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 11/06/2009

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

(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 QUALITY OF CARE 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: A. Based on observation, staff interview, policy and procedure review and medical record review, the facility failed to ensure care and services were provided as ordered for 1 of 4 residents (#64) who received treatments for non-pressure related wounds. This failure resulted in an avoidable ulcer. The findings were: According to the 6/12/07 history and physical resident #64 was admitted with diagnoses that included chronic venous stasis dermatitis. According to a faxed order request to the physician on 3/18/09, the resident's foot was looking "very good." The physician responded on 3/18/09 with an order to discontinue the previous treatments and for the wound team to evaluate and treat the resident's right foot. Review of the 9/1/09 physician's progress note documented the resident continued to have chronic dependent edema and stasis dermatitis on both legs. The physician further noted, the condition had "improved with whirlpool baths and the use of a UNA-boot..." Interview with the director of nursing (DON) on 11/5/09 at 2:10 PM revealed that on 3/18/09 the wound team evaluated the foot and wrote orders for twice weekly dressing changes on Mondays and Thursdays to coincide with the	F 309	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 the 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. This plan of correction serves as the facility's allegation of compliance. F309 It is the practice of the facility to ensure each resident receives and the facility provides 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. Corrective Action: Resident #64 – wounds have been assessed and measured by a licensed nurse and documentation of the assessment and measurements has been noted in the resident's medical record. Weekly skin assessments have been performed and documented in the medical record. TX AM provided orders per MD order. Resident #1 – Bowel status will be monitored daily via observation and Care Tracker reports. Laxatives will be	12/11/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Reaume — TITLE: — (X6) DATE: 12-2-09

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.

Accepted 12/22/09 w/changes per phone call w/ NHA & DON DEC 02 2009 Hand Delivered

Office of Healthcare Licensing and Surveys

Susan

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F 309	Continued From page 1 resident's shower schedule. The DON stated the wound team did not perform the actual treatments. She stated the floor nurses were responsible for doing the wound treatments. In addition, the DON stated the floor nurses who did the treatments were expected to document once a week using the facility's non-pressure skin condition record to show how the area was doing. The DON commented that she did not know if there was a current open area on the resident's right foot, as she had not seen it recently. Review of the facility's policy and procedure for skin management, revised in March 2008, showed: "When the skin check is completed each week, the licensed nurse should document Plus (+) for intact if there are no alterations in skin integrity Minus(-) for alterations or changes in skin integrity..." The policy further described procedures related to lower extremity ulcers: "Resident, family and attending physician are notified of the development of the vascular ulcer...Etiology of the ulcer is determine as well as the treatment plan. This is achieved via the attending physician...Skin care team to assess weekly and document status/progress on the non-pressure skin record..." Observation on 11/6/09 at 2 PM of the resident's right outer foot revealed an open area. Measurements done by the DON at that time showed the area to be 1.9 cm by 1.8 cm with a depth of 0.2 cm. Further observation revealed the wound bed was yellow and the surrounding tissue was red and tender to touch. The following concerns were noted regarding the lack of care and services for this resident's wound: a. On 9/20/09 the physician was notified that there was increased blood coming from the	F 309	administered as ordered. The resident's care plan has been updated to reflect any changes to the resident's bowel regime. Resident #18 – Bowel status will be monitored daily via observation and Care Tracker reports. Laxatives will be administered as ordered. The resident's care plan has been updated to reflect any changes to the resident's bowel regime. Identification of Others: The DON or designee completed an audit of residents with non-pressure wounds (lacerations, surgical wounds, etc.). Measurements were obtained and documented in the medical record. No other stasis/diabetic ulcers were identified. The Unit Manager or designee will audit care tracker reports for residents with 9 or more shifts without a documented bowel movement. Those residents found to have not had a BM for 9 or more shifts will be assessed by a nurse and interventions implemented. Those residents identified as having a risk for constipation will be evaluated for appropriateness of their bowel regime, physician orders will be obtained if necessary and their care plans will be updated. Systemic Changes:	

