POC accepted 2/7/13 JE

RECEIVED
WY Dept of Health
JAN 30 2013
Healthcare Licensing and Surveys

PRINTED: 01/10/2013
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
	535025	A. BUILDING _____ B. WING _____	C 01/03/2013

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

(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	F 000	Preparation and/or execution of the response and plan of correction do not constitute admission of 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.	
	The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing LPN-Licensed Practical Nurse MDS- Minimum Data Set RN-Registered Nurse CAA-Care Area Assessment Less commonly used abbreviations will be annotated in each deficiency.		FTAG 157 Corrective Action : Resident #2 POA /or interested family was notified of change of condition on 1/29/13 Resident #6 's POA was notified of residents condition and all of the change of conditions on 1/29/13. Residents #1 was discharged from facility on 12/22/12. ID OF OTHERS: The DON/Designee will review any new Change of Conditions for the past 14 days to ensure physician, POA's or interested families were informed.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157	SYSTEM MEASURES: DON/designee will in service all nursing staff that they must immediately inform physician and if there is a legal representative or interested family of any changes of conditions/concerns or occurrences that involve resident which results in injury and has a potential for physician intervention, a significant change in	

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Reaume | TITLE: NHA | (X6) DATE: 1-28-13

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

POC accepted. Message left for Jennifer Reaume, NHA on 2/7/13 @ 2:15 pm. Janice Cook, OTR/L

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F 157	Continued From page 1 specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure the family was notified of a change in condition for 3 of 5 sample residents (#1, #2, #6). The findings were: 1. Review of the January 2013 physician's recapitulation of orders for resident #2 showed s/he was admitted to the facility on 12/21/11 with diagnoses including coronary atherosclerosis and history of myocardial infarction. Review of the 12/31/12 nursing notes timed at 11:40 PM showed the resident complained of chest pain which radiated down the left arm at 10:20 PM. Review of the notes revealed the resident's blood pressure (B/P) was 179 over 101 at that time. Further review showed the physician was notified and ordered nitroglycerine. If the nitroglycerine was not effective, the physician ordered a transfer to the hospital emergency room for evaluation. Continued review of the 12/31/12 timed at 11:40 PM nursing notes showed the nitroglycerine did not relieve the resident's chest and arm pain so s/he was transported to the emergency room with his/her B/P in the 190's over 150's. The resident remained in the hospital overnight. Review of the change of condition report and the nursing notes	F 157	condition in residents physical, mental or psychosocial status , a need to alter treatment significantly, or a decision to transfer or discharge the resident from the facility as specified in 483.12. The nurse leadership team will review of all new orders and the 24 hours report in morning meeting Monday thru Friday and identify any situation that may need the notification of physician or residents legal representative or interested family. Unit managers /designees will verify that they were indeed notified and any follow up needed occurred. Random weekly audit by DON /designee of Change of Conditions, Incidents and any other conditions that may need to alter treatment significantly will occur weekly for 8 weeks then randomly monthly for three months then re-reviewed at QAPI. Monitoring Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QAPI committee by DON/designee. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly X3..	02/14/13

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F 467	Continued From page 2	F 467		

showed no evidence the family was notified of the resident's change in condition. Interview with the unit manager and DON on 1/3/13 at 1:40 PM verified there was no evidence the family was notified of the resident's change in condition.

2. Review of the January 2013 physician's recapitulation of orders for resident #6 showed s/he was admitted on 6/3/09 with diagnoses including convulsions, oropharyngeal dysphagia, and chronic airway obstructive disease. Review of the medical record showed the resident experienced a change in condition five times from October 2012 through December 2012 (10/29/12, 11/14/12, 11/19/12, 12/17/12, and 12/24/12). Changes in condition included blood in the urine, elevated temperatures twice, an eye infection, and a change in tube feeding nutrition. Review of these change of condition reports and all nursing notes showed no evidence the family was notified of any of the five condition changes. Interview with the unit manager and DON on 1/3/13 at 1:40 PM verified there was no evidence the family was notified of the resident's changes in condition. They further said, family should have been notified.

