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

6/13/17

PRINTED: 05/25/2017
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 05/11/2017

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 5/10/17 through 5/11/17. This survey was prompted by complaint intake WY000002402. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living ARD- Assessment Reference Date BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide DON- Director of Nursing Services IDT- Interdisciplinary Team LPN- Licensed Practical Nurse MAR- Medication Administration Record MDS- Minimum Data Set RN- Registered Nurse SBAR- Situation, Background, Assessment, Recommendation Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. The plan of correction serves as the facility's allegation of compliance.	
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or	F 323	F 323 **Corrective Action** Resident #2 was provided a tilt and space wheelchair with an increased seat depth by the physical therapist on 5/16/17. Resident #2 was reassessed on 5/15/17 for a new pressure relieving cushion and cushion was placed on 5/15/17. Fall care plan for resident #2	6/12/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Hancock | TITLE: NHA | (X6) DATE: 6/5/17

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.

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JUN 12 2017
Healthcare Licensing and Surveys

Accepted on 6/13/17 with Change on page 4. Changes made based on conversation with Brenda Hancock NHA on 6/13/17 @ 11:20 AM.
Kaylee Rivera 6/13/17

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F 323	Continued From page 1 bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to implement planned interventions to prevent falls for 1 of 2 sample residents (#2) reviewed for falls. This failure resulted in harm to a resident with a fractured hip, who continued to have falls which displaced the fracture. The findings were: Review of the significant change MDS assessment with an ARD of 11/15/16 showed resident #2 had diagnoses that included non-Alzheimer's dementia, muscle weakness, and a history of traumatic brain injury. The resident required the extensive physical assistance of two persons for ADLs such as bed mobility and transfers, and the extensive physical assistance of one person for locomotion and toileting. The resident had two falls that did not result in injury since the previous assessment. Review of the IDT post-fall notes with an "effective" date and time of 11/18/16 at 9:36 AM showed the resident fell out of bed in his/her room and the fall was unwitnessed. The resident	F 323	was reviewed and updated by the IDT on 6/1/17. **Identification of Others** The Rehab Program Manager and Rehab team conducted an audit of 100% of residents for proper wheelchair positioning and wheelchair seat cushions on 5/16/17. Identified concerns were corrected. An audit was conducted on 6/1/17 by IDT of all residents who have had repeat falls in the last 30 days. The care plan were reviewed and updated (where appropriate) to ensure effectiveness of interventions. **Systemic Change** Upon admission, quarterly and PRN the Therapy Department screens residents for positioning and proper cushion and addresses any concerns that are identified. The facility staff was provided in-service by the Staff Development Coordinator to recognize and report any improper positioning	

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F 323	Continued From page 2 was sent to the hospital due to hip pain, where a left hip fracture was diagnosed. Review of the 11/18/16 computed tomography scan results showed "fixation hardware" in the resident's right hip and a "subtle non-displaced fracture involving the left greater trochanter." The following concerns were identified: 1. Wheelchair positioning and transfer safety: a. Observation on 5/10/17 at 10 AM showed the resident was in a wheelchair in the front lobby. The resident had slid down in the chair and was leaning to one side. The resident appeared as though s/he was uncomfortable. Interview with the resident at that time revealed s/he needed assistance to reposition. There was a receptionist at the front desk who was on the phone, and no other staff members were available in the lobby. The surveyor located an aide down the hallway and asked the aide to assist the resident. Observation on 5/10/17 at 10:23 AM showed CNA #1 and RN #1 assisted the resident to reposition in the wheelchair. At that time the resident was noted to cry out when moved up in the wheelchair. b. Observation on 5/10/17 at 11:56 AM showed LPN #1 attempted to transfer the resident from a recliner in the front lobby to his/her wheelchair. A second LPN (#2) had been assisting the resident with fluids. During the transfer LPN #2 stood back and did not provide a second physical assist while LPN #1 used a gait belt and assisted the resident to a standing position. LPN #1 asked and encouraged the resident to turn so s/he could sit into the wheelchair. The resident was unable to perform the task so LPN #1 then lowered the resident back into the recliner and a sit-to-stand	F 323	observations to the therapy department using the "Hey Therapy," or the "Stop and Watch" tools as an optional form of communication. This training was completed on 6/9/17. On 5/31/17 in-service training was provided to the therapy department by the Rehab Program Manager regarding proper positioning observation,\ reporting and correction techniques. With each fall the IDT evaluates the circumstances of each fall and attempts to identify an appropriate intervention to attempt to prevent future falls and the care plan is updated. On 6/1/17 in-service training was provided to the IDT by the District Director of Clinical Services regarding fall management, interventions care planning and monitoring. **Monitoring** The Rehab Program Manager monitors the therapy screen of proper seating or positioning and observations of cushion appropriateness of 10 residents per week. The Rehab Program Manager	

