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

PRINTED: 09/28/2016
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 09/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(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 On 9/13/16 through 9/14/16 a complaint survey was conducted at Cheyenne Health Care Center, in Cheyenne, Wyoming. The complaint survey was prompted by complaint intake #WY000002288.	F 000	**F309 Provide Care / Services for Highest Well Being** **Corrective Action** Resident # 5 expired on 08/11/2016 Resident #6 Discharged to home on 09/06/2016 **Identification of Others** An audit of clinical documentation for the past two weeks has been completed by nursing management to identify change of condition and response. Corrective actions will be taken as needed for any identified concerns. **Systemic Changes** The Director of Nursing or designee will review clinical reports daily Monday through Friday during daily clinical meeting to identify resident change of condition and response. Corrective actions will be taken as needed. The Staff Development Coordinator or designee will educate licensed nurses on policy for significant change of condition and follow up. The education will include timely and appropriate interventions, timely physician notification, documentation of change of condition and interventions, follow up evaluation and documentation r/t change of condition	10/6/16
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 staff interview, medical record review, and review of the facility's clinical practice standard, the facility failed to ensure the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being was provided for 1 of 1 sample residents (#5) whose change in condition required immediate medical care. This failure resulted in actual harm for the resident, who was not transported to the hospital until more than 4 hours after staff were aware of the resident's symptoms of a stroke. In addition, the facility failed to provide ongoing assessment for 1 of 3 sample residents (#6) whose change in condition required monitoring. The findings were: Review of the 6/18/16 quarterly minimum data set (MDS) assessment showed diagnoses for	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/6/16

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: V9QQ11 Facility ID: WY000005 If continuation sheet Page 1 of 8

RECEIVED
OCT 06 2016
WY Dept of Health
Healthcare Licensing and Surveys

Spoke w DON Rhonda on 10/12/16 at 2:30 pm. Plan of correction was accepted. Facility to send hard copy w signature.

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F 309	Continued From page 1 resident #5 included hypertension, dementia, dysphagia/oropharyngeal phase, and diabetes mellitus. Further review showed the resident had clear speech, cognitive impairment, no swallowing difficulties and required extensive and limited assistance with most activities of daily living. Review of the Situation Background Assessment Recommendation (SBAR) communication form and progress note, dated 8/2/16, showed the resident was sitting in the wheelchair in the dining room "not able to swallow, or when talking, not making sense, checked for signs of stroke, resident had slight facial droop on the left side, able to squeeze fingers with both hands, aware of name, can stick out tongue, vital signs normal... called physician at 7:45 AM." Further review of the SBAR communication form and progress note showed the relevant change in condition included decreased consciousness, decreased mobility, trouble swallowing, and garbled speech. This review showed the resident was transported to the hospital at 11:30 AM. Review of the hospital records showed the resident was admitted to the hospital on 8/2/16 and returned to the nursing care facility on 8/5/16. Review of the hospital discharge summary showed the resident was diagnosed with a stroke, "a right sided ischemic event with fairly profound aphasia and cognitive impact." Review of the 8/6/16 physician's progress notes showed plans for the resident to receive hospice/end of life care. The following concerns were identified: a. On 9/14/16 at 10 AM the licensed practical nurse (LPN #3) who wrote the 8/2/16 SBAR communication and progress note was interviewed. During the interview she stated she tried to administer the morning medications to the resident at around 7:15 AM on 8/2/16 and noted	F 309	and shift to shift report on change of condition. **Monitoring** The Director of Nursing or designee will audit compliance for 90 days through random record review of documentation of 10 change of conditions twice weekly for timely and appropriate interventions, physician notification and documentation. Corrective actions will be taken as needed for identified concerns. Results of the change of condition audits will be reported to the QAPI committee monthly by the Director of Nursing or designee for tracking and trending. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	

