WDH - Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF024	A. BUILDING _____ B. WING _____	10/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOME OF BUFFALO	1 NORTH KLONDIKE BUFFALO, WY 82834

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SALF	LIC REGS FOR ASSISTED LIVING FACILITIES WYOMING DEPARTMENT OF HEALTH AGING DIVISION RULES FOR PROGRAM ADMINISTRATION OF ASSISTED LIVING FACILITIES Chapter 12 Section 4. Definitions (qq) "Registered Nurse (RN)." A registered Nurse duly licensed by the Wyoming State Board of Nursing per the Wyoming Nurse Practice Act W. S. 33-21-119 et seq. [Wyoming State Board of Nursing Rules and Regulations. Chapter 3, Standards of Nursing Practice. ...Section 2. Standards of Nursing Practice for the Registered Professional Nurse. (a) (i) The registered professional nurse shall: ... (A) Have knowledge of the statutes and regulations governing nursing; (B) Practice within the legal boundaries for nursing through the scope of practice authorized in the Wyoming Nurse Practice Act and the board ' s administrative rules and regulations;... (D) Base professional decisions on nursing knowledge and skills, the needs of clients and the expectations delineated in professional standards;...] The REQUIREMENT was not met as evidenced by: Based on medical record review and staff	SALF		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Bruce Fenton Administrator TITLE (X6) DATE 11-7-11

STATE FORM 6899 6GYV11 If continuation sheet 1 of 11

The POC was approved with changes made on 11/23/11 @ 10:40 AM by Robin Ruff, facility manager and Karen Womack RN Health Surveyor.

Received Wyoming Dept of Health NOV 09 2011 Office of Healthcare Licensing Surveys

11/28/11 POC extension for dietary manager approved! 2/12/12 SH

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SALF	Continued From page 1 interview, the facility failed to ensure it followed standards of nursing practice with regard to pressure ulcer care, treatment, and staging for 1 of 1 residents (#1) with a greater than stage one pressure ulcer. The findings were: Observation during the facility tour on 10/11/11 of the bedroom for resident #1 at 7:58 AM showed the bed had an air overlay mattress. The facility manager at that time confirmed the observation and stated the resident required the air overlay mattress for spinal contractures and "skin breakdown on his/her 'bottom.'" The following concerns were found related to the care treatment, and the staging of area: a. Review of the medical record showed the area was first documented on 9/12/11 in the nurse's notes as a "lg [large] area on the bottom open [and] bleeding. Appears to have happen Sunday." Notes dated 9/13/11 documented the nurse was treating the area with saline gauze. Notes on 9/14/11 documented the area as free from "old blood and any dead (eschar) skin" and the plan to treat the area with medical honey. By 9/18/11 the nurse documented that the medical honey was "...applied to areas needing debridement..." Nurses' notes documentation on 9/20/11 documented she met with the resident's sons regarding the ulcer care and the need for physician intervention. b. Interview with the nurse on 10/11/11 at 8:45 AM revealed she had never staged the area, nor had she actually measured it. She stated she lacked experience in dealing with pressure ulcers. She stated at one point she believed it to be a stage III to IV, but was unsure of the staging. A second interview at 3:19 PM on 10/11/11 revealed she just confirmed the stage by reference to the definitions at www.bedsores.com. She stated by definition, it	SALF		

