POC accepted PBurnes

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Healthcare Licensing and Surveys

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

PRINTED: 01/07/2013
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
	53A002	A. BUILDING _____ B. WING _____	P P 12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIE HOLT CARE CENTER	497 W LOTT BUFFALO, WY 82834

(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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADLs Activities of daily living CNA Certified Nurse Aide CAA Care Area Assessment RN Registered Nurse LPN Licensed Practical Nurse MDS Minimum Data Set RD Registered Dietitian NA Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 staff interview and medical record review, the facility failed to ensure the care plan was followed as planned for 1 of 10 sample residents (#8) and 2 non-sample residents (#22, #33) who were being monitored for weight loss. The findings were: 1. Review of the November and December 2012 weight records for non-sample resident #22 showed significant fluctuating weights. Review of the undated care plan showed goals for the resident to maintain current weight within 5	F 282	Amie Holt Care Center will ensure that care plans are followed for residents being monitored for weight loss. This will be accomplished by: A)The DON will observe that meals and snacks are documented as specified by the care plans for residents number 8, 22 and 33. B)All residents could potentially be affected by weight loss and inadequate nutritional monitoring. On a weekly basis Nurse Team Leaders and dietary (DM or RD) will review each resident individually to determine those	

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

Administrator 1/16/13

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.

1/28/13 @ 8:15 Am telephone call with administrator, POC accepted as submitted. — PBurnes

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F 282	Continued From page 1 pounds (lbs) and to eat an average of 75% of meals through the next quarter. For the interventions, the care plan showed "see ADL flow sheets & nutritional assessment for specific dietary plans." Review of the ADL flow sheets for December 2012 showed meal intakes were to be recorded in a percentage format for breakfast, lunch, and dinner. In addition, snacks were to be offered and checked as to whether they were accepted or refused. Review of the intakes from 12/1/12 to 12/19/12 showed 9 meals with no information available. Review of the AM, PM and HS (at bedtime) snack intake record showed 19 of 57 times when there was no information recorded related to being offered snacks. Interview on 12/20/12 at 8:30 AM with the RD verified the documentation for nutrition interventions and monitoring for residents was sometimes lacking. 2. Review of the 11/27/12 RD note showed non-sample resident #33 was being monitored for weight loss and the RD agreed with interventions to include high protein and high calorie snacks for the resident in addition to fortified meals. Review of the 12/3/12 RD note showed the resident had a significant weight change from 117 lbs to 110 lbs in a "couple of weeks." The note showed his plan was to continue the interventions in place. Review of the November and December 2012 ADL flow sheets showed there was an area for snacks to be recorded four times daily with the amount of cc's (cubic centimeters) consumed or a percentage of the snack consumed. From 11/27/12 to 12/18/12, there were 22 times when there was no documentation if a snack was offered or refused. The remaining information did not consist of cc's or percentages; instead there	F 282	with weight loss and ensure meal and snack charting are complete. Dietary aides and CNAs will document the meal intake in % and cc's consumed for those specified residents. Residents with unplanned weight loss or decubs will have designated snacks recorded in cc's or % consumed. In-servicing and corrective action will be taken with dietary aides and CNAs if documentation is not complete. C)DON will develop a policy, with input from RD, to explain care planned nutritional documentation expectations to staff. This will be reviewed with dietary aides, CNAs, and nurses. D)A performance improvement tool will be developed to ensure care plans are followed in regards to nutritional documentation for residents with unplanned weight loss. This monitor will be completed monthly and reported quarterly to the PI committee. Nurse Team Leaders will be responsible for compliance.	2-3-13

