Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0018	A. BUILDING: _____ B. WING _____	10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Nursing Care Facilities, Chapter 11, effective 06/26/2000 Rules and Regulations for Licensure of Nursing Care Facilities, Chapter 19, effective 06/26/2000 A licensure survey was conducted by Healthcare Licensing and Surveys from 10/1/17 to 10/4/17. 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 Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S2960	Ch 11 Sec 9 (a)(vi) Nursing Services The facility shall have sufficient nursing staff to meet the needs of the residents. (a) Director of Nursing Services. The facility shall designate a Registered Nurse to be a full-time director of nursing services, and he/she shall have experience in areas such as nursing service administration, rehabilitation nursing, psychiatric or geriatric nursing. The director of nursing services shall be responsible for: (vi) Insuring daily nursing rounds are conducted to ensure each resident receives adequate care to meet his/her needs.	S2960		10/27/17

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S2960	Continued From page 1 This State Rule and Regulation is not met as evidenced by: Based on medical record review, staff, family, and hospital case manager interviews, and policy and procedure review, the nursing services failed to meet the needs of the residents. This failure was evident in the untimely response to physician orders and nursing care not provided in accordance with professional standards of practice for 1 of 1 residents (#113) who had a significant change in condition. In addition, the nursing staff failed to implement measures to effectively manage pain for 1 of 7 sample residents (#114) who were assessed as needing pain management. The findings were: 1. Review of the medical record for resident #113 showed an admission date of 9/2/15 with a discharge date of 2/23/17. The resident had diagnoses which included muscle weakness, history of falling, essential hypertension, atherosclerotic heart disease of native coronary artery, asthma and other specified disorders of nose and nasal sinuses. The following concerns were identified: a. An interdisciplinary progress note dated 2/19/17 and timed 12:30 AM noted the resident had a pulse of 89 beats per minute (bpm), an oxygen saturation level of 86%, and "expiratory wheeze noted in RLL [right lower lung] and LLL [left lower lung], more significant wheeze in LLL. Audible crackles without stethiscope [sic]. Resident displays/reports no SOB [shortness of breath]. Asked resident to deep breathe and cough multiple times. Resident attempted each time but struggled to produce a productive cough. Resident is in no acute distress...left resident in	S2960	S2960 1. Resident #113 discharged on 02/23/2017. Resident #114 discharged on 09/05/2017. 2. The Director of Nursing or designee completed an audit of residents with a change of condition to validate residents with a change of condition to ensure residents with a change of condition are monitored every shift and treatment is provide timely as ordered by the physician. The Director of Nursing or designee completed an audit of resident□s pain to validate their pain is adequately controlled per the residents□ plan of care. 3. The Staff Development Coordinator or designee re-educated facility nurses to validate resident change of condition is being monitored every shift and treatment is provided timely as ordered by the physician and to re-educate facility nurses to validate resident□s pain is adequately controlled per the residents□ plan of care. 4. The Director of Nursing or designee will complete an audit 5 days a week for two(2) weeks, three (3) times per week for two(2) weeks, then weekly times one (1) month of residents□ having a change of condition to validate the resident is being monitored every shift and treatment is provided timely as ordered by the physician.	

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S2960	Continued From page 2 bed in the lowest position, to go back to sleep. Will continue to monitor." Further review of progress notes showed the next entry was dated three days later, on 2/22/17 and timed 2 PM, and showed the resident was started on Duonebs (an inhalation solution that dilates lung cells) every 6 hours for 5 days and Azithromycin (an antibiotic) for 5 days with a diagnosis of upper respiratory infection. No evidence was provided to show the resident was assessed during the three days between progress notes, or that the resident's sign/symptoms had been addressed. b. Review of an SBAR communication form showed the medical doctor was notified of the resident's condition on 2/19/17 at 4:15 AM by fax. A faxed response dated 2/20/17 showed an order for Duoneb (a breathing treatment) every six hours for five days, and Azithromycin (an antibiotic) 250 milligrams, 2 tablets by mouth on the first day, followed by 1 tablet daily for 4 days. However, review of the medication administration record showed the resident did not receive either the Duoneb inhaler or the Azithromycin antibiotic until 2/22/17. c. Further review of a progress note, dated 2/23/17 and timed 3:45 PM showed the resident had a pulse of 131 bpm and temperature of 101.1 Fahrenheit (F), and the following day the progress note dated 2/24/17 at 4 AM noted a pulse of 124, temperature of 101.6 F and oxygen saturation of 87% on 3L (liters of oxygen). The note showed the resident was short of breath and sweating. The note further showed the doctor had contacted the facility, and thought the resident may have had pneumonia and may have been going septic, and ordered for the resident to be transferred to the hospital for evaluation and treatment. The resident was transferred to the emergency department on 2/24/17. d. Interview on 10/4/17 at 3:02 PM with the	S2960	The Director of Nursing or designee will complete an audit 5 days a week for two(2) weeks, three (3) times per week for two(2) weeks, then weekly times one (1) month of residents□ pain to validate their pain is adequately controlled per the residents□ plan of care. The Director of Nursing or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	

