Received and approved after discussion w/ Chris Tanner on 10/10/06 @ 3rd Sm Linda Brown RN

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

PRINTED: 09/11/2006 UHA
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
	535036	A. BUILDING _____ B. WING _____	C 09/07/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WY HEALTHCARE &	542 16TH STREET RAWLINS, WY 82301

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F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure two (#10, #11) of four sample residents who required incontinence care, received care as planned. The findings were: 1. Medical record review for resident #10 revealed an annual resident assessment instrument (RAI) dated 7/6/07. The facility documented the resident required extensive assistance with toileting and assessed the resident as frequently incontinent of bladder. Review of a resident assessment protocol (RAP) module for incontinence, dated 7/6/07, revealed the resident required a check and change program every two hours. Review of the resident's care plan, dated 7/13/06, revealed staff were instructed to toilet the resident every two hours and change the resident every two hours. A continuous observation of the resident on 9/7/06 from 9:15 AM, when the resident was in bed, through the lunch period, and ending at 12:49 PM (three hours, 34 minutes after the start of the observation) revealed the resident was not toileted or checked and changed as planned. Interview with the director of nursing (DON) on 9/7/06 at 5:16 PM revealed staff should have been following the resident's toileting schedule in the care plan.	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *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 it is required by the provisions of federal and state law.* F-282 COMPREHENSIVE CARE PLANS CORRECTIVE ACTIONS FOR IDENTIFIED RESIDENTS 1. Licensed staff will review bowl and bladder program and written care plans for residents (#10, #11) to make sure they receive proper incontinence care according to their written care plan. IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED 2. All residents that are incontinent have the potential to be affected. MEASURES TO PREVENT RECURRENCE 3. A random audit by the UC or designee will be performed on three residents per week for two months. These will be performed to insure physician's orders and plan of care for all residents are being carried out. This audit will also be performed to insure resident's plan of care is communicated to all necessary licensed staff for all staff to review. All staff will be inserviced on incontinent care per our C.N.A competencies. The DNS or designee will be responsible to insure compliance with this system.	Complet on Date: Oct 13, 2006

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

EXECUTIVE DIRECTOR 9/20/06

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.

SEP 25 2006

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F 282	Continued From page 1 2. Review of the medical record for resident #11 revealed the resident's most recent assessment was a quarterly Minimum Data Set (MDS) assessment dated 8/25/06. According to the MDS, the resident required extensive assistance with toileting and was totally incontinent of urine. Review of the resident's care plan (dated 8/29/06) revealed "staff to offer toilet ac [before meals] and HS [at bedtime]" and "check and change." A continuous observation of the resident was done on 9/7/06. The observation started at 9:14 AM when the resident was observed in his/her wheelchair, through the lunch period, and continued until the resident was assisted in the bathroom at 1:16 PM (four hours and one minute from the start of the observation). During the observation, staff did not offer bathroom assistance or attempt to check the resident for incontinence. Interview with the DON on 9/7/06 at 5:16 PM, revealed staff should have been following the resident's toileting schedule in the care plan.	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *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 it is required by the provisions of federal and state law.* MONITORING QUALITY ASSURENCE 4. Audits performed by the DNS or designees will be brought to our monthly Performance Improvement meeting for review until compliance is met. Completion Date: Oct. 13, 2006	

CERTIFIED MAIL

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F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure two (#10, #11) of four sample residents who required incontinence care, received that care. The findings were: 1. Observation of resident #10 on 9/7/06 revealed the following: At 9:15 AM when the observation stated, the resident was lying in bed, asleep, tilted to the right side. Although certified nurse aide (CNA) #1 entered the room at 10:31 AM, the CNA did not provide care and exited at 10:34 AM. At 10:54 AM the director of nursing (DON) entered, but provided no care other than offering fluids. By 11:09 AM, CNA #1 re-entered the room, assisted the resident up and into a wheelchair, and transported the resident to the assisted dining room. The CNA did not check the resident for incontinence and did not offer assistance to the bathroom. The observation continued through lunch when the resident was removed from the dining area at 12:49 PM (3 hours, 34 minutes after the start of the observation). The resident	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *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 it is required by the provisions of federal and state law.* F-315 URINARY INCONTINENCE CORRECTIVE ACTIONS FOR IDENTIFIED RESIDENTS 1) Nurse will ensure residents (#10, #11) are reevaluated for bowl and bladder then placed on a program that meets their needs. IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED 2) Residents that are incontinent have the potential to be at risk. MEASURES TO PREVENT RECURRENCE 3) The Staff Development Coordinator or designee will in-service the licensed staff on caring for incontinent patients in check and change or toileting on a routine basis. The designee will monitor licensed staff to make sure proper incontinence care is being performed. They will be evaluated per C.N.A competencies related to incontinence.	Completion Date: Oct 13, 2006

