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

PRINTED: 08/14/2016
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
	535025	A. BUILDING _____ B. WING _____	C 08/31/2016

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 A complaint survey was conducted by Healthcare Licensing and Surveys on 8/31/16. The survey was prompted by complaint intake #WY00002281. The following common abbreviations are used throughout the document: CNA - Certified Nurse Aide DON - Director of Nursing LPN - Licensed Practical Nurse MDS - Minimum Data Set RN - Registered Nurse SBAR - Situation Background Assessment Recommendation Less commonly used abbreviations will be annotated in each deficiency.	F 000	F314 TREATMENT AND SERVICE TO PREVENT / HEAL PRESSURE ULCERS It is the practice of the facility to strive to ensure that based on comprehensive assessment of a resident, that a resident who enters the facility without a pressure sore does not develop pressure sores unless the resident'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 pressure sores from developing.	9/27/16
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 observation, medical record review, and staff interview, the facility failed to ensure	F 314	CORRECTIVE ACTION Resident #1 was discharged from the facility on 9/3/2016. IDENTIFICATION OF OTHERS Facility residents will have head to toe skin checks completed before date of compliance to identify any skin concerns. Evaluation and documentation will be completed on any identified wounds, appropriate interventions put into place and care plan revised as needed.	

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

Administrator | 9/24/16

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.

Accepted, Tami the NHA was notified by phone and to respond in addition to pg 2. Sarah 10/7/16

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F 314	Continued From page 1 residents with pressure ulcers received treatment and services to prevent wound decline for 1 of 3 sample residents (#1) with wounds. This failure resulted in actual harm to resident #1. The findings were: Review of the 7/10/16 admission MDS assessment showed resident #1 was admitted to the facility with diagnoses that included hypertension, renal insufficiency, non-Alzheimer's dementia, and chronic obstructive pulmonary disease. The resident required the extensive assistance of two persons for activities of daily living such as bed mobility, transfers, dressing, toilet use, and personal hygiene, and was at risk for pressure ulcers. The resident was always incontinent of both bowel and bladder. Review of the 7/3/16 Nursing Admission Data Collection form showed the resident did not have any pressure ulcers. Review of the 8/8/16 Head to Toe Skin Check showed the resident did not have any pressure ulcers. The following concerns were identified: a. Review of the medical record showed no head to toe skin checks were completed after 8/8/16. b. Review of the 8/9/16 SBAR Communication Form and Progress Note showed the resident had an abrasion to the sacrum just above the coccyx. Review of the 8/9/16 Weekly Non-pressure Condition Record showed the resident had an abrasion to the sacrum that measured 6 inches by 4 inches. c. Review of the progress note dated 8/11/16 and timed at 3:06 PM showed "Resident along with [his/her] right buttocks shearing/blister wound also has some blister wounds are (sic) [his/her] lower back. All wounds have red wound beds. Right bottom wound does have some	F 314	SYSTEMIC CHANGES The licensed nursing staff will be educated on skin management policies, including weekly head to toe evaluation, weekly wound evaluation and documentation on weekly pressure ulcer record and weekly non pressure ulcer record, documentation of skin concerns on daily skilled charting form, obtaining physician orders, by the Director of Nursing or designee by the date of compliance. Nursing staff including CNAs will be educated on prevention of pressure ulcers and reporting of new changes in skin condition and reporting of changes in wound or need for dressing change by the Director of Nursing or designee by the date of compliance. During morning clinical meeting the facility will continue to review the PCC dashboard, 24 hour report for any changes in skin condition, any new wound treatment orders, assigned head to toes skin checks for timely completion and new admissions for any skin concerns. Corrective actions will be taken as needed for any identified concerns. The Director of Nursing or designee will review new admissions and residents with significant change of condition for potential for skin breakdown and initiate / update preventative measures on care plan as needed.	

