issue with meal service. During an interview on 8/2/12 at 3:45 PM, the administrator confirmed the meal service should start in the main dining room at 12:00 PM for lunch and 5:00 PM for dinner and not start 15 minutes after the identified meal times. This had been discussed previously with the dietary manager.	F 244	Monthly audits on serving times will be done by the DM or designee and brought to QA on a monthly basis until resolved. It will also be asked at the monthly resident council meetings and will be addressed after that by Activities Director or designee and brought to QA on a monthly basis until resolved.	9/1/12

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F 244	Continued From page 2 Dining Observations The noon meal was observed on 8/1/12. At 11:45 AM, fifteen residents were seated in the main dining room. At 12:15 PM, one of sixteen residents seated in the main dining room was served. The residents were served table by table. All residents in the main dining room were served at 12:30 PM. The last room tray was delivered at 12:45 PM.. Some residents waited up to 30 minutes for meal service. The evening meal was observed on 8/1/12. At 5:36 PM, two resident tables in the main dining room were not served. All residents in the main dining room were served at 6:00 PM. The last room tray was delivered at 6:10 PM. The noon meal was observed on 8/2/12. At 11:45 AM, ten residents were seated in the main dining room. At noon, twenty residents were seated in the dining room. The residents were served table by table. All twenty residents in the main dining room were served by 12:25 PM. The last room tray was delivered at 12:40 PM. Some residents waited up to 25 minutes for meal service. Observations showed the meal service began after designated meal times.	F 244		
F 250 SS=E	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	F 250		

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F 250	Continued From page 3 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on documentation review, family and staff interviews, the facility failed to identify approaches and document underlying causes that may eliminate or minimize resident to resident aggression in the Secure Unit. Both the Social Worker & Unit Manager identified 6 of 19 residents in the Secure Unit that had been involved in disruptive verbal or physical behavior over a three month period in 2012. The following documentation review / interview was provided by the facility Social Worker& Unit Manager on 8/2/2012 at approximately 9:20 AM. 1. May 6, 2012: Female resident 5 scratched female resident 18. No severe injuries were reported. 2. June 5, 2012: Male resident 2 slapped male resident 17 and the slap was returned. Police were called. No serious injury noted. 3. June 7, 2012: Female resident 5 diagnosed with behavior symptoms and cognitive impairment grabbed the necklace of female resident 18 who is diagnosed with behavior symptoms and cognitive impairment was scratched along the neck. According to the Social Worker an open wound was present and treated. 4. June 27, 2012: Male resident 10 who is	F 250	F250 The facility will provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well being resident. 1) Resident #5, 18, 2,17,5, 10 as well as all residents will be monitored by CNA's on a hourly basis to ensure that there are no resident to resident altercations and all residents are safe. If there are any altercations it will be reported to Social Service within 24 hours and the SS partnered with DON or designees to review meds, baseline labs including a UA and treat as needed on findings; this will enable us to have a plan put in place to protect the resident(s) and that the CNA's can follow that plan. Altercations will be brought to QA on a monthly basis until resolved and then quarterly at the Care Plans. There will always be two CNA's in the Unit during the times of 5:30AM-10PM, if a CNA is at lunch a CNA, nurse or designee will go over to the unit until the CNA is back from lunch. This will be periodically monitored on a monthly basis and brought to QA on a quarterly basis until resolved.	9/1/12

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F 250	Continued From page 4 diagnosed with dementia, hypertension, hypertrophy and reflux esophagitis slapped male resident 2 who is diagnosed with acute delirium, fatigue, myocardial infarction,chronic pain and esophageal reflux. According to the Social Worker edema and redness was noted on resident 2's left cheek. 5. June 28, 2012: Male resident 10 kicked male resident 17, in the calf who is diagnosed with cognitive impairment and behavior symptoms. According to Social Worker there was no observed injury. 6. July 02, 2012: Male resident 17 diagnosed with behavior symptoms and cognitive impairment punched male resident 9 in the chest. Resident 9 is diagnosed with dementia and depression. According to the social worker no bruising was noted. Two family members who wish to stay anonymous were called on August 2, 2010. The first complained that on her occasional visits "observed one staff member always alone on the unit in charge of 20 or so residents ". The second family member stated "many of the residents have nothing to do but react negatively toward one another when left to entertain themselves".	F 250	The Alzheimer calendar will have times put on of events that are scheduled for the day. Each day of the week will have set times for the scheduled events. 9/1/12	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change	F 274		

