POC accepted 2/1/05 Jeanette C

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

PRINTED: 01/21/2005
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 _____	01/06/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 276 SS=B	483.20(c) RESIDENT ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by HCFA not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a scheduled quarterly Minimum Data Set (MDS) assessment for one (#70) of twelve sample residents who required quarterly assessments. Findings were: Medical record review revealed the most recent quarterly MDS assessment for resident #70 was completed on 9/24/04. Further record review showed the next quarterly assessment was to be completed by 12/24/04. There was no evidence the facility had completed the quarterly assessment within the required time frame. An interview with the MDS coordinator on 1/6/05 at 2:35 PM confirmed the most recent quarterly assessment was dated 9/24/04 and the next quarterly assessment was not completed.	F 276	Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by provision of Federal and State law. This plan of correction is the facility's credible allegation of compliance. F-276 –Resident #70's MDS was completed on December 2, 2004. A review of the MDS for timeliness was completed and action taken on any other issues noted. a.) Random checks will be done by the MDS Coordinator/Director of Nursing or designee to ensure MDS' are completed timely. b.) A review of the RAI completing MDS' timely will be completed by the MDS Coordinator and reviewed by the Director of Nurses or designee. Results of the random MDS reviews for timeliness will be reviewed at the QA&A committee for trends. Recommendations will be followed to ensure continued compliance monthly X 3 months and then revaluated. Date of compliance is February 19, 2005.	
F 313 SS=D	483.25(b) QUALITY OF CARE To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced	F 313		

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

[signature] | Administrator | 01/31/05

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. POC accepted per phone on 2/1/05 @ 1522 E Rob Snyder, SCW

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F 313	Continued From page 1 by: Based on family and staff interviews and medical record review the facility failed to ensure desired vision services were obtained for one of one (#69) sample resident whose glasses were missing. Findings were: Review of the 7/29/04 significant change Minimum Data Set (MDS) assessment revealed resident #69 had adequate vision with glasses. According to the 11/9/04 significant change assessment, the resident was visually impaired and no longer wore glasses. Review of documentation on the current, undated plan of care showed the resident's glasses had been broken, but that the family chose not to replace them. During an interview on 1/4/05 at 7:35 PM a family member stated the resident's glasses were missing and the resident was unable to see without the glasses. The family member stated the resident was examined by an optometrist for a new prescription, but that the facility had never contacted the family related to the next step needed in obtaining glasses for the resident. The family member felt the matter was "just dropped." Interview with the social worker on 1/5/05 at 3:55 PM revealed she was unaware of the resident¿s missing or broken glasses or the documentation on the plan of care. Interview with the previous social worker (employee #143) on the same date and time confirmed the resident saw the optometrist, but stated she was unaware of any follow-up which might have occurred. On 1/5/05 at 4:04 PM interview with the unit manager (employee #133) revealed she was the person who wrote the comment on the plan of care that stated the family chose not to replace the glasses. The unit manager stated she did not	F 313	F-313: The facility will work with the family to obtain glasses for Resident #69. Review residents with glasses for the following: a.) Repairs; b.) Cleanliness; c.) Appropriate fit; and d.) Adequate for resident. The Social Services Director or designee will review the telephone orders in morning meeting for new glasses ordered or referral to ophthalmologist. Review the 24 hour report for changes in vision or lost or damaged items by the Social Services Director, Administrator, or designee. Review the care plans for accuracy and needs for wearing glasses for residents by Social Services Director, Administrator, or designee. In-service licensed staff on referral form regarding resident needs for glasses. This will be completed by Unit Managers, Director of Nurses, or designee. Review of the 24 hour report for visual problems will be reviewed by the QA&A committee for trends. Recommendations will be followed to ensure continued compliance monthly X 3 months and then revaluated. Date of compliance is February 19, 2005.	

