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

PRINTED: 09/13/2013
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
	53A065	A. BUILDING _____ B. WING _____	08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	310 9TH STREET KEMMERER, WY 83101

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SEP 2
Wyoming Department of Health
Health Facility Licensing & Certification

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(X5) 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 DON: Director of Nursing LPN: Licensed Practical Nurse CAA: Care Area Assessment ADL: Activities of Daily Living Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 272 SS=F	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;	F 272	South Lincoln Nursing Center will ensure a comprehensive assessment of the resident's needs is conducted initially and periodically, including documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). 1. The Care Area Assessments for residents #1, #2, #4, #10, #11, #18 and #20 will be amended to include the identified areas that failed to show an analysis of the finding that were comprehensive. 10/13/13 2. The MDS Coordinator has attended the webinar "Enhancing Person Centered Care through MDS 3.0 Assessment Accuracy". 9/19/13 3. The MDS Coordinator will also be registered for the "Navigating MDS 3.0: RAI Training for Nursing Facility Staff" Seminar December 5-6, 2013 for further training on comprehensive completion of Care Area Assessments. 10/8/13 4. The Nursing Center Clinical Supervisor will develop a quality monitoring tool to ensure residents have an initial and periodic comp-	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Eric Boley
TITLE: CEO
(X6) DATE: September 19,2013

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.

Changes made per phone conv with Eric Boley, CEO on 10/1/13 @ 9:30am
POC accepted
Jamelle Cox, QMRC

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F 272	Continued From page 1 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure assessments were comprehensive in a variety of areas for 7 of 7 sample residents (#1, #2, #4, #10, #11, #18, #20). The findings were: 1. Review of the 6/21/13 admission MDS assessment, section V showed resident #20 required comprehensive assessments for the following care areas: cognitive loss/dementia, visual function, communication, activities of daily living, urinary incontinence/indwelling catheter, falls, nutrition status, dehydration/fluid maintenance, dental care, pressure ulcer and pain. Review of the CAAs for these areas failed to show an analysis of findings that was comprehensive. The analysis failed to describe the problem, the causes and contributing factors, and identified risk factors associated with the care areas for the individual resident. 2. Review of the 8/16/13 significant change MDS	F 272	prehensive assessment and documentation of care areas triggered. The results of the the monitoring tool will be reported at the monthly QA/QI meeting and the monthly Medical Director meeting until compliance is met.	10/8/13

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F 272	Continued From page 2 assessment, section V showed resident #18 required comprehensive assessments for the following care areas: cognitive loss/dementia, visual function, communication, urinary incontinence/indwelling catheter, psychosocial well-being, behavior symptoms, activities, falls, nutrition status, pressure ulcer and psychotropic drug use. Review of the CAAs for these areas failed to show an analysis of findings that was comprehensive. The analysis failed to describe the problem, the causes and contributing factors, and identified risk factors associated with the care areas for the individual resident. 3. Review of the 3/21/13 annual MDS assessment, section V showed resident #4 required comprehensive assessments for the following care areas: cognitive loss/dementia, visual function, communication, urinary incontinence/indwelling catheter, psychosocial well-being, mood state, behavior symptoms, activities, falls, nutrition status, dehydration/fluid maintenance, dental care, pressure ulcer, psychotropic drug use and pain. Review of the CAAs for these areas failed to show an analysis of findings that was comprehensive. The analysis failed to describe the problem, the causes and contributing factors, and identified risk factors associated with the care areas for the individual resident. 4. Review of the 12/4/12 admission MDS assessment, section V showed resident #1 required comprehensive assessments for the following care areas: cognitive loss/dementia, visual function, communication, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, mood state, falls, nutritional status, dental care, pressure	F 272		

