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Healthcare Licensing and Surveys

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

PRINTED: 04/09/2013
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
	535032	A. BUILDING _____ B. WING _____	C 03/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	1330 PRAIRIE AVENUE CHEYENNE, WY 82009

(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 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, medical record review, and review of facility night shift "get up" lists, the facility failed to ensure the dignity of 8 sample residents (#38, #47, #51, #57, #63, #72, #102, #125) and 27 non-sample residents (#1, #6, #20, #23, #27, #30, #32, #34, #35, #48, #53, #54, #55, #64, #65, #66, #67, #70, #81, #88, #97, #101, #110, #111, #131, #137, #143) regarding their preferences for being dressed and/or out of bed before 5 AM. The findings were: Observation upon entrance to the facility on 3/27/13 at 4:10 AM showed 5 residents (unable to identify at that time) were out of bed on the unit I and II nursing station. Attempts to interview each resident were unsuccessful due to their cognitive impairment. Interviews on 3/27/13 with CNA #2 at 4:10 AM and CNA #1 at 4:20 AM revealed the CNAs were assigned the tasks of getting residents dressed and/or in their wheelchairs according to the posted lists, located on the interior side of the clean utility room doors on each of the 4 resident halls (north, south, east, west). The aides confirmed the residents that were out of bed at 4:10 AM were from the "get up" lists. The CNAs were unaware of any criteria used to formulate the "get up" and "dress in bed"	F 241	F241 The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. A) Residents' # 47, 63,102, ~~105,~~ 125, 1, 20, 23, 27, 30, 32, 35, 48, 53, 54, 55, 64, 66, 81, 97, 131, 137, and 143 preferences regarding what time they wake up in the morning will be followed and will be left to sleep until after 5 AM. Residents' # 51, 57, 72, 6, 34, 65, 70, 88, 101, 110, and 111 preferences regarding waking up in the morning will be followed and will be dressed in bed only on rounds before 5 AM. Resident # 38, 63, and 67 were discharged from the facility. B) Residents will not be woken up by staff prior to 5 AM routinely without prior investigation and documentation of resident preference regarding waking up in the morning. C) Random audits will occur to ensure that residents'	5/12/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: B Merrell — TITLE: Executive Director — (X6) DATE: 4/30/13

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.

5-1-13 - 12:55 p - Spoke with Bryan Merrell, Adm - plan of correction accepted with one change, mutually agreed. RaeAnne White RW

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F 241	Continued From page 1 lists. The following concerns were noted: a. Review of the posted assignment for the west hall revealed night shift staff were to dress residents #6, #53, #51, #1, and #64, and leave them in bed for the day shift staff to transfer them to their wheelchairs. Review of the east, north, and south night shift "get up" lists showed staff were required to get up the following residents before their shift ended: #20, #23, #27, #30, #48, #54, #55, #81, #97, #137, #143. In addition, night shift staff were required to dress the following residents in bed: #32, #34, #35, #38, #57, #63, #65, #66, #67, #70, #72, #88, #111, #131. b. Review of the most recent 2013 MDS assessments and care plans for 8 sample residents (#38, #47, #51, #57, #63, #72, #102, #125), all on the night shift "get up" lists, revealed each had cognitive impairment and required extensive assistance with incontinence care, dressing, and transfers. Further record review revealed no information that identified the residents as having a preference for getting dressed and/or out of bed before 5 AM. c. On 3/27/13 from 4:12 AM to 5:30 AM, random observations of CNAs #1, #2, #3, and #4 revealed the provided incontinence care for residents, dressed them, and transferred them to their wheelchairs. d. During an observation on 3/27/13 at 4:15 AM, resident #101 was dressed, out of bed, and in his/her room in a chair. An attempt to interview the resident showed s/he did not comprehend what was being asked. e. Observation on 3/27/13 at 4:30 AM revealed residents #53, #51, and #64 were fully dressed in bed, and resident #125 sat dressed in his/her wheelchair in the hallway dozing. Residents #6 and #47 were partially dressed in	F 241	preferences and choice regarding waking up are being followed. These random audits will include resident #: 38, 47, 51, 57, 63, 72, 102, 125, 1, 6, 20,23, 27, 30, 32, 34, 35, 48, 53, 54, 55, 64, 65, 66, 67, 70 81, 88, 97, 101, 110, 111, 131, 137, 143. D) A Performance Improvement Audit Tool will be utilized for random audits. Any problems identified will result in immediate education of staff. Random audits will be performed by the Nurse Managers and Charge Nurses. E) The Director of Nursing will conduct an in-service for all nursing staff regarding the importance of resident dignity relating to choice and preferences. This will be accomplished on or before May 12, 2013. F) The Director of Nursing will report the results of audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. Reporting will occur for a period of no less than 3 months or until ongoing	

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F 241	Continued From page 2 bed. At 4:50 AM, CNA #1 provided incontinence care and finished dressing resident #6. At 5 AM, the CNA performed incontinence care, finished dressing resident #47, and transferred the resident to his/her wheelchair. At that time the CNA stated she had partially dressed residents #6 and #47 before 4 AM when she provided incontinence care. She further stated she had to start dressing residents at 3:45 AM to complete the tasks according to the posted assignment on the clean utility door. f. Observation on 3/27/13 at 4:50 AM revealed CNA #2 dressed resident #81, transferred him/her to a wheelchair, and wheeled him/her to the bathroom. The CNA provided incontinence care and toileting assistance at that time. After the observation at 5 AM, the resident said that it was usually okay for staff to get him/her up before 5 AM, but sometimes would like to sleep later. The resident also stated staff had never asked about his/her get up time preference. g. Interview with the DON on 3/27/13 at 8:30 AM revealed the unit managers were responsible for posting the staff assignments, and he was not aware of the criteria used to make the determination. He further stated the facility expectation was that residents should not have to get up or get dressed in bed before 5 AM unless that was their preference.	F 241	compliance has been achieved.	