rec'd amended page 5 POC
via FAX on 8/27/12

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F 274	Continued From page 5 means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to conduct a significant change in status assessment for 1 (Resident #3) of 11 residents reviewed. Specifically, a quarterly assessment was completed on 7/25/12 when a hospice revocation statement indicated a significant change in status assessment. The findings included: Assessement Reference The required utilization guidance for resident assessments is the Centers for Medicare and Medicaid Services Resident Assessment Instrument (RAI) Version 3.0 Manual. The RAI includes both the minimum data set (MDS), and the utilization guidelines. According to the RAI Manual, chapter 2: Assessments for the RAI, a Significant Change in Status Assessment (SCSA) is appropriate as follows: " There is a determination that a significant change (either improvement or decline) in resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent	F 274	F274 The facility will conduct a comprehensive assessment of a resident within 14 days after the facility determines or should have determined that there has been a significant change in the resident's physical or mental condition. A) A significant change assessment will be done on resident # 3. B) The MDS coordinator will be going to MDS Boot Camp to help her with the importance of significant changes. C) The IDT team will hold weekly meetings to ensure that we have identified any residents that may need a significant change. This will be reviewed monthly at QA until resolved and then quarterly thereafter.	9/1/12

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F 274	Continued From page 6 Comprehensive assessment and any subsequent quarterly assessments; and The resident's condition is not expected to return to baseline within two weeks." "A SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The Assessment Reference Date (ARD) must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill.)" Record Review The hospice agency document titled " Live Discharge/Transfer Summary " dated 6/30/12 was reviewed and showed the following: The date of election of hospice benefit was 5/9/11. Resident 3 was discharged from hospice on 6/30/12. Residents 3's signs and symptoms were currently managed. The Quarterly MDS dated 7/25/12 for Resident 3 was reviewed and showed the folowing: The ARD date was 7/23/12. The resident was assessed as having the ability to understand others and makes self understood. Interviews	F 274		

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F 274	Continued From page 7 The MDS coordinator was interviewed on 8/1/12 at 2:30 PM. The MDS coordinator confirmed that after Resident 3 was discharged from hospice, a quarterly assessment was done and not a SCSA.. On 7/31/12 at 9:50 AM, Resident 3 was interviewed. The resident stated that hospice had come into the resident's home before admission to the nursing home and no longer received hospice services at the nursing home.	F 274		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and interview, the facility failed to assure 2 (resident 1 and 8) of 8 sample residents were administered medications with adequate indications for use. Specifically, medications ordered on an as needed basis (PRN) were administered without identification of the reason for administration and the effects of the medication. The findings included: 1. A review of the Medication Administration Records (MAR) over the past six months for resident 1 identified incomplete documentation for alprazolam given on an as needed basis (PRN). a. On the March 2012 MAR PRN administration of alprazolam was given to the resident 29 different times. None of those administrations were documented on the MAR for time, reason for the administration and effects of the medication for the resident's symptoms. b. On the April 2012 MAR PRN administration of alprazolam was given to the resident 29 different times. None of those administrations were documented on the MAR for time, reason for the administration and effects of the medication for the resident's symptoms. c. On the May 2012 MAR PRN administration of alprazolam was given to the resident 30 different times. None of those administrations were documented on the MAR for time, reason for the administration and effects of	F 329	F329 Each resident's drug regimen will be free from unnecessary drugs. Resident #1 will have completed documentation for the alprazolam every time it is given PRN. The documentation will include, time, reason for the administration and the efficacy. Resident #8 will have a completed documentation for all PRN medication given. The documentation will include time, reason for the administration and the efficacy. All residents who are on PRN medications will have adequate indications for use including time, reason for administration and efficacy. Monthly audits will be conducted by DON or designee that all PRN medications are following facilities Medication Administration Policy. The audit will be brought to QA monthly until it is resolved.	9/1/12

