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SEP 18 2014

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

PRINTED: 09/08/2014
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 Healthcare Licensing and Surveys	C 08/22/2014

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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADL-Activities of Daily Living CNA-Certified Nurse Aide LPN-Licensed Practical Nurse MAR-Medication Administration Record MDS-Minimuna Data Set Less commonly used abbreviation will be annotated in each deficiency.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement be 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 the state and federal law. For the purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of allegation of compliance in accordance with the State Operations Manual.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM 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: Based on medical record review, review of facility policy and procedure, and staff interview, the facility failed to ensure the physical restraint of residents was required to treat medical symptoms for 1 of 1 sample resident with restraints (#1). The findings were: Review of a physician's order dated 7/18/14 for resident #1 showed, "May apply lap tray to W/C [wheelchair] - poor safety awareness. Release for activities and ADL." Review of a physician's order dated 7/24/14 showed the resident was sent to the hospital. Review of re-admission orders dated 7/27/14	F 221	F221 1. Resident #1- lap tray was discontinued on 07/30/2014. 2. Director of Nursing or designee will complete an audit by	10/02/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Assistant NHA | (X6) DATE: 09/18/2014

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.

9/19/14- This POC accepted on 9/19/14 between administrator Dan Stackis and Tara Madden - Surveyor with a POC of 10/2/14 for all tags. 9/19/14

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F 221	Continued From page 1 showed the resident did not return from the hospital with orders for restraint use. Review of the pre-physical restraint and reduction assessment dated 7/27/14 showed the wheelchair tray was no longer being considered a restraint because the resident was able to remove the tray. Review of the resident's care plan for restraints dated 7/18/14 showed the restraint care plan was discontinued on 7/28/14, and contained instructions to refer to the resident's ADL care plan. Review of the resident's care plan for ADLs showed "Tray to W/C [wheelchair] to assist with positioning" but failed to show any instructions for when the tray was to be used, or how often the resident was to be released. Review of the facility policy and procedure entitled, "Restraint Management," last revised August 2012, showed "Any resident using a restraint will have a current order with the following components: a. Exact type of restraint; b. When to use the restraint; c. Medical symptom for using the restraint; and d. A release/exercise statement." Review of the CNA care guide, printed out by LPN #1 on 8/22/14 at 10:40 AM showed the resident was not included on the guide. LPN #1 confirmed at that time the guide had not been updated with the resident's care requirements since the resident's re-admission on 7/27/14. Interview with the DON on 8/22/14 at 11:25 AM confirmed the care guide on the computer was how facility CNAs learned the care needs of their assigned residents. Review of a physician's telephone order dated	F 221	10/02/2014 to ensure restraint orders are in place upon admission/ readmission. 3. Director of Nursing or designee to educate staff by 10/02/2014 regarding the purpose of a restraint and physician orders for restraints. Director of Nursing or designee will review newly admitted or readmitted residents monthly for 90 days to ensure orders are obtained for restraints as needed. 4. Director of Nursing or designee will review restraints monthly for 90 days to ensure continued use, physicians orders, restraint assessments and care plans are in place. Results of monitoring will be reported to the facility QAPI committee monthly for 90 days or until substantial compliance	

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F 221	Continued From page 2 8/19/14 showed "W/C [wheelchair] with tray dc'd [discontinued] 7/30/14..." Review of skilled nursing notes dated 8/3/14, 8/4/14, 8/5/14 and 8/7/14, however, showed the resident had been restrained with a wheelchair lap tray on those dates. Interview with the DON and the resident care manangement director on 8/22/14 at 9:05 AM revealed the resident had broken his/her original wheelchair lap tray, a plastic tray that fastened with velcro, on 7/30/14, and the facility had been putting the resident into another resident's wheelchair with a slide-on lap tray that could not be removed by the resident. The interview further confirmed the resident had been restrained without appropriate assessments, consents, or physician orders for the restraint.	F 221	has been achieved and sustained as determined by the committee. F281 1. Resident #94- was discharged on 8/18/2014. Resident #1- lap tray was discharged on 07/30/2014. 2. Director of Nursing or designee will complete an audit of Medicated creams and physical restraint orders by 10/02/2014 to confirm the physician orders are transcribed and carried over monthly on the computerized physician orders. Any medicated creams or physical restraints found during the audit will be updated with accurate physician orders by 10/02/2014.	10/2/14
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. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy and procedure, and staff interview, the facility failed to follow physician's medication orders for 1 of 11 sample residents (#94), and failed to obtain appropriate physician orders for restraint use for 1 of 1 sample resident who had used restraints (#1). The findings were: 1. Review of nursing daily skilled summaries for the months of July and August, 2014 showed resident #94 regulary complained of itching, and	F 281		