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SALF	Continued From page 2 was a stage II pressure ulcer. She confirmed by location it was a pressure ulcer and not a wound. She further confirmed it involved the coccyx and left buttock. c. Review of the medical record showed no orders for treatment of the pressure ulcer. Interview with the nurse on 9:27 AM on 10/11/11 confirmed she had not contacted the physician to obtain treatment orders, but believed during an office visit toward the end of September, the physician viewed the area. According to "Nursing Interventions and Clinical Skills," fourth edition, copyright 2007, wound and pressure ulcer management includes assessment which documents parameters such as wound dimensions, presence of undermining, sinus tracts, or tunnels and type of tissue in wound bed as well as a list of other items. Treatments include the proper order for topical agent or dressings as to ensure the proper medication and treatment are administered. Staging the wound is needed to describe the extent of tissue destruction. According to the Wyoming Board of Nursing nurse practice act 33-21-120. "Definitions. (a)(i) "Advanced practice registered nurse (APRN)" means a nurse who: (A) May prescribe, administer, dispense or provide nonprescriptive and prescriptive medications including prepackaged medications, except schedule I drugs as defined in W.S. 35-7-1013 and 35-7-1014;..." According to the Board of Nursing rules Chapter 4. Section 8.," (a) The board may authorize an advanced practice registered nurse to prescribe medications and devices, within the recognized scope of advanced practice nursing role and population focus, and in accordance with all applicable state and federal laws..."	SALF	RN has studied pressure ulcer care, treatment and staging ulcers through the Braden Scale for predicting pressure score risk. She has also read "Nursing Interventions and Clinical Skills" to further her knowledge. She will now be prepared to assess pressure ulcers. She will immediately consult with a physician and determine care procedures. She will discharge/transfer any resident not meeting health requirements. Resident #1 was discharged from the Bee Hive facility October 21st, 2011.	11/21/11

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SALF	Continued From page 3 Section 7. (b)(iii)(B)The assessment shall include at least the following information: ...(VII) Discharge potential...(X) Rehabilitation potential... The REQUIREMENT was not met as evidenced by: Based on medical record review and staff interview, the facility failed to address resident discharge potential and rehabilitation potential for 5 of 5 resident records (#1, #2, #3, #4, #5) reviewed. The findings were: Review of the medical record assessments for residents #1, #2, #3, #4, and #5 showed none of the assessments documented the discharge potential and rehabilitation potential of the resident. Interview with the facility manager and the registered nurse on 10/12/11 at 3:19 PM revealed the items were not included in the assessment nor were they in the medical records.	SALF	The RN has developed charting documentation to ensure discharge and rehabilitation potential is addressed. All files #1-#5 have been completed as have all additional 9 residents. ~~Rehabilitation potential is a part of the Physician assessment. See attached new physician's assessment.~~	10/21/11 and she will monitor.
	Section 7. (b)(vi)Resident assistance plan. (B)(I) Who will provide the care/services. The REQUIREMENT was not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure each resident assistance plan specified who will provide care/services for 2 of 5 resident records (#2, #5) reviewed. The findings were: Review of medical records for residents #2 and #5 showed resident assistance plans did not address who would provide care and services. Interview with the registered nurse on 10/12/11 at 3:19 PM confirmed some the resident assistance		RN will ensure that all care plans will be completed to show who provides care. All existing care plans have been corrected. RN will be more diligent in ensuring all plans are correctly filled out. Manager will also monitor care plan.	10/21/11

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SALF	Continued From page 4 plans did not state who would provide the service/care. Section 7. (b)(vi)Resident assistance plan. (B) (VII) Dated signature of the RN, the facility manager, and the resident or the resident's responsible party. The REQUIREMENT was not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 3 of 5 resident assistance plans (#1, #3, #4) had the required signatures. The findings were: Review of resident assistance plans for residents #1, #3, and #4 showed all were missing at least one or more of the required signatures. a. The assistance plan for resident #1 lacked the resident/resident's representative signature and the manager's signature. b. The assistance plan for resident #3 lacked the registered nurse's signature and the manager's signature. c. The assistance plan for resident #3 lacked the registered nurse's signature. Interview with facility manager on 10/12/11 at 3:29 PM confirmed all resident assistance plans should have the required signatures. Section 7. (j)(iii)(A) Day to day responsibilities for food production and management of the dietary services shall be assigned to a person with nutrition and food service management experience equivalent to that of a Certified Dietary Manager.	SALF	Signed Assistance plans were ~~singed~~ by resident, RN, manager. RN is responsible for signatures as well as manager. They will be completed in full on all further incoming residents.	10/21/11