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S2960	Continued From page 3 DON revealed the facility had reviewed the charting and assessments for resident #113 and confirmed it was not sufficient. The DON stated the nurse who had made the progress note entry on 2/19/17 "was new" and had not placed the resident on alert charting for follow up from her assessment. The facility provided education to staff on 3/8/17 regarding charting requirements. e. Review of inservice education attendance sheets dated 3/8/17 indicated education was provided to staff which included 24 hour documentation. Handouts included the facility policy for "Alert Charting Guidelines" which stated the following for upper and lower respiratory infections: "Alert charting Q (every) shift until condition improves or resolves. Vital Signs Q shift - Allow to sleep on 3rd shift unless condition warrants interruption. Lung sounds Q shift or as condition warrants. Characteristics of sputum. Activity tolerance. Oxygen use, Oxygen saturation. Dietary tolerance, fluid intake." For exacerbation of cardiac/respiratory condition, the guideline stated "Alert charting Q shift. VS Q shift. Heart & lung sounds. Circulatory changes, edema. Daily weight. Activity tolerance. Oxygen use, oxygen saturations. Medications: response to, side effects." 2. Review of the medical record showed resident #114 was admitted from the hospital on 8/24/17 and diagnoses included intractable low back pain, chronic kidney disease and chronic obstructive lung disease. Further review showed at the hospital the resident's pain was effectively managed with a Lidocaine patch, Fentanyl patch, and Norflex (all are medications for pain). Review of the nursing admission assessment revealed the resident did not have cognitive impairment and required assistance with toileting and transfers. This review also revealed the resident	S2960		

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S2960	Continued From page 4 had "constant pain" in his/her lower back. Review of the physician admission orders showed orders for Percocet 10/325 milligrams (an opiod pain medication) every 4 hours as needed for pain. Review of the nursing notes, dated 8/30/17, showed the resident received a neuromuscular block injection in the lumbar area of the spine. According to the nursing notes the resident reported the procedure "greatly improved" the pain, but s/he continued to need the Percocet pain medication every 4 hours. Review of the physician orders, dated 8/31/17, showed an order to apply a Lidocaine transdermal patch to the lower back each day for lumbar stenosis pain. The following concerns were identified regarding ineffective pain management: a. Review of the narcotic book sign out sheet for the resident showed after receiving the daily Lidocaine patch the resident continued to need Percocet for pain. This review revealed 25 doses of Percocet were administered after the Lidocaine patch was started on 8/31/17 and before the facility obtained an order for a Fentanyl patch on 9/5/17 (5 days). b. Review of the nursing assessments before and after administering the pain medication showed the medication was effective only for a short time. Interview with LPN #1 on 10/4/17 at 3 PM revealed the resident had a lot of pain and it was never completely controlled. The LPN stated the resident was unable to participate in a lot of activities and bedside therapy due to the pain. He further stated it was difficult to get the physician to prescribe additional medications. c. Interview with the hospital case manager on 10/9/17 at 9:10 AM revealed she visited the resident at the hospital prior to the transfer to the nursing home and was concerned when she saw the resident at the nursing home on 9/5/17 because there was a noticeable decline	S2960		