3. Review of the medical record for resident #1 showed s/he was admitted to the facility on 12/31/11 with diagnoses including dementia, brain neoplasm, and pressure ulcers. The quarterly MDS assessment dated 9/14/12 showed the resident was cognitively impaired and required extensive assistance with activities of daily living (ADLs). The CAA assessment dated 1/20/12 showed the resident triggered for pressure ulcers. Review of the care plan updated on 3/9/12 showed interventions for pressure ulcers

Tag 280
Resident #6 care plans were up dated to reflect current NPO status of resident on 1/3/13.
Identification of Others:
Current diet orders will be reviewed by DON/Designee and care plans will be reviewed to ensure reflection of those changes.
Systems/Measures:
RCD/Designee to complete re-education for MDS nurses and IDT on updating care plans as changes occur on or before 2/13/13.
DON/designee to review residents with change of condition by reviewing 24 hour report and new physician orders daily Monday thru Friday to ensure care plans reflect current status of resident. Nurse on call will report any changes of condition occurring on the weekend to DON and DON/Designee will ensure care plan updated.
Monitoring:
Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QAPI committee by DON/designee. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly X3.
Correction date: 02/14/2013

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F 167	Continued From page 3 included; observe skin weekly and document findings. Review of the head to toe skin assessment on 12/5/12 showed the resident had an open area on the coccyx. Interview with LPN #2 on 1/4/13 at 1:50 PM verified the resident had an open area at the crease of the coccyx on 12/6/12 .The LPN also verified she had not called the family. Review of the medical record showed no evidence the family was notified by any staff member of the development of the pressure sore.	F 167	It is the practice of the facility to ensure that based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	
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 observation, medical record review	F 280	Tag 314 **Correction Action: Resident #1 was discharged from facility on 12/22/12. Resident #6 treatment in place, is being documented and reviewed by DON/Designee weekly.** **Id of Others: Facility wide Head to toe skin assessments completed by DON/designee on 1/16/13** . Residents identified to have skin problems will be assessed, physicians notified and treatment plans implemented. Care plans will be developed or revised as necessary. Systemic Changes: The IDT reviewed the Facility Skin System to assure that it is appropriate to meet the needs of the identified residents. The Facility's skin system requires that staff complete a skin assessment and the Braden Scale for all new admissions to determine the level of risk for each individual resident.	

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F 280	Continued From page 4	F 280		
	and staff interview, the facility failed to ensure staff reviewed and revised the care plan to accurately reflect the resident's status for 1 of 5 sample residents (#6). The findings were: Review of the January 2013 physician's recapitulation of orders for resident #6 showed s/he was admitted on 6/3/09 with diagnoses including convulsions, oropharyngeal dysphagia, chronic airway obstructive airway disease, and muscle atrophy. Review of the current care plan showed the following concerns: a. Review of the care plan showed an intervention to keep fluids at the bedside within the resident's reach. This intervention was dated 2/22/12. Observation on 1/2/13 and 1/3/13 showed no fluids were in the resident's room. Interview with the unit manager and DON on 1/3/13 at 1:40 PM revealed the resident had been placed on NPO (nothing by mouth) since s/he was re-admitted in September 2012 and the care plan had not been updated to reflect this change. b. Review of the care plan showed interventions to provide extra fluids at each medication pass and at each meal as tolerated. These interventions were written on the care plan in March 2012. However, interview with the unit manager and the DON on 1/3/13 at 1:40 PM revealed these interventions were no longer appropriate because the resident was placed on NPO status in September 2012. They said the care plan was not updated to accurately reflect the current NPO status of the resident.		Once a resident is determined to be at risk the IDT develops a plan of care, which is individualized to meet the needs and condition of the resident. The plan of care is implemented based on unique resident needs and the plan is monitored for effectiveness. The Braden Scale assessment process will be completed for 3 additional weeks after admission for a total of 4 weeks. Pressure Ulcers identified during the assessment process will be assessed and documented on the Weekly Pressure Ulcer Record. Documentation will include stage, size in cm, depth, undermining, exudates type and amount, surrounding skin condition and pain related on the wound. Non-Pressure Skin Conditions will be assessed and documented on the Weekly Non-Pressure Skin Condition Record. Such documentation will include size in cm, depth, characteristics, exudates type and amount, progress, treatment and pain related to the wound. Weekly skin checks will be completed by licensed nursing staff and results will be documented on the Treatment Administration Record (TAR). If the resident experiences a change in their clinical condition and the change may impact the integrity of the skin	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		