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F 323	Continued From page 3 mechanical lift was used with the assist of both LPNs to complete the transfer. During the observation it was noted the cushion in the resident's wheelchair was in poor condition with the front section flattened. c. Observation on 5/10/17 at 5:30 PM showed the resident was in the wheelchair in the assisted dining room. There were staff members in the room; however, none noticed the resident was poorly positioned in the wheelchair. The resident was leaning to one side, had slid forward on the seat, and had his/her legs tucked under the chair. At 5:50 PM the resident was taken from the table and transported in the wheelchair by CNA #2. The aide did not reposition the resident and the resident's feet were dragging under the chair as the CNA transported the resident down the hallway. Interview with CNA #2 on 5/10/17 at 6:52 PM revealed she was not aware of any technique or plan for the resident to prevent the feet from dragging. d. Interview with Physical Therapist #1 on 5/11/17 at 10:15 AM revealed there had been past attempts made to equip the resident's wheelchair with various foot rests and none were accepted by the resident. Further, the therapist verified in the past other chairs and cushions had been tried for the resident to allow for better positioning. However, no attempts had been made to increase the height of the seat on the resident's current chair. He verified it was possible this may help to better position the resident. The therapist stated staff should ask the resident to lift his/her legs while being transported. A later interview on 5/11/17 at 11:32 AM with the therapist verified the cushion that was being used in the resident's chair was not the correct cushion, and the cushion's condition made it ineffective for comfort or positioning.	F 323	reports any identified trends to the Quality Assurance Performance Improvement Committee for their review and resolution. The Resident Care Management Coordinator monitors the residents with falls and works with the IDT to ensure that appropriate interventions are put in place and the care plan is updated ~~5 times per week~~. Any identified trends are reported to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue for 90 days unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	

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F 323	Continued From page 4	F 323		

2. Review of the SBAR notes from November 2016 to May 2017 showed the resident fell an additional 16 times after the 11/18/16 fracture. Review of the SBAR communication and IDT progress notes from these falls and their respective dates showed the following falls were unwitnessed;

a. Review of the SBAR dated 11/21/16 and timed 10:19 PM showed the resident was found "in room laying on the floor on back, noted incontinent of urine, had been in [his/her] w/c [wheelchair]." The SBAR further showed the resident was " ...not able to comprehend (elc) that [s/he] is not safe enough to be up ambulating by [him/herself] and that [s/he] has a fx [fracture]." And " ...up by nurses station so [s/he] can be monitored." Review of the IDT post fall review for this fall showed the resident was unable to demonstrate the use of the call light in the room or in the bathroom. The summary of the interdisciplinary team showed "Resident while awake needs to be within sight of staff, encourage resident to remain close to nurses station."

b. Review of the SBAR dated 11/24/16 and timed 11:25 PM showed the resident was "found lying on floor in bathroom on L [left] side with towel rack in hand." The resident's wheelchair was in the doorway.

c. Review of the SBAR dated 12/23/16 and timed at 6:46 AM showed the resident attempted to transfer him/herself from bed to chair, lost balance and "fell out of bed." Review of the IDT post fall review for this fall showed the resident was unable to demonstrate the use of the call light in the room or in the bathroom. The summary of the interdisciplinary team showed "Change the get up time to earlier in the morning

