9/3/13 CR

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WY Dept of Health
AUG 28 2013

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

PRINTED: 08/19/2013
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
	535043	A. BUILDING Healthcare Licensing B. WING Chief Surveyor	C 08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	503 S 18TH ST LARAMIE, WY 82070

(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 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR 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 medical record review, hospital record review, facility policy and procedure review, and family and staff interview, the facility failed to accurately assess a type of wound, and obtain treatment in a timely manner for 1 of 5 sample residents (#75) at risk for impaired skin integrity, which resulted in health decline and hospitalization for the resident. The findings were: Resident #75 was admitted to the facility on 6/17/13 with diagnoses of pneumonia, obstructive uropathy, urinary tract infection, non-Alzheimer's dementia, hypothyroidism and bladder dysfunction. Review of the resident's admission data collection tool dated 6/18/13 revealed the resident had no wounds, although "bruises were noted on body." Review of Medicare daily skilled nursing notes dated 7/11/13 revealed the resident developed a "hard raised area" on [his/her] L [left] upper buttocks next to coccyx. Area blanches. Notified MD via nurse [nurse's name]...Notified family of area. N.O. [nursing order] to monitor area q.d [every day] et [and] notify MD if area increases in size." The size of the raised area was not noted in	F 309	F309 Corrective Action: The resident is not currently in the facility. Identification: Residents currently residing at facility will have a total skin evaluation done by a nurse manager to be completed prior to the allegation of compliance. Immediate action to include, the initial wound evaluation, treatment orders and notification of MD/Family will be provided for any issues noted, additionally, the plan of correction is written to address all such residents. The care plans will be reviewed/revised/updated as indicated at that time.	9/9/13

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

Andrea Stannard — NHA — 82813

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.

9/4/13 Plan of correction accepted per conversation with Andrea Stoddard. on 9/4/13 @ 1618. Date of compliance = 9/9/13.

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F 309	Continued From page 1 the nursing notes. Review of Physician's Telephone Orders revealed an order dated 7/11/13 revealed "Stage II to L buttock resolved. DC hydrocolloid. Hard 2 cm X 2 cm raised area noted on L [left] buttock, next to coccyx. Monitor q [every] day et [and] notify MD if area increases in size." The order was not signed by the physician. Review of a Physician's Telephone Order dated 7/14/13 (three days later) revealed "Notification: Hard, red, swollen area on L [left] inner buttock. Please advise." Review of the facility's "Skin and Wound Management Program Overview," last revised on 6/1/07, revealed "When a break in skin integrity is identified, the licensed nurse will document a detailed assessment in the medical record including type (pressure ulcer arterial ulcer, venous insufficiency ulcer/wound etc.) size, stage, location, drainage, odor of area. Documentation will also contain treatment orders obtained, a detailed personalized care plan and notification to the Interdisciplinary Skin/Wound Management Committee (ISWMC)." Interview with the facility's wound care nurse on 8/8/13 at 4:10 PM revealed the facility utilized a form entitled "Initial Wound Evaluation" to record detailed initial assessments of breaks in skin integrity, and "Daily Wound Assessment" and "Weekly Wound Progress Note" forms for ongoing assessments of wounds. Review of the resident's medical record revealed a single form, a "Wound Weekly Progress Note" dated 7/18/13, which revealed the wound measured "3.0 X 3.0 X unknown" on 7/14/13, with the measurements for "Last week" left blank. No initial wound evaluation that would have recorded the type of wound, the	F 309	Systemic Changes: Prior to the allegation of compliance all nursing staff will be inserviced by the DON/Designee on the wound management program according to policy and procedure; Residents will be reviewed for their risk of skin breakdown on admission, weekly times 4 weeks after admission, quarterly, annually, and with significant changes in status. Licensed nurses will complete a weekly skin evaluation on each resident and document completion in the treatment administration record and follow up action to include, the initial wound evaluation with initial wound measurements, treatment orders signed by the physician, and notification of MD/Family will be provided for any issues noted. Licensed nurses will be in serviced on communicating any newly identified skin issues to the IDT via the 24 hour report.	