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F 281	Continued From page 3 had multiple open areas on his/her skin from scratching and/or picking at his/her skin. Review of admission physician orders showed an order for triamcinolone 0.5% cream (a corticosteroid cream used for itch relief) to be applied topically twice daily. Additionally, review of the resident's care plan for non-pressure ulcer skin impairment showed the resident had "itching - picks at skin." Interventions included "Kenalog [brand name for triamcinolone] 0.5% cream topically BID [twice daily]." Review of the July 2014 MARs showed the resident received the triamcinolone 0.5% cream twice daily as ordered; however, review of the August 2014 MARs showed the medication was no longer listed. Interview with the DON on 8/21/14 at 12:03 PM confirmed the facility had failed to transfer the medication to the August 2014 MARs. 2. Review of a physician's order dated 7/18/14 for resident #1 showed, "May apply lap tray to W/C [wheelchair] - poor safety awareness. Release for activities and ADL." Review of a physician's order dated 7/24/14 showed the resident was sent to the hospital. Review of re-admission orders dated 7/27/14 showed the resident did not return from the hospital with orders for restraint use. Review of the pre-physical restraint and reduction assessment dated 7/27/14 showed the wheelchair tray was no longer being considered a restraint because the resident was able to remove the tray. Review of a physician's telephone order dated 8/19/14 showed "W/C [wheelchair] with tray dc'd	F 281	has been achieved and sustained as determined by the committee. F314 1. Resident #1- Wound orders and wound measurements were obtained on 08/22/2014 and treatment continues. 2. Director of Nursing or designee will complete an audit of residents with wounds to ensure no further skin breakdown has occurred by 10/02/2014. 3. Director of Nursing or designee to educate Licensed and Certified Nursing staff by 10/02/2014	10/2/14

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F 281	Continued From page 4 [discontinued] 7/30/14..." Review of skilled nursing notes dated 8/3/14, 8/4/14, 8/5/14 and 8/7/14 however, showed the resident had been restrained with a wheelchair lap tray on those dates. Review of the facility policy entitled, "Restraint Management" showed "No restraint may be applied (except during an emergency) unless there is a specific physician order." Interview with the DON on 8/22/14 at 9:05 AM revealed the resident had broken his/her original wheelchair lap tray on 7/30/14, and the facility had been putting the resident into another resident's wheelchair with a slide-on lap tray that could not be removed by the resident. The interview further confirmed the resident had been restrained without a physician order for the restraint.	F 281	regarding timely identification/ prevention of wounds. Director of Nursing or designee will review weekly skin assessments, 24-hr reports and telephone orders to ensure new wounds are identified and the appropriate interventions and care plans are timely updated. 4. Results of monitoring will be reported to the facility QAPI committee monthly for 90 days or until substantial compliance has been achieved and sustained as determined by the committee.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL 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, medical record review and staff interview, the facility failed to ensure a	F 314		

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F 314	Continued From page 5 resident having a pressure ulcer received timely identification of an additional unstageable pressure ulcer for 1 of 1 sample resident with pressure ulcers (#1). The findings were: Review of the 8/9/14 admission MDS assessment showed resident #1 was re-admitted to the facility on 7/27/14 with diagnoses that included traumatic brain injury, deep venous thrombosis, and coronary artery disease. The assessment further showed the resident required the extensive assistance of two or more persons with nearly all ADLs, was always incontinent of bowel, and was at risk for pressure ulcers but did not have any unhealed pressure ulcers. Review of the nursing daily skilled summary dated 8/17/14 showed the resident had been found to have a new unstageable wound to the right ischial area. Review of the nursing daily skilled summary dated 8/20/14 showed only the right ischial pressure sore and "Excoriation to buttocks; trach site; PEG." Observation on 8/21/14 at 2:38 PM of the resident's dressing change revealed after cleansing and dressing the right ischial wound, the DON prepared to replace the resident's incontinence brief without checking the resident's left ischial area for breakdown or excoriation. Upon request, the resident was rolled so the left ischial area could be visualized, and an additional pressure ulcer was identified. The DON measured the wound as 0.5 by 0.4 centimeters and determined it was unstageable due to slough at the wound bed. (Slough is soft, moist, dead tissue. Its presence indicates a stage III or higher wound, however, staging cannot be done until the wound bed is fully visible). Interview with the DON at that time confirmed the facility had been unaware of the second pressure ulcer.	F 314		

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