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F 315	Continued From page 3 was then taken to his/her room and assisted to the bathroom. At that time, the resident's urine-soaked incontinence brief was removed. The following concerns were noted related to this resident's incontinence care needs: a. Medical record review revealed an annual resident assessment instrument (RAI) was completed on 7/6/06. Per that assessment, the resident required extensive assistance with toileting and was frequently incontinent of bladder. Review of a resident assessment protocol (RAP) module for incontinence for this resident, dated 7/6/06, revealed the resident required a "check and change" program every two hours. Review of the resident's care plan, dated 7/13/06, revealed staff were to toilet the resident every two hours and change the resident every two hours. b. Interview with CNA #1 on 9/7/06 at 12:50 PM revealed the resident required assistance into the bathroom every two hours. When asked, the CNA stated she thought the resident was last toileted at 10:30 AM. However, the aforementioned continuous observation revealed the resident was not provided with care at that time. Interview with the DON on 9/7/06 at 5:16 PM revealed staff should have been following the resident's toileting schedule in the care plan. 2. Observation on 9/7/06 from 9:15 AM to 1:23 PM revealed the following information about resident # 11: At 9:15 AM the resident was seated in a wheelchair beside his/her bed. At 10:31 AM, CNA #1 entered the resident's room and offered to take the resident to the announced activity. The resident refused. After chatting with the resident, the CNA left at 10:34 AM. The door to the room	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *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 it is required by the provisions of federal and state law.* MONITORING QUALITY ASSURENCE 4) Audits will be performed on residents who are incontinent of bladder to make sure proper toileting care is being carried out. Audits performed by the DNS or designee will be brought to our monthly Performance Improvement meeting for review until compliance is met. The Administrator is responsible for overall compliance. Completion Date: Oct 13, 2006	

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F 315	Continued From page 4 was left open, and the observation revealed the CNA did not provide any care for the resident. At 10:54 AM the DON entered the room, but provided no care other than offering fluids. At 11:12 AM, the resident was assisted to the dining room. As the observation continued, the resident was assisted back to his/her room at 1:11 PM. Then at 1:16 PM (four hours and one minute since the start of the observation), the resident was assisted, without asking, into the bathroom by CNA #1. The observation revealed the resident was incontinent of a large amount of foul-smelling urine. At that time, interview with the CNA revealed the resident "usually" was able to state his/her toileting needs. The CNA further stated, she thought the resident went into the bathroom "right before lunch." However, the aforementioned observation showed the resident was not provided with incontinence care prior to going to lunch. The follow concerns were found related to the resident's need for assistance and incontinence care: a. Review of the resident's medical record revealed the resident's most recent assessment was a quarterly Minimum Data Set (MDS) assessment dated 8/25/06. According to the MDS, the resident required extensive assistance with toileting and was totally incontinent of urine. Review of the resident's care plan (dated 8/29/06) revealed "staff to offer toilet ac [before meals] and HS [at bedtime]" and "check and change." b. Interview with the DON on 9/7/06 at 5:16 PM revealed staff should be following the resident's toileting schedule in the care plan.	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *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 it is required by the provisions of federal and state law.*	