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F 309	Continued From page 2 size, location, drainage or odor was found in the medical record. Additionally, no daily wound assessments were found in the medical record. Interview with the regional health director on 8/8/13 at 3:15 PM confirmed these documents were not filled out, and further confirmed an initial wound evaluation form should have been filled out for the wound on 7/11/13 when it was discovered. Interview with the resident's family member on 8/9/13 at 11 AM revealed the family member had been shown the wound when it was first discovered. S/he stated it looked like "a little boil." S/he further stated that s/he had gone to visit her parent the morning of 7/16/13, at which time s/he noted a "terrible odor" after which s/he had her parent lean forward. S/he checked the back of his/her parent's incontinence brief and saw a foul-smelling, runny substance that s/he thought must be diarrhea. S/he left to allow her parent to be "cleaned up" and later received a call from the facility informing him/her that the "boil" had ruptured and the contents were "oozing out." Further review of Medicare Daily Skilled Nursing Notes revealed no assessment of this wound on 7/12/13, 7/13/13, 7/14/13, or 7/15/13. A Medicare Skilled Nursing Note dated 7/16/13 revealed "Hydrocolloid to coccyx, open area has foul odor. Blood from area noted, drainage noted from open areas." No evidence of physician notification that the area was open and draining could be located in the medical record. Review of a Social Progress Note dated 7/17/13 revealed the resident "has had a significant change in condition since his last assessment. [The resident's] change is related to weight loss	F 309	Residents with wounds will be reviewed daily utilizing The Daily Wound Assessment tool (FFS670) which includes assessment of drainage, wound bed description, odor, and pain. The wound progress will be evaluated weekly with corresponding documentation noted on the Weekly Wound Progress Note (FFS673) which includes measurements of the wound and the weekly wound description. The IDT will review residents with wounds at the weekly at risk meeting. The care plans will be reviewed/revised/updated as indicated at that time. Prior to the allegation of compliance the DON/Designee will reeducate the staff on the utilization of the 24 hour report to communicate any resident skin integrity concern. Prior to the allegation of compliance the DON/Designee will reeducate the staff on the wound management system to include assessment and timely treatment of skin integrity issues	

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F 309	Continued From page 3 and a new pressure ulcer on his coccyx" and the resident "doesn't seem as alert as he was on his first assessment." Medicare Daily Skilled Nursing Notes dated 7/17/13 revealed "Dressing on L [left] buttock changed; foul-smelling discharge; tender and red surrounding area. Dr. [physician name] office notified and got an appt. [appointment] to see the MD tomorrow AM." Medicare Daily Skilled Nursing Notes dated 7/18/13 revealed "Went to see Dr. [physician name] at 0815 [8:15 AM]. Resident went directly to ER from MD's office." Review of physician office visit notes dated 7/18/13 revealed the resident was at the physician's office with a family member who had been told "[his/her] decubitus is worse" and noted "our office was informed yesterday [7/17/13] therefore an appt was set up." Examination of the resident's "skin/buttock region" at that time showed "evidence of a large erythematous area encompassing both buttock region/lumbosacral region with central area of stage II/III decubitus with foul smelling odor and greenish exudates expressed, no active bleeding." The resident was diagnosed with "Pressure ulcer buttock," "Pressure ulcer stage III," and "Sepsis," and "advised to go to the er [emergency room] for evaluation and treatment." Review of a History and Physical from the hospital dated 7/18/13 revealed the resident to have a "Decubitus ulcer, infected - wound culture pending. This wound is large and I suspect it goes all the way to his sacrum. Will need wound care with PT [physical therapy] and may also need surgical intervention if the patient survives his acute episode of sepsis."	F 309	a) Monitoring: Telephone orders will be reviewed in the morning meeting (stand-up) to review new orders and follow up as needed with orders pertaining to skin integrity concerns. Director of Nursing and/or designee will facilitate. Nurse Managers will review the resident's Treatment Records for the weekly skin assessments ordered treatment and wound progress documentation 3 times a week, for one month, then weekly for one month then monthly thereafter.	

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F 309	Continued From page 4 Review of a General Surgery Documentation Report dated 7/19/13 revealed the resident to have a "Sacral wound with purulent drainage. Needs I/D [incision and drainage] and surgical debridement." Review of the results of a CT [computed tomography] scan of the abdomen/pelvis with contrast performed on 7/25/13 revealed "There appears to be an open wound in the soft tissues just interior to the rectum which appear to connect into the pelvic cavity with air tracking along the perineum and to the left side of the rectum internally. There are hypodense collections seen projecting to the right of the rectum within the pelvic cavity and to the left of the bladder inferiorly and prostate gland which contains small air bubbles and is worrisome for an abscess." Review of documentation from the hospital's social worker revealed that hospital social services met with the resident's family on "approximately 7/31/13" to discuss "possible end of life care after being told that [his/her] [parent] was not a surgical candidate due to [his/her] aortic stenosis and how involved the sacral ulcer was." Interview with the facility's regional health director on 8/8/13 at 10:45 AM confirmed there were problems with the wound assessment process, acknowledged the facility could have obtained treatment for the resident sooner and stated "deficient practice may have occurred." At 3:15 PM that same day, she further revealed "for all intents and purposes we didn't follow our own policy."	F 309	Results of Treatment Sheet reviews and trends will be reviewed by the Director of Nursing/ Designee in the QA&A committee (IDT) monthly for one month then quarterly thereafter. Recommendations will be addressed as needed to ensure continued compliance. Identified issues will be reported to the monthly QAA committee to ensure the plan has been implemented, achieved, sustained and evaluated for its effectiveness. Allegation of compliance will be complete by September 9, 2013.	

Andrea Stannard