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

PRINTED: 12/03/2015
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
	536024	A. BUILDING _____ B. WING _____	C 11/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR CASPER, WY 82601

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F 000	INITIAL COMMENTS The following common abbreviations were used throughout this document: DON- Director of Nurses MDS- Minimum Data Set MAR- Medication Administration Record RN- Registered Nurse LPN- Licensed Practical Nurse	F 000	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	12/2/15 10
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a	F 279	<u>F-279: Develop Comprehensive Care Plans</u> **Corrective Actions:** Resident #115 has been discharged and the Care Plan (CP) cannot be corrected. **Identification of Others:** A review of CP's for residents with psychotropic drugs, behaviors to include interventions, or wound care that has a co-morbidity of diabetes has been completed by the MDS Coordinator. Residents without CP's addressing these areas have had their CP updated accordingly.	

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

Administrator — 12/11/15

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.

POC accepted. Call to Tony Janusz, NHA on 12/16/15 @ 2:11pm
Janeece Collins 10716/L

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F 279	Continued From page 1 comprehensive plan of care for 1 of 13 sample residents (#115). The findings were: Review of the admission orders dated 9/5/15 showed resident #115 had diagnoses to include mood disorder, diabetes and right foot wound. Review of the November 2015 MAR showed the resident was prescribed quetiapine (an anti-psychotic) for mood disorder and behavior monitoring. It further showed the resident had wound care to be completed every 3 days. The MAR showed the resident refused the medications the nurse attempted to administer. Review of the care plan showed weight loss and activities were addressed. There was no documentation in the electronic medical record or paper chart to show a care plan had been developed for the use of psychotropic drugs, behaviors to include any interventions, or diabetes to include monitoring and wound care. During an interview with MDS coordinators #1 and #2 on 11/17/15 at 8:30 AM, they indicated care plans would be located either in the electronic medical record or paper chart. During an interview with the DON on 11/18/15 at 6:25 PM, she indicated she would look for additional care plans. No further documentation related to care plans for the resident were provided.	F 279	**Systemic Changes:** The RCMB and staff who have the potential to write CP's have been educated on F-279: Development of Comprehensive Care Plans by the DDCM Director. The RCMB or designee will review the orders of current or newly admitted residents who have had a psychotropic drug prescribed, exhibit behaviors, or have a new wound that requires care and a co-morbidity of diabetes and update their CP accordingly and have it placed in their Medical Record (MR). **Monitoring:** These changes will be reviewed and documented on the Daily Clinical Tool at least 3 times per week by the IDT during morning clinical meeting. Any non-compliance will be corrected at that time. A report will be presented to the monthly QAPI for review and corrective actions if necessary until resolved.	
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 and staff	F 281	<u>F-281: Services Provided Meet Professional Standards</u> **Corrective Action:** Resident #114 has been discharge	12/2/15

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F 281	Continued From page 2 interview, the facility failed to provide assessment and care planning sufficient to meet the needs of newly admitted residents for 1 of 13 sample residents (#114). The findings were: Review of the history and physical dated 11/10/15, for patient #114 showed diagnoses to include history of left hip fracture. Further, it showed the resident had a history of a compression fracture of the back and complained of back pain that was worsening. Review of the facility admission record showed the resident was admitted on 11/12/15. Admission diagnoses included low back pain and bronchopneumonia. In addition the Admit/Discharge To/From Report showed the resident had died on 11/16/15. Further review of the medical record failed to show an interim care had been developed. During an interview with the DON on 11/18/15 at 5:45 PM she verified there was no documentation to support a care plan had been developed.	F 281	and an interim CP cannot be added. **Identification of Others:** A review of residents admitted to the Facility for the last 60 days has been reviewed by the RCMB. Residents without an Interim CP have had one developed and added to their Medical Record. **Systemic Changes:** The RCMB and LN staff who have the potential to write Interim CP's have been educated on F-281: Services Provided Meet Professional Standards by the DDCM Director. The DON or designee will review newly admitted resident's charts at least 3 times per week for compliance and document in the Daily Clinical Tool to ensure an Interim CP has been developed and added to their MR. Non-compliance with F-281 will have an Interim CP developed and added to the MR upon discovery. **Monitoring:** A report on compliance will be presented to the monthly QAPI	
F 309 SS=G	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 medical record review, observation,	F 309		