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F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure the certified staff performed tasks for which they were qualified and within their scope of practice. One (#9) of three sample residents who required oxygen, had his/her oxygen adjusted by certified nurse aide (CNA) staff. The findings were: Observation on 9/7/06 at 10:40 AM revealed resident #9 was assisted with a transfer from the bed to the wheelchair. The resident's oxygen nasal cannula, which was connect to a concentrator, was removed. A second nasal cannula was then placed on the resident. This cannula was connected to a portable oxygen tank at the back of the wheelchair. During the observation, CNA #2 used the oxygen flow regulator on the portable tank to adjust the resident's liter flow of oxygen to two liters. There was no documentation or other signage posted on the oxygen container to indicate the flow rate for thsi resident. When asked during the observation how the CNA knew what rate of oxygen flow the resident required, the CNA stated, "Most [residents] are on two liters." Review of the resident's medication administration record for September 2006 revealed the date of the oxygen order was	F 492	*This Plan of Correction is the center's credible allegation of compliance.* *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 it is required by the provisions of federal and state law.* F-492 ADMINISTRATION (OXYGEN) CORRECTIVE ACTIONS FOR IDENTIFIED RESIDENTS 1. The Licensed staff will operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes with accepted professional standards. The CNAs will only use the oxygen flow regulator on Resident # 9 only when it is clearly marked on the resident's regulator. IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED 2. All residents who are on oxygen have the potential to be affected. DNS or designee will develop system to properly administer oxygen. MEASURES TO PREVENT RECURRENCE 3. The DNS or designee will make sure all residents who are on oxygen have up to date orders. All oxygen regulators will be labeled with the proper amount of oxygen usage for each specific resident. The nursing staff will be inserviced by the DNS or designee on how to properly adjust oxygen levels for residents according to the State Wyoming Board of Nursing. The	Completion Date: Oct 13, 2006

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F 492	Continued From page 6 8/25/06. The order documented the resident needed oxygen at two to three liters by nasal cannula. According to the May 2001 decision by the Wyoming Board of Nursing (BON), a CNA may be delegated the task of adjusting the oxygen liter flow if the liter flow is clearly marked by the nurse on the concentrator and/or oxygen tank. Interview with the director of nursing on 9/7/06 at 5:09 PM revealed she was aware CNA staff could not adjust the oxygen flow rate without a posted rate, or the Wyoming BON decision.	F 492	*This Plan of Correction is the center's credible allegation of compliance.* *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 it is required by the provisions of federal and state law.* DNS or designee will be responsible to insure compliance with this system. MONITORING QUALITY ASSURENCE 4. Audits will be performed by the DNS or designee to ensure that all CNAs are following proper procedure. Results will be brought to our monthly Performance Improvement meeting for review until compliance is met. Completion Date: Oct 13, 2006	
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS 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 medical record review, policy review, and staff interview, the facility failed to ensure one (#41) of three closed record reviews were complete and accurate. The findings were: Medical record review for resident #41	F 514	F-514 CLINICAL RECORDS CORRECTIVE ACTIONS FOR IDENTIFIED RESIDENTS 1. Resident has been discharged as of this date. IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED 2. All discharged residents have the potential to be affected. MEASURES TO PREVENT RECURRENCE 3. The Medical Records Manager or designee will audit the medical record of other residents to assure that all appropriate notes and forms are in place. The SDC or designee will review the Discharge/Transfer	Complet on Date: Oct 13, 2006

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F 514	Continued From page 7 revealed "resident progress notes" dated 8/17/06 at 7:45 AM, which documented the resident fell. At 10 AM the documentation revealed further assessment information and an attempt to contact a family member. No further documentation related to the resident's condition, or status after that. Review of physician's orders revealed an order dated 8/17/06 in which the physician directed the resident be transferred to the hospital. Review of the medical record with the medical records director and the director of nursing (DON) on 9/7/06 at 4:55 PM verified that the facility transfer form was not in the record. Interview with the DON at that time revealed the transferring nurse should have documented the resident's status, and a facility transfer form should have been completed. Review of the facility's transfer form policy, #FRM 67300, revealed staff was to use the form in the event of a transfer to an acute care facility or to another skilled care facility.	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *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 it is required by the provisions of federal and state law.* Policy and Procedure with nurses. An inservice will be given on proper charting and correct procedures upon residents discharge and transfers. The SDC or designee will include this as part of the orientation of new hires as indicated. MONITORING QUALITY ASSURENCE 4. The Medical Records Manager or designee will audit clinical records of newly discharged/transferred residents. Discharge Audit (completed when a resident is discharged). The audits will be forwarded to the DNS and Executive Director as they are completed. The data will be reviewed and analyzed monthly for three months and results will be brought to the monthly PI meeting. The Administrator is responsible for the overall compliance. Completion Date: Oct. 13, 2006	