8/10/10 POC accepted per telephone call with Shelly Griffin, DNS. PP

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

PRINTED: 08/02/2010
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 07/20/2010

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. RN - Registered Nurse DON - Director of Nursing Vital signs - pulse rate, temperature, and respiratory rate	F 000	Preparation and execution of the response and plan of correction does not constitute an 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. For the purpose of any allegation that the facility is not in	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure assessment, monitoring, and fall prevention measures were consistently implemented for 1 of 5 sample residents (#90) who was identified at risk for falls. The findings were: Review of the admissions orders for Resident #90 showed s/he was admitted on 7/8/10 from the hospital following surgery for a subdural hematoma. It was further noted that the admission orders included a physician's order for removal of the surgical staples on 7/10/10. Review of the 7/8/10 nursing admission assessment showed the resident used a walker due to an unsteady gait. Review of the initial plan of care, dated 7/9/10, showed staff assessed the	F 323	substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. **F323 Supervision to prevent accidents** **It is the practice of the facility to ensure that the residents' environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.** **Corrective Action:** **Resident #90 was discharged to the hospital on 7/14/10.** **Identification of others:** **Nurse managers to review new admissions x last 30 days to ensure fall interventions are implemented and care planned appropriately. Any discrepancies will be updated as needed.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Reaume | TITLE: N.H.A | (X8) DATE: 8-12-10

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.

8/2/10 Telephone calls with Shelly Griffin/DNS for administrative Hand Delivered

RECEIVED AUG 12 2010 Wyoming Department of Health

8:55 AM POC accepted

Office of Healthcare Licensing and Survey

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 PP 07/20/2010

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 323	Continued From page 1 resident was at risk for falls, however, there were no interventions that addressed this concern in the care plan. Review of the 7/9/10 speech therapy evaluation showed, the resident was "aware of balance issues but does not show adequate use of safety strategies/precautions...fiercely independent, doesn't like to ask for or wait for any length of time for assistance." Review of the 7/9/10 and 7/10/10 documentation in the nursing daily skilled summary, vital signs records and nurse's notes revealed the resident's vital signs were stable and staff planned to continue to monitor the resident. There was no documentation for 7/11/10 or 7/12/10. Further review revealed the resident had an unwitnessed fall at 1 AM on 7/13/10, and was admitted to the hospital on 7/14/10 due to a subdural hematoma. In interviews on 7/20/10 at 3:40 PM with the unit manager and at 3:50 PM with RN #1, verified the documentation for 7/11/10 and 7/12/10 had not been done, but should have been. Each of these interviews also revealed that the lack of documentation made it difficult to determine whether or not the resident had a change in condition that contributed to the resident falling on 7/13/10. In an interview on 7/20/10 at 4:45 PM, the DON stated staff moved the resident to a room closer to nurse's station and placed a protective floor mat near his/her lowered bed prior to 7/13/10, because the resident was unsteady and did not consistently use his/her call light to ask for assistance. The DON further stated that an intervention such as bed alarm might have been effective, but was not implemented.	F 323	**Systemic Changes:** **SDC will educate licensed nurses on fall system on or before 8/18/10. Fall system will include the following: Upon admission, the admitting nurse will complete the fall risk assessment and then weekly X3 additional weeks. The nurse will complete the initial care plan and address risk factors related to the resident on the care plan and implement appropriate interventions as identified. Resident will be assessed for risk quarterly, annually, and for significant changes using the fall risk assessment. IDT to review new admits within 24-72 hours of admission to ensure fall risk assessments, interventions, and care plan in place per residents' individual need. When a fall occurs, assess resident for injury. Communicate all resident falls to the attending physician and the resident's family and document on the interdisciplinary post fall review form. The licensed nurse documents family/responsible party and physician notification on the post fall review form. The nurse will communicate the resident fall to the IDT via the 24-hour report.**	
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION	F 327		

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 07/20/2010

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 327	Continued From page 2 The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of hospital admission records and staff interview, the facility failed to assess and monitor the hydration status of 1 of 5 sample residents (#89) whose records were reviewed for dehydration risk factors. The facility further failed to ensure the resident received adequate hydration. The cumulative effect of the facility's failures resulted in an avoidable decline in health status and hospitalization for the resident. The finding were: According to Smith, Duell and Martin, "Clinical Nursing Skills Basic to Advanced Skills," Prentice Hall, Inc., 2008: "Hourly urine output less than 30 milliliters (mL) an hour for two consecutive hours or twenty-four hour urine output less than 500 mL can indicate dehydration or internal bleeding and can result in acute renal failure." Review of the medical record for resident #89 revealed the resident was admitted to the facility on 7/6/10 from the hospital. Further review showed the resident received intravenous fluids, during hospitalization, that were discontinued the day s/he was transported to the facility. Review of the 7/6/10 admission nursing assessment showed staff noted the resident was totally dependent on staff for all activities of daily living, including nutrition and fluid intake; had a stage IV pressure sore and urinary catheter; and needed pureed foods and thickened liquids due to	F 327	**The IDT will review all resident falls within 24-72 hours at the morning IDT meeting to evaluate circumstances and probable case for the fall. The care plan will be updated with new interventions to minimize repeat falls. The IDT will complete the post fall review form and place in medical record.** **Monitoring:** **The DON or designee will track and trend results of the falls, interventions, care plans 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 compliance: 8/18/10**	