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F 314	Continued From page 6 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of 24 hour shift reports and facility policies and procedures, and medical record review, the facility failed to ensure staff assessed, monitored, and implemented measures to prevent and treat skin breakdown for 2 (#1, #6) of 5 sample residents who had or were at risk for skin breakdown. This lack of assessment, monitoring, and implementation of measures likely contributed to worsening of a pressure ulcer for resident #6. The findings were: 1. Review of the most recent MDS assessment, a quarterly assessment dated 8/25/12, for resident #6 showed s/he was at risk for pressure ulcers. Review of the 12/5/12 Braden risk assessment showed the resident was at high risk of developing a pressure ulcer. The following concerns with pressure ulcer prevention and management were identified: a. Review of the 11/17/12 nursing notes timed at 1:35 PM showed a CNA notified RN #3 there was an open area on the resident's left buttock. Review of the entire medical record showed no evidence the open area was assessed until 12/5/12 (18 days later) at which time it was unstageable. Interview with the wound care nurse/DON and unit manager on 1/5/13 at 2 PM	F 314	condition the change is noted on the 24 hour report and the physician and responsible party is contacted. Any new orders received by the physician are promptly documented on the plan of care and implemented. Residents with identified Pressure Ulcers and/ or skin issues will be reviewed weekly at the IDT Skin Management Meeting to evaluate the effectiveness of the plan of care. New interventions will be discussed and reviewed as indicated. Care plans will be reviewed, updated and communicated to staff. Resident Care Specialist (C.N.A.) Care Cardexes will be updated as necessary. Families/responsible parties will be notified of changes to the plan of care. The DON/designee will provide education to licensed nurses on the above mentioned facility skin system on or before 2/14/13. Newly hired nurses will receive this education during orientation to the facility. DON/designee will review TAR's weekly to assure that treatments are done as ordered and to determine the effectiveness of the treatments. The DON or designee will make random rounds and perform skin observations to assure that treatments are in place as	

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F 314	Continued From page 6	F 314		

verified the open area should have been assessed on 11/17/12 when it was first identified. They both agreed new open areas should be assessed immediately, not 15 days later.

b. Review of the weekly skin check forms showed no evidence the weekly skin checks were performed after 11/12/12. Review of the November 2012 TAR showed the weekly skin checks were due on 11/19/12 and on 11/26/12, however, both of these areas were left blank indicating the skin checks were not performed on those dates. Interview with the wound care nurse/DON and unit manager on 1/3/13 at 2 PM verified the weekly skin checks were not performed weekly as they should have been after 11/12/12.

c. Review of the entire medical record showed no evidence the physician, the family, or the wound care team was notified of the open area until 12/5/12, 18 days after the CNA notified RN #3. Interview with the unit manager and DON/wound care nurse on 1/3/13 at 2 PM revealed they were unaware of the pressure ulcer until 12/5/12. According to the wound care nurse/DON, on 1/3/13 at 2 PM, the wound now had a foul odor to it.

2. Review of the medical record for resident #1 showed s/he was admitted to the facility on 12/31/11 with diagnoses including dementia, brain neoplasm, and pressure ulcers. The quarterly MDS assessment dated 9/14/12 showed the resident was cognitively impaired and required extensive assistance with activities of daily living (ADLs). The CAA assessment dated 1/20/12 showed the resident triggered for pressure ulcers. Review of the care plan updated on 3/9/12 showed interventions for pressure ulcers

ordered, care plan interventions are effective, and goals set forth in care plans are being met.

Monitoring:
Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QAPI committee by DON/designee. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly X3.

