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 07/25/2019

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 from 7/25/19 to 7/25/19. The survey was prompted by complaint intake WY000002884. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living BIMS- Brief Interview for Mental Status DON- Director of Nursing Services MDS- Minimum Data Set MAR- Medication Administration Record PACE- Programs of All-Inclusive Care for the Elderly TAR- Treatment Administration Record RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		8/8/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/08/2019

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F 686	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, PACE provider interview, review of PACE provider notes, review of the State Survey Agency incident reporting database, and quality assurance information review, the facility failed to ensure pressure wounds were effectively assessed, monitored and treated for 1 of 5 sample residents (#3). This failure resulted in actual harm to resident #3 who had wound deterioration related to lack of treatment provided by the facility. Corrective measures were implemented by the facility prior to the survey, and compliance was determined to be met on 5/12/19. The findings were: 1. Review of the 4/19/19 admission orders showed resident #3 was admitted to the facility for respite care. The resident had diagnoses of dementia and renal failure. The resident's usual care was provided by a PACE organization, and the resident usually spent Monday to Friday at the organization's day facility. Review of the "Nursing Admission Data Collection" form dated 4/19/19 at 3:40 PM showed "No" the resident did not have any skin issues, and the resident was independent with mobility and walking. Review of the 4/19/19 admission care plan showed the resident wandered and used a "wander alert" device. Wounds and pressure ulcers were not identified on the care plan. Under the category "Dressing/Splint Care" the care plan showed the resident preferred to wear non-slip gripper socks. Review of the "Participant Transfer Form" dated 4/19/19 showed there was a wound on the resident's right foot, which was being monitored by the staff at the PACE organization. Additionally, the resident was a known "wanderer"	F 686	Past noncompliance: no plan of correction required.	

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and "flight risk." Review of the "Admission Orders" dated 4/19/19 showed "Notify PACE for any change on Rt [right] foot. Monitor for change, care at PACE daily." Interview on 7/30/19 at 5:22 PM with PACE RN #1 revealed the nursing facility to which the resident was admitted had been on "quarantine", and the resident did not attend the PACE day program after s/he was admitted to the nursing facility. Further, the PACE RN did not see the resident at the nursing facility, however, there had been telephone communication between the facility and PACE. Review of the admission MDS assessment with an assessment reference date of 4/26/19 showed the resident had 2 stage 3 pressure ulcers and signs of infection of the foot. Review of the PACE wound care log showed the "right foot pad" wound had made progress since 3/6/19. The 3/25/19 entry showed "wound- no drainage opening closed redressed with 2 x 2 [spouse] still dressing." No other foot wounds were noted in the PACE documentation. Further, review of the PACE progress note dated 3/25/19 at 12:45 PM showed the resident's right foot was "looking good" had no drainage and a dremel tool was used to "grind off the callus a little." The following concerns were identified:

a. Review of the nursing facility head-to-toe skin check with an effective date and time of 4/23/19 at 1:08 AM (4 days after admission) showed "existing pressure ulcer." The wounds were described as "pressure ulcer on plantar surface of L [left] foot, scabs to L [left] toe, scabs to dorsal surface of two R [right] toes ...Admitted with all sores." The wounds on the right toes were identified as stage 2 pressure ulcers. There were no measurements of any of these wounds included on this skin assessment.

b. Review of the medical record showed there were no pressure wound condition reports;

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however, there were 2 weekly non-pressure condition reports dated 4/23/19 that showed the right and left toe wounds were identified as "abrasions" with onset dates of 4/22/19.

c. Review of the Situation Background Assessment Recommendation (SBAR) form dated 4/23/19 at 10 PM showed RN #3 notified the physician and the PACE program RN related to "wounds to bilateral feet, plantar and dorsal aspects bilaterally" that started on 4/23/19. The PACE program RN gave an "...OK to cover wounds with medihoney and kerlex (sic) until PACE was able to come see [the resident] in the a.m."