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SALF	Continued From page 5 The REQUIREMENT was not met as evidenced by: Based on interview and review of course work, the facility failed to ensure it employed a manager with nutrition and food service management experience equivalent to that of a Certified Dietary Manager. The facility census was 9. The findings were: Interview with the facility manager on 10/11/11 at 1:40 PM revealed the facility did not have a manager with nutrition and food service management experience equivalent to that of a Certified Dietary Manager. The manager stated she was two-thirds of the way through the course offered by the University of North Dakota and would be taking the March 2012 exam. Review of coarse work confirmed this. Section 10. (c) Level 2 Direct Care Staff. In addition to meeting all other requirements for direct care staff stated in this Chapter, assisted living Level 2 direct care staff must receive additional documented training in: (i) The facility or units philosophy and approaches to providing care and supervision of persons with severe cognitive impairment; (ii) The skills necessary to care for, intervene, and direct residents who are unable to independently perform activities of daily living; (iii) Techniques for minimizing challenging behaviors: (A) Wandering; (B) Hallucinations, illusions, and delusions; and (C) Impairments of senses; (iv) Therapeutic programming to support the highest level of residents function; (A) Large motor activity;	SALF	Manager is on lesson 13 of 16 lessons. ~~She will be taking the National Test in March 2012~~. Owner/Administrator will ensure test is taken and passed. ~~He will~~ ensure updates on progress will be sent OHLS. 11/23/11 3/31/12 JAA POC extension granted 11/28/11 JA	

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SALF	Continued From page 6 (B) Small motor activity; (C) Appropriate level cognitive tasks; and (D) Social/emotional stimulation; (v) Promoting residents dignity, independence, individuality, privacy, and choice; (vi) Identifying and alleviating safety risks to residents; (vii) Recognizing common side effects and reactions to medications; and (viii) Techniques for dealing with bowel and bladder aberrant behavior. At least one staff member with this specialized training must be available on the unit at all times to provide supervision and care to the residents, as well as to assist the residents in evacuation of the facility. The REQUIREMENT was not met as evidenced by: Based on review of personnel files and staff interview, the facility failed to ensure 8 of 9 employees (#2, #3, #4, #5, #6, #7, #8, #9) had the specialized training and at lease one of these persons were available on the unit at all times. The findings were: Review of all nine employee personnel files showed the only employee with the required specialized training was the facility manager. Employees #2, #3, #4, #5, #6, #7, #8, and #9 did not have the required training. Interview with the facility manager at 1:17 PM on 10/12/11 during the file review confirmed she was the only one with the required training. She stated she was present during the daytime hours. She stated those who worked evening and nights had not met the requirement for training.	SALF	All newly hired staff will have additional training on Dementia care as part of initial training. It will be documented in personnel files. Training will be based on "Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes." Manager\trainer will address this course to include memory, judgment, self care, ability to solve problems, mood changes, behavior, wandering, and diet. All existing staff will receive this training as of November 8th, 2011. Administrator\owner\manger will monitor.	11/08/11

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SALF	Continued From page 7 Section 10. (e)(ii) Assistance Plans for residents of secure units must at a minimum, address the following: (A) Memory; (B) Judgement; (C) self-care ability; (D) Ability to solve problems; (E) Mood and character changes; (F) Behavioral patterns; (G) Wandering; and (H) Dietary needs. The REQUIREMENT was not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure level two resident assistance plans addressed the required issues for 3 of 3 level two residents (#1, #2, #5). The facility housed four Level 2 residents at the time of the survey. The findings were: Medical record review for three level two residents, #1, #2, and #5, revealed the resident assistance plans did not address the required items. Interview with the manager and registered nurse on 10/12/11 at 3:19 PM revealed the required assistance plan items were not addressed. Section 10. (f) Level 2 Discharge Requirements. In addition to Level 1 discharge criteria residents of Level 2 facilities must be discharged when one or more of the following situations exist: (i) They score less than 10 on the MMSE; (ii) When it has been determined that intermittent nursing care has become ongoing; or (iii) When the resident requires more than limited assistance to evacuate the building. ["Section 8. Services Which Cannot be Provided By The Level 1 Assisted Living Facility Staff. (a) The following services cannot be provided: (i) Continuous assistance with transfer and mobility;...(viii) Incontinence care by facility staff;...(ix) Stage II skin care and beyond;..."]	SALF	RN has developed an all inclusive care plan for level 2 residents. These care plans are now in effect on #1, #2, #5. RN will use new care plan on all future residents. Manager will also monitor care plans.	10/25/11