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F 313	Continued From page 2 contact the family prior to documenting the statement. She verified that nothing further had been done to assist the resident and the resident's family in obtaining a new pair of glasses.	F 313	F-314 – Resident #77 and #66 are repositioned every 2 hours. Review of resident's RDS to determine resident's risk of potential skin problems. Action to be taken as needed. Create a list of residents: a.) That need to be laid down after meals. Place a copy in the RFPR's and MAR's. Review weekly. Monitoring will be performed by the Unit Managers, Director of Nurses, or designee. b.) Do random rounds to ensure residents are being laid down and repositioned timely. c.) In-service nursing staff on the process when you find a pressure ulcer and steps taken to treat. The in-service will be conducted by the Unit Managers, Director of Nurses, or designee. d.) Review the 24 hour report in the morning meeting for any changes and ensure areas are treated and evaluated timely and adequately. To be performed by the Director of	
F 314 SS=D	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of policies and procedures, and staff interview, the facility failed to provide care and services to promote healing for one (#77) of three sample residents with pressure sores. In addition, the facility failed to assure staff provided preventative care and services for one (#66) of four sample residents who were at risk for pressure sores. The findings were: 1. Review of the 11/26/04 quarterly Minimum Data Set (MDS) assessment showed resident #77 required extensive assistance with bed mobility, transfers, and toilet use. Further review showed the resident required cueing and supervision, was incontinent of bladder daily and incontinent of bowel two to three times per week. The MDS also showed the resident had two state	F 314		

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F 314	Continued From page 3 2 stasis ulcers. Review of the assessment information showed the resident was at risk for the development of pressure sores due to decreased mobility, impaired ability to reposition self, and incontinence. Observation on 1/3/05 at 3 PM showed certified nurse aides (CNAs) #53 and #55 transferred the resident from the wheelchair to the toilet, a process that took approximately 30 seconds. The resident was incontinent of urine and had a dressing on the left buttock. At the time of the observation, the CNAs were interviewed and stated they were unaware of the reason for the dressing on the resident's buttock. Observation on 1/4/05 at 7:17 AM revealed the resident was seated on a Maxifloat Gel Cushion (a static cushion to reduce pressure). Interview on that date with CNA #53 at 4:45 PM revealed the resident remained in the wheelchair from 7:17 AM to 3 PM, except for time taken to toilet the resident at 10:11 AM and 1:20 PM. The elapsed time from 7:17 AM to 10:11 AM was 2 hours and 54 minutes. The elapsed time from 10:11 AM to 1:20 PM was 3 hours 9 minutes. On 1/4/05 at 3 PM, observation with the occupational therapist and the regional director of nursing revealed the wound that had been covered with a dressing was located on the left buttock and measured 7 cm by 3 cm, was described as unstageable and consisted of 90% necrotic tissue. According to "Nursing Interventions & Clinical Skills" by Elkin, Perry, and Potter, 3rd Edition: If immobility of inactivity are risk factors, "...reposition...at least every two hours." The authors further state that static devices are non-powered and are pressure reducing. They reduce pressure or provide relief, but clients must still be repositioned regularly	F 314	Nurses, Unit Managers, or designee. e.) In-service nursing staff on policy and procedure RC2 – 0101.00 and 0102.00. This will be completed by the Unit Managers, Director of Nurses, or designee. f.) Update care plans to reflect resident's condition will be performed by the Unit Managers, Director of Nurses, or designee. Review results of random rounds to ensure residents are being laid down and repositioned timely. Results will be reviewed by the QA&A committee for trends. Recommendations will be followed to ensure continued compliance monthly X 3 months and then revaluated. Date of compliance is February 19, 2005.	

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F 314	Continued From page 4 reduce pressure or provide relief, but clients must still be repositioned regularly 2. Observation of resident #86 on 1/5/05 at 3:01 PM revealed the resident was dependent on staff for incontinence care, repositioning, and transferring. Interview with CNA #13 at that time revealed the resident was totally dependent for repositioning, transfers, and incontinence care. Medical record review revealed a quarterly Minimum Data Set (MDS) assessment dated 11/1/04 which documented the resident was totally dependent on staff for care in the areas of bed mobility, transfers, dressing, hygiene, and bowel and bladder incontinence. The facility's resident data sheet assessment, dated 10/23/04, assessed the resident as at risk for pressure sore development. A second continuous observation on 1/6/05 from 7:46 AM until 12:55 PM showed the resident remained in his/her wheel chair for a period of five hours and nine minutes without repositioning or incontinence care. From 12:55 PM to 1:11 PM the observation showed staff transferred the resident to bed and provided incontinence care. The observation revealed the resident had skin redness to the lower third of the buttocks and upper half of the thighs, skin indentations from clothing wrinkles, and urinary incontinence. On 1/6/05 at 12:40 PM, interview with the licensed practical nurse (LPN) caring for the resident revealed she was unaware the CNA had not repositioned or checked the resident for incontinence. Review of the working care plan used by CNAs dated 8/2/00 revealed CNAs were instructed to "turn every 2 hours and PRN [as needed]" and check for incontinence "upon rising, before and after meals, and PRN." 3. According to "Nursing Assistant: A Nursing	F 314		

