STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	C 02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 000	INITIAL COMMENTS A survey was conducted by Healthcare Licensing and Surveys on 2/3/16 through 2/5/16. The survey was prompted by complaint intakes WY00002143 and WY00002177. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CAA: Care Area Assessment CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set NHA: Nursing Home Administrator Less commonly used abbreviations will be annotated in each deficiency.	F 000	*F309* *This plan of correction is the centers credible allegation of compliance. 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 conclusion 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.*	
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 observation, medical record review, staff interview, and policy review, the facility failed to ensure the services provided maintained the highest practicable physical well-being for 1 of 5 sample residents (#28) who had skin breakdown.	F 309	~~2/26/16~~ 3/12/16 1. *How corrective action accomplished for the identified residents?* Resident #28 is being provided wound care in accordance with the physician's order including weekly wound measurements and updated nurse's notes. The skin integrity care plan has been reviewed and updated also.	

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

Executive Director | 2/25/16

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.

2/26/15-2061 spoke with Brenda DON. Plan of Correction accepted. DOC 2/26/15

Tim Cotter

spoke with Dan Stalls Regional VP of operations on 3/10/16 at 1:47pm Agreed to change DOC to 3/12/16 for facility request. Received

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F 309	Continued From page 1 The findings were: 1. Review of the skin integrity policy updated July 2014 showed "...7. Upon discovery of newly identified skin impairment (abrasion, bruise, burn excoriation, pressure sore, rash, skin tear, surgical wound, etc.), the LN [licensed nurse] completes the following: Documents skin impairment that includes measurements of size, color, presence of odor, exudates, and presence of pain associated with the skin impairment in Nurse's Notes and on the Weekly Wound Evaluation...Evaluates environment, mobility equipment, functional and cognitive ability, medications, and labs to identify interventions to promote healing/resolution of skin impairment. Implements interventions and document on the resident's care plan and Care Directive...11. Abrasions and bruises are evaluated by the LN (excoriations, rashes, skin tears, etc.) and documented on the Weekly Wound Evaluation..." The following concerns were identified: a. Observation on 2/4/16 at 9:25 AM showed resident #28 had an open area on the lower right gluteal cleft and an open area on the lower left gluteal cleft. The DON and unit manager confirmed the open areas on 2/4/16 at 5:35 PM. b. Review of a progress note dated 1/26/16 and timed 4 PM showed resident #28 had "excoriation to buttocks, bleeding noted." No further documentation was present in the progress notes related to the area after 1/26/15. c. Review of a weekly skin evaluation dated 1/26/16 showed the resident's buttocks were "pink/beefy red" and "bloody" throughout with peripheral tissue edema. The skin assessment did not identify measurements of the area at that time. No assessment or review was completed after 1/26/16.	F 309	2. *How you will identify other residents with the potential of being affected by the same practice?* The DNS/Designee has conducted a facility-wide audit to verify that resident's wound care is completed in accordance with the physician's order. The DNS/Designee has conducted a facility-wide audit to verify the presence of wound measurements and verify they are charted correctly in the Weekly Wound Evaluation. 3. *Address what measures will be put in place to ensure deficient practice will not recur.* The DNS/Designee has provided education to licensed nurses addressing the following: 1. Verify, assess, and document the treatment of the wound; 2. On-going evaluation to obtain accurate weekly wound measurements; and	

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F 309	Continued From page 2 d. Review of the skin integrity care plan last revised on 8/17/15 showed resident #28 had chronic dermatitis and was to have skin assessments completed weekly and as needed. e. Interview with the DON and Unit Manager on 2/5/16 at 11:35 AM confirmed the facility did not follow the skin integrity policy for resident #28.	F 309	3. Education addressing wound care has been provided to licensed nurses.	
F 314 SS=G	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 medical record review, staff interview, and policy review, the facility failed to ensure necessary treatment and services to promote healing were provided for 1 of 2 sample residents (#31) with pressure ulcers. This failure resulted in harm for resident #31. The findings were: 1. Review of the admission MDS assessment dated 11/10/15 showed resident #31 had diagnoses that included muscle wasting and atrophy. Continued review showed the resident required extensive assistance of 2 or more persons for bed mobility, transfers and toilet use, and was at risk for skin breakdown. Review of the care plan for skin integrity impairment, not dated	F 314	4 ***How will the plan be monitored to ensure the solutions are sustained?*** The DNS/Designee will conduct weekly audits for ninety (90) days of TARS to verify wound care is completed per physician's order and audit the Weekly Skin Evaluation forms to verify wound measurements. Findings of audits to be brought to QAPI for evaluation and further educational opportunities.	

