POC accepted 2/28/13

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WY Dept of Health
FEB 22 2013
Healthcare Licensing
Civil Surveys

PRINTED: 02/22/2013
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
MAR 4 2013	535048	A. BUILDING _____ B. WING _____	R-C pf 02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	4041 SOUTH POPLAR STREET CASPER, WY 82601

(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: MDS-Minimum Data Set MAR-Medication Administration Record PRN-As Needed. Less commonly used abbreviations will be annotated in each deficiency.	{F 000}	Preparation and execution of this response and 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 the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law. For the purposes of any allegation the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations manual.	New Date 2/24/13 pp
{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 staff interview and medical record review, the facility failed to ensure physician orders were followed for 1 of 13 sample residents. The findings were: Review of the medical record for resident #64 showed s/he had diagnoses including hypertension (high blood pressure). Review of the January 2013 and February 2013 physician recapitulation of orders for the resident showed an order dated 10/10/12 for weekly blood pressure readings. However, review of the January 2013 and February 2013 MARs showed no evidence the resident had his/her blood pressure on a weekly basis. Interview with unit manager #2 on 2/8/13 at 3:30 PM verified no blood pressure readings were obtained as ordered by the physician.	{F 281}	F 281 The facility will provide services that meet professional standards. This will be accomplished by: A)The physician order for Resident #64 was clarified to read: Vital signs weekly and PRN. B)An audit of resident weekly vital sign orders was completed to identify any other residents with the same omissions. C)Licensed staff was educated on or before 02/24/13 by the Staff Development Coordinator and/or designee to follow physician orders as written. D)Physician orders for residents with weekly vital sign orders will be reviewed daily for 1 week/5 times per week, weekly for 3 weeks and monthly for an additional 60 days to ensure that physician orders are being followed as written. The results of the reviews will be reported to the Performance Improvement Committee monthly by the DON or designee for the next 90 days or until the committee determines substantial compliance has been achieved.	1/13/13
{F 309}	483.25 PROVIDE CARE/SERVICES FOR	{F 309}		1/13/13

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

ED 2/28/13

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: J2YC12 Facility ID: WY0013 If continuation sheet Page 1 of 10

Per telephone Jennifer Brauer, Executive Director on 2/28/13 @ 11:10 AM POC accepted with additions. pPirnie RN

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(F 309) SS=E	Continued From page 1 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure all necessary assessments, monitoring, and nursing measures were implemented for pain management for 5 of 13 sample residents (#24, #61, #64, #77, #81) who experienced pain. In addition, the facility failed to ensure assessments, monitoring, and nursing measures were implemented for management of anxiety for 1 of 2 sample residents (#105). The findings were: In regard to management of anxiety: 1. Review of the medical record for resident #105 showed s/he had diagnoses including chronic airway obstruction, shortness of breath, and anxiety. Review of the 12/25/12 annual MDS assessment showed the resident had shortness of breath upon exertion while sitting and while lying flat. Review of the 1/21/13 nursing notes timed at 2:41 AM showed the resident had "non stop coughing and anxiousness this evening hollering non stop stating "I Can't breathe help me!...Res [resident] on 3.5 l [liters] on per NC [nasal cannula] and 02 sats are 79 to 87%, will	(F 309)	F309 The facility will ensure all necessary assessments, monitoring, and nursing measures were implemented for pain management. This will be accomplished by: A)Resident # 105 medical record documentation will show anxiety attempts to decrease anxiety with the use of non-pharmacological interventions and/or utilization of PRN anxiolytic medication and that the Primary Care Provider was notified of anxiolytic medication ineffectiveness with request for further intervention from Primary Care Provider. #24 PP Residents# 61, #64, # 77 and #81's medical record documentation will show pain intensity level, attempts to decrease pain with the use of non-pharmacological interventions and/or utilization of PRN pain medication and that the Primary Care Provider was notified of pain medication ineffectiveness with request for further intervention from Primary Care Provider. B)An initial audit of PRN pain medication and anxiolytic medication effectiveness was completed by Nursing Administration to identify other resident records with the same omissions. C)Nursing staff was educated by the DON and ADON on 2/12/13 and 2/13/13 on proper documentation of PRN pain medication and anxiolytic medication effectiveness along with appropriate follow-up to Primary Care Provider. D)PRN pain medication and anxiolytic medication effectiveness documentation and physician notification of these medication ineffectiveness will be monitored by nursing administration daily for 30 days, weekly for 30 days, then monthly for an additional 2 months. The results will be reported to the Performance Improvement Committee monthly by the DON or designee for the next 90 days or until the committee determines substantial compliance has been achieved.	New Date 2/24/13 PP

