Approved 8/3/10. Discussed w DON 8/4/10 (NHA didn't return call 8/3 & went away 8/4) at 3pm Linda Brown RN

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

PRINTED: 07/22/2010
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 07/08/2010

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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document. DON - Director of Nursing MDS - Minimum Data Set MAR - Medication Administration Record NHA - Nursing Home Administrator	F 000	F250 It is the practice of the facility to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure staff adequately addressed the psychosocial needs of 1 (#63) of 6 sample residents. The findings were: Review of the medical record for resident #63 showed s/he was admitted with diagnoses including depressive disorder. Review of the 4/14/10 nursing notes written at 3 PM showed the resident "stated [s/he] wanted to choke [him/herself] with the O2 [oxygen] tubing 'I just want to die.'" The following concerns were identified: a. While staff requested a consult with a psychologist from Deer Oaks Psychological Services, the consult did not include diagnosis, risk factors, mental status examination, or presenting behaviors/symptoms. The consult consisted only of a note dated 4/14/10	F 250	Corrective Action: Resident #63 was fully assessed by social services for psycho/social needs and psychological services were started for depression. Identification of Other Interview alert and oriented residents to identify residents that state their psychosocial needs are not being met. Any identified will be reassessed by social services. Systemic Changes: Residents will be assessed by social services upon admit, quarterly, annually, and with significant changes to ensure psychosocial needs are met.	

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

Jennifer Reaume — NHA — 7/30/10

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.

Hand Delivered Susan

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F 250	Continued From page 1 documenting the resident was seen and said s/he had no intention or plan to hurt him/herself. However, review of the nursing notes (4/14/10 at 3 PM) showed the resident did have a plan, using the oxygen tubing to choke him/herself, and s/he also had the means because the resident did use oxygen tubing daily. The psychological consultant noted she would speak with the facility's social worker regarding a possible referral. The psychologist did not indicate what kind of referral or to whom. Review of the 4/17/10 physician's orders showed an order for a psychological evaluation, however, there was no evidence in the medical record an evaluation was performed. b. Review of the social services notes written at 2:35 PM on 4/17/10 (three days after the resident's suicidal statement) showed the resident responded to the social service director's greeting with, "I know what a social worker is for, and none of it is good." The notes also showed the social service director "did not directly address the resident's previous statement regarding wanting to die, but simply talked to [him/her] and [the] roommate, introducing myself as the new social worker." Continued review of these notes showed the social service director called the resident's daughter who agreed to a psychotherapy evaluation for her parent if s/he would cooperate with an evaluation. However, there was no evidence in the record the resident refused the evaluation until 7/7/10 (three months later) when the surveyor asked the facility about the situation. On 7/7/10, during the survey, the psychologist wrote a note regarding the 4/14/10 consult stating the resident was not interested in counseling services three months ago. c. Review of the 6/17/10 nursing notes written at 2:27 PM again revealed the resident stated s/he "didn't care anymore and just doesn't have	F 250	Any residents with signs and symptoms will be further assessed and physician notified for further orders. Social Services notes will be reviewed randomly on a monthly basis to ensure adequate documentation is provided for residents' psychosocial needs. Monitoring: NHA/Designee will track and trend the results of chart reviews and interviews 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 X3, then reassess the need for continued monitoring based on compliance Date of compliance: 8/18/10	

