POC accepted 10/10/12 K

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WY Dept of Health
OCT 02 2012

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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING Mind Surveys B. WING	C 09/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1926 THERMOPOLIS, WY 82443

(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 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 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 staff updated the care plan to accurately reflect the clinical status for 1 of 6 sample residents (#5). The findings were: Review of the medical record for resident #5 showed s/he had diagnoses that included acute cerebravascular accident. Review of the 7/12/12 care plan showed the resident was at risk for dehydration because s/he was dependent upon staff for fluid provisions. The resident had	F 280	Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal state and law. Completion dates are provided for procedural processing purposed and correlate with the most recently contemplated or accomplished corrective action and do not necessarily correspond chronologically to date. The facility is of the opinion it was in compliance with requirements of participation or that corrective action was necessary. **F 280 – Participate in Care Planning** Resident #5 expired The facility ensures that the resident care plans are updated and reflect the resident's current status as related to fluid intake. The MDS Coordinator and the licensed nursing staff will be in-serviced on the importance of revising the care plan to reflect the resident's current status as related to fluid intake and to ensure the interventions do not conflict with one another. To be completed by the DNS/designee.	10-28-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Walter Sandell NHA — (X6) DATE: 10/2/2012

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.

Change to medication Plan Call with Walter Sandell, NHA on 10/10/12 @ 2pm. Janice Cahn, DNS/L

FORM CMS-2567(02-99) Previous Versions Obsolete — Event ID: 07OS11 — Facility ID: WY0008 — If continuation sheet Page 1 of 8

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	535051	A. BUILDING _____ B. WING _____	C 09/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1328 THERMOPOLIS, WY 82443

(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 280	Continued From page 1 dysphagia and required nectar thick liquids. Further review of the care plan showed conflicting interventions as follows: "2. Encourage fluid restriction...7. Encourage fluids frequently." Interview with RN #1 on 9/13/12 at 8:45 AM verified the care plan interventions were contradictory. She further stated the correct intervention was to "encourage fluids" and that she would update the care plan to show accurate and clear interventions.	F 280	Five random care plans will be audited each week to ensure that the fluid intake interventions are current and do not conflict with one another as needed x 90 days. To be completed by the DNS/designee. Audit findings will be reviewed at the CQI meeting.	10-28-12
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to consistently follow written physician orders for 3 of 6 sample residents (#1, #3, #6). The findings were: 1. Review of the medical record for resident #6 showed s/he was transferred to the emergency department (ED) of the hospital on 7/1/12 because s/he "looks bad" and was hypoxic. Review of the ED physician's orders revealed the resident was admitted to the ED with a diagnosis of dehydration. The resident was treated in the ED and released on the same day with the following orders "...encourage-assist [assist was circled to emphasize] with fluids-QID [four times daily]..." Interview with RN #2 on 9/26/12 at 2:40 PM verified orders from the ED physician were considered valid orders and should be	F 281	**F 281 – Professional Standards** Resident #1 is stable, and care is provided in accordance with physician's orders. Resident #3 is stable, and care is provided in accordance with physician's orders. je Resident #5 ~~is stable~~ expired. The facility ensures that the residents receive care as written in the physician's orders. The licensed nurses will be in-serviced on the facility policy and procedure for transcribing physician's orders related to fluid intake, proper positioning during meals and administration of medication in/with food to ensure the physician's order is followed. To be completed by DNS/designee.	

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	535061	A. BUILDING _____ B. WING _____	C 09/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1325 THERMOPOLIS, WY 82443