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F 282	Continued From page 2 was a check mark or an "R" for refusal. Interview on 12/20/12 at 8:30 AM with the RD verified the documentation for nutrition interventions and monitoring for residents was sometimes lacking. 3. Review of the current care plan and October to December 2012 ADL flow sheets for resident #8 showed staff were directed to monitor and record nutritional intake daily. According to the 11/10/12 quarterly care conference dietary notes, the resident had lost 6 lbs since 10/12/12 and 16 lbs in the past six months. Review of the December 2012 weight and skin inspection log showed the resident weighed ninety pounds on 12/19/12 (an additional loss of three pounds since 11/10/12). Review of the October, November, and December 2012 ADL flow sheets showed food consumption had not been recorded in October, December, and for twenty-three days in November. Interview with RN #1 on 12/20/12 at 10:25 AM confirmed staff's failure to document the resident's food consumption as directed by the care plan and ADL sheets.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of	F 323	Amie Holt Care Center will ensure that the resident environment remain as free of accidental hazards as possible, providing adequate supervision for each resident. This will be accomplished by: A)1)The DON will observe that resident #14 is safe in the beauty shop area by: a)ensuring the beautician or a staff member is present if chemicals, hot curling irons, or other such supplies are accessible, and	

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F 323	Continued From page 3 incident reports, and medical record review, the facility failed to assure the resident environment remained free from accident hazards in the beauty shop affecting non-sample resident #14. In addition, the facility failed to systematically assess resident falls for 2 of 6 sample residents (#9 and #26). The findings were: 1. Review of the medical record for non sample resident #14 showed s/he was confused, ambulated independently and required frequent redirection due to wandering. Review of the 11/14/12, 11/15/12, 11/16/12, and 11/26/12 nursing documentation showed the resident required redirection when s/he repeatedly entered other resident rooms and attempted to open exit doors. This review also showed at times staff noted the resident wandered because s/he had difficulty remembering the location of the bathroom. Review of the 12/7/12 physician's note revealed the resident was restless, pacing the halls and attempted to leave the facility. The following concerns were identified regarding environmental safety for the resident: a. During an interview on 12/17/12 at 2:30 PM, LPN #1 revealed the beauty shop doors were left open sometimes and at other times it was closed, but the chemicals, supplies and devices were secured in the locked cabinets. Observations of the facility from 12/17/12 to 12/20/12 revealed the entrance doors to the beauty shop opened directly into the hallway and resident sitting area. Intermittent observations throughout the morning on 12/18/12 showed the entrance door to the beauty shop from the resident sitting area was open and the room was unoccupied. Further observation revealed the hot curling iron plugged into the electrical outlet and	F 323	b)ensuring that such supplies are secured when the room is unoccupied. 2)The LPN Team Leader, with input from IDT, will review recent falls and care plan interventions for residents #9 and 26 and observe that caregivers comply with designated interventions. B)1)The DON will randomly observe that the beauty shop is monitored or potentially dangerous items are secured to protect other confused residents. At least 6 observations will be made per month. Immediate in-servicing and corrective action will be taken as needed. 2)Every resident fall will be discussed by the appropriate Nurse Team Leader and IDT to identify possible cause and evaluate care plan interventions, with the goal of incorporating effective preventative measures. These meetings will take place weekly or more frequently. At least 6 times per month each	

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F 323	Continued From page 4 chemicals on the counter were accessible to anyone who entered the room. Intermittent observations throughout the morning on 12/18/12 showed resident #14 was wandering in the beauty shop area and staff were not present to redirect him/her. b. Periodic observations on 12/18/12 from 7:15 PM to 8:30 PM revealed the chemicals and other beauty shop equipment were stored in unlocked cabinets in the opened and unoccupied beauty shop. Observations during that time revealed the resident paced back and forth in the area without the continuous presence of staff. During the pacing the resident was observed when s/he stopped at the opened beauty shop door. As s/he leaned forward to look into the room, a staff member intervened and redirected the resident. However, the beauty shop door remained open and the cabinets remained unlocked. 2. Review of the falls report for resident #9 showed the resident fell on 11/15/12 and 12/13/12. Both falls were unwitnessed and the reports revealed the resident was found sitting on the floor. Further review showed the reports did not include any evaluation as to why the falls occurred or plans to implement interventions to prevent future falls. During an interview on 12/19/12 at 3:50 PM with LPN #1, she stated care plans were developed from the CAAs at the time of the annual assessment and revised at the quarterly care conferences. She further stated that care was primarily provided according to the ADL flow sheets. The LPN then revealed specific interventions related to resident falls were documented on the incident report, were communicated to staff via the daily shift report,	F 323	Team Leader will randomly monitor that care plan interventions are followed by CNAs. Immediate in-servicing and corrective action will be taken as needed. C)1)The DON will educate the facility beautician and staff members on the importance of monitoring the beauty shop for safety, including locking chemicals in cabinet and ensuring hot curling iron is not accessible if the room is unoccupied. 2)The DON will provide education to the nursing staff regarding providing thorough, accurate information and input when a resident falls and the importance of following care plan directives to promote resident safety. D)A performance improvement tool will be implemented by the DON to ensure the beauty shop is a safe area and falls are evaluated appropriately. These monitors will be completed monthly and reported quarterly to the PI committee. The DON	

