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JUN 07 2017
Healthcare Licensing and Surveys

PRINTED: 05/30/2017
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING _____ B. WING _____	C 05/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	1330 PRAIRIE AVENUE CHEYENNE, WY 82009

(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 A complaint survey was conducted by Healthcare Licensing and Surveys on 5/15/17. This survey was prompted by complaint intake WY000002404. The following common abbreviations are used throughout this document DON- Director of nursing services LPN- Licensed practical nurse MAR- Medication administration record MDS- Minimum Data Set mg/dl- Milligrams per deciliter Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 309	A. LPN #1 was educated regarding blood glucose monitoring and insulin administration within the required time frames. Resident #13's insulin schedule was adjusted for her preferred meal times. B. The facility will conduct a 100% audit of residents that are on short-acting insulin to ensure blood glucose monitoring and insulin is completed according to schedule and that the schedule is coordinated with preferred meal times.	6/28/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: B. Dillwell | TITLE: Executive Director | (X6) DATE: 6/8/17

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.

Over

6/8/17 GM

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F 309	Continued From page 1 care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of professional standards of practice, the facility failed to ensure 1 of 6 sample residents (#13) with diabetic monitoring needs were assessed and administered medications in a timely manner. The findings were: Review of the 3/15/17 quarterly MDS assessment showed resident #13 had diagnoses that included diabetes mellitus and dementia. Review of active physician orders showed the resident was prescribed Lantus (long-acting insulin) 38 units every morning, and "Humalog [insulin lispro, rapid-acting] insulin 6 units SubQ [subcutaneous] twice a day for FSBS >100 [finger stick blood sugar greater than 100 mg/dL] (before breakfast and lunch)." The following concerns were identified: a. Observation on 5/15/17 at 10:46 AM showed LPN #1 obtained the resident's blood	F 309	C. The facility will re-educate all licensed nursing staff regarding the importance of completing blood glucose monitoring and insulin administration on schedule according to the resident's meal preference. The Director of Nursing or designee will conduct weekly audits to ensure compliance with blood glucose monitoring and insulin administration. D. The DON will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

6/8/17 - This POC accepted between Clint Scearce, DNS and Tony Madden, State Health Surveyor.

6/8/17

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F 309	Continued From page 2 glucose level, which was 154 mg/dL. At that time the nurse told the resident, "lunch comes at 1 [PM], so I'll bring your insulin at noon." The nurse left the resident's room and documented the blood glucose level of 154 mg/dL on the MAR. b. Observation on 5/15/17 at 12:52 PM showed a meal tray was delivered to the resident in his/her room. At 12:58 PM, LPN #1 return to the resident's room to administer the insulin (2 hours and 12 minutes after obtaining the blood glucose level). She reminded the resident of the earlier blood glucose reading of 154 mg/dL, then injected 6 units of Humalog into the resident's arm. The 2-hour old blood glucose reading was the basis for administering the dose of insulin. Interview with the LPN after exiting the resident's room revealed she liked to wait until room trays were delivered before administering insulin, "just in case the kitchen is running late." The nurse then documented on the MAR the Humalog was given at 11 AM. c. Interview with the DON on 5/15/17 at 5:03 PM revealed his expectation was for insulin to be administered "in a timely fashion" prior to eating. d. Interview with LPN #1 on 5/15/17 at 5:09 PM revealed she did not recheck the resident's blood glucose levels prior to administering the insulin, even though the blood glucose level the insulin dose was based on had been obtained 2 hours previously. She further stated the MAR showed the blood glucose level was scheduled to be checked at 11 AM, so that was why she checked it at that time. e. During an interview with the DON on 5/15/17 at 5:11 PM, he acknowledged that "anything could happen" to affect blood glucose levels between the time the resident's blood glucose level was checked and the time when the insulin was administered. He stated he was	F 309		

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F 309	Continued From page 3 unsure if a 2 hour window between checking the blood glucose levels and administering insulin was acceptable. f. According to Vallerand, Sanoski, and Deglin, "Davis's Drug Guide for Nurses," Fourteenth Edition, 2015: "Insulins (rapid acting)... Dose depends on blood glucose, response, and many other factors... Administer insulin lispro within 15 min [minutes] before or immediately after a meal..."	F 309		

6/8/17 am