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F 329	Continued From page 9 the medication for the resident's symptoms. d. On the June 2012 MAR PRN administration of alprazolam was given to the resident 11 different times. None of those administrations were documented on the MAR for time, reason for the administration and effects of the medication for the resident's symptoms. e. On the July 2012 MAR PRN administration of alprazolam was given to the resident 29 different times. One administration was documented on the MAR for time,and reason for the administration. None of those administrations were documented for the effects of the medication for the resident's symptoms. f. The facility's DON was interviewed on 7/31/12 at 2:30 PM. The DON confirmed the time of administration, reason for administration, and effects of the medication should be documented on the back of this resident's MAR for PRN medications and the information was not recorded. 2. A review of the Medication Administration Records (MAR) over the past three months for resident 8 identified incomplete documentation for several medications given on an as needed basis (PRN). a. On the May 2012 MAR: (i) PRN administration of lorazepam was given to the resident 37 different times. Only 12 of those administrations were documented on the MAR for time, reason for the administration and effects of the medication for the resident's symptoms.	F 329		

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F 329	Continued From page 10 (ii) PRN administration of Imodium was given to the resident five different times. Only two of those administrations were documented on the MAR for time, reason for the administration and effects of the medication for the resident's symptoms. b. On the June 2012 MAR: (i) PRN administration of lorazepam was given to the resident 44 different times. Only 11 of those administrations were documented on the MAR for time, reason for the administration and effects of the medication for the resident's symptoms. c. On the July 2012 MAR: (I) PRN administration of hydrocodone/acetaminophen was given to the resident 22 different times. Only 14 of those administrations were documented on the MAR for time, reason for the administration and effects of the medication for the resident's symptoms. (ii) PRN administration of lorazepam was given to the resident 51 different times. Only six of those administrations were documented on the MAR for time, reason for the administration and effects of the medication for the resident's symptoms. 3. The facility's Director of Nursing (DON) was interviewed on 8/2/12 at 10:00 AM. The DON stated that each time PRN medication is administered documentation should be made on the back of the MAR of the time, route, dose, reason for administration, and the effects of the medication for the resident's symptoms.	F 329		

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F 329	Continued From page 11 4. A review of the facility's Medication Administration Policy regarding as needed (PRN) medications was reviewed on 8/2/12. Section IIA2, paragraph C5 of the policy states that, "When PRN medications are administered, the following documentation is provided: a. Date and time of administration, dose, route of administration (if other than oral), and if applicable, the injection site. b. Complaints or symptoms for which the medications was given. c. Results archived from giving the dose and the time results were noted. d. Signature or initials of person recording administration and signature or initials of person recording effects, if different from the person administering the medications."	F 329		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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 514	Continued From page 12 failed to assure a closed record was complete for one (resident 14) of two closed resident records. The findings included: Record Review The closed medical record for resident 14 was reviewed on 8/2/12. A 7/6/12 daily skilled nurse's note for night shift was signed by staff B, a licensed practical nurse (LPN). The note identified the resident experienced abnormal breathing at 2:26 AM, the oxygen level continued to decline and the time of death was 2:55 AM. The morticians receipt was dated 7/7/12 at 3:56 AM. The medical record did not contain documentation to show that an RN had evaluated the LPN assessment of the time of death. Interview During an interview on 8/2/12 at 1:30 PM the administrator stated that the facility does not have a policy for pronouncement of death. The administrator confirmed that there was no other records for resident 14. Practice Reference A clarification from the State board of nursing dated 8/2/12 at 4:01 PM was reviewed. The clarification stated "Pronouncement is the determination made after an assessment that there is an absence of human responses, spontaneous breathing and heart beat. The LPN may certainly assess for human responses and vital signs but the evaluation of the assessment and final determination is in the scope of an RN (registered nurse). Facility policy should direct the	F 514	F514 The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. A policy has been put in place when there is a death in the facility when an LPN is the charge nurse during the death. All nurses and department heads will be in serviced on the new policy that has been put in place on the announcements of death. Audits will be done monthly on all deaths at the facility to ensure that the policy was followed and taken to QA on a quarterly basis until resolved. The audit will be done by Medical Records or designee.	9/1/12

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F 514	Continued From page 13 method and personnel responsible for this. Pronouncement is not to be confused with, or construed as a certification of death which involves diagnosis and is done by a physician."	F 514		