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F 309	Continued From page 2 bottom of the resident's right foot. However, there had been no weekly skin condition records or other entries regarding the status of the resident's right foot since the orders to evaluate and treat were written on 3/18/09. b. Review of the July, August, September and October TARs showed the dressing changes were not done twice a week as planned. These included: 11 days from July 10- July 22 (the TAR showed a slash mark on 7/13, 7/16, and 7/20 however there was no indication of what the slash mark ment); 11 days between Aug 12- Aug 24; 15 days from Sept 21- Oct 7; 6 days between Oct 27- Nov 3. c. During an interview on 11/6/09 at 1:50 PM, licensed practical nurse (LPN) #1 stated she last changed the dressing on the resident's right foot the week before (10/27/09). She stated she did not make any notes other than marking on the treatment administration record (TAR) that the dressing change was done. She commented that there was not any open area on the foot at that time. d. According to a review of the October 2009 TAR and the medical record, there had been no weekly skin assessments documented for this residents. The weekly skin assessment done for the first week of November 2009 showed a plus sign (+) on 11/3/09 indicating the skin was intact with no alterations. However, on 11/3/09 an order was received for whirlpool baths three times a week on Monday, Wednesday, Friday. Order clarification was then received for the dressing changes to coincide with these bath days. Review of the medical record failed to show why the whirlpool baths were added at that time. e. According to a review of the physician's assessment/plan from the 8/1/09 nursing home visit notes, the resident's venous statis dermatitis	F 309	The SDC or designee will provide inservice education to licensed nurses including but not limited to: protocol for weekly skin assessments and documentation, notification of the wound team for any skin alterations, contacting attending physician for wound treatment orders, facilities bowel regime, monitoring of resident bowel status including bowel sounds, abdominal assessment and review of Care Tracker reports. Newly hired nurses will receive this education during orientation to the facility. The SDC or designee will provide inservice education to Resident Care Specialists regarding Care Tracker documentation including but not limited to accurate documentation of bowel movements. The Unit Manager or designee will audit TARs weekly for the completion of skin assessments. Nurses who fail to complete skin assessments per facility policy will receive one to one education/counseling. The night charge nurse will print care tracker reports for residents daily and list those residents with 9 or more shifts without a BM. This list will be passed to the day nurse for implementation of individual resident interventions as ordered by the attending physicians. The Unit Manager or designee will audit care tracker reports weekly for residents with 9 or more shifts without a documented	★ Per phone w/ [illegible] NHA + DON 12/2/09

★ weekly DON or designee will randomly check for tx orders to ensure appropriate tx are being done.

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F 309	Continued From page 3 "Appears to be doing well at this time with UNA-boot and whirlpool baths." However, review of the July, August, September, October and November 2009 bathing reports for the resident showed 7/2/09 was the last time the resident received a bath. The other types of bathing shown were all showers. Observations during the days of survey (11/4-11/6/09) revealed there was not an UNA-boot in use. Review of the medical record failed to show a discontinuation of these treatments. f. Interview with the DON on 11/6/09 at 12:25 PM verified that the treatment orders for the resident's right foot did not appear to have been followed based on the documentation in the medical record. Later that day, at 2 PM as she changed the dressing, the DON confirmed the foot had an open area and assessed the wound. B. Based on medical record review and staff and resident interview, the facility failed to ensure monitoring was completed as planned for 2 of 2 sample residents (#1, #18) who were identified with constipation issues. The findings were: 1. Medical record review for resident #18 revealed the October 2009 medication administration record (MAR) which showed the resident received Senna (a laxative) daily and Colace (a stool softener) twice a day for constipation. The MAR also showed the resident could have lactulose or milk of magnesia (both laxatives) or a fleets enema as needed for constipation. During review of the routine bowel and bladder shift charting, it was noted the resident had a large bowel movement on 10/18/09, a medium bowel movement on 10/19/09, and a small bowel movement on	F 309	bowel movement. Those residents identified as having 9 or more shifts without a documented BM will have the facility bowel regime started and will be monitored for effectiveness of the regime. Monitoring: Re: Bowel The Unit Manager or designee will track and trend the weekly care tracker audits and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. The Unit Manager or designee will track and trend the weekly TAR audits and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Correction: 12/11/09	