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F 309	Continued From page 3 staff interview, and electronic communication from a family member, the facility failed to adequately assess and recognize a change in condition and notify the physician of decline for 2 of 2 sample residents (#114, #115) reviewed with identified changes, resulting in harm to both residents, and failed to follow physician orders related to the use of compression devices for 1 of 1 sample residents (#30) with compression device orders. The findings were: Related to the change in condition: 1. Review of the history and physical dated 11/10/15 for patient #114 showed diagnoses to include history of left hip fracture. Further, it showed the resident had a history of a compression fracture of the back and complaints of back pain that was worsening. The resident lived with a family member and ambulated with a walker. The physician noted the family member reported the resident usually eats and drinks, was usually conversant and denied any baseline dementia. Following the physical examination of the resident, the physician noted for psychiatric: "Hard to assess, but I suspect (s/he) has a degree of dementia." The following concerns were identified: a. Review of the facility admission record showed the resident was admitted on 11/12/15. Admission diagnoses included low back pain and bronchopneumonia. b. Review of the "Nursing Daily Skilled Charting" note dated 11/12/15 showed the resident was alert and oriented to person, place and time. His/her cognition level was intact with short-term memory loss. The document further showed the resident was continent of bowel, hand grips were equal and strong, and there were no	F 309	meeting for review and corrective actions if necessary until resolved. <u>F-309: Provide Care/Services for Highest Well Being</u> **Corrective Action:** Residents #114 and #115 have been discharged and cannot have a Change of Condition added to their MR. Resident #30 currently has an order for an Unna Boot and it is being applied per physician order. **Identification of Others:** A review of the PCC 24 hour report has been reviewed by the DON or designee for the last 30 days for any resident who may have had a Change of Condition (COC) and compliance with F-309: Provide Care/Services for Highest Well Being. Residents found to have had a COC and have not had physician and/or family notification and LN assessments completed will be corrected upon discovery and added to their MR. A review of residents with new physician orders for compression devices for the last 30 was	12/22/15

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F 309	Continued From page 4 mood or behavior concerns. Auscultated lung sounds showed they were clear. c. Review of the 11/13/15 "Nursing Daily Skilled Charting" note showed the resident was oriented to person and place only. Further, it showed the resident had short and long-term memory loss and did not indicate the resident was cognitively intact as it had the previous day. For communication, the assessment showed the resident had "Difficulty understanding others" and "Difficulty being understood." The 11/12/15 assessment did not show problems with communication. The note further indicated the resident was incontinent of bowel and hand grips were equal and "weak." Documentation showed the resident's lung sounds were clear but diminished. The note showed for mood and behaviors, the resident was angry, withdrawn, had a flat affect and was sad. The previous assessment did not indicate a problem with behaviors and mood. There was no documentation the physician was notified of the resident's decline in mentation or changes noted during the physical assessment. d. Further review of the record failed to show any additional daily skilled nurse assessments were completed. Review of the nurse's note dated 11/15/15 revealed: "Resident continues to rest in bed doesn't want to sit in wheelchair, not talking...continues to not eat, only few bites...sleeping a lot." There was no documentation to show the physician was notified. e. Review of the "Respiratory Care Services Progress Notes" dated 11/16/15 showed the respiratory therapist noted the resident's breath sounds were diminished with crackles. The therapist further noted the resident did not communicate, and the therapist discussed his	F 309	completed by the DON or designee for compliance with F-309: Provide Care/Services for Highest Well Being. Noncompliance will be corrected upon discovery and have the treatment added to their MR. Systemic Changes: LN staff has been educated by the Staff Development Coordinator (SDC) or designee regarding COC, physician and family notification documentation, LN assessment completion and adherence to physician orders regarding compression devices. Monitoring: The DON or designee will audit the facility 24 hour report at least 4 times per week during the Daily Clinical Meeting for residents who may have had a COC, notification of family and physician for any COC documented with an SBAR, and corresponding nurse assessments and compliance with documentation of compression devices. The DON or designee will document findings on the Daily Clinical Tool. Noncompliance will be corrected upon discovery.	