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F 250	Continued From page 2 the energy..." and requested [his/her] daughter be called in. While review of the nursing notes showed the resident's mood was "pleasant" after the daughter visited, there was no evidence staff addressed the resident's depressed mood. Medical record review revealed the social service director performed a geriatric depression scale assessment at 9:30 AM on 7/8/10 and again at 10:25 AM; however, there was no evidence the resident's depression was assessed, monitored or addressed by staff until the concern was identified by the surveyor on 7/7/10. d. Interview with the DON, the NHA, and the social services director (SSD) on 7/8/10 at 1:45 PM revealed they did not think the resident's depression was really an issue and the resident "just said those things when s/he was frustrated." They said they called the psychologist who performed the consult on 7/7/10 and the psychologist then wrote a note on 7/7/10 stating the resident said s/he was not interested in counseling. e. Review of the care plan conference attendance record and comments for the resident showed the only time the resident's social service needs were addressed was during the 3/24/09 meeting. The meeting notes documented the resident made "mean" remarks to the staff. Review of all of the other care conference notes showed no social service issues were identified or discussed, despite the resident's depressive disorder and suicidal remarks made in both April and June 2010.	F 250		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS 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 3 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff followed professional standards of practice in regard to physician orders for 2 (#52, #89) of 6 sample residents. The findings were: 1. Review of a 4/8/10 faxed order request to the physician for resident #52 showed the resident had experienced an eleven pound weight loss from the previous month. The order request also showed the resident had diuretic medication adjustments during that month, and the nursing staff thought the weight loss might be due to the diuretic. Nursing staff requested an order from the physician to perform weekly weights for monitoring and the physician responded yes on 4/9/10. Review of the medical record including nursing notes and flowsheets showed weights were not performed weekly as ordered. Review of the weight flow sheet showed the resident was weighed on 4/13/10, 6/7/10, 6/21/10, and 7/7/10. During an interview with the DON on 7/8/10 at 1:45 PM, she said she was unable to find evidence the resident was weighed weekly as ordered. 2. Review of the admission face sheet for resident #89 showed s/he was admitted with diagnoses including hypertension. The following concerns were identified: a. Review of the admission physician's orders written on 12/28/09 showed an order for blood pressures (B/P) to be taken twice daily. Review of the nursing notes, the MARs, the treatment administration records (TARs), and review of the neurological check flowsheets, showed the	F 281	F281 It is the practice of the facility to ensure the services provided or arranged by the facility meet professional standards of quality. **Corrective Action:** Resident #52 weekly weights were discontinued on 7/29/10. Resident #89 was discharged to another facility. **Identification of Others:** Review residents for the last 30 days to ensure weights are done per MD order. Any weights not completed will be obtained. Review residents with blood pressure orders to ensure blood pressures are obtained as ordered. Blood pressures not available will be obtained. **Systemic Changes:** SDC/Designee to educate licensed nurses on need to ensure staff obtain weights and blood pressures per physician order and document in medical record on or before 8/18/10. Unit managers/Designee will complete weekly audits of medical record to ensure blood pressures and weights are obtained and documented. 1:1 education will be provided as	

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F 281	Continued From page 4 following dates when the resident's B/P readings were not taken twice daily as ordered: In January 2010, on 1/6, 1/7, 1/8, 1/16, 1/20, 1/21, 1/22, 1/23, 1/24, 1/27, 1/28, 1/29, and 1/30. In February 2010, on 2/1,2/2, 2/3, 2/8, 2/15, 2/16, 2/17, 2/18, 2/22, 2/23, 2/24, and 2/25. In March, on 3/2, 3/3, 3/5, 3/10, 3/11, 3/12, 3/13, 3/19, 3/22, 3/24, 3/25, 3/26, 3/29, 3/30, and 3/31. In April 2010, on 4/5, 4/7, 4/13, 4/14, 4/16, 4/17, 4/18, 4/21, 4/28, and 4/30. In May 2010, on 5/3, 5/5, 5/6, 5/9, 5/11, 5/12, 5/14, and on 5/17. b. Review of the 12/28/09 physician's order showed an order for Amlodipine Besylate for hypertension which included an order to take a B/P reading prior to administration of the medication because, if the B/P reading was under 140/90, the medication should be held. Review of the MARs during this resident's stay in the facility showed on the following dates the B/P reading was not taken prior to the medication being administered: 1/31/10, 2/15/10, 2/16/10, 2/17/10, 4/3/10, 4/8/10 and 4/22/10. c. Review of the January, February, March, April, and May 2010 MARs showed the antihypertensive medication was administered to the resident on fifty days during a four and a half month stay, despite the fact the B/P was less than 140/90. By physician's order the medication was to be held whenever the resident's B/P was below 140/90. The resident's B/P readings ranged from 90/58 to 139/76 on the following 2010 dates: 1/6, 1/7, 1/16, 1/19, 1/26, 1/30, 2/1, 2/2, 2/3, 2/5, 2/18, 2/20, 2/24, 3/3, 3/5, 3/6, 3/10, 3/11, 3/14, 3/15, 3/16, 3/17, 3/24, 3/28, 3/29, 3/30, 3/31, 4/1, 4/5, 4/6, 4/7, 4/9, 4/10, 4/13, 4/14, 4/17, 4/18, 4/19, 4/20, 4/21, 4/22, 4/24, 4/25, 4/30, 5/3, 5/4, 5/5, 5/9, 5/16 and 5/19. Review of the physician's order dated 1/25/10 showed an order for diligent brushing of the	F 281	identified. Night nurse to review blood pressure documentation daily for completion. Monitoring: DON/Designee will track and trend the results of chart reviews 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 X3, then reassess the need for continued monitoring based on compliance Date of Compliance: 8/16/10	