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(F 309)	Continued From page 2 notify MD [medical doctor] of res [resident] anxiety and assessment in AM". Review of the 1/21/13 nursing notes timed at 3:20 PM, 13 hours later, showed the resident continued to yell out that s/he could not breathe stating "Help me help me I can't breathe...[s/he] was just so anxious, [s/he] was taking short shallow breaths and continued to yell". Review of the January 2013 and February 2013 physician's recapitulation of orders showed the resident had Xanax (anti-anxiety) 0.25 milligrams (mg) three times daily as needed. This order was written on 11/19/12. The following concerns with managing the resident's anxiety were identified: a. Review of the January 2013 MAR showed the resident received Xanax due to increased anxiety from feeling short of breath on 1/2/13 at 7 AM and at 3 PM, on 1/6/13 at 8 PM, on 1/13/13 at 8:15 PM, on 1/16/13 at 1:38 AM, on 1/18/13 at 7:20 PM, on 1/19/13 at an undocumented time, on 1/23/13 at 8 PM, on 1/25/13 at an undocumented time, on 1/26/13 at 7 PM, on 1/30/13 at an undocumented time, and on 1/31/13 at 5 AM. Review of the MAR showed no evidence the resident was re-assessed to determine the effectiveness of the Xanax in relieving his/her anxiety on any of these times. b. Review of the January 2013 MAR showed the resident was administered Xanax for anxiety related to feeling short of breath on 1/6/13 at 4:30 AM with no relief by 5:30 AM, on 1/6/13 at 4:15 AM with no relief by 5:30 AM, on 1/6/13 at 6 PM with no relief by 6:30 PM, on 1/7/13 at 11:30 AM with no relief by 12 noon, on 1/10/13 at 9 AM with no relief by 10 AM, on 1/10/13 at 4:10 PM with no relief by 5 PM, on 1/12/13 at 3 PM with no relief by 4 PM, on 1/14/13 at 1:15 PM with no relief by 2 PM, on 1/18/13 at 8 AM with no relief by 9 AM.	(F 309)		

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(F 309)	Continued From page 3 and on 1/30/13 at 5:30 PM with no relief. Review of the medical record showed no evidence non-pharmacological alternatives were attempted. c. Review of the February 2013 MAR from 2/1/13 through 2/4/13 showed the resident was administered Xanax for anxiety due to shortness of breath on 2/1/13 at 3:20 PM with no evidence a re-assessment was performed to determine the effectiveness of the medication. Further review of this MAR showed on 2/3/13 the resident received a Xanax at 4:30 PM with no relief and on 2/4/13 at 8:20 AM with no relief or improvement. In regard to pain management: 1. Review of the medical record for resident #81 showed s/he had chronic pain, muscle weakness and osteoarthritis. Review of the January 2013 physician orders showed the resident was ordered Percocet 10 mg one tablet every 4 to 6 hours as needed for pain. The February 2013 physician orders showed the resident was ordered Percocet 10 mg every four hours while awake. In addition, a pain assessment was to be done each shift using a pain scale of 1-10 with 10 representing the worst pain. The resident reported his/her acceptable pain level was 3/10. Review of the nurses notes dated 1/4/13 at 9:58 AM showed the resident complained of hip pain "averaging 8" prior to the pain medication and took the medication as often as it was permitted. The resident reported "moderate relief" from the pain medication. Review of the nursing notes dated 1/5/13 and timed at 10:05 AM showed the resident continued to complain of hip pain radiating to the groin and it remained at the level of 8/10. In addition the resident stated the	(F 309)		

