2/19/09

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HU..AN 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
	535025	A. BUILDING _____ B. WING _____	C 01/23/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

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F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to promptly notify a physician when one resident developed a swollen arm and hand. The failure was identified	F 157	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the Truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. F157/D 1. Resident #31's swollen arm has been reported to the physician and action taken. 2. Any resident with a change of condition will have that condition reported to the physician timely and appropriate action taken. 3. Nursing staff will be inserviced on identification of change of condition and when and how to report to the physician. Unit Managers will audit 24 hour report sheets, telephone orders, labs, and incident forms to ensure proper notification is made to the physician and response received daily or 5x a week. 4. Results of the audits will be brought to the monthly QA & A meeting for review, comments, and recommendations. 5. Compliance Date: 3/6/09	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lyreca Patterson — TITLE: Administrator — (X6) DATE: 2/13/09

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.

Faxed by Paulette Dreas

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Wyoming Dept of Health
FEB 18 2009
Office of Healthcare Licensing and Survey

O Charges 2/19/09

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F 157	Continued From page 1 for 1 (#31) of 16 sample residents whose care was reviewed for changes in condition. The findings were: Observation of resident #31 on all days of the survey revealed the resident's left arm, hand, and partially contracted fingers were swollen. Review of the interdisciplinary post fall review for the resident revealed the resident fell from the bed to the floor onto his/her left side on 1/17/09 at 6:30 AM. Further review revealed the fall resulted in skin tears on his/her left arm and hand. At that time, staff reported the incident and skin teare to the physician. Review of the 1/17/09 to 1/21/09 nurse's notes and assessments revealed staff first noted the resident's swollen left arm and hand on 1/17/09 at 9:30 PM (15 hours after the resident fell). The record showed the swelling did not decrease, and the resident received pain medication specifically for left arm pain on 1/17-1/19/09. Review of the 1/16 -1/21/09 physician's update fax order request forms for the resident revealed staff did not report the change in condition to a physician. During an interview on 1/21/09 at 9:50 AM, RN #1 (the nurse who assessed the resident after the resident fell on 1/17/09) confirmed the resident's swollen arm and hand was a change in the resident's condition and the change had not been reported to a physician.	F 157	F221/D 1. Resident #35 is no longer in the facility therefore no individual plan of correction can be addressed. 2. Residents receiving a restraint will have a pre physical restraint assessment completed to determine why restraint is needed. 3. Nursing staff will be inserviced on Restraint policy and procedures to ensure all necessary steps are taken. Unit Managers will audit residents with restraints weekly for one month then monthly to ensure all policy and procedures have been followed. 4. Results of audits will be brought to the monthly QA & A meeting for review, comments, and recommendations. 5. Compliance Date: 3/6/09	
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by:	F 221		

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F 221	Continued From page 2 Based on medical record review and staff interview, the facility failed to perform an evaluation to ensure the use of physical restraints was required to treat medical symptoms for 1 (#35) of 4 sample residents who had physical restraints. The findings were: Review of the medical record revealed a physical restraint to prevent rising a lap cusion called a "Lap Buddy" was ordered for resident #35 on 8/29/08 and was used until it was discontinued on 10/1/08. Record review also showed there was no assessment or evaluation done to determine why the restraint was needed in August or the reason it was discontinued in October. Interview with the director of nursing (DON) on 1/22/09 at 2:10 PM confirmed an assessment was not done for resident #35 concerning the use of the restraint.	F 221	F272/E 1. Residents #3, 26, 29, 31, 35,42, and 64 will have new comprehensive bowel assessments completed. 2. Each residents bowel assessment will be reviewed and updated as necessary to be comprehensive and accurate so that MDS assessments can be coded correctly. 3. Licensed nursing staff will be inserviced on the bowel assessments and how to fill them out correctly. The Staff Development Coordinator will audit Bowel assessments on admission and quarterly assessments to ensure they are being completed correctly weekly for one month, monthly for three months, and quarterly thereafter to ensure compliance. 4. Results of the audits will be brought to the monthly QA & A meeting for review, comments, and suggestions. 5. Compliance Date: 3/6/09	
F 272 SS=E	483.20, 483.20(b) 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 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;	F 272		

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F 272	Continued From page 3 Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; 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 comprehensive bowel assessments were completed for 7 (#64, #35, #26, #29, #42, #31, #3) of 8 sample residents who were incontinent of bowel as identified by their Minimum Data Set (MDS) assessments. The findings were: 1. Review of the 9/1/08 quarterly MDS assessment for resident #64 showed s/he was occasionally incontinent of bowel. Review of the 11/26/08 quarterly MDS showed the resident had declined to being incontinent of bowel all or most all of the time. Review of the record revealed the most current assessment related to the resident's bowel incontinence was done on 3/11/08, and there had not been an assessment done that addressed the resident's decline in bowel continence status. Futhermore, interview with the DON on 1/23/09 at 10:55 AM revealed the bowel assessments were not comprehensive. She stated more education was needed in this area. 2. Review of the admission MDS assessment for	F 272		

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F 272	Continued From page 4 resident #35 dated 8/27/08 showed s/he was continent of bowel. Review of the significant change MDS assessment for the resident dated 12/14/08 showed the resident had declined in bowel continence status. Review of the 12/14/08 bowel assessment revealed the assessment was neither comprehensive nor complete. 3. Review of the significant change MDS assessment for resident #26 dated 12/21/08 showed s/he was incontinent of bowel. Review of the bowel assessment revealed it was not comprehensive or complete. The form being used as an assessment had an area to document a summary for bowel retraining potential, which it was left blank. In addition, the bowel assessment form was not dated or signed. 4. Medical record review for resident #29 revealed a quarterly MDS assessment dated 10/29/08. The MDS assessment revealed the resident was frequently incontinent of bowel. Further review showed the facility used a bowel retraining review sheet for an assessment. The summary for bowel retraining potential was not completed and the form was not signed or dated. 5. Medical record review for resident #42 revealed an admission MDS assessment dated 10/2/08. The MDS assessment revealed the resident was occasionally incontinent of bowel. According to a quarterly MDS assessment dated 1/2/09, the resident's bowel incontinence declined to total incontinence. Further record review revealed a bowel retraining review form dated 9/25/08 did not include a summary for bowel retraining potential for the resident. In addition, when the resident's bowel continence status declined, an updated bowel assessment was not	F 272		

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F 272	Continued From page 5 completed. 6. Review of the 10/27/08 significant change MDS assessment for resident #31 revealed s/he had multiple daily episodes of bowel incontinence. Review of the full nursing assessment documented that there was no comprehensive assessment of causative or contributing factors. Review of the plan of care revealed bowel incontinence was assessed as a problem. Review of the medical record revealed staff documented information on a bowel retraining form dated 9/24/08 regarding the resident's bowel habits. Further review revealed the form was incomplete, and no evaluation or assessment was completed utilizing the information collected. 7. Review of the 12/30/08 quarterly MDS assessment for resident #3 revealed s/he had multiple daily episodes of bowel incontinence. Review of the full nursing assessment revealed there was no comprehensive assessment to determine the causative factors. Review of the plan of care revealed bowel incontinence was assessed as a problem. Review of the medical record revealed a bowel retraining form, dated 12/20/08, that included information about the resident, but there was no evaluation or assessment utilizing the information collected on the form.	F 272		
F 278 SS=E	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		

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F 278	Continued From page 6 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments for 3 (#80, #48, #64) of 16 sample residents were accurately coded. The findings were: Review of MDS assessments for residents #80, #64, and #48 revealed the residents had significant declines in function. Record review identified the following inaccuracies: a. Review of two quarterly MDS assessments dated 5/13/08 and 8/7/08 revealed resident #80 declined in his/her ambulation ability, from needing limited assistance to being non-ambulatory. Further record review revealed	F 278	F278/E 1. Residents # 48, 64, and 80 will have their MDS assessments corrected if applicable. 2. Each resident will receive an accurate MDS assessment on Admission, quarterly, and/or with a significant change. 3. The Resident Care Management Director will attend Ron Orth MDS training on 2/12/09 in Denver. The Resident Care Management Director will audit MDS assessments completed by the MDS Coordinator monthly for three months, prior to locking for accuracy. 4. Results of the audits will be brought to the monthly QA & A meeting for review, comments, and recommendations. 5. Compliance Date: 3/6/09	

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F 278	Continued From page 7 the July 2008 daily rehabilitation and restorative service delivery record showed the resident was ambulating throughout the month. Interview on 1/23/09 at 10:20 AM with the MDS coordinator confirmed the 8/7/08 quarterly MDS assessment was coded incorrectly for ambulation. b. Medical record review of an annual MDS assessment dated 6/5/08 and a quarterly MDS assessment dated 9/2/08 revealed resident #48 had a decline in ambulation from being totally independent to being non-ambulatory. Further review revealed a therapy progress note dated 8/27/08 that showed the resident was ambulatory with a front wheeled walker. Interview on 1/23/09 at 10:20 AM with the MDS coordinator confirmed the 9/2/08 quarterly MDS assessment was mis-coded for ambulation. c. Review of the 9/1/08 quarterly MDS assessment for resident #64 showed s/he was occasionally incontinent of bowel, and usually continent of bladder. Review of the 11/26/08 quarterly MDS assessment showed the resident had declined, and was now incontinent of bowel and bladder all or most of the time. Interview with the MDS coordinator on 1/23/09 at 10:20 AM revealed this information was inaccurate. She revealed her review of the flow records for the 11/26/08 MDS assessment time frame showed the assessment was mis-coded. The resident was not incontinent and had not had a significant decline. At this time the MDS coordinator stated she and the other nurse completing MDS assessments were new to the job and more attention needed to be paid to accuracy.	F 278		
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to follow acceptable professional standards concerning medication administration for 1 non-sample (#78) and 3 sample (#85, #26, #69) residents. The findings were: 1. Observation on 1/21/09 at 8:55 AM, revealed registered nurse (RN) #1 used his/her hands to break one of resident #78's pills in half. Further observation at 9:35 AM revealed the RN touched one of resident #18's pills with his/her hands as s/he prepared to administer the resident's medications. According to "Nursing Interventions and Clinical Skills", 2007 4th edition, by authors Elkin, Perry and Potter, pages 374 and 383, the nurse should, "avoid touching tablets and capsules"... and "not touch medications with fingers..." prior to and during administration of medications. 2. According to the sixth edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, one of the six rights to safety is "documentation", ie, "the nurse should document the name of the drug, the dose and route and time administered." The following concerns were identified: a. Review of the medical record for resident #85 showed s/he had diagnoses that were treated with the following physician's orders: glargine insulin (for diabetes) 4 units to be given subcutaneously (SQ) at bedtime (HS) ordered on 10/18/08; levetiracetam (for seizures) 250mg to be given by mouth (PO) twice a day ordered on	F 281	F281/E 1. Residents #26, 69, 78 and 85 will receive their medication appropriately and be documented on MAR appropriately. 2. Each resident will receive their medication as ordered and documented on the MAR appropriately. 3. Licensed nursing staff will be inserviced on medication administration policy and procedures. The Staff Development Coordinator will randomly audit a licensed nurse's med pass weekly for one month, monthly for three months and quarterly thereafter to ensure compliance. The Unit Managers will audit MAR's and TAR's weekly for holes and take appropriate action. 4. Results of the audits will be brought to the monthly QA & A meeting for review, comments, and recommendations. 5. Compliance Date: 3/6/09	

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F 281	Continued From page 9 9/23/08; simvastatin (for hyperlipidemia) 40mg to be given PO at HS, ordered on 9/23/08; and levothyroxine sodium (for hypothyroidism) 25 micrograms (mcg) to be given PO daily ordered on 10/18/08. Review of the October 2008 medication administration record (MAR) showed no documented indication as to whether or not the 10/29/08 8 PM dose for glargine insulin wad administered. Review of the November 2008 MAR showed indication as to whether or not no initialing or refusals of the 11/25/08 doses for the levetiracetam 250mg and simvastatin 40mg were administered. Review of the December 2008 MAR showed no indication as to whether or not the 12/11/08 5 AM dose of levothyroxine sodium 25mcg and the 12/16/08 8 PM dose of simvastatin 40mg were given. b. Review of the medical record for resident #26 showed s/he had diagnoses including uncontrolled type II diabetes mellitus. Review of the physician's orders revealed a 10/9/08 order for: gabapentin (for neuralgia) 600 milligrams (mg) to be given through the resident's percutaneous endoscopic gastrostomy (PEG) tube three times a day. There was also an order dated 10/16/08 for ipratropium bromide/albuterol sulfate 2.5-0.5 mg/milliliter (ml) solution to be administered by nebulizer three times a day. Review of the December 2008 MAR for the resident showed no indication as to whether or not the 12/06/08 doses at 8 AM and 12 noon for the gabapentin, or the 12/26/08 doses for the ipratropium bromide/albuterol sulfate as 12N or 4 PM were given. Interview with the DON on 1/22/09 at 11:15 AM confirmed that if a MAR was blank for a dose of medication, it could not be determined if the medication was administered.	F 281		

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F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of the facility's report of residents identified with pressure sores, and medical record review, the facility failed to implement identified skin breakdown interventions, and promptly identify a pressure sore. This failure resulted in an avoidable delay in treatment for 1 (#31) of 6 sample residents with pressure sores. The findings were: Review of the 10/27/08 Minimum Data Set (MDS) quarterly assessment and corresponding resident assessment protocol (RAP) summary revealed resident #31 did not have a pressure sore, but was at risk for developing pressure sores. The resident was noted to be at risk because s/he required extensive assistance for bed mobility and transfers, had multiple daily episodes of urinary and fecal incontinence and poor nutritional intake. Review of the 10/10/08 Braden Scale assessment also documented the resident was at risk for developing pressure sores. Review of the resident's plan of care, updated on 11/7/08, revealed interventions for preventive skin care included weekly head to toe skin assessments	F 314	F314/D 1. Resident #31's pressure sore has been assessed, treated, and will be followed weekly until healed. 2. Any resident identified as having a skin issue will be assessed, treated, and followed weekly until healed. Any resident at risk will have interventions put into place to prevent pressure sores. 3. Nursing staff will be inserviced on skin policy and procedures. Nursing staff will be inserviced on when and how to notify wound team of potential skin issues so that preventative measures can be taken. Unit Managers will audit Braden scales on Admission and quarterly and put appropriate interventions in place to prevent breakdown. Unit Managers will audit skin assessments weekly for 3 months, and monthly thereafter to ensure compliance. Unit Managers will audit toileting and positioning weekly for one month and monthly thereafter to ensure compliance. 4. Results of the audits will be brought to the monthly QA & A meeting for review, comments, and recommendations. 5. Compliance Date: 3/6/09	

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

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
	535025	A. BUILDING _____ B. WING _____	C 01/23/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 11 and routine turning and repositioning. Review of the facility's skin management policy and procedure, revised March 2008, revealed guidelines for staff to turn and reposition at risk residents every two hours and perform weekly skin assessments with documentation of findings on the treatment administration record (TAR). The following concerns related to this resident's care were identified: a. Review of the January 2009 TAR revealed staff performed a head to toe skin assessment on 1/8/09 and documented no open skin areas. However, the assessment was not documented as having been done the week of 1/15/09. b. Observation on 1/20/09 at 1:35 PM revealed certified nurse aides (CNA) #1 and #2 transferred the resident to bed and provided urinary and fecal incontinence care. Observation revealed the resident had an open, reddened stage II pressure sore on the coccyx that measured approximately 1 x 6 cm. The CNAs applied barrier cream to the open area and positioned the resident on his/her right side. Interview with the CNAs on 1/20/09 at 1:35 PM, revealed they did not know when the resident developed the skin breakdown. Continuous observation of the resident on 1/20/09 from 1:35 PM to 4:30 PM (2 hours and 55 minutes), revealed the resident remained in bed throughout the time period and staff did not reposition the resident until CNA #3 and CNA #4 removed his/her feces saturated brief at 4:30 PM. Review of the 1/20 and 1/21/09 nurse's notes and TAR revealed no documentation, treatment, or monitoring related to the open skin area on the resident's coccyx. Interview with RN #1 on 1/22/09 at 10 AM, revealed the nurses were not aware of the resident's compromised skin area until 1/22/09.	F 314		

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F 314	Continued From page 12 c. Observation of the resident on 1/22/09 from 9:20 AM to 11:45 AM (2 hours and 35 minutes), revealed the resident remained in bed throughout the time period and staff did not reposition the resident until 11:45 AM when CNA #1 and CNA #5 removed the resident's disposable brief that was saturated with urine and feces. d. Interview with the DON on 1/22/09 at 1:45 PM revealed staff were expected to reposition the resident every two hours and perform weekly head to toe skin assessment. The DON also said the CNAs should have reported to the charge nurse on 1/20/09 as soon as the CNAs identified the open skin area. e. Review of the 1/22 -1/23/ 09 nurse's notes and pressure sore care plan intervention updated on 1/22/08 revealed the resident's stage II pressure sore on the coccyx required hydrocolloid treatment instead of the barrier cream that was applied on 1/20/09.	F 314	F428/D 1. Resident #3's medications will be reviewed with the physician for irregularities and discontinuation if necessary. 2. Each resident will have their medications reviewed monthly by the Pharmacist and recommendations made to the physician for any irregularities. 3. The DON will audit the pharmacist report monthly to ensure that each resident is being reviewed, irregularities identified, and physician's notified. 4. Results of the audit will be brought to the QA & A meeting for review, comments, and recommendations. 5. Compliance Date: 3/6/09	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure medication irregularities were reported to the physician for 1 (#3) of 16	F 428		

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F 428	Continued From page 13 sample residents. The findings were: Review of resident #3's medical record and physician's orders revealed the resident's medication regime included 18 different daily medications and 11 as needed (prn) medications. Review of the monthly pharmacy review records from 9/1/08 to 1/22/09 (almost five months) for the resident revealed the pharmacist did not identify and report the following irregularities: a. Five (Miralax, Citracel, Colace, Fleets and milk of magnesia) of the 29 medications were for treatment of constipation. b. Seven (Duroreb, Nitrolinqual spray, Fleets, mom, artifical tears, Reglan, and Ultracet)of the 11 prn medications were not used during the time period. c. One (Ultracet) of the 3 prn pain medications (Ultracet, Oxycodone and Roxanol) was not used during the time period. d. One daily medication (Reglan) and 2 prn medications (Reglan and Phenergan) were ordered for nausea and vomiting, however, 1 of the prn medications was not used during the time period. During an interview on 1/22/09 at 12:15 PM, the pharmacist said he sent monthly reports of his reviews to the director of nurses (DON), but his review did not routinely include a review of irregularities regarding duplicate medications. During an interview on 1/22/09 at 3:45 PM, the DON confirmed the pharmacist did not identify and report the irregularities.	F 428		