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F 309	Continued From page 5 observations with the nurse. The therapist was informed the resident was "a failure to thrive." Review of the facility's "Admit/Discharge To/From Report" showed the resident died on 11/16/15. There was no nursing documentation of the death to include family and physician notification. f. During an interview with the DON on 11/18/15 at 5:45 PM, she indicated an SBAR (Situation, Background, Assessment, Request) was not completed by the nurse and sent to the physician, indicating the changes in the resident were not identified as a decline. She further acknowledged the nurses needed to continue to assess the resident daily for at least the initial 72 hours after admission. g. Review of an electronic communication from a family member dated 11/16/15 showed the resident was admitted to the facility on 11/12/15. The resident was coherent and speaking. The following day, on 11/13/15, the family member indicated the resident was not speaking and noted this was unusual behavior. The family member discussed the concern with a facility nurse and the nurse informed the family the resident had been speaking earlier. The family member further noted the resident was only moving the left hand and not the right hand. The resident was unable to squeeze the family member's fingers with the right hand. The family member attempted to converse with the resident, asking him/her to perform simple tasks and the resident did not seem to understand what was being asked. The family member informed the nurse of the observations and the nurse instructed a CNA to obtain vital signs. There were no further assessments completed by the nursing staff. The nursing staff told the family member the resident was not speaking due to his/her anger at being admitted to the facility. The electronic	F 309	**Monitoring:** A report of the audits will be presented to the monthly QAPI for review and corrective action if necessary until resolved.	

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F 309	Continued From page 6 communication further reiterated the family was very concerned about the change in condition of the resident and felt the facility was ignoring those concerns. 2. Review of the admission orders dated 9/5/15 showed resident #115 had diagnoses to include mood disorder, diabetes and right foot wound., Review of the "Skin-Head to Toe Checks" dated 11/4/15, showed the resident had a callus on the right foot that had reopened. Further, it showed the wound was weeping fluid and was "very tender." The nurse applied a dressing. The following concerns were identified: a. Review of the medical record failed to show any evident the physician had been notified of the re-opened wound. b. Review of the nurse's note dated 11/7/15 and timed 4:30 PM showed a family member had visited the resident and informed the nursing staff the resident's right foot was "looking bad" and that it was warm to touch and purple in color. The note further showed a dressing change was completed and documented the feet were warm and the right lower extremity was warmer then the left. Further, it showed the feet were discolored. The nurse had also documented the resident had been under 2 blankets with clothes and socks on. Further review of the nurse's note and vital sign records failed to indicate the nurse checked the resident's temperature at that time. c. Review of the nurse's note dated 11/7/15 timed at 9:30 AM showed the family member had taken the resident to a local hospital and had later called the facility to inform them the resident had been admitted to the hospital for an infection of the right foot. d. During an interview with the DON on 11/18/15 at 5:25 PM, she acknowledged the	F 309		

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F 309	Continued From page 7 physician needed to be notified of the re-opened right foot wound. Related to the use of compression devices: 1. Review of the October 2015 medication administration record for resident #30 showed diagnoses to include cellulitis of the leg and foot and edema. Review of the physician order dated 10/26/15 showed the resident was to have bilateral UNNA boots (used to treat chronic ulcers of the legs) applied twice a week. The following concerns were identified: a. Review of the October and November 2015 treatment administration records failed to show any evidence the UNNA boots were applied in the two weeks following the date of the physician's order. b. Review of the "Doctor's Progress Notes" dated 11/2/15 showed the physician was concerned the order for UNNA boots had not been implemented and asked, "why?" The physician's note further documented the resident's right lower extremity had increased edema, bubbling and blistering. The note showed lower extremity edema was "worse no unna boot." c. Review of the physician note dated 11/9/15 showed the the UNNA boots were in place the day of the exam. The note further showed there was no further blistering and bubbling of the skin and there was decreased crusting. Finally the note showed edema of the lower extremities had improved with consistant UNNA boot use and the right lower leg cellulitis had improved. d. During an interview with the DON on 11/17/15 at 4:45 PM, she indicated UNNA boots were not recommended for treatment for residents with cellulitis and the treatment was	F 309		