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(F 309)	Continued From page 4 pain did not "go lower than a 4." The 1/12/13 nurse's note showed the resident continued to ask for his/her pain medication before it was due. Review of the January 2013 MAR showed the resident's pain was between 7/10 to 8/10 ninety one percent of the time. Review of the February 2013 MAR showed the resident continued to have pain rated 7/10 to 8/10 seventy five percent of the time. Review of an orthopedic consult dated 12/21/12 showed the resident had a left hip fracture repair 18 months ago. Further review of this consult showed the screw used to repair the fracture could be contributing to the resident's ongoing pain. At the time of the consult on 12/21/12, the resident received an injection of lidocaine for pain which the resident said was only helpful for one to two days. The following concerns with pain management were identified: a. Review of the Physician Interim Orders dated 1/4/13 showed Percocet order was changed from PRN to every four hours on a routine schedule. However, it was thirteen days before the resident was seen on a follow-up visit (on 1/17/13) by the orthopedic physician at which time the resident's left hip pain was noted to be "exquisitely tender". On this visit a computed tomography (CT) scan of the left hip was ordered. b. Review of the nurse's notes dated 1/17/13, showed the CT scan was scheduled for 1/21/13, another four days. Further, a follow-up appointment with an orthopedic physician was scheduled on 1/29/13, now 99 days after the initial consult on 12/21/12 for left hip pain rated 7/10 to 8/10 despite pain medication. Review of the physician interim orders dated 1/29/13 showed the resident had non-union of the greater trochanter with hardware pain. The resident was.	(F 309)		

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(F 309)	Continued From page 6 scheduled for surgical removal of the hardware on 2/20/13. While there was an order written on 1/4/13 to increase the frequency of the pain medication (Percocet), the resident continued to be in pain rated at 7/10 to 8/10 for 47 days with no further pharmacological or non-pharmacological interventions developed to make the resident more comfortable while awaiting surgical intervention after 1/4/13. 2. Review of the medical record for resident #24 showed s/he had diagnoses including osteoporosis, spinal stenosis, and chronic pain. Review of the January 2013 and February 2013 physician's recapitulation of orders showed an order dated 6/10/10 for Tylenol 325 mg one to two tablets every four hours as needed for pain. Review also revealed an order dated 11/16/11 for a Fentanyl patch 25 mcg/hr (microgram's per hour) patch. Further review showed on 7/18/12 an additional pain medication was ordered which was oxycodone 5/325 mg every night at bedtime. On 10/31/12 Percocet 5/325 mg (pain medication) was ordered every four to six hours as needed for breakthrough pain. The following concerns with pain management were identified: a. Review of the January 2013 MAR showed the resident received Tylenol for pain on 1/1/13 and on 1/10/13, however it was not documented whether the resident was administered one or two tablets. Additionally, review of the medical record showed no evidence an assessment or re-assessment of the resident's pain was performed. There was no intensity of pain rated, no location of pain noted, and no time documented. b. Review of the January 2013 MAR showed this resident was administered Percocet on 1/3/13	(F 309)		

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(F 309)	Continued From page 6 for pain. Review of the medical record showed the time the medication was administered was not documented and there was no evidence an assessment or re-assessment of pain was performed. c. Review of the January 2013 MAR showed the resident received Tylenol on 1/8/13 at 10:16 AM, however there was no documentation as to how many tablets the resident received and there was no pain assesement or re-assessment performed. 3. Review of the 11/14/12 annual MDS assessment for resident #54 showed s/he had occasional pain rated 8/10. Review of the February 2013 physician's orders showed an order for Tylenol extra-strength 1000 milligrams (mg) PRN for pain (no time frames were provided) dated 9/18/08. Further review of the February 2013 physician orders showed hydrocodone-APAP (acetaminophen) 5/325 mg was ordered every 4 to 6 hours as needed for pain. The following concerns were identified: a. Review of the January 2013 MAR showed the resident received hydrocodone-APAP for a pain rating of 8/10 on 1/2/13. However, no time of administration was documented and there was no evidence the resident's pain level was re-assessed to determine the effectiveness of the medication. Interview with unit manager #2 on 2/8/13 at 3:30 PM revealed the resident's stated acceptable level of pain was 5/10. She further verified there was no evidence the resident's pain was re-assessed. b. Review of the January 2013 and February 2013 physician's orders showed no time frame parameters for administering the PRN Tylenol extra-strength 1000 mg. were established.	(F 309)		

