STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 9/18/18 through 9/20/18. This survey was prompted by complaint intake WY000002688. The following common abbreviations are used through this document: ADON- Assistant Director of Nursing DON- Director of Nursing MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 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 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure effective monitoring was provided for 1 of 4 residents (#2) who received anticoagulant therapy. This failure resulted in actual harm for the resident who experienced adverse effects from blood levels that exceeded the therapeutic range. The findings were:	F 684	1. Resident #2 was identified as being affected by this alleged deficient practice and is no longer a resident in the facility. 2. No other residents were identified as being affected. All residents receiving anticoagulant therapy requiring monitoring of PT/INR have the potential to be affected.	10/5/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/12/2018

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F 684	Continued From page 1 Review of the 6/23/18 annual MDS assessment showed resident #2 had a history of embolism, thrombosis, and urinary tract infections. Current diagnoses included obstructive uropathy, anemia, and multiple sclerosis. Further review showed s/he received daily anticoagulation therapy, and had severe cognitive impairment with limited mobility. Review of the corresponding care plan showed s/he required assistance with all activities of daily living and supra-pubic catheter care. Review of the August 2018 and September 2018 medication administration records showed the resident received daily doses of Coumadin (an anticoagulation). Review of the anticoagulation/INR (The international normalized ratio is a number that measures the time it takes for an individual's blood to clot. An INR range of 2.0 to 3.0 is generally an effective therapeutic range for people taking Coumadin) monitoring record for resident #2 showed the following information: On 8/7/18, the INR was 2.9 and the physician ordered recheck INR in 3 weeks and continue Coumadin 2.5 milligrams (mg) every Tuesday, Thursday, Saturday and Sunday, and 5 mg every Monday, Wednesday and Friday. On 8/28/18 the INR was 3.5 and the physician ordered staff to hold the 8/29/18 and 8/30/18 doses and decrease the Coumadin to 2.5 mg every Tuesday, Wednesday, Friday, Saturday, and Sunday, and 5mg every Monday and Thursday, with a recheck of the INR in 3 weeks. Interview on 9/19/18 at 3 PM with the ADON revealed the resident was sent to the hospital emergency department on 9/6/18 due to recurrent nose bleeding and returned to the facility later that same day with instructions to use nasal spray and packing if the bleeding reoccurred. He stated	F 684	3. Current and new Residents who are receiving anticoagulant therapy will be tracked by a designated licensed nurse. This tracking will include documentation of the PT/INR results, resulting order changes (if any) from the notified physician and when the next PT/INR draw is due. Documentation of the above will be maintained on a tracking log. Nursing staff will be re-educated on signs and symptoms of potential adverse side effects related to anticoagulant therapy. 4. The DON and/or designee will audit the tracking log at least one time weekly for the next 60 days and monthly thereafter to verify compliance. 5. Results of the audits will be reported to the QAPI committee monthly for the next 60 days.	

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F 684	Continued From page 2	F 684		

the resident's nose was not bleeding at the time s/he was at the emergency department, but s/he vomited bloody emesis. He further stated he did not understand why the emergency department care provided did not include checking the resident's INR. Review of the emergency room report showed no lab tests were done.

Review of the 9/7/18 nursing notes and medication administration record showed the resident received the prescribed dose of Coumadin that day and had an episode of bloody emesis. There was no evidence the facility contacted the physician about the bloody emesis.

Review of the 9/8/18 nursing notes showed the following events occurred: The resident had a large amount of bloody emesis with blood clots at 4:30 AM. At 6 AM, the nurse performed an INR test at the facility, and the result was 7.1. This was reported to the physician who ordered the Coumadin to be held. At 1 PM, the resident complained about "bad chest pain" and received a pain medication. At that time his/her nose began to bleed again and pressure was applied. There was no evidence the physician was contacted about the chest pain or recurrent nose bleed. At 7 PM, the resident's temperature was 102.7 degrees Fahrenheit. The physician was contacted, and ordered the resident transferred to the hospital for evaluation of bloody emesis and fever. The resident was transported at 8 PM.

Review of the 9/8/18 nursing notes, timed at 10 PM, showed the hospital reported the resident was septic and bleeding into [his/her] bowels. Review of the 9/9/18 nursing notes showed the resident expired at the hospital that morning.

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F 684	Continued From page 3 Interview on 9/20/18 at 9:30 AM with the DON revealed the nurses thought the recurrent nose bleeding was the result of the resident placing his/her fingers in his/her nose repeatedly; and the bloody emesis was drainage from nose bleeds. She stated her expectations of the nursing staff would be timely recognition and assessment of the possible cause and effect relationship between anticoagulant therapy, most recent INR of 3.5, and recurrent nose bleeds with bloody emesis. She further stated staff thought the emergency department physician would check the resident's INR on 9/6/18 because the anticoagulant therapy and information about the 8/28/18 INR lab result of 3.5 were documented on the hospital transfer form.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, medical record review, and policy and procedure review the facility failed to complete a post-fall assessment for 2 of 3 sample residents (#5, #8) who had recurrent falls. The findings were: 1. Review of the 6/9/18 annual MDS assessment showed resident #8 had diagnoses that included dementia and Parkinson's disease. Further	F 689	1. Residents #5 and #8 were identified as being affected by this alleged deficient practice. Resident #5 discharged on 8/22/18 and, therefore, no corrective action could be made. A post fall investigation was completed for the 8/18/18 fall for Resident #8 on 10/8/18. The chair used by Resident #8 was also assessed and is functioning correctly.	10/5/18