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F 309	Continued From page 8 discontinued. She acknowledged the physician needed to be informed of any changes to treatment orders.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and resident interviews, observation and review of policies and procedures, the facility failed to ensure treatment was provided as ordered for catheter irrigations and care provided according to policies and procedures for 1 of 1 sample residents (#43) observed with a Foley catheter. The findings were: Review of the October 2015 MAR for resident #43 showed diagnoses to include chronic pain due to trauma, fractured femur and fractured dorsal vertebra (spinal column), and bladder disorder. Review of the annual MDS assessment dated 9/3/15 showed the resident was cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15. The following concerns were identified:	F 315	<u>F-315: No Catheter, Prevent UTI, Restore Bladder</u> **Corrective Action:** Resident #43 has had a physician order to discontinue daily 60cc of Normal Saline flushes added to their MR. The physician was notified of the noncompliance. **Identification of Others:** A review of current residents who have catheters was completed for physician orders to flush daily. Noncompliance with F-315 has been corrected upon discovery and the correction added to their MR. Observations of perineum care of current residents with indwelling catheters to include resident #43 was completed by the SDC or designee for compliance with F-315 and the facilities Policy and Procedure (P&P) entitled "Indwelling urinary catheter (Foley) care and management". Staff that was noncompliant was educated at the time of the observation.	12/17/15

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F 315	Continued From page 9 a. During an interview with the resident on 11/16/15 at 11:15 AM, s/he indicated the nursing staff did not adequately clean the perineum well after the resident had a bowel movement. Observation on 11/17/15 at 12:20 PM showed LPN #1 and RN #1 completed perineum care for the resident following a bowel movement. The resident had a Foley catheter (tube inserted into the bladder to drain the urine). The LPN cleaned the posterior perineum area and did not clean the anterior perineum to include the Foley catheter. Interview with the LPN following the observation confirmed the catheter needed to be cleaned. b. Review of a "Progress Note" dated 11/17/15 and timed 10:30 AM showed the resident had a bowel movement. The LPN cleaned the fecal matter from the resident and had noted she had visualized there was no fecal matter on the catheter tubing. c. Review of the policy and procedure entitled "Indwelling urinary catheter (Foley) care and management" revised 10/2/15 showed: "...To avoid contaminating the urinary tract, always clean by wiping away from-never toward-the urinary meatus. Use soap and water or a perineal cleaner to clean the periurethral area after each bowel movement..." d. Review of the Physician Telephone Orders dated 10/20/15 showed the Foley catheter was to be flushed daily with 60 cc (cubic centimeter) of normal saline. Review of the MAR for October and November 2015 showed the catheter was flushed only 2 times between 11/20/15 and 11/16/15. e. During an interview with the DON on 11/17/15 at 4:45 PM, she indicated the resident did not like to be moved. She further revealed the resident had chronic urinary tract infections and received routine antibiotics. She further revealed	F 315	**Systemic Changes:** LPN #1 and RCS#1 were educated by the SDC or designee in providing perineum care for residents to include resident #43 with indwelling catheters was educated on F-315 and the facility's P&P regarding indwelling catheters. Staff involved in providing perineum care for residents to include resident #43 with indwelling catheters was educated on F-315 and the facility's P&P regarding indwelling catheters by the SDC or designee. **Monitoring:** The SDC or designee will observe 3 staff who gives perineum care to residents with indwelling catheters per week for one month than once per week thereafter for compliance. Noncompliance will be addressed upon discovery. The results of the audit will be reported to the monthly QAPI meeting for review and corrective actions if necessary until resolved.	

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F 315	Continued From page 10 the catheter was not flushed daily because the practice was contraindicated. She further acknowledged the physician needed to be notified.	F 315		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	<u>F-356: Posted Nurse Staffing Information</u> **Corrective Action:** The facility scheduler or designee has added the facility census for each day back to 9/1/2015 **Identification of Others:** No residents were affected by the failure to post the daily census on the Daily Nurse Staffing Form. **Systemic Changes:** The facility scheduler will post the census on the Daily Nurse Staffing Form. The facility scheduler and staff who have the potential to post the Daily Nurse Staffing Form have been educated on the need to include the daily census by the Administrator. **Monitoring:** The Administrator or designee will monitor the Daily Nurse Staffing	12/27/15

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F 358	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on review of the daily nurse staffing sheets and staff interview, the agency failed to ensure the census was included on the staffing sheets for 3 of 3 months reviewed. The findings were: Review of the "Daily Nurse Staffing Form" posted each day showed the the census was not included for 15 of 15 days in November 2015, 28 of 31 days in October 2015 and 30 of 30 days in September 2015. During an interview with the administrator and DON on 11/17/15 at 4:45 PM, they acknowledged the census needed to be included.	F 358	Form at least 3 times per week during the Daily Morning Meeting for compliance and documented on the Daily Morning Meeting Form. Noncompliance will be addressed at time of discovery. A report will be presented at the monthly QAPI for review and corrective actions if necessary until resolved.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	<u>F-431: Drug Records, Label/Store Drugs & Biologicals</u> **Corrective Actions:** The insulin pens on cart #2 which were opened and unlabeled were immediately removed upon discovery of the Surveyor. **Identification of Others:** The facility medication carts have been audited for any medications not compliant with F-431 regarding insulin pens opened and not labeled	12/2/15

