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

PRINTED: 01/21/2016
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
	53A051	A. BUILDING _____ B. WING _____	01/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

(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: ADLs- Activities of Daily Living CNA- Certified Nurse Aide DON- Director of Nursing Services MDS- Minimum Data Set LPN- Licensed Practical Nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157	South Lincoln Nursing Center will ensure residents physicians are notified of any change in residents condition. 1. Progress notes and 24 hr. reports reviewed for resident #2 to identify subsequent change in condition requiring physician notification 2.Progress notes and 24hr. report reviewed on all other residents to identify change in condition requiring physician notification. 3.A quality monitoring tool will be implemented by the nursing supervisor to ensure resident change of condition will be reported to physician or primary care provider.	2/15/16 2/15/16

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: C.E.O. | (X6) DATE: 3/25/16

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.

3/30/16 - Plan of correction accepted. Administrator Ken Archer notified by phone. J. VanDyke

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F 157	Continued From page 1 specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to notify the physician of a resident change of condition for 1 of 2 sample residents (#2) with a change in condition. The findings were: Review of the 11/13/15 quarterly MDS assessment showed resident #2 had diagnoses that included cerebrovascular disease, hypertension and dementia. Review of the 12/31/15, timed 3:43 PM, progress note showed "This morning before breakfast a CNA requested help with this resident in [his/her] bathroom. CNA stated that resident had walked to the bathroom with her without incident. After having a BM [bowel movement], resident was unable to stand. This nurse observed resident sitting on the toilet, leaning forward. [S/he] had [his/her] right hand on the grab bar, the other was limp in [his/her] lap. This nurse had to kneel down on the floor to be able to look up into [his/her] face. [S/he] had a slack, flat affect. I asked [him/her] how [s/he] was doing and got no response. Eyes were open and blinking. I asked [him/her] if [s/he] could smile for me with no reaction. It took two people to assist [him/her] to stand, and one to wipe and pull up [his/her] clothes. We then realized that [his/her]	F 157	4. The results of the quality improvement monitoring tool will be reported at the monthly medical directors and QA/QI meeting until compliance is demonstrated. *Change in condition will be given verbally to shift change. * Change in condition will also be documented. * Quality monitoring tool will be used on all change in condition. * Change in condition will be tracked monthly.	

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F 157	Continued From page 2 underwear were wet with urine. The CNAs changed [his/her] clothes, this nurse assessed the catheter which was leaking from the stoma site. Adjusted catheter and placed 44 at site. Again, with one person on each side we assisted [him/her] to stand and into a wheelchair. Questioned resident as to how [s/he] was feeling, to which [s/he] replied I think I'm okay. Resident has not been able to ambulate today. Charge nurse aware." Further review of the medical record failed to show any evidence the physician was notified of the resident's change of condition. Interview with the interim DON and restorative nurse on 1/6/16 at 2:20 PM revealed the author of the progress note was not the nurse assigned to the resident on 12/31/15, but had assisted with the resident when CNAs requested help. She then gave report on the resident's condition to the nurse assigned to the resident. The interim DON and restorative nurse confirmed there was no evidence the physician had been notified of the resident's change in condition.	F 157		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, review	F 248	South Lincoln Nursing Center will provide an ongoing program of activities designed to meet residents needs 1. A full time activities director was hired effective Jan. 7, 2016. 2. Activities director has been interviewing and observing all residents to develop individual comprehensive activities care plan.	1/7/16 2/29/16

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F 248	Continued From page 3 of activity calendars and staff interview, the facility failed to provide an ongoing program of activities designed to meet resident needs for 3 of 5 months reviewed (November 2015, December 2015, January 2016) The findings were: Group interview with 5 residents on 1/5/16 beginning at 1 PM, revealed the facility had been experiencing difficulties with the activities program. All of the residents stated they were bored and did not have enough to do. Review of the activity calendar for the month of November 2015 showed 15 of 30 days (50%) had no scheduled activities. Of the 15 days that had scheduled activities, 5 days showed a single scheduled activity, and 4 listed only food or drink, such as "hot chocolate" or "banana split." Review of the December 1015 activity calendar showed 12 of the 31 days had two activities scheduled for the day. Seven days showed a single scheduled activity such as "Snowman Word Search" or "Christmas Movie." Only 2 days of 31 had an activity scheduled after 2:30 PM. Review of the January 2016 activity calendar showed no activities were scheduled on 3 of 31 days. Sixteen days had two activities scheduled. Seven days showed a single scheduled activity such as "Crosswords." No activities were scheduled after 12:30 PM. Observation of the posted activity schedule in the facility milieu on 1/5/16 at 9 AM showed "Noodleball" was scheduled at 9:30 AM, and "Humorous Stories" was scheduled for 12:30 PM. Continued observation of the milieu showed the scheduled "Noodleball" activity did not occur.	F 248	3. In addition to the monthly activities calendar, the activities director will act on resident activities suggested during monthly Resident's Council Meetings. 4. A quality monitoring tool will be implemented by the nursing supervisor to ensure: a. activities care plans will be reviewed during quarterly MDS assessments and pm b. activities director will follow up on resident suggestions made during resident council meetings 5. The results of the quality improvement monitoring tools will be reported at the monthly QA/QI meeting until compliance is demonstrated. *We will develop monthly activities calendar. *We will assess all residents at least quarterly for activities in their care plans. *We will interview all residents at least monthly for individual plans.	3/2/16