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F 323	Continued From page 5 and documented on the ADL flow sheets by the team leader. Review of the 5/18/12 care plan for the resident showed the resident required a one person stand by assist for mobility and was to wear a tabs alarm so staff could be aware of his/her movements. However, continued review showed the documentation on the ADL flow-sheet failed to show the interventions were consistently implemented for the entire month of December 2012. Review of the 12/13/12 fall incident report showed the resident was not wearing a tabs monitor at the time of the fall. 3. Review of the 11/15/12 quarterly MDS, 2/19/12 annual MDS and 2/19/12 CAA for resident #26 showed s/he was at risk for falls due to limited mobility and cognitive impairment. Review of the medical record showed s/he was found on the floor on 6/14/12. At that time the resident was confused and the fall did not result in injuries. Further review showed the resident fell from the toilet to the floor on 10/14/12, and sustained non-serious injuries. Review of the wound assessment form completed on 12/12/12 showed the resident received a skin tear on 12/5/12 during a wheelchair transfer. Interview with LPN #2 on 12/18/12 at 11:15 AM revealed the resident's skin tear treatment included dressing changes, pain medications as needed, and antibiotic therapy. In an interview on 12/19/12 at 3:30 PM, LPN #1 stated staff had been instructed to monitor the resident's skin closely, but an evaluation after each fall/incident to identify contributing factors that could prevent recurrent falls and injury related incidents had not been completed.	F 323	will be responsible for beauty shop safety; the Nurse Team Leaders will be responsible for falls.	2.3.13
F 325 SS=E	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		

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F 325	Continued From page 6 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to develop an effective system for monitoring nutritional intake for 1 of 1 sample (#8) and 2 non-sample residents (#22, #33) who experienced significant weight loss. The findings were: 1. Review of the December 2012 weight records for non-sample resident #22 showed significant weight loss. On 12/4/12 the resident's weight was recorded as 118 lbs and on 12/19/12 the recorded weight was 110 lbs, an 8 lb weight loss (6.7%) in three weeks. Review of the 11/5/12 nutrition progress notes completed by the RD showed the resident's weight decreased and s/he had an increased nutrition risk associated with choking. Further review showed, the diet texture was changed, and the physician was aware of the resident's decreased meal intake. Review of the 11/26/12 nutritional progress note completed by the RD revealed some of the resident's medications were discontinued and s/he was	F 325	Amie Holt Care Center will develop an effective system for monitoring nutritional intake for residents who experience significant weight loss. This will be accomplished by: A)RD or DM and Nurse Team Leaders for residents #8, 22 and 33 will review residents' nutritional status, assess the monitored data, and update care plan interventions accordingly. DON will observe that meals and snacks are recorded for theses residents as specified by their care plans. B)All residents could potentially be affected by weight loss and inadequate nutritional monitoring. Nurse Team Leaders and dietary (RD or DM) will review each resident individually to determine those with unplanned weight loss. Dietary aides and CNAs will document the meal intake in % and cc's consumed for those specified residents. Residents with unplanned weight loss or decubs will have designated	