d. Review of the April 2019 TAR showed an order dated 4/23/19 at 5:53 PM to "Cover wounds on bilateral feet with Medihoney and Kerlex (sic) overnight one time only related to UNSPECIFIED OPEN WOUND, RIGHT FOOT". Continued review of the TAR showed no documentation the dressing was applied.

e. Review of the physician office visit note dated 4/26/19 at 1:45 PM showed the resident's wounds were debrided. The resident was " ...Confused; decreased sensation in both feet ... 3 cm diameter deep wound with purulent discharge R [right] plantar foot region; more superficial 3 cm wound L [left] plantar foot region. Superficial dried ulcers on dorsum of bilat [bilateral] toes. ... Assessment: 1. Open wound of right foot, initial encounter. Deep with purulent discharge. Superficial and deep cultures taken. Sharply debrided. Plan to pack and then dress with wet to dry dressing daily... 2. Open wound of left foot, initial encounter. More superficial than above, sharply debrided. Plan for wet to dry dressing daily...Plan: As above. 14 days of Keflex 500 milligram (mg) TID [3 times a day] ordered. F/u [follow up] cultures."

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f. Review of the "Telephone Encounter" dated 4/26/19 at 5 PM showed PACE program RN #4 called the nursing facility and provided a verbal order for wound care for bilateral foot wounds. The dressings were to be changed daily, and the pharmacy would be delivering Keflex (an antibiotic) directly to the facility.

g. Review of the progress note dated 4/27/19 at 6:29 AM showed "New wound care orders ... Pack right foot wound daily and apply wet to dry dressing daily. Dress left foot with wet to dry daily. Start Keflex 500 mg three times a day for 14 days."

h. Review of the 4/29/19 timed at 2:17 PM progress note showed the PACE program nurse called to inform the facility a different antibiotic was being ordered for the resident. The Keflex was changed to Bactrim related to Methicillin-resistant Staphylococcus aureus (MRSA) and Klebsiella pneumoniae in the wound.

i. Review of the April 2019 TAR showed on 4/30/19 at 4:39 PM (4 days after the verbal order was provided) the order for wound care to the left foot was added to the record. However, the TAR failed to show documentation the dressing was applied on that day. Further review of the April 2019 TAR filed to show the wound care orders for the right foot. In addition, review of the nursing notes for April 2019 failed to show documentation the dressings were applied or changed.

j. Review of the May 2019 TAR showed an order (dated 4/30/19) for "Right foot clean with wound cleaner, pack with plain packing strip, place a wet to dry dressing and secure with kerlex. Every night shift for wound care and monitoring." Continue review showed the facility documented the dressing as completed on 5/1, 5/2, and 5/3 (the resident was discharged on 5/2/19). Additionally, the TAR showed an order

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dated 4/30/19 for "Left foot clean with wound cleaner, place a wet to dry dressing and secure with kerlex." The review further showed the left foot dressing was not documented as being completed on 5/1/19 or 5/2/19. Review of the nursing notes for 5/1/19 to 5/2/19 failed to show evidence the left foot dressing was applied.

k. Review of the care plan initiated on 5/2/19 (also the date the resident discharged from the facility) showed the resident was "admitted with pressure ulcers to the plantar surface of the right and left feet. Interventions included "administer treatment as ordered and observe for effectiveness ..."

l. Interview with the resident's spouse on 7/31/19 at 9:02 AM revealed s/he had been applying the dressing for the resident at home prior to the resident's admission to the facility. S/he stated the resident had 1 open wound that was about the size of a dime on the right foot below the great toe when admitted to the nursing facility, and no wounds on the left foot. Further, the resident's spouse stated she told the facility about the resident's foot wound at the time of admission.

m. Interview with PACE program RN #1 on 7/30/19 at 5:22 PM revealed the PACE program had been in contact with the nursing facility on 4/30/19 related to concerns with wound care.

n. Review of the 4/30/19 at 4:48 PM "Telephone Encounter" showed PACE program RN #2 documented "Multiple call to [name] DON today and yesterday to discuss wound care orders and antibiotic orders not being followed per provider instructions. Call to her personal cell and left message requesting call back. Unable to go over to facility to speak with her at this time as [nursing facility] is closed to visitors d/t [due to] Quarantine from NoroVirus." Review of the