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F 689	Continued From page 4 review showed the resident had 2 non-injury falls. Review of the 2018 fall risk evaluations for resident #8 showed the score was 17 on 3/21/18, and 22 on 6/7/18 (10 or higher is at risk). Review of the 6/9/18 care plan showed interventions to address risk for falls due to alteration in mobility included use a mechanical lift as needed, nonskid strips at bedside, mobility enhancer and fall risk evaluation. Review of the 7/9/18 nursing notes showed the resident fell 3 times in 48 hours without major injuries. Review of the 8/9/18 nursing monthly summary showed the resident required extensive assistance with activities of daily living with the exception of eating with limited assistance. Review of the fall incident documentation showed staff did not complete a post-fall assessment for each fall to identify contributing factors and measures to reduce likelihood of recurring falls. Interview on 9/19/18 at 1:15 PM with the ADON verified the lack of post-fall assessments for the resident. 2. Review of the 6/23/18 quarterly MDS assessment showed resident #5 had diagnoses that included dementia, lumbago, and anxiety. Further review showed the resident's Brief Interview for Mental Status score was 12 (8-12 is moderately impaired cognition); and s/he could perform all activities of daily living independently. This review also showed the resident did not have a history of falls, but was at risk. Review of the 8/18/18 nursing notes showed the resident had an unwitnessed fall, slid out of recliner, and did not have the oxygen on at the time of the fall. Interview with the resident on 9/19/18 at 4:20 PM revealed s/he fell out of the recliner because s/he was unable to reposition the footrest. At that time s/he demonstrated the problems s/he continued to have repositioning the footrest and stated staff	F 689	2. All residents who fall have the potential to be affected. 3. Licensed nursing staff have been in-serviced on completing the post fall assessment section of the incident report document. All incident reports will be reviewed by nurse management the following business day to ensure the assessment and evaluation of cause of fall has been completed and to determine if other interventions may be appropriate in preventing future falls. 4. The DON and/or designee will audit incident reports at least one time weekly for the next 60 days to verify compliance. 5. Results of the audit will be reported to the QAPI committee monthly for the next 60 days.	

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F 689	Continued From page 5 had not addressed this problem. Review of the fall incident documentation showed staff did not complete a post-fall assessment to identify contributing factors and measures to reduce likelihood of recurring falls. Interview on 9/19/18 at 1:15 PM with the ADON verified the lack of a post-fall assessment for the resident. 3. Review of the fall policy, titled, "Falls - Clinical Protocol", revised September 2012, showed policy interpretation and implementation included the following: The staff will look for evidence of a possible link between the onset of falling (or an increase in falling episodes) and recent changes in the current medication regimen. Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls. The staff will seek to identify environmental factors that may contribute to falling such as lighting and room layout.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(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. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff and resident review the facility failed to ensure effective pain management for 1 of 3 residents (#5) who required pharmacological interventions in addition to non-pharmacological interventions for pain. The findings were:	F 697	1. Resident #5 was identified as being affected by this alleged deficient practice. A pain assessment was completed for Resident #5 on 10/8/18 and facility is working with the Resident on her pain management plan.	10/5/18

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F 697	Continued From page 6 Review of 6/23/18 quarterly MDS assessment showed resident #5 did not have cognitive impairment, performed all activities of daily living independently, and had frequent pain. Further review showed the resident's frequent pain made it hard to sleep at night and the worst pain was rated 8 on a 0 to 10 pain scale (10 is the worst). Review of the corresponding care plan showed directions for the charge nurse to provide pain monitoring sheets to the physician for evaluation/treatment if the current interventions were not effective. Review of the 7/16/18 physician's progress notes showed Ibuprofen, Gabapentin and Tramadol were ordered for lumbago with sciatica pain. Further review showed the resident understood to ask for non-scheduled pain medications, and staff were to "report which medications work to improve symptoms." Review of the physician's orders showed Gabapentin 100 milligrams (mg) 3 times daily was ordered on 5/25/17. Review of the physician's orders also showed Tramadol 50 mg was ordered as needed at supper and bed time on 8/13/18, in addition to the 2 times daily scheduled doses of Tramadol 50 mg. Further review showed Ibuprofen 400 mg every 4 to 6 hours as needed was ordered on 12/20/16. The following concerns were identified: a. Interview on 9/19/18 at 4:20 PM with resident #5 revealed s/he asked for pain medications for "awful back pain"; sometimes the pain medication helped; and other times it did not. S/he further stated the nurses who administered the pain medication did not consistently return to ask if the medication was effective. b. Review of the August 2018 medication administration record showed Tramadol 50 mg as needed was administered 14 times. Further review showed Ibuprofen 400 mg	F 697	2. All residents with pain have the potential to be affected. 3. Resident #5 and all other residents Medication Administration Records (MAR) have been revised to include documentation on the back of the MAR that addresses pain level prior to and after the administration of any as needed pain medication (PRN). Licensed nursing staff have been in-serviced on completing this on the back of the MAR as a way to document that pain has been assessed prior to and after PRN pain medication is administered to ensure the medication is effectively managing the resident s pain. 4. The DON and/or designee will audit the MAR s at least one time weekly for the next 60 days to verify compliance. 5. Results of the audits will be reported to the QAPI committee monthly for the next 60 days.	

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F 697	Continued From page 7	F 697		

was administered one time. This review showed no evidence an assessment prior to administering the medications was completed; nor was an assessment for effectiveness completed after administering the medication.

c. Review of the September 2018 medication administration record showed Tramadol 50 mg as needed was administered 5 times. Further review showed Ibuprofen 400 mg was administered one time. This review showed no evidence an assessment prior to administering the medications was completed; nor was an assessment for effectiveness completed after administering the medication.

d. Interview on 9/19/18 at 12:30 PM with the ADON and DON verified the lack of pre and post pain assessments. They further stated they had identified this problem and were working to implement a system to ensure the assessments were done.