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F 314	Continued From page 7 included: observe skin weekly and document findings. Review of the head to toe skin assessments showed the resident was admitted with a Stage II pressure ulcer on his/her coccyx which was healed in March 2012. The following concerns were identified: a. Review of the head to toe skin assessment on 12/6/12 showed the resident had an open area on the coccyx. Review of the 12/12/12 assessment showed the resident continued to have an open area on the coccyx (now 7 days). Review of the 12/6/12 and 12/12/12 treatment administration record (TAR) also showed the resident had an open area to the coccyx. Review of the 24 hour shift reports and the entire medical record, however, showed no evidence the physician and wound team were aware of the pressure ulcer. In addition, review of the medical record showed no evidence the open area on the coccyx was assessed, treated or managed by the wound team and physician. b. Review of a 12/22/12 physician's order revealed the resident was sent to the hospital emergency room for treatment of altered mental status. Review of the hospital history and physical dated 12/22/12 at 9:01 AM showed a Stage II pressure area on the coccyx was observed upon arrival in the emergency room. c. Interview with RN #2 on 1/3/13 at 1:55 PM revealed nurses were responsible for performing head to toe skin assessments on residents. Any new open area on the resident's skin was to be documented on the assessment forms and on the TAR, the physician and the wound care nurse were to be notified of the open area(s), and the nurse also should fill out an Inter Act form. The nurse explained the Inter Act form prompts the nurse to notify the resident's physician and family	F 314		

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F 314	Continued From page 8 of a change in condition. The RN further said the nurse performing the assessment should notify the unit manager and the DON. Finally, the RN said the presence of an open area should be documented on the 24 hour shift report. Interview with the DON on 1/3/13 revealed she expected the nurses to follow this protocol. d. Interview with LPN #2 on 1/4/13 at 1:50 PM verified the resident had an open area at the crease of the coccyx on 12/5/12 and that she had informed the day shift unit manager. The LPN also said the protocol was " different for the night shift " . She said the night nurse informed the day shift unit manager and the manager filled out the Inter Act form, notified the physician, the resident's family, and the DON. The treatment was then to be initiated by the wound care nurse. A review of the facility policy dated 2012 showed,"skin assessments 16.D. A Change of condition form is to be completed and new physician's order obtained for new incidence of compromised skin integrity".	F 314		

kim mccoll <kim.mccoll@wyo.gov>

POC accepted: Cheyenne Healthcare

2 messages

janelle conlin <janelle.conlin@wyo.gov> Thu, Feb 7, 2013 at 2:37 PM
To: LTC <wdh-ltc@wyo.gov>
Cc: Julia VanDyke <julia.vandyke@wyo.gov>, Rae Anne White <raeanne.white@wyo.gov>, Catherine Hoff <catherine.hoff@wyo.gov>, Connie Chapman <connie.chapman@wyo.gov>

For complaint survey 1/3/13. DoC- 2/14/13. Will require on-site followup because of "G" level tag.

--
Janelle Conlin, OTR/L
State Health Surveyor
Healthcare Licensing and Surveys
6101 Yellowstone Rd, Suite 186C
Cheyenne WY 82002
ph: 307-777-7123
fax: 307-777-7127
janelle.conlin@wyo.gov

CHC CO POC.pdf
3291K

laura hudspeth <laura.hudspeth@wyo.gov> Thu, Feb 7, 2013 at 3:23 PM
To: janelle conlin <janelle.conlin@wyo.gov>
Cc: LTC <wdh-ltc@wyo.gov>, Julia VanDyke <julia.vandyke@wyo.gov>, Rae Anne White <raeanne.white@wyo.gov>, Catherine Hoff <catherine.hoff@wyo.gov>, Connie Chapman <connie.chapman@wyo.gov>

Janelle, thank you for going over this process with Rae Anne, Julia, Catherine, and Connie. Laura
[Quoted text hidden]
--
Laura Hudspeth, MSc, RD, LD
Chief, Healthcare Surveillance Branch
Aging Division, Healthcare Licensing and Surveys
6101 Yellowstone Road
Suite 186C
Cheyenne, WY 82002
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1 message

kim mccoll (Google Drive) <kim.mccoll@wyo.gov> Thu, Feb 7, 2013 at 3:28 PM
To: kim.mccoll@wyo.gov
Cc: kathryn.may@wyo.gov, linda.brown@wyo.gov

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