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4/30/19 at 5:08 PM "Telephone Encounter" showed PACE program RN #1 documented the facility called back and stated they did not have any known wound care orders, and thought the PACE program was going to be changing the resident's dressing daily. The PACE RN explained to the facility that verbal orders had been provided, and additionally, hardcopy orders had been delivered to the facility by the PACE RN on 4/26/19. The PACE RN provided verbal orders again at that time.

o. Review of the State Survey Agency incident reporting database showed the facility made an infectious disease report on 4/22/19, and "several residents" had been identified with nausea, vomiting and/or diarrhea. Between 4/21/19 and 4/25/19 31 residents were identified with symptoms.

p. Review of the "SBAR Summary" dated 5/2/19 at 6:30 AM showed the resident had a fever and "worsening wounds to bilateral feet." Review of the vital signs on this summary showed they were dated 4/26/19. The SBAR summary further showed "wound infection" and the resident's spouse had requested the resident go to the hospital for treatment. Review of a progress note dated and timed 5/2/19 at 8:04 AM showed the resident was sent to the emergency room. Review of a progress note dated and timed 5/2/19 at 8:39 PM showed the resident was admitted to the hospital for cellulitis.

q. Review of the Consultation Orthopedic Surgery notes dated 5/2/19 at 4:58 PM revealed "Musculoskeletal: Right foot- ulcer under 1st mt [metatarsal] head with minimal drainage. Appears to go down to bone. Also ulcer over the dorsal aspect of [his/her] 2 and 3rd toes. Palp [palpable] pulses. No swelling. Left foot- ulcer under first mt head with surrounding dry gangrene. There is

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redness up to the midfoot. Foul smelling. No significant drainage today." Continued review showed " ...Plan: [s/he] has a difficult problem. [S/he] likely has osteomyelitis with exposed bone. Amputation would be an option with a transmetatarsal amputation. [S/he] would have to be able to limit [his/her] weight bearing. There (sic) other option would be to continue to monitor things and see how [s/he] responds to abx [antibiotics], [his/her] wounds would likely never heal, but [s/he] could continue weight bearing ..."

r. Interview with the DON, administrator, and MDS coordinator on 7/26/19 at 1:29 PM revealed they were aware of the missed wound care orders, lack of treatment documentation, and lack of assessments for the resident's wounds. However, they felt that the status of the resident's wounds upon discharge were related to the debridement.

2. Interview with the DON, the administrator, and the district director of clinical services on 7/25/19 at 4:25 PM revealed the case with resident #3 had brought issues to their attention. A root cause analysis was completed, and the facility addressed the findings through Quality Assurance Performance Improvement (QAPI). Review of the "Ad Hoc QAPI Meeting Agenda/Summary" showed on 5/3/19 improvement areas included: following orders, documenting medication administration and treatments, entering orders correctly, skin system education, and skin assessments. Immediate corrective actions taken showed suspension of a nurse, investigation into causes, and education to all nurses. Review of the "Corrective Actions" showed the following:

a. The time line started on 4/29/19 with identification of wounds on feet and missing orders for care.

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F 686	Continued From page 8 b. Identification of others at risk was completed on 5/4/19 with a "skin sweep" of all residents. In addition, a review of each residents' orders (all possible forms of orders) from 4/1/19 to present was done. Corrections were made as needed. This had a completion date of 5/12/19. c. Systemic changes were made by providing education to licensed nurses with a target date of 5/31/19 and a completion date of 5/10/19. d. Monitoring was shown to be assigned to the current DON on 5/2/19. The monitoring included facilitation of "medication reconciliation daily", and documenting completion and actions taken, and also to report and identify patterns/trends of concerns to the QAPI Committee monthly. These were shown with a target date of 5/2/19 and a completion date of "on going." 3. In addition to 2 closed records, 3 sample residents with pressure wounds were reviewed, and no current non-compliance was identified.	F 686		