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Healthcare Licensing and Surveys

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FORM APPROVED
OMB NO. 0938-0391

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

| 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 10/10/2013 |

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

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| F 000 | INITIAL COMMENTS<br><br>The following common abbreviations are used throughout this document:<br><br>ADON Assistant Director of Nursing<br>DON Director of Nursing<br><br>Less commonly used abbreviations will be annotated in each deficiency where used. | F 000 | F309 Each resident will receive and the facility will 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. | 11/24/13 |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview and review of the facility's non-pressure ulcer protocol, the facility failed to ensure 1 of 3 sample residents (#140) with wounds received consistent monitoring and ongoing assessment for wounds. In addition the facility failed to ensure timely action on laboratory test results for 2 of 8 sample residents (#94, #141). The findings were:<br><br>Regarding lack of wound assessment and monitoring:<br><br>1. Medical record review showed resident #140 resided at the facility from 6/12/13 to 10/1/13. Review of the 6/12/13 wound/incision admission | F 309 | A. Resident #94 was treated for urinary tract infection on 9/19/13. Resident #140 was discharged on 10/1/13 and resident #141 was discharged on 8/7/13.<br><br>B. Random audits will be completed to ensure weekly skin assessments are completed as scheduled. Non-pressure wounds will be audited randomly to ensure that non-pressure wounds are systemically evaluated for effectiveness of treatments and interventions.<br><br>Random audits of completed labs will occur to ensure treatments are initiated timely.<br><br>C. Licensed nurses will be re-educated regarding the importance of scheduled skin assessments and monitoring effectiveness of non- | |

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

Executive Director 11/21/13

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.

POC accepted. Message left with Bryan Monrad, E.D., on 12/9/13 @ 2:55p.



Jennie Collins, OTR/L

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| F 309 | Continued From page 1<br>assessment showed the resident had a surgical site wound on his/her back, double lumen peripherally inserted central catheter (PICC), urinary catheter, and percutaneous endoscopic gastrostomy (PEG) tube. This assessment also showed no additional wounds or pressure ulcers other than both heels were soft. Review of the 7/12/13 nursing notes showed a raised hard red area on the left lower leg was discovered by the therapist. Review of the 9/16/13 nursing notes showed the left lower leg wound had escher with serosanguineous drainage, and measured 3x3 centimeters. Review of the 9/18/13 nursing notes showed the wound "most likely came from" a blood clot ; and it was biopsied. This review also showed the biopsy was negative but the wound was not healing well.<br><br>Review of the 10/1/13 wound/incision assessment showed the resident continued to have the surgical site wound on his/her back, a double lumen PICC line, urinary catheter, PEG tube, and soft heels. However, further review of this assessment showed the following wounds had developed since the 6/12/13 assessment: the left calf blood clot biopsied site, a red area on the left inner thigh, open red areas on the coccyx, red areas on the right and left great toes, and small red areas on the right lower leg.<br><br>Review of the 9/25/13 care plan for resident #140 showed the resident was at risk for impaired skin integrity and pressure ulcer development due to decreased functional mobility related to back surgery, history of wound infections and "resident stays in bed most of the time." Further review of the care plan showed interventions included completing weekly skin assessments, documentation, and reporting findings to the | F 309 | pressure wound treatments and interventions.<br>Licensed nurses will be re-educated regarding timely initiation of treatment following labs. Nursing administration will monitor timely treatment with Lab Tracking Tool.<br><br>D. The facility will utilize a Performance Improvement Audit Tool to perform random audits of skin assessments and non-pressure wound monitoring. The facility will utilize a Performance Improvement Audit Tool to perform random audits to ensure treatments are initiated timely following completed labs. Random audits will be completed by Nurse Managers and/or Charge Nurses.<br><br>E. The Director of Nursing will report results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of at least three months or until ongoing compliance has been achieved. | |

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| F 309 | Continued From page 2<br>wound nurse. The following concerns were identified:<br>a. Review of the September 2013 treatment administration record documentation showed the nurses provided treatments for the resident's legs and feet, but not for the coccyx and inner thigh areas.<br>b. Review of the weekly skin assessments for July, August and September 2013 showed assessments were completed three times in July, two times in August, and four times in September. Further review revealed the weekly skin assessments did not consistently include the date each wound was first identified, the appearance and location of the areas, effective treatments and interventions, and information regarding whether the wounds had worsened.<br>c. Review of the non-pressure ulcer protocol provided by the facility on 10/10/13 revealed ongoing assessment and monitoring were not included in the protocol. Further review of the protocol revealed no evidence of a systematic approach for evaluating the effectiveness of treatments and interventions.<br>d. Interview on 10/10/13 at 2 PM with the wound care nurse revealed the wound care clinic staff provided the treatments for the resident's left leg wound and the facility nursing staff provided the treatments for the other areas. During the interview, the wound care nurse stated assessments were completed by the clinic staff; and she would arrange to have them sent to the facility for the surveyors. As of 11/13/13 the facility had not provided evidence the resident's wounds were routinely and consistently assessed by either the wound care clinic staff or the facility staff.<br><br>Regarding the lack of timely action on laboratory | F 309 | | |

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| F 309 | Continued From page 3<br>test results:<br>1. Review of the medical record for resident #141 revealed a physician's order dated 7/16/13 for Rocephin (a broad-spectrum antibiotic) 1 gram IVPB (intravenous piggy back) to be given for 10 days for diagnosis of infection. Review of nursing notes dated 7/16/13 and timed 5:22 PM revealed attempts by nursing staff to establish a peripheral intravenous (IV) line were unsuccessful. Further review of the same nursing note revealed new physician orders were received for an intramuscular dose of Rocephin to be given, and the resident was to have a PICC line inserted at the hospital.<br><br>Review of nursing notes dated 7/17/13 timed 9:41 PM revealed the resident had returned from the hospital with a PICC line, and had begun to receive Rocephin through it. Nursing notes dated 7/18/13 timed 10:46 AM revealed the resident was "continent of loose stool this morning." Nursing notes dated 7/18/13 timed 7:08 PM revealed the facility was "Awaiting collect stool for C-diff [Clostridium difficile]."<br><br>Review of laboratory test results printed on 7/20/13 revealed a stool sample for the resident was collected on 7/18/13, and final results indicating a positive result for Clostridium difficile were available 7/20/13 at 10:10 AM, however, nursing notes dated 7/22/13 timed 5:27 PM revealed the positive Clostridium difficile result was not acted upon until that date. Further review of nursing notes revealed the resident received doses of IV Rocephin on 7/20/13 and 7/21/13 before his/her medication was changed to reflect the results of his/her laboratory results, and that s/he continued to have intermittent diarrhea. | F 309 | | |

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| F 309 | Continued From page 4<br>Interview with ADON on 10/10/13 at 10:10 AM revealed the positive Clostridium difficile result was received on a Saturday, and when laboratory test results are received on the weekend, the nurse on duty was expected to contact on-call physicians with the results, rather than wait until the following Monday.<br><br>2. Review of the medical record for resident #94 revealed results of a urine laboratory test for a urinary tract infection, including a completed culture and sensitivity were available 9/14/13 at 10:03 AM. However, review of physician's orders revealed treatment for the urinary tract infection was not initiated until 9/19/13. Interview with RN #1 on 10/10/13 at 10:50 AM verified that a five-day delay in treatment for a urinary tract infection is too long. Interview with the DON on 10/10/13 at 11 AM revealed the physician for resident #94 had a history of not responding to facility messages in a timely manner. | F 309 | | |