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F 325	Continued From page 7 doing better. This review showed staff were directed to continue to monitor the resident's status; however, information regarding how to do the monitoring was lacking. Review of the undated care plan showed the goals were for the resident to maintain current weight within 5 lbs and to eat an average of 75% of meals through the next quarter. For the interventions, the care plan documented "see ADL flow sheets & nutritional assessment for specific dietary plans." The following concerns were identified with monitoring the nutritional status: a. Review of the ADL flow sheets for December 2012 showed meal intakes were to be recorded in a percentage format for breakfast, lunch, and dinner. In addition, snacks were to be offered and checked as to whether they were accepted or refused. Seventeen of 57 meals were documented as refused by the resident from 12/1/12 to 12/19/12. In addition, there were 9 meal intakes that were left blank with no intake information available. Review of the AM, PM and HS (at bedtime) snack intake record showed 19 of 57 times when there was no information recorded related to being offered snacks. b. Review of the nutrition progress notes showed there was no documentation to identify the significant weight loss in December 2012, or any evidence the monitoring data was being assessed. c. Interview with the dietary manager on 12/20/12 at 8:30 AM revealed the current system for monitoring residents who were at risk for unplanned weight loss consisted of verbal communication between staff. The staff communicated weight changes and poor nutritional intakes. She further stated there was not a formal process for monitoring individuals	F 325	snacks recorded in cc's or % consumed. The list of monitored residents and documentation will be reviewed weekly by Nurse Team Leaders. In-servicing and corrective action will be taken with dietary aides and CNAs if documentation is not complete. C)DON will develop a policy, with input from RD, to explain nutritional documentation expectations to staff. This will be reviewed with dietary aides, nurses, and CNAs. D)A performance improvement tool will be developed to ensure nutritional intake is monitored for residents who experience significant weight loss. This monitor will be completed monthly and reported quarterly to the PI committee. Nurse Team Leaders will be responsible for compliance.	2-3-13

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F 325	Continued From page 8 who were at risk for weight loss. d. Interview on 12/20/12 at 8:30 AM with the RD verified documentation of the nutrition interventions and monitoring for residents was sometimes lacking. 2. Review of the 11/9/12 quarterly MDS assessment for resident #8 showed s/he had severe cognitive impairment, required limited assistance with eating, and had unplanned weight loss. According to the 11/10/12 quarterly care conference dietary notes, s/he lost 6 lbs since 10/12/12 and 16 lbs in the past six months. His/her ideal body weight was 99 to 121 lbs, and the percentage of food consumed each meal varied. The resident's diet consisted of fortified meals with high protein and increased calorie snacks. According to the 11/10/12 care conference notes, the resident weighed 93 lbs at that time. Review of the current care plan and October to December 2012 ADL flow sheets, showed staff were directed to monitor and record the resident's nutritional intake daily. Review of the December 2012 weight and skin inspection log showed the resident weighed 90 lbs on 12/19/12 (an additional loss of three pounds since 11/10/12). Further review of the log showed staff were monitoring a stage II pressure ulcer on the resident's coccyx. Observation of the resident's skin on 12/18/12 at 11:15 AM, and review of the wound care tracking record, showed the pressure ulcer had improved, but the healing process was slow. The following concerns were noted: a. Review of the October, November, and December 2012 ADL flow sheets showed food consumption had not been recorded in October, December, and for twenty-three days in November.	F 325		

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F 325	Continued From page 9 b. Interviews with the dietary manager on 12/19/12 at 12:02 PM and RD on 12/20/12 at 8:45 AM revealed completed food consumption records would have been helpful in determining the resident's nutritional needs and assessing the weight loss. The RD stated the nutritional assessments for the resident were primarily based on the fluctuating weekly weights because food consumption records had not been completed. He further stated weight loss problems can be identified earlier by reviewing food consumption records. c. Interview with RN #1 on 12/20/12 at 10:25 AM confirmed staff's failure to document the resident's food consumption as directed by the care plan and ADL flow sheets. She further stated that monitoring nutritional intake for this resident was important due to the slow healing pressure ulcer and progressive weight loss. d. Observation of the resident during mealtimes on 12/17/12 at 5:10 PM, and 12/18/12 at 8:15 AM showed s/he consumed less than 50% of the meal. 3. Review of the 11/27/12 RD note showed non-sample resident #33 was being tracked for weight loss and the RD had agreed with interventions to include high protein and high calorie snacks in addition to fortified meals. Review of the 12/3/12 RD note showed the resident had a significant weight change from 117 lbs to 110 lbs in a couple of weeks. The plan was to continue the interventions in place. Review of the November and December ADL flow sheets showed there was an area for snacks to be recorded four times daily with the amount of cc's (cubic centimeters) consumed or a percentage of intake. Documentation was lacking 22 times from	F 325		