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F 431	Continued From page 12 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the "Recommended Expiration Dates" document, the facility failed to ensure all opened medications were labeled with the expiration date for 1 of 2 medication carts reviewed for expired medications. The findings were: Review of the south medication cart with LPN #2 on 11/18/15 at 5:55 PM showed there were 19 resident insulin pens open and available for use. Further observation showed the pens were not labeled with the date they were opened. They included the insulins Lantus, Novolog and Levemir. During an interview with the LPN at that time, she acknowledged the pens needed to be labeled with the date they were opened. Review of the "Recommended Expiration Dates" document showed it was recommended insulin and related products were to be discarded between 28-42 days after they were opened.	F 431	with date opened. Medications requiring a label of date opened were also audited and any medication not in compliance was removed and replaced. Systemic Changes: LN staff was educated by the SDC. LN staff will check for compliance on labeling the open date on insulin pens daily. Noncompliance will be corrected at time of discovery. Monitoring: The DON or designee will spot check the facility med carts 3 times per week for one month for compliance on labeling of open insulin pens. Noncompliance will be corrected upon discovery and education will be conducted. A report will be presented to the monthly QAPI for review and corrective actions when necessary until resolved.	
F 492	483.75(b) COMPLY WITH	F 492		

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F 492	Continued From page 14 a. Further review of the October and November 2015 treatment administration record failed to show any evidence the UNNA boots were applied after the physician's order. b. Review of the "Doctor's Progress Notes" dated 11/2/15 showed the physician was concerned the order for UNNA boots had not been implemented and asked, "why?". The physician's note further documented the resident's right lower extremity had increased edema, bubbling and blistering. The note showed lower extremity edema was "worse no UNNA boot." Review of the physician note dated 11/9/15 showed the the UNNA boots were in place the day of the exam. c. During an interview with the DON on 11/17/15 at 4:45 PM, she indicated UNNA boots were not recommended for treatment for residents with cellulitis and the treatment was discontinued. She acknowledged the physician needed to be informed of any changes to treatment orders. 3. Review of the "Admission Record" for resident #112 showed an admission date of 9/29/15. Diagnoses included congestive heart failure, presence of a prosthetic heart valve and atrial fibrillation. Review of the October 2015 MAR showed the resident was prescribed medications to include warfarin (an anti-coagulant). It further showed the medication was discontinued on 10/9/15. The following concerns were identified: a. Review of the 10/7/15 lab results showed the INR (international normalized ratio) blood level was 1.4 and the Coumadin (generic name warfarin) dose was to be increased to 3 mg (milligrams) from 2.5 mg. Further, labs were to be repeated on 10/14/13. b. Review of the "Doctor's Progress Note"	F 492	F-492: Comply With Federal/State/Local Laws/Prof STD Corrective Action: Resident #43 has had a physician order to discontinue daily 60cc of Normal Saline flushes added to their MR. The physician was notified of the noncompliance. Resident #30 currently has an order for an Unna Boot and it is being applied per physician order. Resident #112 has been discharged therefore there can be no correction. Resident #114 has been discharged therefore there can be no correction. Identification of Others: The DON or designee has reviewed physician orders regarding catheter care flush orders, Unna Boots, and Coumadin labs for compliance with F-492 for the last 30 days. Noncompliance has been corrected upon discovery.	12/17/15