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F 281	Continued From page 5 resident's teeth with fluoride twice daily and to rinse with ACT Restore mouthwash. Review of the TAR showed no evidence this order was followed twice daily on the following dates: 1/25, 2/7, 2/24, 2/25, 2/26, 3/12, 3/17, 3/24, 4/3, 4/8, 4/14, 4/20, 4/27, 5/1, 5/3, 5/12, 5/14, 5/15, and 5/17/10. 4. Interview with the DON and NHA on 7/8/10 at 1:45 PM confirmed the physician's orders should have been followed as written.	F 281	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 #63 was reassessed for pain and care plan updated. Resident #89 was discharged to another facility. **Identification of others:** Residents will be reassessed for pain and plan of care updated by nurse managers. **Systemic Changes:** SDC Educate nurses on assessing residents before and after pain and documenting on the pain flow sheet. Residents where pain is not controlled the licensed nurse will call the physician for new orders on or before 8/18/10. Pain will be assessed by nursing upon admit, quarterly, annually, and with significant changes on the pain assessment form.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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: Based on resident and staff interview, medical record review, and review of the pain management policy, the facility lacked evidence nursing staff provided the necessary assessments and monitoring to ensure adequate pain management for 2 (#63, #89) of 4 sample residents who had pain. The findings were: 1. Interview with resident #63 on 7/6/10 at 11:45 AM revealed s/he had "terrible" abdominal pain. At 12:25 PM on that same day, the resident again stated to the MDS coordinator and a CNA that s/he had a "bellyache" and needed something for pain. The resident stated s/he had been asking	F 309		

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F 309	Continued From page 6 for something to relieve the "bellyache" all morning but continued to experience pain. Review of the MAR revealed the resident had received the pain medication, Lortab at 8:15 AM, which was prescribed PRN (as needed) every six hours. Therefore, 11:45 AM was too soon for another Lortab. However, the MAR and physician's orders also showed the resident had an order for Tylenol 650 milligrams ordered for pain, which the resident had not received. Furthermore, there were orders for Mylanta and Miralax for constipation, which the resident stated was the probable cause of his/her "bellyache." The following concerns with pain management were identified: a. Review of the nurses medication notes flowsheet for May 2010 showed the resident experienced pain and received a PRN pain medication 17 times during the month. Continued review of the May 2010 flowsheet and the May 2010 nursing notes showed that on 9 of 17 occasions (53%) there was no evidence the resident was reassessed to determine the effectiveness of the pain medication in relieving the discomfort. The specific dates and times were: 5/1/10 at 5:30 and 10 AM, on 5/4/10 at 9 AM, on 5/15/10 at 11:30 AM, on 5/21/10 at 7:50 AM, on 5/26/10 at 9:30 AM, on 5/28/10 at 10:30 AM, and on 5/30/10 at 12:25 PM and 1 AM. b. Review of the June 2010 nurses medication notes showed the resident received pain medication on 6/21/10 at 8 AM and on 6/30/10 at 12:30 PM. Review of this document and also the nursing notes showed no evidence a re-assessment was done to determine if the pain medication provided relief either time. c. Review of the July 2010 nurses medication notes and the pain management flowsheet showed the resident received a pain medication	F 309	Unit Managers/Designee will complete weekly MAR and pain flow sheet audits weekly to ensure documentation is completed timely. 1:1 education will be provided by DON/Designee where applicable. Monitoring: DON/Designee will track and trend the results of pain assessments, documentation 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 X3, then reassess the need for continued monitoring based on compliance Date of Compliance: 8/18/10	

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F 309	Continued From page 7 on 7/1/10 at 5:30 AM. Review of these documents and the nursing notes showed no evidence a re-assessment was done to determine the effectiveness of the pain medication. d. Review of the 9/24/09 annual MDS assessment, as well as and the 3/18 and 6/10/10 MDS assessments showed the resident had mild to excruciating pain on a daily basis. However, review of the resident's current care plan dated 6/8/10 showed pain was not addressed as a concern for this resident. e. Interview with the DON on 7/7/10 at 3:45 PM revealed pain should be re-assessed within an hour after receiving a pain medication to determine it's effectiveness. 2. Review of the 5/14/10 nursing notes written at 3:10 PM for resident #89 showed his/her right hand was bruised and swollen. Review of the 5/14/10 nursing notes written at 4:30 PM showed the right hand had an 8 centimeter (cm) by 7 cm dark blue bruise with swelling over the first two fingers extending up to the middle of the hand. The resident complained of pain upon touch or when the fingers were moved. The resident received Tylenol 650 milligrams (gm) for pain at 5 PM (30 minutes after stating s/he experienced pain). The 5/14/10 nursing notes documented the resident sustained a fracture to the right hand and was transported to the emergency room (ER) for treatment. Review of the 5/14/10 nursing notes written at 11:10 PM showed the resident received intravenous pain medication (Toradol 15 mg) at 9 PM in the ER. Upon return to the facility the resident had an order for Vicodin 5/500 mg every six hours as needed. The following concerns with pain management were identified: a. Review of the nurses medication notes showed the resident received Tylenol 650 mg for	F 309		