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F 272	Continued From page 3 ulcer, psychotropic drug use, physical restraints, pain, and return to community referral. Review of the CAAs for these areas failed to show an analysis of findings that was comprehensive. The analysis failed to describe the problem, the causes and contributing factors, and identified risk factors associated with the care areas for the individual resident. 5. Review of the 4/11/13 annual MDS assessment, section V showed resident #10 required comprehensive assessments for the following care areas: cognitive loss/dementia, visual function, communication, urinary incontinence and indwelling catheter, behavioral symptoms, falls, nutritional status, dehydration/fluid maintenance, dental care, pressure ulcer, physical restraints and pain. Review of the CAAs for these areas failed to show an analysis of findings that was comprehensive. The analysis failed to describe the problem, the causes and contributing factors, and identified risk factors associated with the care areas for the individual resident. 6. Review of the 4/25/13 admission MDS assessment, section V showed resident #11 required comprehensive assessments for the following care areas: visual function, communication, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, psychosocial well-being, falls, nutritional status, dental care, pressure ulcer, pain and return to community referral. Review of the CAAs for these areas failed to show an analysis of findings that was comprehensive. The analysis failed to describe the problem, the causes and contributing factors, and identified risk factors associated with the care areas for the individual	F 272		

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F 272	Continued From page 4 resident. 7. Review of the 12/18/12 Annual MDS assessment, section V, showed resident #2 triggered for the following comprehensive assessments: cognitive loss, communication, ADLs, functional/rehabilitation potential, urinary incontinence/catheter, mood state, falls, nutritional status, pressure ulcers, psychotropic drug use, physical restraints, and pain. However, review of the CAAs for this resident showed no evidence these triggered areas were comprehensively assessed. 8. Interview with the MDS coordinator on 8/29/13 at 10:05 AM verified these assessments "needed more" and were not comprehensive. She further revealed she was new to the position and had additional training scheduled related to the MDS assessment process.	F 272		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident interview and staff interview, the facility failed to follow the written care plan related to pain assessment for 1 of 5 sample residents (#11) assessed as having moderate to severe pain constantly or frequently. The findings were:	F 282	South Lincoln Nursing Center will ensure the services provided or arranged by the facility is provided by qualified persons in accordance with each resident's written plan of care. 1. The Nursing Center Clinical Supervisor will educate the nursing staff and the CNA staff on the Resident Pain Assessment and Control policy. The Nursing Center Clinical Supervisor will also review with the nursing staff how to accurately complete the pain management flow sheet. 2. The Nursing Center Clinical Supervisor will also educate the staff on assessing resident #11 pain intensity level utilizing 0-10 pain scale with medication passes and provide pharmacological therapy for pain levels above 7/10.	9/27/13 9/27/13

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F 282	Continued From page 6 Resident #11 was admitted to the facility on 4/19/13 with diagnoses that included mononeuritis, arthropathy, and chronic pain. Observation of the resident on 8/26/13 at 4:05 PM revealed no obvious visual signs of pain; however, when asked if s/he was having any pain at the time, the resident stated s/he was having pain. When asked to rate that pain on a scale of 0-10, with 10 being the worst pain s/he had ever felt, the resident rated his/her pain as an "8." Review of the resident's 4/25/13 admission MDS assessment, as well as the 7/24/13 quarterly MDS assessment revealed the resident had frequent pain that interfered with his/her ability to sleep. On both MDS assessments, the resident's pain intensity was assessed at "08." Review of the resident's care plan revealed interventions including "Nursing staff will assess [the resident's] pain intensity level utilizing 0-10 pain scale with med passes" and "Provide pharmacological therapy... for pain levels above 7/10." Review of Pain Management Flow Sheets for the date of 8/26/13 (the day the resident complained to surveyors at 4:05 PM of pain at an intensity of 8/10) revealed documentation on the resident's pain as follows: a. Documentation timed at 6 AM showed "N/C [no complaints] voiced." The 0-10 pain scale was not utilized. b. Documentation timed at 8 AM showed "denies." The 0-10 pain scale was not used. c. Documentation timed at 12 PM showed "denies." The 0-10 pain scale was not used. d. Documentation timed at 6 PM showed "denies." The 0-10 pain scale was not used.	F 282	3. The Nursing Center Clinical Supervisor will develop a quality monitoring tool to ensure all residents are questioned at each medication pass to rate their pain intensity using a scale of 0-10. The results of the monitoring tool will be reported at the monthly QA/QI meeting and the monthly Medical Director meeting until compliance is met.	10/8/13