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F 325	Continued From page 10 11/27/12 to 12/18/12 and the remaining information did not consist of cc's or percentages; instead there was a check mark, or an "R" for refusals.	F 325		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	Amie Holt Care Center will ensure staff uses acceptable hand hygiene practices. This will be accomplished by: A)The Infection Control Nurse (ICN), or her trained designees, will observe staff performing personal cares for residents #20, 21, 24 and 28. Resident #16 has passed away. The ICN or designee will observe that hand hygiene practices are acceptable, including following glove removal. B)All residents could be affected by improper hand hygiene. The ICN or her designees will observe nurses and CNAs providing personal resident cares and, if improper hand hygiene is observed, immediate in-servicing and corrective action will be taken. At least 6 random observations will be made per month. Results will be reported to the ICN.	

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
	53A002	A. BUILDING _____ B. WING _____	pp 12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIE HOLT CARE CENTER	497 W LOTT BUFFALO, WY 82834

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F 441	Continued From page 11 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policy and procedure, the facility failed to ensure staff used acceptable hand hygiene practices during 5 of 8 random observations of personal care for residents (#16, #20, #21, #24, #28). The findings were: 1. NA #2 was observed providing toileting assistance and perineal care for resident #16 on 12/18/12 at 9:06 AM. During the tasks the NA removed the soiled brief with ungloved hands, then donned gloves to perform perineal care. After completing the perineal care, she removed the gloves, and put the clean brief on the resident with ungloved hands. Hand hygiene was not performed at any time during the observed tasks. 2. CNAs #12 and #8 were observed providing fecal and urinary incontinent care for resident #28 on 12/18/12 at 7:55 PM. During the observation CNA #8 removed her gloves after she cleansed the resident's skin and donned another pair of gloves without performing hand hygiene. While wearing the clean pair of gloves she repositioned the resident in bed, then removed that pair of gloves, and donned a third pair of gloves to apply protective skin barrier. Hand hygiene did not occur until after the CNA completed the tasks. In an interview on 12/18/12 at 8:26 PM, the CNA stated she knew she should have performed	F 441	C)Nurses and CNAs will be required to watch a video of the ICN demonstrating and explaining appropriate hand hygiene. Nurses and CNAs will be required to demonstrate appropriate hand washing technique to the ICN or designee. D)A performance improvement tool will be developed to ensure appropriate hand hygiene. This monitor will be completed monthly and reported quarterly to the PI committee. The ICN will be responsible for compliance.	2-3-13

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F 441	Continued From page 12 hand hygiene after she removed her gloves, but she forgot to do it. 3. Observation of perineal care 12/18/12 at 9:50 AM for resident #24 revealed CNA #10 did not perform hand hygiene between glove changes when removing the soiled dressings from bilateral gluteal excoriated areas. Consecutive observation at that same time of LPN #2 showed she changed the indwelling catheter after the perineal care for the same resident. The LPN failed to perform hand hygiene after removing the gloves, and prior to assisting the CNA in applying clean clothing to the resident. Interview with CNA #10 and LPN #2 immediately following the observation revealed both were aware they should have washed their hands or should have used wipes between glove changes. 4. On 12/18/12 at 8:24 PM CNA #12 was observed removing gloves following the provision of pericare for resident #20. Further observation showed the CNA failed to perform hand hygiene before applying lotion to the resident's extremities. 5. On 12/18/12 at 9:56 AM CNA #6 was observed removing gloves following the provision of perineal for resident #21. Further observation showed the CNA failed to perform adequate hand hygiene before leaving the bathroom to get the nurse. 6. Review of the Hand Hygiene Policy, dated 12/11/95 and revised March, 2008 showed hand washing or use of an alcohol-based hand rub was indicated before and after applying gloves.	F 441		