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F 314	Continued From page 5 Process Approach," ninth edition, by Hegner, Acello, and Caldwell, the measures used to prevent pressure sores include keeping the skin clean and dry, removing feces or urine from skin, and changing a resident's position every two hours or more.	F 314	F-316: Resident #66 and #77 will be toileted and changed every 2 hours. Review resident's toileting plan for accuracy of toileting program and appropriateness. a.) List of residents that need to be toileted and/or checked and changed. This will be performed by the Unit Managers, Director of Nurses, or designee. b.) Review the equipment for residents for toileting to ensure the equipment is appropriate. This is to be performed by the Unit Managers, Director of Nurses or designee. c.) Update the care plans to reflect the resident's needs for toileting. Do random round reviews to ensure residents are toileted or changed timely. Results of the random reviews for residents toileted timely will be reviewed by the QA&A committee for trends. Recommendations will be followed to ensure continued compliance monthly X 3 months and then revaluated. Date of compliance is February 19, 2005.	
F 316 SS=D	483.25(d)(2) QUALITY OF CARE A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to assure staff provided care and services to maintain dryness for 2 of 11 sample residents (#66, #77) with urinary incontinence. The findings were: 1. Review of the 11/26/04 quarterly Minimum Data Set (MDS) assessment showed resident #77 required extensive assistance with toilet use, needed cues and supervision, and was incontinent of bladder daily. According to the 9/22/04 bladder retraining review, the resident was alert and oriented to self, but had symptoms of urinary urgency and diminished perception of the need to urinate. Review of the care plan showed staff were to toilet the resident upon arising, before and after meals, at bedtime, and as needed. Observation on 1/4/05 showed registered nurse (RN) #138 answered the resident's call light at 9:50 AM, and the resident requested to use the toilet. Instead of assisting the resident immediately, the RN told the resident	F 316		

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F 316	Continued From page 6 she would get a certified nurse aide (CNA) and left the room. The resident kept repeating, "I'm going to be wet" and "I need to use the bathroom." At 9:58 AM CNA #79 entered the room, the resident requested to use the toilet, and the CNA left briefly to get CNA #8. Upon their return, the resident's roommate requested to use the toilet, so the CNAs took the roommate into the bathroom first. Resident #77 was not taken into the bathroom until 10:11 AM. During this entire time period the resident kept yelling s/he would be wet; the CNAs stated the resident was incontinent of urine when toileted 21 minutes after the light was first answered. 2. Observation of resident #60 on 1/6/05 at 3:01 PM revealed the resident wore disposable briefs, was incontinent of urine, and dependent on staff for incontinence care. Interview at that time with CNA#13, who was responsible for the resident's care, revealed the resident was totally dependent on staff for incontinence care and was on an every two hour check and change schedule. Interview with the resident's licensed practical nurse (LPN) on 1/6/05 at 12:40 PM verified the resident was on a check and change program. Medical record review revealed an annual resident assessment instrument (RAI) dated 8/18/04, which documented the resident was incontinent of bladder. The facility's resident data sheet assessment dated 10/23/04 showed the resident remained incontinent of urine and used pads/briefs to contain the incontinence. The last bladder assessment dated 8/27/02 documented the resident was incontinent of bladder, was not a candidate for retraining, was dependent on staff for perineal care, and was placed on a scheduled program for incontinence care. The program	F 316		

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F 316	Continued From page 7 schedule was upon arising, before meals, after meals, at bedtime, and as needed. According to the incontinence care plan dated 8/8/04, staff were directed to check and change the resident¿ s pads/briefs with "rounds" and as needed at night. The working CNA plan of care dated 8/2/00 documented for CNA staff that the resident was unable to sit on a toilet and needed to be checked for incontinence upon arising, before and after meals, and as needed. Observation of the resident on 1/6/05 from 7:46 AM to 1:11 PM showed the resident was not checked for incontinence or changed until 12:55 PM (a period of 5 hours and 9 minutes). At 7:46 AM the resident sat in the dining room, having breakfast. At 8:34 AM, the resident was taken to his/her rooms and parked next to the bed. The staff member did not check the resident for incontinence. At 10:24 AM, thickened liquids were placed in the room, but the staff member did not check the resident for incontinence, At 11:30 AM, a CNA entered the room and took the resident to the dining room without checking the resident for incontinence. Interview with the resident¿s LPN at 12:40 PM on 1/6/05, while the resident was still in the dining room, revealed she was unaware the CNA had not checked the resident. At 12:55 PM the resident was taken to his/her room and checked. The resident had been incontinent of urine.	F 316		
F 329 SS=D	483.25(l)(1) QUALITY OF CARE Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		