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F 314	Continued From page 3 and printed on 2/3/16, showed the resident had an open pressure wound on his/her left heal that required daily dressing change. The following concerns were identified: a. Review of weekly skin evaluation sheets between 12/2/15 and 1/25/16 showed resident #31 had a 3 centimeter area that was "pink/beefy red" with serous (typically pale yellow and transparent fluid) drainage that was not staged on 12/2/15. The wound was evaluated again on 12/9/15 and described as an "open blister" and measured 2 centimeters by 5 centimeters. There was no weekly documentation between 12/9/15 and 1/1/16. The 1/1/16 assessment showed the area was not staged, was "normal for skin", and measured 3 centimeters by 3 centimeters with serosanguinous (containing or relating to both blood and the liquid part of blood) drainage. The 1/5/16 assessment showed the area was a "L. [left] heel blister" and remained 3 centimeters by 3 centimeters with no drainage. Review of the 1/12/16 and 1/20/16 assessments showed the area remained unchanged. Review of the 1/25/16 assessment showed the area was a Stage III pressure ulcer and measured 3.5 centimeters by 5 centimeters by .3 centimeters. b. Review of a physician's order dated 12/2/16 showed the resident was to keep shoes off until left heel blister healed and optifoam was to be applied daily until healed. Review of a physician's order dated 12/23/15 showed the facility was to discontinue the optifoam to the left heel and leave the area open to air. c. Review of a Physician Fax Orders Form dated 1/1/16 showed the resident's "left heal where previous blister from 12/2 has reopened." The physician order portion was filled out with treatment orders; however, there was no nurse or physician's signature on the document.	F 314	F 314 *This plan of correction is the centers credible allegation of compliance. 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 conclusion 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.* ~~3/26/16~~ 3/12/16 1. *How corrective action accomplished for the identified residents?* Resident #31 has been discharged from the facility and no further corrective actions can be taken.	

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F 314	Continued From page 4 d. Review of the treatment administration record for January 2016 showed the resident was to receive optifoam to the left heel daily; however, the resident did not receive the treatment on 1/23/16 or 1/24/16. e. Review of a progress note dated 1/25/16 and time 5:45 PM showed "dressing chg [sic] to left heel not completed on 1/23/16 or 1/24/16. Wound blister now opened." f. Review of a Nutrition Hydration Skin committee review dated 1/27/16 showed "res [resident] wound to L [left] heel went from a fluid filled blister with clear fluid. Wound then deteriorated, presented as a stage III." 2. Interview with the DON and unit manager on 2/5/16 at 11:35 AM confirmed there were missed assessments between 12/9/16 and 1/1/16, the order dated 1/1/16 was not signed by a nurse or physician, and the wound deteriorated as a result of missed treatments on 1/23/16 and 1/24/16. 3. Review of the skin integrity policy updated July 2014 showed "...7. Upon discovery of newly identified skin impairment (abrasion, bruise, burn excoriation, pressure sore, rash, skin tear, surgical wound, etc.), the LN [licensed nurse] completes the following: Documents skin impairment that includes measurements of size, color, presence of odor, exudates, and presence of pain associated with the skin impairment in Nurse's Notes and on the Weekly Wound Evaluation...Evaluates environment, mobility equipment, functional and cognitive ability, medications, and labs to identify interventions to promote healing/resolution of skin impairment. Implements interventions and document on the resident's care plan and Care Directive...10. Weekly Wound Rounds are to be completed by a	F 314	2. *How you will identify other residents with the potential of being affected by the same practice?* The DNS/Designee has conducted a facility-wide audit to verify that residents with pressure ulcers are being treated in accordance with the physician's order and those orders contain nurse or physician signature. The DNS/Designee has conducted a facility-wide audit to verify that residents with pressure ulcers have had weekly skin assessments with measurements completed. *3. Address what measures will be put in place to ensure deficient practice will not recur.* The DNS/Designee has provided education to licensed nurses addressing the following: 1. Verify, assess, and document the treatment of the wound;	

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F 314	Continued From page 5 team consisting of the DNS and Resident Care Manager's (RCM's) designee. Arterial, Pressure, Stasis, Venous Ulcers, significant surgical wounds, and burns are evaluated, measured, and documented on the wound evaluation. This evaluation includes pain associated with the wound during wound care. If a wound condition fails to improve after 2 weeks of treatment or the condition of the wound deteriorates, the Physician and Resident's Responsible party are notified..."	F 314	2. On-going evaluation to obtain accurate weekly wound measurements; and 3. Education addressing wound care has been provided to licensed nurses. 4 ***How will the plan be monitored to ensure the solutions are sustained?*** The DNS/Designee will conduct weekly audits for ninety (90) days of TARS to verify wound care is completed per physician's order and audit the Weekly Skin Evaluation forms to verify wound measurements Findings of audits to be brought to QAPI for evaluation and further educational opportunities.	