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F 248	Continued From page 4 Interview with CNA #1 at 9:53 AM confirmed the activity was supposed to occur in the milieu. The CNA did not know why the activity had not occurred. Interview with the activities director on 1/6/16 at 1:38 PM revealed she worked part-time and only worked until 2 PM on the days she worked. She further revealed the activity program was "in transition" and was not adequate for resident needs.	F 248		
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 medical record review and staff interview, the facility failed to perform nursing assessments for 1 of 2 sample residents (#2) with a change in condition. The findings were: Review of the 11/13/15 quarterly MDS assessment showed resident #2 had diagnoses that included cerebrovascular disease, hypertension and dementia. Review of the 12/31/15, timed 3:43 PM, progress note showed "This morning before breakfast a CNA requested help with this resident in [his/her] bathroom. CNA stated that resident had walked to the bathroom	F 309	South Lincoln Nursing Center will 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. 1. Progress notes and chart for resident #2 were reviewed for subsequent change in condition - none found 2. Progress notes and chart for all other residents reviewed for subsequent change in condition none found 3. Any change of condition reported to charge nurse will be followed up by charge nurse and include a documented nursing assessment, vital signs, notification of family or legal representative, and resident placement on alert charting and 24 hr. report.	2/15/16 2/15/16 2/15/16

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F 309	Continued From page 5 with her without incident. After having a BM [bowel movement], resident was unable to stand. This nurse observed resident sitting on the toilet, leaning forward. [S/he] had [his/her] right hand on the grab bar, the other was limp in [his/her] lap. This nurse had to kneel down on the floor to be able to look up into [his/her] face. [S/he] had a slack, flat affect. I asked [him/her] how [s/he] was doing and got no response. Eyes were open and blinking. I asked [him/her] if [s/he] could smile for me with no reaction. It took two people to assist [him/her] to stand, and one to wipe and pull up [his/her] clothes. We then realized that [his/her] underwear were wet with urine. The CNAs changed [his/her] clothes, this nurse assessed the catheter which was leaking from the stoma site. Adjusted catheter and placed 44 at site. Again, with one person on each side we assisted [him/her] to stand and into a wheelchair. Questioned resident as to how [s/he] was feeling, to which [s/he] replied I think I'm okay. Resident has not been able to ambulate today. Charge nurse aware." Further review of the medical record failed to show any evidence a nursing assessment was completed on the resident. Additionally, no vital signs such as blood pressure, temperature and respirations were recorded for the resident on 12/31/15. No vital signs were recorded until 1/4/16. Interview with the interim DON and restorative nurse on 1/6/16 at 2:20 PM revealed the author of the progress note was not the nurse assigned to the resident on 12/31/15, but had assisted with the resident when CNAs requested help. She then gave report on the resident's condition to the nurse assigned to the resident. The interim DON	F 309	4.A quality monitoring tool will be implemented by the nursing supervisor to ensure nursing assessment and documentation is completed when resident change of condition is noted 5.The results of the quality improvement monitoring tool will be reported at the monthly medical directors and QA/QI meeting until compliance is demonstrated. * Change in condition will be given verbally at change of shift. Also change in condition will be documented *This will be tracked monthly.	

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F 309	Continued From page 6 and restorative nurse confirmed there was no evidence a nursing assessment, including measurement of vital signs, had been performed.	F 309		
F 323 SS=E	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 observation, staff and resident interview, review of the fall prevention program, and medical record review, the facility failed to ensure a safe environment related to hot water temperatures for 3 of 3 resident sinks (room #112, #107 and the shower/tub room bathroom sink) that were tested. In addition, the facility failed to provide adequate assistance to prevent falls for 1 of 3 sample residents (#9) who had falls. The findings were: 1. On 1/5/16 the hot water temperatures were taken to ensure safety. The following concerns were identified: a. The sink in the bathroom adjoined to the shower/tub room was tested at 9:40 AM and showed 135.4 degrees Fahrenheit (F). b. The sink in room 107 was tested at 9:55 AM and showed 120.6 degrees F. c. The sink in room 112 was tested at 9:47 AM and showed 120 degrees F.	F 323	We will place a governor to limit temperature on all sinks in all rooms to ensure does not exceed temperatures above 110 degrees. We will QA/QI the temperatures for a quarter then continue quarterly after that. And will be monitored monthly in QA/QI meetings. Plant manager will monitor this for continuation.	3/15/16