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F 309	Continued From page 4 10/21/09. Review of the October 2009 MAR, showed PRN milk of magnesia was given on 10/20/09 and 10/21/09. Further review of nurses' notes dated 10/21/09 at 1 PM showed the resident requested an enema. The nurse documented the resident's abdomen was distended and firm and bowel sounds were sluggish, but the "resident was denied an enema due to the assessment being normal." According to a later nurses note on 10/21/09 at 3:30 PM, the resident was sent to the emergency room (ER). Review of the ER services report from 10/21/09 included the results of a CT scan of the abdomen which revealed a distended bladder and a distended rectum with fecal impaction. A fecal disimpaction was done. The following concerns were Identified related to bowel monitoring: a. According to an interview on 11/5/09 at 11 AM with unit nurse manager #1, it was revealed that the facility did not have a written bowel protocol. The unit nurse manager (#1) did state that they followed a bowel monitoring system that included having the CNAs track bowel movements in the computer daily for all residents. The unit manager stated she would then pull off a report daily that showed which residents had not had any bowel movements over in the past 9 shifts. The unit manager stated the floor nurses would then assess the residents and call the physician for orders as needed. b. After the resident returned to the facility from the emergency room because of a fecal impaction, the bowel and bladder shift charting revealed the resident did not have a bowel movement from 10/25/09 until the third shift on 10/29/09, a total of 12 shifts. Review of the October 2009 MAR showed the resident was not given any doses of milk of magnesia or lactulose, nor was the resident offered or given a fleets	F 309		

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F 309	Continued From page 5 enema during that time. 2. Review of the November 2009 medication administration record (MAR) for resident #1 showed the resident routinely received lactulose 10 gm/15 ml solution daily for constipation. During a medical record review, a physician's update/order request form, dated 10/31/09, for this resident revealed the resident was having complaints of constipation. The documentation went on to show there had been no bowel movements charted by the certified nurse aides (CNAs) for the previous 6 days. The nurse completing the form asked for an as needed order for lactulose as well as for a stool softner. A faxed order was received back from the physician on the next day. Review of a nursing note written on 11/1/09 at 5:30 PM showed the resident was able to have a bowel movement after s/he received the as needed dose of stool softener. The following concerns were identified: a. Review of the "Resident Bowel and Bladder by Shift Chart" for this resident from 10/24/09 shift 3 to 11/1/09 shift 3 showed there were no BMs charted for 25 shifts. b. According to an interview on 11/5/09 at 11 AM with unit nurse manager #1, it was revealed that although the facility did not have a written bowel protocol, staff followed a bowel monitoring system that included having the CNAs track bowel movements in the computer daily for all residents. The unit manager reviewed the daily report that showed what residents had not had any BMs over the past 9 shifts. She stated the floor nurses would then assess the residents and call the physician for orders as needed. The unit manager stated she was uncertain why this resident was not identified for potential constipation after 9 shifts.	F 309	F332 It is the practice of the facility to ensure that it is free of medication error rates of five percent or grater. Corrective Action: Resident #62 – Receives medication as ordered following the "five rights" of medication administration. Resident #77 – Receives medication as ordered following the "five rights" of medication administration. LPN #1 – The SDC or designee has provided one to one education regarding medication administration. This education has been documented in the employee's personnel file. LPN #1 – The SDC or designee has provided one to one education regarding medication administration. This education has been documented in the employee's personnel file. Identification of Others: The DON or designee will routinely observe licensed nurse medication pass for accuracy. Those nurses who commit errors will receive one to one education.	