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F 492 SS=E	Continued From page 13 FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, and review of the Wyoming Nurse Practice Act, the facility failed to follow physician orders for 4 of 13 sample residents. (#30, #43, #112, #114). The findings were: 1. Review of the Physician Telephone Orders dated 10/20/15 for resident #43 showed the Foley catheter was to be flushed daily with 60 cc (cubic centimeter) of normal saline. The following concerns were identified: a. Review of the MAR for October and November 2015 showed the catheter was flushed only 2 times between 11/20/15 and 11/16/15. b. During an interview with the DON on 11/17/15 at 4:45 PM, she revealed the catheter was not flushed daily because the practice was contraindicated. She further acknowledged the physician needed to be notified. 2. Review of the October 2015 MAR for resident #30 showed diagnoses to include cellulitis of the leg and foot and edema. Review of the physician order dated 10/26/15 showed the resident was to have bilateral UNNA boots (used to treat chronic ulcers of the legs) applied twice a week. The following concerns were identified:	F 492	The DON or designee has reviewed residents with physician orders for per shift vitals for compliance for the past 30 days. Noncompliance has been corrected upon discovery. Systemic Changes: LN staff has been educated by the DON or designee Coumadin orders, Vital Signs and Unna Boots. Monitoring: A review of physician orders regarding Coumadin Labs, catheter care flush orders, Unna Boots, and vital signs will be conducted at least 3 times per week by the DON or Designee during the Daily Clinical Meeting and findings documented on the Daily Clinical Tool. Noncompliance will be corrected upon discovery. A report will be presented to the monthly QAPI for review and corrective actions where necessary until resolved.	

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F 492	Continued From page 15 dated 10/26/15 and timed 3:30 PM showed when the physician was reviewing the paperwork for the resident to be discharged, it was noted the increase in the Coumadin dose and ordered lab work had not been completed. Further, the note showed the resident had not received anticoagulant therapy since 10/9/15 (17 days). The physician wrote the resident "...must have anticoagulant d/t [due to] high risk CVA [cerebral vascular accident]. c. During an interview with the DON and administrator on 11/17/15 at 4:45 PM, they indicated that when the physician identified the errors, the facility started to put processes in place to prevent similar incidents from occurring related to Coumadin dosing and lab monitoring. 4. Review of the history and physical dated 11/10/15 for patient #114 showed diagnoses to include history of left hip fracture. Further, it showed the resident had a history of a compression fracture of the back and complained of back pain that was worsening. Review of the facility admission record showed the resident was admitted on 11/12/15. Admission diagnoses included low back pain and bronchopneumonia. The following concerns were identified: a. Review of the "Patient Education Materials" form dated 11/12/15 showed it included orders signed by the physician. The orders included vital signs were to be obtained every shift. b. Review of the vital signs documentation showed they were only taken a total of 2 days, 2 times on 11/12/15 and 1 time on 11/13/15. The resident was admitted from 11/12/15 through 11/18/15. c. During an interview with the DON on 11/18/15 at 5:45 PM, she verified the vital signs needed to be taken every shift during the	F 492		

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F 492	Continued From page 16 resident's admission. 5. According to the Wyoming Nurse Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, nursing must function under the direction of a licensed physician.	F 492		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the agency failed to ensure the physician was promptly notified of INR (international normalized ratio) results for 1 of 4 sample residents (#70) receiving coumadin therapy. The findings were: Review of the physician orders for resident #70, signed on 11/11/15 showed lab orders included the resident's INR (International Normalized Ratio) level was to be checked on 11/13/15. Additional orders included; "No Warfarin (anticoagulant) for 11/11- [through] 11/12. The following concerns were identified: a. Review of the INR lab value dated 11/13/15 showed it was 3.5. b. Review of the physician nursing home visit note dated 11/16/15 showed the physician had not been notified of the INR results. The physician ordered another INR level to be drawn immediately and the medication held. c. During an interview with the DON on	F 505	**F-505: Promptly Notify Physician of Lab Results.** **Corrective Actions:** Resident # 70 has been discharged therefore there can be no corrective action. **Identification of Others:** The DNS or designee has reviewed Coumadin lab results for 30 days to ensure that the results were reported to the physician. Noncompliance was corrected upon discovery. **Systemic Changes:** The LN staff was educated on F-505 and an active facility developed Performance Improvement Plan regarding notification of the physician of lab results by the DON or designee. **Monitoring:** The IDT will review the weekly drawn labs and new lab orders at least 3 times per week during the Daily Clinical Meeting for physician	12/27/15

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F 505	Continued From page 17 11/17/15 at 4:45 PM, she acknowledged the nursing staff needed to contact the physician with the lab results.	F 505	notification and Documented on the Daily Clinical Tool. Noncompliance will be corrected upon discovery. A report will be presented to the monthly QAPI for review and corrective actions when necessary until resolved.	