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S2960	Continued From page 5 in health status and the resident complained of severe back pain. d. Interview with the family on 10/10/17 at 5:45 PM and again on 10/13/17 at 9:50 AM revealed the family visited 1 to 2 times daily and verbalized their concerns about the resident's pain to the nursing staff. During the interview the family member described the resident's pain as s/he "was always hurting" and the resident remained in bed most of the time due to the pain. e. Review of the admission and nutrition hydration status care plans, developed on 8/24/17, showed pain was an identified problem, but there were no documented interventions for this problem. The facility was unable to provide evidence of an individualized plan for managing the resident's pain, an initial pain assessment to establish desirable goals, and evaluation of this effectiveness of non-pharmacological approaches. f. Interview with the DON on 10/4/17 at 10:30 AM revealed staff talked with the physician about the resident's pain, but the physician was reluctant to prescribe different medications. Review of the documentation provided by the facility revealed the nursing staff contacted the physician on 8/31/17 and 9/5/17 to report the pain medication was not effective. This review also revealed additional efforts to report the ineffective pain management to the physician and/or request for involvement from other practitioners were lacking. g. Review of Pain Management Policy -495, updated June 2016, showed the following procedures were included in the measures for effective pain management: When pain is not adequately controlled by current regiment, I, or if there is newly identified pain, the Licensed Nurse (LN) contacts the physician for consideration of new or modified treatment orders. The	S2960		

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S2960	Continued From page 6 information on the Pain Evaluation Record is used in conjunction with the Center's other evaluation and data collection tools to develop an individualized care plan including non-pharmacological interventions, if appropriate.	S2960		
S2984	Ch 11 Sec 9 (g)(iii) Nursing Services The facility shall have sufficient nursing staff to meet the needs of the residents. (g) Storage of Drugs and Biologicals. Drugs and biologicals shall be stored in locked rooms, cabinets, or carts. Procedures for storing and disposing of medications at the nurses' station shall be established in consultation with the pharmacist. (iii) The refrigerator in which drugs and biologicals are stored shall not be accessible to residents, shall be used only for the storage of drugs and biologicals, and shall be in a locked refrigerator or a locked box in a refrigerator or in a protected area. The refrigerator shall be maintained at the proper temperature. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview and review of facility policy, the facility failed to ensure medications stored in 6 of 6 medication carts were not past their expiration date. The findings were: 1. Observation of medication cart A located on first floor on 10/3/17 at 10:20 AM revealed clortrimazole TRO 10 milligram (mg) did not have	S2984	S2984 1. Clortimazole TRO 10 mg, located in the first floor medication cart A was removed from cart on 10/04/2017. Klor-Con 20 mg located in the first floor medication cart B was removed from cart on 10/04/2017. Zofran 4 mg located in the medication cart on the second floor was removed from	10/27/17

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S2984	Continued From page 7 an expiration date on the label. Interview with RN # 1 revealed the medications in the cart were for resident use. 2. Observation of medication cart B located on the first floor on 10/3/17 at 10:33 AM revealed Klor-Con 20 milliequivalent(meq) did not have an expiration date on the label. Interview with LPN # 3 revealed the medications in the cart were for resident use. 3. Observation of the medication cart located on the second floor on 10/3/17 at 11:35 AM revealed Zofran 4 mg with an expiration date of 5/26/17 on the label. Interview with RN # 2 revealed the medications in the cart were for resident use. The RN also stated the Zofran came from the home of a resident who was admitted 8/29/17. The RN further stated the resident had not received that medication since admission. 4. Observation of medication cart B located on the third floor on 10/3/17 at 2:25 PM revealed 4 vials of Lidocaine 1% 20 milliliters (ml) did not have the date opened recorded on the label. Interview with LPN # 2 revealed the vials were used for residents. Review of the Vials and Ampules of Injectable Medications policy showed "The date opened and initials of the first person to use the vial are recorded on multidose vials on the vial label....." 5. Observation of medication cart A located on the third floor on 10/3/17 at 3:00 PM revealed Dulcolax suppository had an expiration date of 5/15/17 and oxycodone/acetaminophen 0.5mg/325mg had an expiration date of 7/18/17. Interview with LPN # 1 revealed the medications were for resident use and were past their expiration date.	S2984	cart on 10/04/2017. Vials of lidocaine located in the third floor medication cart B was removed from cart on 10/04/2017. Dulcolax suppository and oxycodone 0.5mg/ 325 mg located in the medication cart A on the third floor was removed from cart on 10/04/2017. Multi vitamin with iron located in the medication cart on the third floor secured unit was removed from cart on 10/04/2017. 2. The Director of Nursing or designee will complete an audit on or by 10/27/2017 of medication carts to validate medications are labeled with an expiration date, expired medications are removed and open vials are initialed and dated when opened. 3. The Staff Development Coordinator or designee will educate facility nurses on or before 10/27/2017 to validate medications are labeled with an expiration date, expired medications are removed and open vials are initialed and dated when opened. 4. The Director of Nursing or designee will complete a weekly audit for 60 days of medication carts to validate medications are labeled with an expiration date, expired medications are removed and open vials are initialed and dated when opened. The Director of Nursing or designee will report the tracking and trending of the audit to the facility monthly Quality	

