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WY Dept of Health
APR 09 2013
Healthcare Licensing and Surveys

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

PRINTED: 03/27/2013
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
	535021	A. BUILDING _____ B. WING _____	C 03/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure assistance with activities of daily living was provided for 3 of 4 sample residents (#1, #4, and #5) requiring extensive assistance with personal hygiene. The findings were: 1. Review of the medical record for resident #5 showed the resident was readmitted to the facility on 12/28/12 with diagnoses including morbid obesity, dementia, insulin-dependent diabetes mellitus, and a fractured femur. Further review of the medical record showed the resident did not have surgical repair for his/her fractured femur related to multiple health conditions. The medical record showed the resident was supposed to wear an immobilizer at all times except when bathing to stabilize the fractured leg. Review of the significant change MDS assessment dated 1/1/13 showed the resident was moderately cognitively impaired and was dependent on staff for personal hygiene and bathing. The resident also required the use of a mechanical lift to transfer him/her. Review of the care plan dated 1/9/13 showed interventions to include baths 2 times a week and nail care 2 times a week on bath days. The care plan also showed the	F 312	This Plan of Correction Constitutes Our Allegations of Compliance Resident #1, #4 and #5 care plans were updated to reflect 1-2 baths per week. CNAs were re-educated on nail care and proper care of nails for those residents who have diabetes. Floor CNAs were informed they are expected to assist with baths if the bath aide schedule is full and additional baths are needed to be completed. CNAs were educated on the new bath schedule during the in-service held on March 26th and 27th. The CNA who is assigned bath aide duties will monitor baths each week, through the use of a spread sheet, to make sure baths are given according to schedule as indicated on the care plan. The facility Nurse Manager, or designee, will be responsible to monitor the bath aide to make sure baths were completed as scheduled and nails have been cleaned and trimmed. CNAs who do not complete baths as scheduled or who have not completed tasks as assigned (nail care) will be re-educated to improve performance or receive disciplinary actions. The Wyoming Retirement Center is actively filling the six open positions mentioned. As the positions are filled, the new CNAs will be placed on the bathing schedule.	05/01/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/9/2013

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.

This POC accepted by/mail Richard Brinkley - Admin Asst Tony Hadley, Surveyor on 4/11/13.

4/11/13

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F 312	Continued From page 1 resident was a diabetic but, "bath aides may do fingernails, charge nurse or podiatrist to trim toe nails total dependence 2 person assist as needed." The following concerns were identified: a. Periodic observations on 3/12/13, 3/13/13, and 3/14/13 revealed the resident had long, jagged fingernails with brown debris under the nail beds. Observation on 3/12/13 at 5:30 PM showed the resident eating finger foods with his/her hands. b. Review of the resident's bathing schedule from 1/6/13 through 3/10/13 showed the resident had been bathed one time weekly on 1/6/13, 1/16/13, 1/21/13, 1/30/13, 2/7/13, 2/16/13, 2/22/13, 2/27/13, and 3/9/13. There were 2 occasions when the resident went 10 days between baths. c. Interview with CNA #1 on 3/14/13 at 9:10 AM revealed the resident received a bed bath "one time a week." The CNA verified that on occasion the resident went for more than 7 days before receiving a bath. The CNA revealed s/he had been "the only bath aide on [the unit] since about October [2012]" and that she was aware that baths were missed at times. She further revealed she had asked the nursing home administration to provide more assistance with bathing residents, stating that there was not enough staff to assist the residents with bathing and hygiene needs. In addition, s/he stated the resident's, "fingernails were trimmed by the nurse because [s/he] was a diabetic." d. During an interview on 3/14/13 at 9:45 AM, the DON observed and verified resident #5 needed his/her fingernails trimmed and cleansed. The DON also verified the resident was supposed to be bathed 2 times weekly. The DON stated the resident was a diabetic and that "the CNA can	F 312	Continued from page 1 The Nurse Manager, or designee, will report her findings to the Quality Assurance Committee who will monitor compliance with this requirement. The Nurse Manager will report her findings monthly for three (3) months and thereafter as compliance is demonstrated, as determined by the QA Committee.	