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(F 309)	Continued From page 7 According to 2008 Edition of the "Nurse's Drug Handbook" by George R. Spratto and Adrienne L. Woods, pages 12-13, the usual and recommended parameters for Tylenol 1000 mg was every six hours with the following warning "Do not exceed 4 grams/24 hours in adults..." c. Review of the January 2013 MAR showed the resident received hydrocodone-APAP for pain on 1/3/13 at 7:30 AM. However, the resident's pain was not assessed as to intensity, location, or type. Furthermore, review of the medical record showed no evidence the resident's pain level was re-assessed to determine the effectiveness of the medication. Interview with unit manager #2 on 2/6/13 at 3:30 PM verified there was no evidence the resident's pain was re-assessed. d. Review of the January 2013 MAR showed the resident was administered Tylenol extra-strength 1000 mg for pain on 1/4/13 at 8 PM. However, the resident's pain was not assessed as to intensity, location, or type. Furthermore, review of the medical record showed no evidence the resident's pain level was re-assessed to determine the effectiveness of the medication. Interview with unit manager #2 on 2/6/13 at 3:30 PM verified there was no evidence the resident's pain was re-assessed. e. Review of the January 2013 MAR showed the resident received hydrocodone-APAP for pain on 1/10/13 at 10 PM. However, the resident's pain was not assessed as to intensity, location, or type. Furthermore, review of the medical record showed no evidence the resident's pain level was re-assessed to determine the effectiveness of the medication. Interview with unit manager #2 on 2/6/13 at 3:30 PM verified there was no evidence the resident's pain was re-assessed. f. Review of the February 2013 MAR showed	(F 309)		

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{F 309}	Continued From page 9 the resident was administered Tylenol extra-strength 1000 mg on 2/1/13 at 6 PM. Review of the medical PRN administration record and the MARs showed no evidence the resident's pain was assessed in regard to intensity, location, or type. In addition, review of the medical record revealed no evidence the resident's pain was re-assessed to determine the effectiveness of the medication in relieving his/her pain. 4. Review of the medical record for resident #77 showed s/he was admitted with diagnoses including chronic pain syndrome, muscle weakness, and difficulty walking. Review of the 1/30/13 initial MDS assessment showed the resident had frequent pain that made it hard to sleep and limited his/her daily activities. The resident rated his/her worst pain as 6/10 on a scale of 1 to 10 with 10 being the worst (10/10). Review of the January 2013 and February 2013 physician's recapitulation of orders showed the resident had an order for hydrocodone/acetaminophen 10/325 mg dated 1/18/13 every six hours for pain as needed. The following concerns with paid management were identified: a. Review of the pain flow sheet for January 2013 showed on 1/22/13 at 1 AM the resident complained of leg pain rated at 7/10 and was administered hydrocodone/acetaminophen. However, review of the medical record showed no evidence the resident was re-assessed to determine if the pain medication was effective in relieving his/her pain. In addition, there was no evidence non-pharmacological alternatives were attempted. b. Review of the PRN administration record for February 2013 showed the resident was	{F 309}		

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(F 309)	Continued From page 9 administered hydrocodone/acetaminophen on 2/4/13 at an undocumented time with no description of the pain intensity, location, or type. In addition, review showed no evidence the resident's pain was re-assessed to determine the effectiveness of the medication. 6. Review of the medical record for resident #61 showed s/he had diagnoses to include muscle weakness and traumatic fracture of the upper leg. Review of the January 2013 physician's recapitulation of orders showed the resident was to have a pain assessment completed each shift. Review of the MAR showed the pain assessment was not completed 6 times between 1/23/13 through 1/31/13. In addition, the resident's acceptable pain level was not indicated. Interview with three unit managers, the ADON (assistant director of nursing) the administrator, and medical director on 2/8/13 at 3:30 PM verified PRN medications should be re-assessed to determine the effectiveness in managing a resident's complaint regardless of whether the source of discomfort was pain or anxiety. The unit manager further verified the lack of re-assessment, lack of relief, and lack of non-pharmacological interventions as noted throughout all of the above examples.	(F 309)		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535049	A. Building B. Wing	2/7/2013

Name of Facility	Street Address, City, State, Zip Code
LIFE CARE CENTER OF CASPER	4041 SOUTH POPLAR STREET CASPER, WY 82601

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 01/13/2013	ID Prefix F0243 Reg. # 483.15(c)(1)-(5) LSC	Correction Completed 01/13/2013	ID Prefix F0244 Reg. # 483.15(c)(6) LSC	Correction Completed 01/13/2013
ID Prefix F0253 Reg. # 483.15(h)(2) LSC	Correction Completed 01/13/2013	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 01/13/2013	ID Prefix F0333 Reg. # 483.25(m)(2) LSC	Correction Completed 01/13/2013
ID Prefix F0353 Reg. # 483.30(a) LSC	Correction Completed 01/13/2013	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 01/13/2013	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 01/13/2013
ID Prefix F0514 Reg. # 483.75(l)(1) LSC	Correction Completed 01/13/2013	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date: 5/13/13	Signature of Surveyor: Kathryn Kinney	Date: 5 Mar 13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/29/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO