Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF005	A. BUILDING: _____ B. WING _____	C 12/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CA	1866 SO BEVERLY STREET CASPER, WY 82609

2/20/14 CV

(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) COMPLETE DATE
S5023	Ch 12 Sec 7 (b)(iv)(A-C) Assisted Living Facility (ALF) Core Services (b) Resident Assessment and Services. The staff/contract Registered Nurse (RN) shall conduct initial and, at a minimum annually, an accurate, standardized, reproducible assessment of each resident's functional capacity, physical assessment and medication review. (iv) Frequency of assessment. An assessment must be conducted: (A) No earlier than one (1) week prior to admission; (B) Immediately upon any significant change in the resident's mental or physical condition; or (C) No less than once every twelve (12) months. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to perform a resident assessment after a change of condition for 2 of 7 sample residents (#27, #32). The findings were: 1. Review of the medical record for resident #32 showed s/he was admitted to the facility on 8/7/13 with a history of general decline/failure to thrive. Nursing notes dated 9/13/13, timed at 9:30 AM, revealed "Nights [night shift] stated resident found on floor. Abrasion R [right] shin, skin tears both elbows scabbed area R eyebrow..." There was no evidence of a nursing assessment completed at the time of the fall. The resident had a previously scheduled appointment with his/her physician the afternoon of 9/13/13. Interview with the facility	S5023	**Policy:** Any resident that has a significant mental or physical change of condition will be reported to the Nurse and an assessment must be completed. The resident's physician will be notified by telephone or fax. **Who:** Floor nurse and/or Director of Nursing. **How:** A nursing department meeting will be conducted January 2014 to educate nursing staff on the new Change of Condition form and example of change of conditions. The change of condition form and rules are now posted at the nurses' station. Resident #27 was sent to her physician on 10/16/13 and 10/29/13. Resident #32 has passed away, therefore no action could be taken. Resident #6 was sent to her physician on 11/15/13. **QA:** Executive Director and Director of Nursing will review documents each month for compliance. A new DON started in January and is reviewing every resident file to ensure no additional errors have been identified.	2/10/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kenyne Dahlager — TITLE: Director — (X6) DATE: 1/2/14

Kenyne Schlager Director 2/20/14

POC accepted 2/20/14. Message left for Kenyne Schlager on voice mail. Alleged date of compliance 2/10/14. Janie VanDyke, SURVEYOR

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	ALF006	A. BUILDING: _____ B. WING _____	C 12/13/2013

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S5023	Continued From page 1 director of nursing (DON) on 12/12/13 at 2:50 PM revealed the resident was sent from that physician's office to the hospital, where s/he was admitted for treatment of pneumonia and fractures to the arm and ribs. The resident was subsequently admitted to hospice, and expired on 9/17/13. Interview with the facility administrator and DON on 12/13/13 at 9:30 AM confirmed the lack of nursing assessment at the time of the 9/13/13 fall. 2. Review of the medical record for resident #27 showed s/he was admitted to the facility on 6/25/09 with a history of stroke. Nursing notes dated 9/7/13, timed at 10:30 PM, revealed "...Was reported to me that res. [resident] had slurred speech, drooping mouth with drool on L [left] side early this afternoon. V.S. [vital signs] were taken and WNL [within normal limits]. Res. will be watched closely over next few days. Tonight denies any H/A [headache], blurred vision, or weakness." There were no nursing notes from the 6 AM to 2 PM shift or the 2 PM to 10 PM shift on that day. No evidence of a nursing assessment completed in the afternoon (when the symptoms occurred) was found. Interview with the facility administrator and DON on 12/13/13 at 9:30 AM confirmed the lack of nursing assessment at the time the symptoms occurred.	S5023	**Policy:** Any resident that has a significant mental or physical change of condition will be reported to the Nurse and an assessment must be completed. The resident's physician will be notified by telephone or fax. **Who:** Floor nurse and/or Director of Nursing. **How:** A nursing department meeting will be conducted January 2014 to educate nursing staff on the new Change of Condition form and example of change of conditions. The change of condition form and rules are now posted at the nurses' station. Resident #27 was sent to her physician on 10/16/13 and 10/29/13. Resident #32 has passed away, therefore no action could be taken. Resident #6 was sent to her physician on 11/15/13. **QA:** Executive Director and Director of Nursing will review documents each month for compliance. A new DON started in January and is reviewing every resident file to ensure no additional errors have been identified.	2/10/14
S5024	Ch 12 Sec 7 (b)(v)(A) Assisted Living Facility (ALF) Core Services (b) Resident Assessment and Services. The staff/contract Registered Nurse (RN) shall	S5024		

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S5024	Continued From page 2 conduct initial and, at a minimum annually, an accurate, standardized, reproducible assessment of each resident's functional capacity, physical assessment and medication review. (v) Use of the assessment. (A) The results of the assessment are used to develop, review, and revise the resident's individualized assistance plan. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to notify the resident's physician of a change of condition for 3 of 7 sample residents (#6, #27, #32). The findings were: 1. Review of the medical record for resident #32 showed s/he was admitted to the facility on 8/7/13 with a history of general decline/failure to thrive. Nursing notes dated 9/12/13, timed 4:30 AM, revealed the resident had been found on the floor in his/her bedroom "this AM" and was noted to have an oxygen saturation level of 76%. Notification of the fall was sent to the resident's physician via fax, however, the abnormal oxygen saturation level was not mentioned in the fax. Additional nursing notes from that same date, untimed, noted "PT [physical therapy] here this am and worked with resident. During exercise O2 sats [oxygen saturation] decreased to 88% RA [room air]. Will continue to monitor." No notification of this abnormal oxygen saturation level was sent to the physician. Nursing notes dated 9/13/13, timed at 9:30 AM, revealed "Nights [night shift] stated resident found on floor. Abrasion R [right] shin, skin tears both	S5024	**Policy:** Any resident that has a significant mental or physical change of condition will be reported to the Nurse and an assessment must be completed. The resident's physician will be notified by telephone or fax. **Who:** Floor nurse and/or Director of Nursing. **How:** A nursing department meeting will be conducted January 2014 to educate nursing staff on the new Change of Condition form and example of change of conditions. The change of condition form and rules are now posted at the nurses' station. Resident #27 was sent to her physician on 10/16/13 and 10/29/13. Resident #32 has passed away, therefore no action could be taken. Resident #6 was sent to her physician on 11/15/13. **QA:** Executive Director and Director of Nursing will review documents each month for compliance. A new DON started in January and is reviewing every resident file to ensure no additional errors have been identified	2/10/14

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S5024	Continued From page 3 elbows scabbed area R eyebrow..." The resident had a previously scheduled appointment with his/her physician the afternoon of 9/13/13. Interview with the facility director of nursing (DON) on 12/12/13 at 2:50 PM revealed the resident was sent from that physician's office to the hospital, where s/he was admitted for treatment of pneumonia and fractures to the arm and ribs. The resident was subsequently admitted to hospice, and expired on 9/17/13. Interview with the facility administrator and DON on 12/13/13 at 9:30 AM confirmed the lack of physician notification of the resident's abnormal oxygen saturation levels. 2. Review of the medical record for resident #27 showed s/he was admitted to the facility on 6/25/09 with a history of stroke. Nursing notes dated 9/7/13, timed at 10:30 PM, revealed "...Was reported to me that res. [resident] had slurred speech, drooping mouth with drool on L [left] side early this afternoon. V.S. [vital signs] were taken and WNL [within normal limits]. Res. will be watched closely over next few days. Tonight denies any H/A [headache], blurred vision, or weakness." Review of the medical record showed no evidence the resident's physician was notified of these symptoms. Interview with the facility administrator and DON on 12/13/13 at 9:30 AM confirmed the lack of physician notification regarding these symptoms. 3. Review of the medical record for resident #6 showed s/he was admitted to the facility on 9/28/13 with a history of hypertension. Nursing notes dated 11/5/13, timed at 11:15 AM, revealed "This am residents pulse was 76 and B/P [blood pressure] 109/61 - on 11/4/13 B/P was 182/80.	S5024	**Policy:** Any resident that has a significant mental or physical change of condition will be reported to the Nurse and an assessment must be completed. The resident's physician will be notified by telephone or fax. **Who:** Floor nurse and/or Director of Nursing. **How:** A nursing department meeting will be conducted January 2014 to educate nursing staff on the new Change of Condition form and example of change of conditions. The change of condition form and rules are now posted at the nurses' station. Resident #27 was sent to her physician on 10/16/13 and 10/29/13. Resident #32 has passed away, therefore no action could be taken. Resident #6 was sent to her physician on 11/15/13. **QA:** Executive Director and Director of Nursing will review documents each month for compliance. A new DON started in January and is reviewing every resident file to ensure no additional errors have been identified.	2/10/14

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S5024	Continued From page 4 Son reports that resident has times where B/P goes high then will come back down. WCTM [will continue to monitor] and report to MD [physician]." Review of the vital signs and weight record for this resident revealed elevated blood pressures on 10/30/13, 10/31/13, 11/4/13, 11/6/13, and 11/13/13. However, there was no evidence staff notified the physician of the elevated blood pressure. Interview with the facility administrator and DON on 12/13/13 at 9:30 AM confirmed the lack of physician notification regarding this resident's elevated blood pressures.	S5024	**Policy:** Any resident that has a significant mental or physical change of condition will be reported to the Nurse and an assessment must be completed. The resident's physician will be notified by telephone or fax. **Who:** Floor nurse and/or Director of Nursing. **How:** A nursing department meeting will be conducted January 2014 to educate nursing staff on the new Change of Condition form and example of change of conditions. The change of condition form and rules are now posted at the nurses' station. Resident #27 was sent to her physician on 10/16/13 and 10/29/13. Resident #32 has passed away, therefore no action could be taken. Resident #6 was sent to her physician on 11/15/13. **QA:** Executive Director and Director of Nursing will review documents each month for compliance. A new DON started in January and is reviewing every resident file to ensure no additional errors have been identified.	2/10/14

Change of Condition Form

2/20/14

Date:_____

Resident name:_____

Change of Condition:_____

_____

_____

_____

_____

_____

_____

Registered Nurse notified ☐

Name of nurse notified:_____

Date:_____

Time:_____

Method of notification:_____

Physician Notified ☐

Name of physician notified:_____

Date:_____

Time:_____

Method of notification:_____

Incident report completed if applicable ☐

Charted in nursing notes ☐

Vital signs charted ☐

Signature of nurse completing this form:_____

Please give completed form to the Director of Nursing.

2/20/14

Change of Condition

- New diagnosis from physician (usually noted with new meds)
- Any hospitalization
- A new identified risk
- New interventions or removal of an intervention
- Any event that results in an injury
- Fall
- Pattern of increasing falls (i.e. 1 per month for 3 months)
- Changes in refusals of medications, services, treatments
- Weight loss or gain (per policy)
- Admit to Hospice
- Admit to a 3rd Party Provider (PT, OT, ST)
- Pattern of change in social participation
- Death of spouse or child
- Pressure wound (including stage I)
- Increased service needs or services being provided by community staff because a previously involved family member is no longer assist in the provision of the service(s)
- Decreased service needs as a result of significant improvement
- Increased service needs due to a resident's increasing confusion and disorientation
- Any abnormal reading of vital signs pertinent to a current or past condition

If there is any change in the resident's condition that prompts you to put them on acute charting or causes you to feel the need to monitor them more closely, please complete the CHANGE OF CONDITION FORM.