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F 312	Continued From page 2 clean and trim the fingernails but the nurse or doctor had to trim the resident's toenails." 2. Review of the medical record for resident #1 showed the resident was admitted to the facility on 8/27/08 with diagnoses including atrial fibrillation, coronary artery disease, hypertension, Alzheimer's disease, non-Alzheimer's dementia, anxiety and depression. Review of the quarterly MDS assessment dated 1/19/13 showed the resident was moderately cognitively impaired and was dependent on staff for personal hygiene and bathing. Review of the care plan dated 1/31/13 showed interventions to include staff assistance with "bath/shower 1-2 X week." The following concerns were identified: a. Review of the facility's bathing records from 1/1/13 to 3/10/13 showed the resident received baths on 1/3/13, 1/8/13, 1/16/13, 1/20/13, 1/30/13, 2/3/13, 2/16/13, 2/22/13, 2/26/13, and 3/8/13. There were 2 occasions when the resident went 10 days between baths, and 1 occasion when the resident went 13 days between baths. b. Interview with CNA #1 on 3/13/13 at 10:45 AM confirmed that she was the sole person responsible for bath/shower assistance on the north end of the facility. She further confirmed the periods of 10 to 13 days when the resident did not receive a bath, stating, "What's in the bath book is what they got." 3. Review of the medical record for resident #4 showed the resident was admitted to the facility on 12/3/08 with diagnoses including hypertension, diabetes mellitus, non-Alzheimer's dementia, psychotic disorder and depression. Review of the quarterly MDS assessment dated 1/12/13	F 312		

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F 312	Continued From page 3 showed the resident was moderately cognitively impaired and was dependent on staff for personal hygiene and bathing. Review of the care plan dated 1/24/13 showed interventions to include staff assistance with "bath/shower 1-2 X week." The following concerns were identified: a. Review of the facility's bathing records from 1/1/13 to 3/10/13 showed the resident received baths on 1/5/13, 1/8/13, 1/19/13, 1/22/13, 1/28/13, 2/6/13, 2/13/13, 2/19/13, 3/2/13, and 3/7/13. There was 1 occasion when the resident went 9 days between baths, and 2 occasions when the resident went 11 days between baths. b. Interview with CNA #1 on 3/13/13 at 10:45 AM confirmed the periods of 10 to 13 days when the resident did not receive a bath. Interview with the DON on 3/14/13 at 9:45 AM revealed, "bathing on the [unit] is a problem." The interview further revealed CNA #1 had recently made her aware that she was overwhelmed and baths were not getting done as scheduled. The DON added the facility had 6 CNA vacancies and this contributed to residents not receiving baths as scheduled.	F 312		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of	F 353	The Wyoming Retirement Center schedules nursing care hours above the required 2.25 hours for each skilled resident in the facility during each 24 hour time period.	05/01/2013

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F 353	Continued From page 4 personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview the facility failed to provide sufficient staff to ensure residents who required assistance received baths and nail care as scheduled for 3 of 4 sample residents (#1, #4, and #5). The findings were: 1. Review of the medical record showed resident #5 was readmitted to the facility on 12/28/12 with diagnoses including morbid obesity, dementia, insulin-dependent diabetes mellitus, and a fractured femur. Further review of the medical record showed the resident did not have surgical repair for his/her fractured femur related to multiple health conditions. The medical record showed the resident was supposed to wear an immobilizer at all times except when bathing to stabilize the fractured leg. Review of the significant change MDS assessment dated 1/1/13 showed the resident was moderately cognitively impaired and was dependent on staff for personal hygiene and bathing. The resident also required	F 353	Continued from page 4 The facility has re-educated our CNAs on their responsibility to help with bathing if the bath aide's schedule is full and additional baths are needed. During an in-service on March 26th and 27th, CNAs were re-trained on their responsibilities to help with baths, as determined by the facility bath aide if she is unable to complete scheduled baths. The CNAs were also re-educated on correct nail care procedures including trimming, cleaning and caring for nails on residents who are diabetic. A facility bath spreadsheet will be developed by the bath aide which will schedule baths according to goals stated on the care plan each day. The bath aide will work with the floor nurse(s) each day to determine if baths should be assigned to other CNAs depending on the bath schedule and will conduct spot checks to determine compliance with the nail care being completed. Additional training or disciplinary action will be used to attain compliance. The Wyoming Retirement Center is actively filling the six open positions mentioned. As the positions are filled, the new CNAs will be placed on the bathing schedule.	