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F 281	Continued From page 2 transcribed onto the appropriate monitoring form. He said an order to encourage and assist with fluids should be entered onto the TAR (treatment administration record). However, review of the July 2012 TAR showed no evidence the order to assist and encourage the resident with fluids four times daily was entered onto the form or followed. There was no evidence of fluid monitoring other than the meal fluid intake which showed an average daily intake of fluids after the ED visit was 310 cc (cubic centimeters) per day. 2. Review of the speech therapy notes from June 2012 showed resident #1 needed to be in an upright position for safe swallowing. Review of the August 2012 physician's orders for the resident showed an order to transfer the resident from the wheelchair to a dining room chair or place a pillow behind his/her back to maintain an upright posture during meals. Observation on 9/12/12 at 12:23 PM showed the resident was seated at the dining room table in a wheelchair and there was no pillow placed behind his/her back as ordered. Interview with the restorative aide at 1:08 PM on 9/12/12 revealed she was just assisting the resident with the meal and was not the person who placed the resident at the table. She said CNA #1 was the person who seated the resident. The restorative aide further said she was unaware the resident required a pillow behind his/her back. Interview with CNA #1 on 9/12/12 at 1:10 PM revealed she assisted the resident into the dining room but was unaware of the order to place a pillow behind the resident's back and verified she had not done so. 3. Review of the August 2012 physician's orders for resident #3 showed the resident should have	F 281	Five random care plans will be audited each week to ensure that specific fluid intake orders, proper positioning during meals and administration of medication in/with food orders are followed x 90 days. To be completed by the DNS/designee. Audit findings will be reviewed at the CQI meeting.	

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	056061	A. BUILDING _____ B. WING _____	C 09/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1326 THERMOPOLIS, WY 82443

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F 281	Continued From page 3 "No cocoa, chocolate..." Observation on 9/12/12 at 12:50 PM showed RN #3 gave the resident chocolate syrup with his/her noon medications. During an interview with the RN at the time, he verified the medications were given with chocolate syrup. The RN was unaware of the order to not give the resident any type of chocolate. Review of the MAR (medication administration record) on 9/13/12 with the MDS coordinator at 8:45 AM revealed the physician's order for "No cocoa, chocolate..." was not noted on the MAR. Interview with the MDS coordinator at that time revealed the reason the resident was not to have chocolate was because it caused him/her to have diarrhea. She said because of the computerized MAR, there was no place to input this information.	F 281		
F 327 SS=D	According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, pages 3-8, nursing must function under the direction of a licensed physician. 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure adequate hydration was provided for 1 of 6 sample residents (#5). The findings were:	F 327	F 327 – Sufficient Fluids Ref #5 applied. The facility ensures that all residents receive adequate hydration. The licensed nurses will be in-serviced on the facility policy and procedure for transcribing physician's orders as related to fluid intake and monitoring to ensure residents are receiving adequate hydration. To be completed by DNS/designee.	10-28-12

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	535041	A. BUILDING _____ B. WING _____	C 08/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1928 THERMOPOLIS, WY 82443

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F 327	Continued From page 4 Review of the medical record for resident #5 showed on 7/1/12 s/he was transferred to the emergency department (ED) of the hospital because s/he "looks bad" and was hypoxic. Review of the ED physician's orders revealed the resident was admitted to the ED with a diagnosis of dehydration. The resident was treated in the ED and released on the same day with the following orders "....encourage-assist [assist was circled to emphasize) with fluids-QID [four times daily]..." Interview with RN #2 on 8/28/12 at 2:40 PM verified orders from the ED physician were considered valid orders and should be transcribed onto the appropriate monitoring form. He said an order to encourage and assist with fluids should be entered onto the TAR (treatment administration record). However, review of the July 2012 TAR showed no evidence the order to assist and encourage the resident with fluids four times daily was entered onto the form or followed. There was no evidence of fluid monitoring other than the meal fluid intake which showed an average daily intake of fluids after the ED visit was 310 cc (cubic centimeters) per day.	F 327	Each week, those charts with fluid intake and monitoring orders written by the physician, will be audited to ensure the orders have been transcribed correctly and that the residents are receiving adequate hydration x 90 days. To be completed by DNS/designee. Audit findings will be reviewed at the CQI meeting.	

kim mccoll <kim.mccoll@wyo.gov>

POC accepted: Thermopolis Rehab

1 message

janelle conlin <janelle.conlin@wyo.gov>
To: LTC <wdh-ltc@wyo.gov>

Fri, Oct 12, 2012 at 2:16 PM

Attached.

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