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F 323	Continued From page 7 d. Interview with the maintenance director on 1/6/16 at 9:25 AM verified the temperatures were too high. The director stated the goal was for the hot water to not exceed 110 degrees F. He further stated the water temperature was adjustable at each sink in the resident rooms. Temperatures were not routinely monitored at the resident level, but were adjusted as needed if nursing staff or residents had concerns. 2. Interview on 1/5/16 at 9:56 AM with resident #9 revealed bruising to his/her face and neck were a result of a fall that occurred at the facility. Observation of the resident's face and neck at that time showed a raised bump with a scab on the right eyebrow and significant bruising that affected his/her eyes, cheeks, nose, and neck. The bruises were dark red, yellow, and faded black in color. The resident stated the fall happened when a staff member was pushing him/her in a wheelchair without foot pedals. The resident couldn't keep his/her feet up and said s/he was thrown out of the wheelchair onto the floor face first. The following concerns were identified: a. Review of the 12/24/15 nurse's note timed at 1:55 PM showed the fall occurred while the resident was being taken in a wheelchair to the clinic for a physician appointment. According to the note, the resident was unable to hold his/her feet up and when the feet fell to the floor it caused the resident to fall out of the wheelchair hitting his/her head. Vitals were taken and the physician was notified at the time of the appointment. First aid was performed. b. Review of the 12/24/15 incident report showed steps to prevent recurrence were for "staff to slow down when pushing resident in w/c [wheelchair] and remind resident often to hold	F 323	South Lincoln Nursing Center will ensue that resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents 1. Foot rests were placed on resident #9's wheelchair. 1/11/16 2. Residents utilizing wheel chairs will be assessed by restorative nurse on admission and prn for foot rest addition. 2/15/16 3. Comprehensive care plan developed and implemented for resident #9, this includes additional interviewing for fall precautions 1/11/16 4. All nursing staff signed documentation they received and reviewed Fall Prevention Program as of August 31, 2015. 5. A quality monitoring tool will be implemented by the nursing supervisor to ensure the Falls Prevention Program is followed through when falls occur. * All residents were assessed for foot rests and none were in need of them. *All falls are reviewed and documented. * Falls prevention protocol will be tracked monthly.	

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F 323	Continued From page 8 feet up. If resident unable slow down more." c. Review of the medical record failed to show a post fall-evaluation to develop effective interventions was completed. d. Review of the interim care plan showed it was developed on the 12/21/15 date of admission. The care plan showed the resident was at risk for falls. The interventions showed "fall precautions," reorient as needed, and ambulate with assistance. There was no update or new care plan developed related to falls after the 12/24/15 fall with injury. e. Review of the Falls Prevention Program showed it included specific steps for ensuring resident safety from falls and also a procedure to follow when a fall occurred. The information showed staff were educated and the program was initiated the last week in August 2015. The process after a fall included the following items to be completed: a list of 10 questions to ask in order to determine root cause, an investigation/post-fall huddle, the incident report, and neurological assessment. f. Interview with the interim DON on 1/6/16 at 11:40 AM revealed after the fall there should have been a team approach to develop new interventions to prevent future falls. She verified the fall program process was not fully implemented and new written interventions for the resident were lacking. Further, education was lacking, only the nurse who was transporting the resident at the time of the fall was provided verbal education related to wheelchair safety.	F 323	6. The results of the quality improvement monitoring tool will be reported in the monthly medical directors and QA/QI meeting until compliance is demonstrated.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each	F 514	South Lincoln Nursing Center will ensure resident documentation contains sufficient information related to the residents final hours.	

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F 514	Continued From page 9 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 medical record review and staff interview, the facility failed to ensure nursing documentation was complete for 1 of 8 sample residents (#16). The findings were: Review of the 12/9/15 physician progress note showed resident #16 was seen for complaints of nausea and loose stools. Review of the nurse's notes from 12/9/15 to 12/10/15 showed the resident was not feeling well and was being monitored. Review of the 12/10/15 nurse's note timed at 9:51 PM showed the resident was "Pale and listless. Confused. Skin is cool and clammy..." The on-call physician was notified. The next note at 10:05 PM showed the on-call physician saw the resident and there were no new orders. The on-call physician planned to speak with the resident's primary care physician in the morning and "go from there." The next note dated 12/11/15 at 12:40 AM showed the on-call physician was notified the resident was "without pulse and without response to stimuli. Expiration confirmed." The following concerns were identified:	F 514	1. Current postmortem protocol reviewed 2. Additional charting details added to protocol 3. Nurses notified of change in protocol 4. nursing supervisor will develop quality monitoring tool to ensure adequate documentation is detailed in the resident record 5. The results of the quality monitoring tool will be reported at the monthly medical director and QA/QI meeting until compliance is demonstrated. * Death protocol will be used as needed. * Death protocol will be tracked monthly.	2/15/16

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F 514	Continued From page 10 a. The nurse's notes failed to document the details related to resident's last hours between 10:05 PM and when s/he was found unresponsive. b. Interview with the interim DON on 1/6/16 at 11:55 AM verified the medical record did not contain documentation to show the details of the resident's last hours and position when found unresponsive. She stated more information was expected for the record to be considered complete.	F 514		