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F 353	Continued From page 5 the use of a mechanical lift to transfer him/her. Review of the care plan dated 1/9/13 showed interventions included staff bathe the resident "2 times a week and provide nail care 2 times a week on bath days." The care plan also showed the resident was a diabetic and that "bath aides may do fingernails, charge nurse or podiatrist to trim toe nails total dependence 2 person assist as needed". The following concerns were identified: a. Periodic observations on 3/12/13, 3/13/13, and 3/14/13 revealed the resident had long, jagged fingernails with brown debris under the nail beds. b. Review of the resident's bathing schedule from 1/6/13 through 3/10/13 showed the resident had been bathed one time weekly on 1/6/13, 1/16/13, 1/21/13, 1/30/13, 2/7/13, 2/16/13, 2/22/13, 2/27/13, and 3/9/13 (there were 2 occasions when the resident went 10 days between baths). c. Interview with CNA #1 on 3/14/13 at 9:10 AM revealed the resident had a bed bath, "one time a week." The CNA verified that on occasion the resident went for more than 7 days before receiving a bath. The CNA revealed s/he had been "the only bath aide on [the unit] since about October [2012]" and that she was aware that baths were missed at times. She further revealed she had asked the nursing home administration for more assistance with bathing residents, stating that there was not enough staff to assist the residents with bathing and hygiene needs. d. During an interview with the DON on 3/14/13 at 9:45 AM the DON observed and verified resident #5 needed his/her fingernails trimmed and cleansed. The DON also verified the resident was supposed to be bathed 2 times weekly and fingernails needed to be trimmed and	F 353	Continued from page 5 The Nurse Manager, or designee, will report to the Quality Assurance Committee compliance with this requirement each month for three (3) months. The QA Committee will determine future frequencies of audits as compliance is demonstrated.	

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F 353	Continued From page 6 cleaned as needed. 2. Review of the medical record for resident #1 showed the resident was admitted to the facility on 8/27/08 with diagnoses including atrial fibrillation, coronary artery disease, hypertension, Alzheimer's disease, non-Alzheimer's dementia, anxiety and depression. Review of the quarterly MDS assessment dated 1/19/13 showed the resident was moderately cognitively impaired and was dependent on staff for personal hygiene and bathing. Review of the care plan dated 1/31/13 showed interventions to include staff assistance with "bath/shower 1-2 X week." The following concerns were identified: a. Review of the facility's bathing records from 1/1/13 to 3/10/13 showed the resident received baths on 1/3/13, 1/8/13, 1/16/13, 1/20/13, 1/30/13, 2/3/13, 2/16/13, 2/22/13, 2/26/13, and 3/8/13. There were 2 occasions when the resident went 10 days between baths, and 1 occasion when the resident went 13 days between baths. b. Interview with CNA #1 on 3/13/13 at 10:45 AM confirmed she was the sole person responsible for bath/shower assistance on the north end of the facility. She further confirmed the periods of 10 to 13 days when the resident did not receive a bath, stating, "What's in the bath book is what they got." 3. Review of the medical record for resident #4 showed the resident was admitted to the facility on 12/3/08 with diagnoses including hypertension, diabetes mellitus, non-Alzheimer's dementia, psychotic disorder and depression. Review of the quarterly MDS assessment dated 1/12/13 showed the resident was moderately cognitively	F 353		

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F 353	Continued From page 7 Impaired and was dependent on staff for personal hygiene and bathing. Review of the care plan dated 1/24/13 interventions to include staff assistance with "bath/shower 1-2 X week." The following concerns were identified: a. Review of the facility's bathing records from 1/1/13 to 3/10/13 showed the resident received baths on 1/5/13, 1/8/13, 1/19/13, 1/22/13, 1/28/13, 2/6/13, 2/13/13, 2/19/13, 3/2/13, and 3/7/13. There was 1 occasion when the resident went 9 days between baths, and 2 occasions when the resident went 11 days between baths. b. Interview with CNA #1 on 3/13/13 at 10:45 AM confirmed the periods of 10 to 13 days when the resident did not receive a bath. Interview with the DON on 3/14/13 at 9:45 AM revealed, "bathing on the [unit] is a problem." The interview further revealed CNA #1 had recently made her aware that she was overwhelmed and baths were not getting done as scheduled. The DON added the facility had 6 CNA vacancies and this contributed to residents not receiving baths as scheduled.	F 353		

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