Per phone call w/ Tammie NHA 10/7/16 SR

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F 314	Continued From page 2 discoloration to the wound bed such as dark red/black areas. Wounds were cleansed and a small amount of skin barrier cream was applied to the open areas. Resident is going to lay in bed after meals and will be turned every 2 hours." d. Review of the Nursing Daily Skilled Charting form for 8/12/16 showed the resident had no skin issues, and no changes in skin integrity. Review of the Nursing Daily Skilled Charting forms for 8/13/16 through 8/18/16 showed the same. e. Review of the medical record showed no other assessment of the right buttock wound between 8/11/16 and 8/19/16. f. Review of the Nursing Daily Skilled Charting form for 8/19/16, timed at 10:30 AM, showed the resident had dehisced (re-opened) surgical wounds, but the form made no mention of skin breakdown on the resident's lower back or buttocks. The form further noted the resident was to go to the wound clinic later that day. g. Review of the progress note dated 8/19/16 and timed at 10:49 AM revealed "...Resident goes to wound care clinic today. Wound care clinic was called to get report on resident's areas of concerns. They were informed of open blisters on lower back and right buttocks, and bi-lateral ankle incisions dehiscing due to lower extremity edema. They will evaluate the areas of concerns and provide a treatment plan." h. Review of wound clinic documentation dated 8/19/16 and timed 1 PM showed the resident's right buttock wound measured 9.5 inches by 5.7 inches. The wound site was described as "Dry black eschar; Moist yellow slough; Adherent yellow slough." The wound clinic also described a suspected deep tissue injury on the resident's right heel that measured 0.6 inches by 1.3 inches, and a suspected deep	F 314	The Director of Nursing or designee will continue to conduct wound rounds weekly and review / complete wound evaluation, documentation and review and update care plan as needed. A designated nurse will assist with wound rounds weekly for consistency and will complete rounds in absence of Director of Nursing for consistency. The Director of Nursing or designee will audit current wounds weekly for 3 months. The audit will include evaluation and measurement of wound and documentation on weekly pressure ulcer and non-pressure ulcer forms and daily skilled charting form, appropriate treatment orders/documentation of treatments and care plan interventions, and completion of head to toe skin checks. Corrective actions will be taken as needed. The Director of Nursing or designee will also complete 2 random observation rounds per week on 6 residents to check dressings and adherence to wound interventions per care plan. MONITORING The Director of Nursing or designee will track and trend the wound audits monthly for any trends / patterns for 3 months. The audit results will be reported to the Quality Assurance Performance Improvement	

86

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F 314	Continued From page 3 tissue injury on the resident's left heel that measured 1.5 inches by 1.5 inches. Further review of the resident's medical record showed neither heel wound was noted prior to the resident's visit to the wound clinic. i. Observation on 8/31/16 at 2:01 PM showed CNA #1 and CNA #2 entered the resident's room to provide care. The resident was rolled onto the left side, and the dressing on the resident's right buttock was visualized. The dressing was completely saturated with brown-colored liquid. The absorbant pad beneath the resident was also saturated with brown-colored liquid. The absorbent pad was changed, and the resident was repositioned. j. Interview with LPN #1 on 8/31/16 at 3:55 PM revealed she was the charge nurse for the resident and had received no report the resident's wound dressing was saturated. k. Observation of a dressing change on 8/31/16 at 6:47 PM with RN #1 and the DON showed the resident's right buttock wound was a large, full-thickness wound with tunneling. Interview with RN #1 and the DON at that time confirmed CNAs should report to the nurse when a dressing is saturated. l. Interview with the DON and the regional director of clinical services on 8/31/16 at 7:45 PM revealed the facility did not, at that time, have a dedicated staff member to oversee and coordinate wound assessments and services. It was further confirmed no head to toe skin assessments had been completed on the resident after 8/8/16, and no assessment was made of the resident's right buttock wound between 8/11/16 and 8/19/16 when the resident went to the wound clinic.	F 314	Committee (QAPI). The QAPI 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 and then reassess the need for continued monitoring based on compliance.	