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S2984	Continued From page 8 6. Observation of the medication cart located in the secure unit on the third floor on 10/3/17 at 2:40 PM revealed multiple vitamin with iron with an expiration date of 9/17. Interview with LPN # 1 revealed the medications were for resident use.	S2984	Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
S3021	Ch 11 Sec 13 (b)(ii) Pharmaceutical Services The Nursing Care Facility shall provide appropriate methods and procedures for the dispensing and administering of drugs and biologicals. Whether drugs and biologicals are obtained from community pharmacist or stocked by the facility, the facility shall be responsible for providing such drugs and biologicals for its residents and for ensuring that pharmaceutical services are provided in accordance with acceptable professional principles and appropriate federal, state and local laws. (b) Pharmaceutical Services Committee (ii) The pharmacist shall submit a written report at least quarterly to the pharmaceutical services committee on the status of the facility's pharmaceutical services and staff performance. This State Rule and Regulation is not met as evidenced by: Based on medical record review, pharmacy drug regimen review, and staff interview, the facility failed to ensure pharmacist recommendations were addressed for 8 of 16 sample residents (#3, #9, #17, #22, #64, #65, #82, #90). The findings were: 1. Review of the 8/28/17 to 8/29/17 Consultant	S3021	S3021 1. Pharmacy Recommendation was followed through on or before 10/27/2017 for resident, #3, #9, #17, #22, #64, #65, #82 and #90. 2. The Director of Nursing or designee will complete an audit on or before	10/27/17

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S3021	Continued From page 9 Pharmacist Medication Regimen Review for resident #3 showed the pharmacist recommended the resident's scheduled Synthroid 25 micrograms (mcg) be changed from being given in the AM to being given at 6 AM or at HS (bedtime) in order to ensure the medication would be given on an empty stomach for optimal absorption. Review of the October 2017 medication administration record (MAR) showed the medication was being given between 6 AM and 10 AM. Further review of the medical record showed that the pharmacist recommendation had not been addressed. Continued review of the Consultant Pharmacist Medication Regimen Review showed the pharmacist noted that the resident's ordered eyedrops were scheduled to be given together. The eyedrop orders were for brimonidine 0.1% scheduled at HS (bedtime), timolol 0.5% scheduled at HS, and dorzolmide 2% scheduled at 8 AM, 2 PM, and 8 PM. The pharmacist made the recommendation to "separate administration of each eye drop by at least 3 to 5 minutes." Review of the October 2017 MAR showed the medications were not specified to be given separately with any interval between medications. Review of the medical record showed that the recommendation had not been addressed. 2. Review of the 8/28/17 to 8/29/17 Consultant Pharmacist Medication Regimen Review for resident #17 showed the pharmacist recommended that the resident's scheduled Synthroid 50 mcg be changed from being given in the AM to being given at 6 AM or at HS (bedtime) in order to ensure the medication would be given on an empty stomach for optimal absorption. Review of the October 2017 MAR showed the medication was being given between 6 AM and 10 AM. Review of the medical record showed	S3021	10/27/2017 of July, August and September Pharmacy Recommendations to validate the recommendations for residents are completed timely. 3. The Staff Development Coordinator or designee will educate facility nurses on or before 10/27/2017 to validate Pharmacy Recommendations for residents are completed timely. 4. The Director of Nursing or designee will complete a monthly audit for 60 days of Pharmacy Recommendations to validate the recommendations for residents are completed timely. The Director of Nursing or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	

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S3021	Continued From page 10 that the recommendation had not been addressed. 3. Review of the 7/24/17 to 7/26/17, 8/28/17 to 8/29/17, and 9/25/17 to 9/26/17 Consultant Pharmacist Medication Regimen Reviews for resident #22 showed the pharmacist recommended that the resident's scheduled Flomax be changed from being given in the AM to being given approximately 30 minutes after the same meal each day since taking this drug on an empty stomach may increase risk of side effects such as blood pressure drop and dizziness. Review of the October 2017 MAR showed the medication was being given between 6 AM and 10 AM. Review of the medical record showed that the recommendation had not been addressed. Continued review of the Consultant Pharmacist Medication Regimen Review showed the pharmacist recommended on 9/26/17 that the resident's 1/22/17 order for Seroquel 50 mg (milligrams) be given in the AM and be considered for a GDR (gradual dose reduction). Review of the October 2017 MAR showed the medication dosage and administration time were not changed. Review of the medical record showed that the recommendation had not been addressed. 4. Review of the 7/24/17 to 7/26/17 and 8/28/17 to 8/29/17 Consultant Pharmacist Medication Regimen Review for resident #64 showed the pharmacist recommended the resident's scheduled Prilosec 20 mg be changed from being given in the AM to being administered approximately 30 minutes before the meal to achieve optimal therapeutic effect. Review of the October 2017 MAR showed the medication was being administered between 6 AM and 10 AM. Review of the medical record showed the	S3021		

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S3021	Continued From page 11 recommendation had not been addressed. Continued review of the Consultant Pharmacist Medication Regimen Review for 8/28/17 to 8/29/17 and 9/25/17 to 9/26/17 showed the pharmacist recommended the resident's scheduled Synthroid 25 mcg be changed from being given in the AM to being given at 6 AM or at HS in order to ensure the medication would be given on an empty stomach for optimal absorption. Review of the October 2017 MAR showed the medication was being administered between 6 AM and 10 AM. Review of the medical record revealed the recommendation had not been addressed. 5. Review of the 8/28/17 to 8/29/17 and 9/25/17 to 9/26/17 Consultant Pharmacist Medication Regimen Review for resident #65 showed the pharmacist recommended the resident's scheduled Synthroid 50 mcg be changed from being given in the AM to being given at 6 AM or at HS in order to ensure the medication would be given on an empty stomach for optimal absorption. Review of the October 2017 MAR showed the medication was being administered between 6 AM and 10 AM. Review of the medical record showed the recommendation had not been addressed. 6. Review of the 8/28/17 to 8/29/17 and 9/25/17 to 9/26/17 Consultant Pharmacist Medication Regimen Review for resident #82 showed the pharmacist recommended the resident's scheduled Synthroid 25 mcg be changed from being given in the AM to being given at 6 AM or at HS in order to ensure the medication would be given on an empty stomach for optimal absorption. Review of the October 2017 MAR showed the medication was being administered between 6 AM and 10 AM. Review of the medical	S3021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0018	A. BUILDING: _____ B. WING _____	10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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S3021	Continued From page 12 record showed the recommendation had not been addressed. 7. Review of the Consultant Pharmacist Medication Regimen Review dated 9/25/17-9/26/17 showed Resident #9 had a prescription for Ativan since 6/17/17. Further review showed the resident had received zero doses in 4 months. The pharmacist recommendation was to provide a risk versus benefit assessment if the current therapy was to be continued. Interview on 10/4/17 at 11:30 AM with the DON revealed "The medication should have been discontinued but it hasn't been." 8. Review of the physician's orders and October 2017 MAR for resident #90 showed Buspar (anti-anxiety medication)15 milligrams (mg) 3 times a day was ordered on 3/1/16, Guanfacine (for treatment of anxiety disorder) 1 mg 2 times a day was ordered on 3/7/15, aripiprazole (antipsychotic) 2 mg daily was ordered on 3/7/15 and venlafaxine ER (antidepressant) 225 mg daily was ordered on 4/12/17. Review of the Consultant Pharmacist Medication Regimen Reviews dated 2/13/17-2/21/17 and 9/25/17-9/26/17 showed the pharmacist recommended the physician review the medications for a possible gradual dose reduction and document a risk versus benefits rationale if the physician determined the reduction should not be done. Review of the pharmacy consultation report, dated 2/27/17, and the Psychoactive Drug and Behavior Medication Review Form dated 6/20/17 showed the physician response on both was for the medication review to be done by the psychiatrist. Interview with the DON on 10/4/17 at 11:10 AM revealed a psychiatrist was not available at the time the pharmacist made his initial recommendation. She further stated the	S3021		

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S3021	Continued From page 13 review for the gradual dose reduction had not been done because they did not have a psychiatrist until September 2017. 9. Interview on 10/4/17 at 12 PM with the consultant pharmacy revealed he had identified the concern with the physician's not acting upon the recommendations and had recently presented it to the facility's quality assurance committee.	S3021		