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F 309	Continued From page 8 complaint of pain in the right hand on 5/14/10 during the 2-10 PM shift (no specific time was noted). Further review showed no evidence a re-assessment was performed to determine the effectiveness of the pain medication for this resident. b. Review of the 5/16/10 nurses medication notes showed the resident received a Vicodin 5/500 mg at 12:56 PM for pain in the right hand. Continued review showed no evidence the resident's pain was re-assessed after the pain medication to determine it's effectiveness. c. Interview with the DON on 7/7/10 at 3:45 PM revealed pain should be re-assessed within an hour after receiving a pain medication to determine the effectiveness. d. Review of the entire medical record revealed no evidence a full pain assessment was performed after the resident fractured his/her right hand, which caused pain and discomfort. Review of the pain management policy, revised on March 2008, showed the following instructions: "... any resident....identified with a new onset of pain, displays new signs or symptoms of pain.....will have a full evaluation of the pain conducted using the Quarterly Pain Assessment Form." Review of this resident's record also showed a concern about the management of his/her hypertensive condition. Refer to F281 for details regarding the resident receiving blood pressure medication outside the parameters ordered by the physician.	F 309	F318 It is the practice of the facility to ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. **Corrective Action:** Resident #89 was discharged to another facility. **Identification of Others:** DON/Designee will review all restorative discharges for the last 30 days to ensure all attempts have been made to maintain current ADL function. New programs will be implemented where identified. **Systemic changes:** DON/Designee will educate restorative on ensuring restorative programs are completed per nursing order. If residents refuse, they need to report to the restorative nurse. The restorative will then reassess program and modify as needed to encourage resident to attend. If resident continues to refuse the physician and family will be notified. Restorative meetings will occur weekly to review residents on programs and modify programs as needed.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives	F 318		

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F 318	Continued From page 9 appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 1 of 3 sample residents (#89) who were prescribed restorative services received the services as planned. The findings were: 1. Review of the admission history and physical for resident #89 showed s/he had been experiencing multiple falls at home. Review of the 1/8/10 initial Minimum Data Set (MDS) assessment showed the resident required limited assistance of one for ambulation. Review of the 1/12/10 nursing notes showed the resident had experienced a fall on that date. Review of the interdisciplinary treatment team notes for falls, written on 1/14/10, showed one of the interventions for fall prevention was for the resident to be evaluated for the "walk to dine " program in order to gain strength. Review of the restorative records revealed the resident was started on the "walk to dine" program for three meals per day and seven days per week on 1/18/10. Interview with the restorative nurse on 7/9/10 at 3:50 PM revealed if the resident refused to participate in the walk to dine program, s/he should then be walked at least once per shift at some other time. The following concerns were identified: a. Review of the January 2010 restorative service delivery record showed the resident was only walked to a meal once, which was to the	F 318	**Monitoring:** DON/Designee will track and trend the results of restorative documentation, meetings, 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 X3, then reassess the need for continued monitoring based on compliance Date of Compliance: 8/18/10	

13

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(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 318	Continued From page 10 noon meal on 1/28/10. b. Review of the February 2010 restorative service delivery record showed the resident was not provided "walk to dine" services on any day. c. Review of the January and February 2010 restorative ambulation program flowsheet showed the resident was not walked at least once, as indicated, on the day and evening shifts on the following dates: 1/20, 1/22, 1/24, 1/25, 1/27, 1/30, 1/31, and 2/2/10. Review also showed the resident was not ambulated at all on these dates: 1/19, 1/21, and 1/26/10. Though the resident refused five different days during the two months, a review of the medical record showed no evidence the resident was not benefiting from the services and was not re-approached for ambulatory exercises at other times throughout the days. The resident was ultimately discharged from the program on 2/4/10 due to a lack of participation.	F 318	F507 It is the practice of the facility to file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. **Corrective Action:** Resident #63 laboratory results were placed in the medical record. **Identification of Others:** Nurse Managers will audit residents on coumadin to ensure results are in the medical record. Any results not present will be filed in medical record. **Systemic Changes:** SDC/Designee will educate licensed nurses on obtaining lab results, notifying physician, and placing results in the medical record on or before 8/18/10. DON/Designee will complete weekly lab audit to ensure labs are placed in the medical record. Any missing labs will be obtained from the lab and placed in the medical record. Night nurses to complete a chart check nightly to ensure labs are filed in the medical record. 1:1 education will be provided by SDC/designee as needed.	
F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure laboratory tests results were received and placed in the record for 1 (#63) of 6 sample residents who had laboratory tests ordered. The findings were: Review of the physicians's orders for resident #63 showed an order for a prothrombin time and	F 507		