SR 6/13/17

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F 323	Continued From page 5 so resident doesn't try to assist [him/herself] on getting up in the morning." d. Review of the SBAR dated 1/3/17 and timed at 10:33 AM showed the resident had an "unwitnessed unassisted self transfer resulting in a fall. Review of the IDT post fall review for this fall showed the resident was in bed prior to the fall, and was unable to demonstrate the use of the call light in the room or in the bathroom. e. Review of the SBAR dated 1/18/17 and timed at 3 AM showed the resident was "self-transferring from wheelchair to bed, couldn't support [his/her] weight and assisted [him/herself] to the mat on [his/her] knees..." Review of the IDT post fall review for this fall showed the recommendation of the interdisciplinary team was "[Resident name] will verbalize understanding of safety precautions and education provided. Will verbalize understanding of potential complications of not complying with safety recommendations. Has poor safety awareness, refuses assistance, stand by and provide help as needed." f. Review of the SBAR dated 2/16/17 and timed at 7:36 PM showed the resident was " ...found on the floor in the small dining room ...Resident had been eating [his/her] supper there. Was noted on [his/her] right side, [his/her] w/c [wheelchair] behind [him/her]. It was noted during supper, resident kept falling asleep and [s/he] had to woke (sic) several times ..." The SBAR further showed the resident was "unable to sit up in w/c, leaning forward and falling asleep." The resident was placed in a recliner by the nurse's station. Review of the IDT post fall review for this fall showed the interdisciplinary team recommendation was "ABX [antibiotics] for URI [upper respiratory infection] and ST [speech therapy] for pocketing food." The	F 323		

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F 323	Continued From page 6	F 323		

recommendation failed to describe interventions related to the resident falling asleep at the table.

g. Review of the SBAR dated 2/19/17 and timed at 12:23 PM showed the "Resident fell forward out of w/c [wheelchair] onto [his/her] knees. [S/he] did this twice trying to transfer [him/herself]." Review of the IDT post fall review dated 2/20/17 at 9:33 AM showed the falls were unwitnessed and the falls occurred in the resident's room.

h. Review of the SBAR dated 2/28/17 and times at 3 AM showed the resident "to have tried to get onto bed and legs gave (sic) [s/he] sat on floor. Resident was sitting (sic) on mat when found ...was in wheelchair."

i. Review of the SBAR dated 4/19/17 and timed at 10:50 AM showed the resident had an unobserved fall. Review of the IDT post fall review for this fall showed the resident fell in his/her room, and the fall was unobserved.

j. Review of the 4/19/17 IDT post fall review timed at 12:42 PM showed the resident had a second fall on 4/19/17. The second fall occurred at midnight when the resident fell out of his/her wheelchair in his/her room. The recommendation of the interdisciplinary team was "Re- educate resident on complications associated with frequent falls. (ie major injury, hospitalization."

k. Review of the SBAR dated 4/21/17 and timed at 9:46 PM showed the resident attempted "...to transfer [him/herself] onto the couch in the south room and slid to floor ..." Review of the IDT post fall review for this fall showed the recommendation of the interdisciplinary team was "Place items within reach and continue interventions on care plan."

3. Review of the current care plan with a revision date of 4/23/17 showed the resident was at high

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F 323	Continued From page 7 risk for falls. The problem area revealed the falls were related to decline in health status and personal choices related to safety precautions. This care plan showed 20 falls occurred while at the facility since 11/1/16. The interventions to prevent falls were shown to include the following: a. 11/1/16: "educate staff to ensure wheelchair cushion is dry prior to application." b. 11/17/16: add an anti-rollback device to the resident's wheelchair. c. 11/21/16: ensure the resident was in a "high visibility area while awake." d. 12/23/16 : "assist resident with AM cares earlier in the morning so resident doesn't try to assist [him/herself]." e. 1/20/17: "ensure proper positioning, in w/c [wheelchair] & bed with each encounter," and "...resident assisted [with] toileting frequently, staff to be with resident and redirect resident when resident tries to stand." f. 2/28/17: "offer recliner as needed for comfort and positioning." 4. Review of X-ray results dated 12/27/16 for the left hip and lateral pelvis showed the fracture had become displaced since 11/18/16. The results showed, "There is a fracture extending through the intratrochanteric portion of the proximal left femur. There is significant angulation and impaction deformity." The 1/23/17 physician consult report showed there were "surgical considerations" however, "currently 0 [no] desire for surgery...also may consider no-op [operative] management as surgical risks are present." 5. Interview with the DON on 5/11/17 at 9:35 AM revealed the resident was his/her own person for decision making, and made poor decisions as a result of his/her mental health diagnosis. The	F 323		

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F 323	Continued From page 8 DON verified many interventions were in place to prevent falls and the staff should follow the care plan.	F 323		