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F 309	Continued From page 6 c. Interview with the resident on 11/6/09 at 9:15 AM revealed s/he remembered telling the nurse she was having constipation for 5 or 6 days, and needed something. The resident stated s/he was better now.	F 309		
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, it was determined the facility failed to ensure that medications administered to 2 of 6 non-sample residents (#62, #77) were free of medication errors. A total of forty seven medications were observed given by three nurses. Three medication errors were made, resulting in a 6.4 % medication error rate. The findings were: a. On 11/5/09 at 7 AM, during a medication pass observation with licensed practical nurse (LPN) #2, the nurse handed resident #62 a Pulmacort 90 mcg inhaler. The resident took one puff from the inhaler and handed it back to the nurse. The nurse did not instruct the resident to take a second puff. Medical record review revealed a physician order for Pulmacort inhaler 90 mcg, two puffs, twice a day. b. Further observations during the same medication pass showed LPN #2 did not administer colace to resident #77. Record review revealed a telephone order on 11/1/09 for the resident to receive colace 100 mg by mouth twice a day. Interview on 11/5/09 at 2 PM with LPN #2 revealed the order was missed and had not yet	F 332	Systemic Changes: The SDC or designee will provide inservice education to licensed nurses including but not limited to: accuracy in medication pass including the "Five Rights of Medication Administration", Aseptic technique, proper dosage administration of inhalers, hand washing, receiving, discontinuing and transcribing medications. Newly hired nurses will receive this education during orientation to the facility. The DON or designee will routinely observe licensed nurse medication passes for accuracy and appropriate technique. Monitoring: The DON or designee will track and trend the routine observation of medication pass and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Correction: 12/11/09	12/11/09

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F 332	Continued From page 7 been noted. c. On 11/6/09 at 8:30 AM during a medication pass observation with LPN #3, the nurse handed resident #62 a Pulmacort 90 mcg inhaler. Just as the day before, the resident took one puff from the inhaler and handed it back to the nurse, and again, the nurse did not instruct the resident to take a second puff from the inhaler.	F 332		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medical records were accurately documented and readily accessible for 2 of 10 sample residents (#102, #18). The findings were: 1. On 11/4/09 the post-discharge plan of care for resident #102 was reviewed. There was a column for the disposition of medications which was not completed. Interview with the DON while reviewing the document on 11/4/09 at 12 PM revealed it should have been filled in and was not. Later that day the administrator presented a copy	F 514	F514 It is the practice of the facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Corrective Action: Resident #102 – The residents disposition of medication is documented and contained in the medical record. Resident #18 – The residents Braden scales and TARs are contained in the medical record. Identification of Others: The HIM or designee completed an audit of resident medical records to identify misfiled forms, missing documentation, etc. Identified misfiled documentation was moved to the appropriate medical records and missing documentaion (TARs, Braden scales, etc.) were filed as necessary.	12/11/09

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F 514	Continued From page 8 of this document to the surveyor along with other documents to provide additional information. Review of the copy showed the disposition of medication columns were now filled in. On 11/5/09 at 10:45 AM interview with the administrator revealed the new information on the document was added the previous day, but the nurse failed to show it as a late entry. 2. Medical record review on 11/4/09 for resident #18 revealed s/he was admitted on 3/13/09 and there were no Braden scale assessments (a tool used to assess risk of developing pressure ulcers) in the resident's record, nor were there any August 2009 treatment administration records (TARs). Interview on 11/5/09 at 12 noon with unit manager #1 revealed all residents had Braden scale assessments done weekly for four weeks after admission, and then quarterly. The surveyor asked at that time if the facility would attempt to locate the missing documents. The following concerns were identified: a. On 11/6/09 at 12:25 PM, two days after being requested, the 3/13/09, 3/20/09, 3/27/09 and 4/7/09 Braden scale assessments were provided. Interview at that time with RN #1 revealed many chart audits had been done recently, and they were found misplaced in an office. She went on to say she could not find the Braden scale assessments that would have been done with quarterly assessments in July and October of 2009. b. The resident's August 2009 TARS were provided on 11/6/09 at 9:47 AM, two days after being requested. Interview at that time with the director of nurses revealed the missing records had been found in another resident's chart.	F 514	Systemic Changes: The SDC or designee will provide inservice education to licensed nursed regarding accurate filing of resident forms/documentation, including but not limited to filing of monthly TARs, Braden scales, discharge forms, etc. Newly hired nurses will receive this education during orientation to the facility. The HIM or designee will audit charts quarterly with routine purging for completeness of medical records including but not limited to monthly TARs, Braden scales, discharge forms, misfiled forms/documentation, etc. Monitoring: The HIM or designee will track and trend the results of the quarterly medical records audits and present findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Correction: 12/11/09	

to include proper late entries
Pre-conf w/ NHA + DNS 12/2/09