HB

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 07/08/2010

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F 507	Continued From page 11 international normalization ratio (PT/INR) every three weeks. Review of the laboratory reports in the medical record showed the results from the 6/5/10 blood draw were not in the record. Interview with the DON on 7/8/10 at 1:45 PM she revealed she had to call the laboratory to obtain the results of the tests.	F 507	**Monitoring:** DON/Designee will track and trend the results of chart reviews, lab 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 X3, then reassess the need for continued monitoring based on compliance Date of Compliance: 8/18/10	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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 observation, resident and staff interview and review of medical records, the facility failed to ensure accurate medical records were maintained for 1 (#63) of 6 sample residents. The findings were: 1. Interview with resident #63 on 7/6/10 at 11:45 AM revealed s/he had "terrible" abdominal pain. Refer to F309 for details regarding the resident's inadequate pain management. The following concerns with inaccurate medical records were identified:	F 514		

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F 514	Continued From page 12 a. Review of the nurses medication notes and the pain management flowsheet, both written on 7/7/10 as a "Late Entry" for 7/6/10, showed Lortab was given for generalized pain at 8 AM. Review of the narcotic record showed the Lortab was given at 8:15 on 7/6/10 (a fifteen minute discrepancy). Further review of the nurses medication notes showed, per the "Late Entry" notation the Lortab was effective in managing the resident's pain by 11 AM. However, this notation was written on 7/7/10 for the previous day. Based on surveyor interview on 7/6/10 with the resident at 11:45 AM and again at 12:25 PM the resident stated continued to experience "terrible" pain and a "bellyache." b. Review of the "Late Entry" nursing notes written on 7/7/10 for 7/6/10 showed the resident requested a Lortab right before breakfast on 7/6/10 and it was given at 8 AM. The nursing notes further indicated the Lortab seemed to be effective as there were no signs of pain noted and the resident rested comfortably in his/her chair in the room after breakfast. The nursing notes revealed the resident did not request pain medication again during that shift. However, interview with the resident on 7/6/10 at 11:45 AM and again at 12:25 PM revealed the resident did ask for pain medications after breakfast. In addition, at noon on 7/6/10 the resident was administered Mylanta and Miralax for abdominal pain. c. Review of the July 2010 MAR showed the resident received Lortab three times on 7/1/10. However, only the 5:30 AM dose was documented on the nurses medication flowsheet so the other two times the Lortab was administered were not indicated on either the flowsheet, on the MAR, or in the nursing notes. The only place the times were documented was	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 #63 pain was reassessed, changes made and care plan updated. Licensed nurse was re-educated on ensuring documentation is completed timely and accurately by the SDC/Designee. **Identification of Others:** Nurse managers completed an audit of residents receiving pain medications to ensure effectiveness was documented accurately and timely.	

LB

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F 514	Continued From page 13 on the narcotic record. Review of this record showed the resident received Lortab at 8 AM, 2:40 PM and 9:45 PM. d. Review of the June 2010 pain management flowsheet showed the resident complained of pain in his/her legs on 6/8/10 (no time was noted); however, the form was incomplete. Review of the form showed no evidence the pain score using the Faces Scale or nonverbal indicators was assessed, there was no interdisciplinary note, no pharmacological or non pharmacological interventions indicated, but the follow-up score was documented with no side effects being noted. Review of the MAR for 6/8/10 and of the nursing notes for June revealed no PRN medications were given for pain on that date. e. Interview with the DON and the NHA on 7/8/10 at 1:45 PM revealed the nurses did not always follow through with their charting.	F 514	**Systemic changes:** SDC/Designee educated licensed nursed on completing accurate and timely documentation of pain medication effectiveness. Nurse managers will complete weekly random interviews of residents to see what level of effectiveness was obtained. Nurse managers will compare the level of pain to the documentation on the pain flow sheet to ensure it is completed accurately and timely. SDC/Designee will provide 1:1 education to licensed nurses as needed. DON/Designee will track and trend the results of audits of pain flow sheets, resident interviews, 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 X3, then reassess the need for continued monitoring based on compliance Date of Compliance: 8/18/10	