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F 282	Continued From page 8 e. Documentation timed at 8 PM showed the resident was complaining of left shoulder/arm pain with an intensity of 6/10. According to the documentation, the resident was repositioned, and received his/her scheduled pain medication. The resident was noted to be asleep at 10 PM. Review of the resident's medical record revealed physician orders for hydrocodone/acetaminophen 7.5/325 mg (a narcotic pain reliever) 1 to 2 tablets every 6 hours as needed for pain, and Flexeril 10 mg (a muscle relaxant) 1/2 tablet (5 mg) every 8 hours as needed for pain. Review of the resident's June 2013, July 2013 and August 1-28, 2013 MARs revealed the resident had received the as needed (PRN) hydrocodone/acetaminophen 7.5/325 mg twice; on 7/6/13 and 7/16/13. The resident received the PRN Flexeril 5 mg twice; on 8/15/13 and 8/20/13. During interview with the resident on 8/27/13 at 10:45 AM s/he revealed his/her pain level at that time to be 7 and 1/2 on a scale of 0 to 10. Review of Pain Management Flow Sheets for the date of 8/27/13 revealed documentation on the resident's pain as follows: a. Documentation timed at 6 AM showed "N/C [no complaints] voiced." The 0-10 pain scale was not utilized. b. There were no documented pain assessments for 8 AM and 12 PM. c. Documentation timed at 6 PM showed "denies." The 0-10 pain scale was not used. d. Documentation timed at 8 PM showed "N/C [no complaints] voiced." The 0-10 pain scale was not used. Review of the resident's MAR for 8/27/13	F 282		

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F 282	Continued From page 7 revealed no PRN medications were administered that day. Interview of the resident on 8/28/13 at 3:15 PM revealed his/her pain level at that time to be 8 on a scale of 0 to 10. Review of the Pain Management Flow Sheet for 8/28/13 at 3:30 PM revealed the only documented pain assessment for that day occurred at 6 AM, at which time the documentation showed "denies." Interview with LPN #1 on 8/28/13 at 3:30 PM revealed the nurse was unaware of the resident's pain level. The nurse stated she "wished [the resident] would tell the nurse" when s/he was in pain, and admitted that she probably didn't "always ask" about his pain with medication passes. The LPN then verified she was not aware the resident's care plan called for his/her pain to be assessed using a 0 to 10 scale with each medication pass.	F 282		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	South Lincoln Nursing Center will ensure that residents receive proper treatment and care for their respiratory and oxygen needs. 1. An oxygen policy will be developed which will give the nursing staff guidelines on assessing oxygen needs using oxygen saturations prior to titration of the residents oxygen liter flow. 2. Nursing staff will be educated to check the resident's oxygen saturations on a daily basis for those residents who are on continuous oxygen therapy, including Res #1, #4, #12 and #30. 3. The Nursing Center Clinical Supervisor will develop a quality monitoring tool to ensure that residents who are on continuous oxygen have an oxygen saturation done daily and	10/8/13 9/27/13

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F 328	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to properly assess oxygen needs for 5 of 6 sample residents (#1, #2, #4, #10, #20) who required supplemental oxygen. The findings were: 1. Review of the medical record for resident #2 showed s/he was admitted on 2/23/11 with diagnoses that included Dementia, Congestive Heart Failure, Hypertension, Osteoporosis, Malaise/Fatigue. Review of physician orders dated 3/04/13 showed the resident used oxygen at 2 liters per nasal cannula which was to be monitored by checking the saturation of oxygen to maintain a level of 90%. Review of the daily shift vitals log from 8/21/13 to 8/28/13 showed the resident's oxygen saturation levels were not checked or recorded on any of those 7 days. 2. Review of the medical record for resident #4 showed s/he had diagnoses that included dementia, congestive heart failure, and anxiety. Review of physician orders dated 3/04/13 showed the resident used oxygen at 3 liters per nasal cannula which was to be monitored by checking the saturation of oxygen to maintain a level of 90%. Review of the daily shift vitals log from 8/21/13 to 8/28/13 showed the resident's oxygen saturation levels were checked and recorded on 1 of the 7 days, 8/27/13. 3. Review of the August 2013 MAR for resident #20 showed a physician order dated 3/4/13 for oxygen "2 liters at bedtime titrate to keep saturation at > [greater] than 88%." Review of the daily shift vitals log from 8/21/13 to 8/28/13 showed the resident's oxygen saturation levels	F 328	with titration of oxygen flow rates. The results of the monitoring tool will be reported at the monthly QA/QI meeting and the monthly Medical Director meeting until compliance is met.	10/8/13