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SALF	Continued From page 8 The REQUIREMENT was not met as evidenced by: Based on observation, medical record review, and staff interview the facility failed the ensure 2 of 3 Level 2 residents (#1, #5) who required a higher level of care and/or did not meet the level 1 and/or 2 criteria were discharge to an appropriate care facility. The facility housed four Level 2 residents and five Level 1 residents. The findings were: 1. Observation during facility tour on 10/11/11 of the bedroom for resident #1 at 7:58 AM showed the bed had an air overlay mattress. The facility manager at that time confirmed the observation and stated the resident required the air overlay mattress for spinal contractures and "skin breakdown on his/her 'bottom'". The following concerns were found related to the appropriateness of this resident to continue residing in the facility: a. Interview with the registered nurse (RN) on 10/11/11 at 8:45 AM revealed the resident had a "pressure sore" which she described as about 5 inches by 4 inches at one time. She stated currently it was approximately 2 inches by 2 inches. She confirmed she had never actually measured it. She further stated she had treated it with medical honey to heal it, and had been treating it since September 2011. b. Later at 3:19 PM on 10/11/11 observation of the resident's activity of daily living (ADL) ability with the manager, certified nurse aide (CNA #5) and the RN revealed the resident required the assistance of two staff to get out of bed, was unable to manage his/her incontinence, required extensive cueing from staff to walk, needed extensive cueing to use a walker, turn, and use	SALF	#1 resident was discharged from the facility. RN and manager will not allow continued occupancy by any resident needing a higher level of care than we are currently capable of. Physician will be appraised of resident condition and need to be moved as well as family. Manager and RN will monitor future resident care needs.	10/21/2011

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SALF	Continued From page 9 the toilet. CNA #5 and the manager both stated the resident typically did not require the extensive cueing to ambulate and use the walker, but over the 'last few days' had required the extensive cueing. The CNA confirmed the resident was not able to manage his/her incontinence briefs. The observation showed the resident had urinary incontinence and CNA #5 confirmed this, but stated the resident was rarely incontinent of bowel. CNA #5 clarified that the resident typically could not get his/her attends and slacks on and off. She stated staff were required to perform the task. The CNA further clarified stating the resident could "never" do the task. Further interview revealed CNA #5 stated at night, the staff changed the resident's attends in bed. c. Interview with the nurse during the aforementioned observation revealed the resident's pressure ulcer was "at least a stage II." She stated she confirmed the staging by definitions at www.bedsores.com, and the area was the coccyx extending to the left buttock. d. Review of the medical record showed the area was first documented on 9/12/11 in the nurses notes as a "lg [large] area on the bottom open [and] bleeding. Appears to have happen Sunday." Nurse's notes documentation on 9/20/11 documented the RN met with the resident's sons regarding the ulcer care and need for the resident to see a physician. 2. Review of the medical record for resident #5 revealed s/he scored a "6" on the MMSE (mini mental screening exam). Interview on 10/12/11 at 11:33 AM with CNA #2 and the facility manager revealed the resident was independent with ADLs but did required his/her clothes to be laid out. CNA #2 stated the resident was continent of bowel and bladder, stating an incontinence episode might happen two to three times a	SALF	Resident #5 has been re-evaluated on the MMSE. On November 4th, 2011 her score was 11. Due to dysphagia, her verbal scores are lowered. Her reasoning, cognitive ability, ability to follow and understand directions are within limits of living in an ALF level facility. ~~(See attached instructions to evaluate test score.)~~	10/23/2011

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SALF	Continued From page 10 month. Interview with the manager revealed the resident had difficulty articulating. She stated she was unaware the regulation which required residents who scored below a '10' on the MMSE to be discharged.	SALF		