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 07/20/2010

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 327	Continued From page 3 swallowing problems. The following concerns were identified: a. During an interview on 7/20/10 at 2:10 PM, the unit manager stated the facility used a care cardex worksheet as an initial plan of care for all new admissions. Review of the 7/6/10 care cardex worksheet for resident #89 showed staff determined "all care" was to be done by staff. The review also showed interventions for monitoring and assessment for dehydration and ensuring adequate hydration were not included in the plan of care. b. Review of the record of intake and output revealed the total urinary output for twenty-four hours was documented as 575 mL on 7/7/10, 250 mL on 7/8/10, and 400 mL on 7/9/10. The review also revealed no documentation of fluid intake. c. Review of the nursing notes, physician's orders and physician progress notes showed no documentation of staff reporting the decreased output to the physician, an assessment of change in the resident's condition, or nursing care interventions that addressed the resident's hydration needs until 7/10/10. d. Review of the 7/10/10 nurse's notes showed the resident's temperature was 104.3 degrees Fahrenheit at 1 PM and s/he was "very sweaty and crying." The last entry in the nurse's note showed the resident was transferred to the hospital later that day at 3 PM. e. In an interview on 7/20/10 at 4:45 PM, the DON and unit manager confirmed the accuracy of the documentation in the intake/output records and nursing notes. They stated the facility's practice of monitoring output for new admissions did not include documenting the fluid intake, They further stated that the lack of nursing interventions to ensure adequate hydration and	F 327	**F327 Hydration** **It is the practice of the facility to provide each resident with sufficient fluid intake to maintain proper hydration and health.** **Corrective Action:** **Resident #89 was discharged to the hospital on 7/10/10.** **Identification of others:** **Residents deemed to be at risk for dehydration x last 30days will be reviewed by Nurse Managers/Designee for hydration risk using the Hydration Management Worksheet and to ensure proper interventions such as 2-3 fluids with meals and/or 8 oz fluid at med pass are in place and documented on the care plan by IDT. Any discrepancies will be re-assessed for hydration needs and care plans updated as needed.** **Systemic Changes:** **Residents will be reviewed for hydration risk on admission, quarterly, annually, and with significant change in condition by IDT.** **Risk factors will include: residents in a coma, with uncontrolled diabetes, vomiting/diarrhea, fever, infection, unable to take fluids independently, use of diuretics, laxatives, cardiovascular agents, enteral/parenteral nutrition, thickened liquids, dsyphagia, and history of refusing liquids.**	

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 07/20/2010

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 327	Continued From page 4 failure to report the decreased output to the physician in a timely manner most likely occurred because the nurses did not review the output records. f. Interview on 7/25/10 at 1:30 PM with one of the resident's family members revealed the family member visited the resident at the facility on four different days from 7/6/10 to 7/11/10. During each visit the family member noted a meal tray in the resident's room with untouched cups/glasses of thickened liquids and barely touched foods The family member stated s/he wanted to give the resident some of the liquids, but staff told him/her not to do this because the resident had swallowing problems. g. Review of the 7/10/10 hospital admission summary completed by the physician showed the resident was admitted to the hospital for treatment for sepsis, a urinary tract infection and dehydration.	F 327	**Newly identified residents with risk factors of dehydration will be reported via 24-hour report. IDT to follow up with assessing for risk factors. Residents identified will be reviewed in care management risk review meeting. Fluid needs will be assessed by the RD or DM and documented in the chart. If resident has a swallowing problem, the resident will be referred to speech therapy as needed. Notes will be written in the medical record regarding risk factors and interventions implemented. MD/Resident and family will be notified of hydration status. Intake and outputs will be implemented by IDT, or when ordered by a physician.** Nurse managers to review records I/Os weekly X4 weeks, then monthly X2. SDC to educate licensed nurses on the hydration system on or before 8/18/10. **Monitoring:** The DON or designee will track and trend results of the weekly care management risk review meeting minutes, I/O audits and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan monthly 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 compliance: 8/18/10**	