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F 309	Continued From page 2 the resident could not swallow the medications. She further stated she notified the unit manager and called the physician. During the interview she stated the resident was not transported to the hospital until 11:30 AM because staff were waiting for the physician to see the resident (this was over 4 hours after staff recognized the signs of a stroke). b. Interview with the physician on 9/14/16 at 12:20 PM revealed he supported decisions to transport residents to the hospital, and expected staff to do this when they recognized residents needed immediate medical care. c. Interview on 9/14/16 at 2:45 PM with the unit manager revealed staff recognized the resident had signs and symptoms of a stroke, called the physician, and monitored the resident until the physician arrived. She stated the facility protocol required the nurses call the director of nursing, assistant director of nursing or herself when they noted a change in a resident's condition, but nothing prohibited staff from bypassing the protocol and sending a resident to the hospital if the condition required immediate medical care. d. Review of the American Heart Association 2016 publication, at http://www.heart.org/HEARTORG, titled "Warning Signs of Heart Attack, Stroke, and Cardiac Arrest", accessed on 9/26/16, revealed the following information: The warning signs for a stroke include facial drooping, arm weakness, and speech difficulty. If the person shows any of these symptoms, even if the symptoms go away, call 9-1-1 and get them to the hospital immediately. e. During an interview on 9/14/16 at 4 PM the director of nursing verified the resident was not transported to the hospital when staff initially	F 309		

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F 309	Continued From page 3 recognized the signs and symptoms of a stroke. 2. Review of the 7/29/16 admission MDS assessment showed resident #6 had diagnoses that included hyperkalemia, severe kidney disease, dementia, tremors, and thrombocytopenia. Further review showed the resident had moderate cognitive impairment, could ambulate without staff assistance, and was easily understood by staff. Review of the nursing notes, dated 8/16/16 and timed between 3:16 PM and 4:15 PM showed the resident complained of left sided chest pain and vomiting after eating his/her birthday meal. At that time the unit manager assessed the resident, determined the resident had upper gastric discomfort, and administered Tylenol with an antacid. The resident's blood pressure was 174/90 and the Tylenol and antacid effectively alleviated the resident's symptoms. Review of the documentation that followed, dated 8/16/16 and timed 11:45 PM, revealed the resident's blood pressure was 216/130 and s/he was again complaining of chest pain. Further review revealed after LPN #1 called the director of nursing and physician, the resident was transported to the hospital. The following concerns were identified related to ongoing assessment and communication of the resident's change in condition between nursing staff at shift change: a. Review of the medical record showed no documentation on 8/16/16 regarding the resident's blood pressure and/or chest pain from 4:15 PM to 10 PM. b. Interview with the unit manager on 9/14/16 at 2:45 PM revealed staff monitored the resident throughout the afternoon and determined the resident had epigastric discomfort because the	F 309		

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F 309	Continued From page 4 Tylenol and antacid relieved his/her symptoms. However, she was unable to provide evidence of the monitoring, additional assessments, or staff's response when the resident's pain returned later. c. Interview with certified nurse aide #1 on 9/13/16 at 9:40 PM revealed she obtained the resident's blood pressure on 8/16/16 at 10 PM, and at that time the resident was flushed, and complaining about his/her chest hurting. She further stated the resident did not "look good". d. Interview with LPN #1 on 9/13/16 at 9:50 PM revealed the resident's blood pressure was 240/136 on 8/16/16 at 10 PM. The LPN further stated he coordinated the transfer of the resident to the hospital for evaluation. e. Interview on 9/13/16 with LPN #1 at 9:50 PM and LPN #2 at 10 PM revealed the off-going day shift did not communicate to the on-coming 6 PM shift on 8/16/16 about the resident's episodes of chest pain and elevated blood pressures that occurred earlier that day. Both nurses stated it is difficult to provide continued monitoring when staff are not aware of the need to provide frequent monitoring and assessments. Review of the hospital records showed the resident was admitted to the hospital after midnight on 8/17/16 and returned to the facility on 8/18/16. The hospital records also showed the resident had stabbing lower mid-sternal chest pain beginning at approximately 6 PM on 8/16/16. This review showed the chest pain had dissipated by the time the emergency department staff assessed the resident; However, his/her blood pressure remained elevated at 180/113. Further review revealed the summary of test results included aortic, tricuspid, and pulmonary valve regurgitation, elevated velocities in the right subclavian artery, a variance in blood pressure in	F 309		

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F 309	Continued From page 5 each arm, and tests for confirming a heart attack were negative. 3. Review of the clinical practice standard, titled "Change in Resident Condition", revised June 2008, provided by the director of nursing showed the following guidelines for staff: a. For life-threatening events: Call 911 if initial assessment indicates that such action is necessary. b. Changes of Condition Forms are used to assess and document changes in condition in an efficient and effective manner; provide assessment information to the physician and provide clear comprehensive documentation. c. Changes in condition are communicated from shift to shift through the 24 hour report management system. d. Changes in the resident status that affect the problems(s)/goal(s) or approach(es) on his or her care plan are documented as revisions and communicated to the interdisciplinary caregivers.	F 309		