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F 328	Continued From page 9 were checked and recorded on 2 of the 7 days, 8/24 and 8/25. 4. Review of the medical record for resident #1 showed s/he had diagnoses that included hypoxemia. Review of physician orders revealed an order dated 3/4/13 for oxygen at "5 L [liters] via NC [nasal cannula] to keep SATS [oxygen saturation levels] > [greater] than 90%." Review of the daily shift vitals logs from 8/21/13 to 8/28/13 showed the resident's oxygen saturation levels were measured and recorded on 1 of the 7 days, 8/27/13. 5. Review of the medical record for resident #10 showed s/he had diagnoses that included hypertension. Review of physician orders dated 3/20/13 for oxygen showed "Inhaled every night. Titrate to 88-90%." Review of the daily shift vitals logs from 8/21/13 to 8/28/13 showed the resident's oxygen saturation levels were measured and recorded on 1 of the 7 days, 8/22/13. 6. Interview with the DON on 8/29/13 at 8:50 AM verified nursing was not measuring oxygen saturations routinely. She stated "We have only been checking sat [saturations] when they're [the residents] are symptomatic." She further acknowledged oxygen can not be titrated without knowing the oxygen saturation.	F 328		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	South Lincoln Nursing Center will ensure food is stored, prepared, distributed and served under sanitary conditions. 1. The cleaning schedules will be revised to the range top, two oven units, removable hood vents, sprinkler heads, condenser unit of walk-in refrigerator,and the interior of small refrigerator.	10/8/13

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F 371	Continued From page 10 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of cleaning schedules, the facility failed to ensure sanitary conditions related to a variety of kitchen equipment and 1 of 1 ice machines. The findings were: 1. Interview with the dietary manager on 8/29/13 8:15 AM verified there was not a schedule filled out for the current week. She further verified the kitchen cleaning schedule needed to be revised and cleaning done more thoroughly. Observation on 8/26/13 at 4 PM and again on 8/28/13 at 11:30 AM showed the following equipment was in need of cleaning: a. The range top and two oven unit was visibly soiled with cooked on food and grease. The side panel of the range/oven unit was encrusted with grease. b. The removable hood vents located above the range and the fryer unit were visibly soiled with grease and dust. c. Three sprinkler heads, two in the main kitchen preparation areas and one located in the dry storage room, were grease and dust covered. d. The condenser unit located in the walk-in refrigerator was visibly dirty with dark colored dust on and around the fans. This dark colored dust build-up was also noted to be on the ceiling of the walk-in refrigerator. e. The interior of a refrigerator unit located	F 371	2. The dietary staff will be educated on the revisions made to the cleaning schedule. 10/8/13 3. The Dietary Manager will develop a quality monitoring tool to ensure that the cleaning has been completed according to the schedule. The results of the monitor will be reported at the monthly QA/QI meeting until compliance is met. 10/8/13	

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	53A061	A. BUILDING _____ B. WING _____	09/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

(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 371	Continued From page 11 near the dietary manager's office was noted to be in need of cleaning. The bottom shelf of the unit had an accumulation of spilled food and liquid. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A).Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 2. Observation of the ice machine on 8/28/13 at 11:30 AM showed the unit had a build-up of hard water minerals on the outside panels. Additionally, the interior of the ice bin appeared to be unclean with dark scuffs and discolored metal and plastic parts. Interview with the dietary manager on 8/29/13 at 8:15 AM verified the ice machine was scheduled to be cleaned and sanitized every two weeks. Review of the 8/18-8/24/13 cleaning schedule showed the ice machine was referred to on the schedule for having the "ice machine vents" cleaned, and this was left blank during this time frame. The dietary manager verified this was the most current cleaning schedule she had to provide. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371	South Lincoln Nursing Center will ensure equipment food-contact surfaces, food-contact surfaces, of cooking equipment and nonfood-contact surfaces of equipment will be kept free of accumulation of dust, dirt, food residue and other debris. 1. A cleaning checklist will be developed for cleaning of the ice machine which will include the outside surfaces as well as the inner surfaces of the ice machine. 10/8/13 2. The Dietary Manager will educate the dietary staff on the cleaning checklist. 10/8/13 3. The Dietary Manager will develop a quality monitoring tool to ensure all surfaces of the ice machine both inside and outside are cleaned appropriately. The results of the quality monitor will be reported at the monthly QA/QI meeting until compliance is reached. 10/8/13	