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F 329	Continued From page 8 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure two of four sample residents (#77, #94) who received hypnotics (psychotropic medication used for sleep) did not receive them unnecessarily. The findings were: Review of the face sheet showed resident #77 was admitted on 5/18/04. Review of the physician's orders revealed 7.5 milligrams of Restoril (a hypnotic) was ordered nightly on 7/6/04. According to the medication administration records (MAR), it was given from that date through 1/4/05. Review of the entire medical record failed to reveal physician documentation of the rationale for exceeding the recommended administration time. According to the 2005 PDR Nurse's Drug Handbook the medication is for short term use only; long term use can cause dependence and withdrawal symptoms. Further review of the Handbook showed rebound insomnia may be experienced after more than three weeks of continuous use. Interview with the director of nursing (DON) on 1/5/05 at 11:45 AM revealed the facility lacked a physician's statement explaining why the hypnotic medication was used nightly since 7/6/04 and why alternative methods of sleep induction, a decreased dose, or different medications were not attempted. In addition, the facility failed to provide evidence that other possible reasons for insomnia (e.g., depression, pain, noise, light, caffeine, new environment) were eliminated. On	F 329	F-329: Resident #77 on ambien was discontinued on January 25, 2005 and the restoril was revaluated by the physician and orders were changed to every other day on January 12, 2005. Resident #94 was unable to reply as resident is deceased. Review psychotropic medications for the following: a.) Adequate medications; b.) Behavior Monitoring Form accuracy and specifics; c.) Appropriate diagnosis; d.) Existence of a care plan; e.) Pharmacy review; f.) Consent; and g.) Quarterly evaluation. In-service nursing staff on approaching a difficult resident. This will be performed by the Unit Managers, Director of Nurses, or designee. In-service staff on alternative approaches other than drug therapy. This will be performed by the Unit Managers, Director of Nurses or designee. Review the 24 hour report for medication changes to be performed by the IDT or designee.	

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F 329	Continued From page 9 1/6/05 at 2:08 PM, the DON confirmed he had reviewed the record and there was no information in the current or thinned record which supported continued use of the medication, documented that other methods of sleep induction were attempted, or documented that the benefits of daily consecutive use for over six months outweighed the risks. Review of the physician's orders in a closed sample medical record showed resident #94 had diagnoses which included renal failure. Further review showed 10 milligrams of Sonata (a hypnotic) was ordered nightly on 7/19/04. Review of the MARs for July, August, and September 2004 showed the resident received the medication as ordered. However there was no statement in the record by the physician documenting the rationale for continued daily use of the medication. According to Mosby's 2003 Nursing Drug Reference, the medication is for short term use only and should be used with caution in the elderly and those with renal disease. On 1/6/05 at 2:08 PM, the DON confirmed he had reviewed the record and there was no information in the current or thinned record which supported continued use of the medication, documented that other methods of sleep induction were attempted, or documented that the benefits of daily consecutive use outweighed the risks.	F 329	Random psychotropic reviews will be done to review the appropriateness of the medication for the resident. This will be performed by the Social Services Director, Director of Nurses, or designee. Random reviews of psychotropic medications for appropriateness of the medications for residents will be reviewed by the QA&A committee for trends. Recommendations will be followed to ensure continued compliance monthly X 3 months and then revaluated. Date of compliance is February 19, 2005.	
F 465 SS=B	483.70(h) PHYSICAL ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 465		

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F 465	Continued From page 10 by: Based on observations and staff interview, the facility failed to assure a clean environment in the laundry area. Findings were: Observation in the laundry area on 1/5/05 at 10:00 AM revealed the area behind the dryers contained approximately two to three inches of accumulated lint. The total area of this accumulated lint was approximately three square feet. In addition, the observation revealed the back covering of one of the dryers had been removed exposing the drive belts. A second observation of this same area on 1/5/05 at 3:00 PM revealed the area behind the dryers had been cleaned and the back covering of the dryer had been put back on. Interview with the facility maintenance director (in charge of laundry, housekeeping and floor) at this same time revealed the laundry area accumulated a considerable amount of lint. Lint is removed from the tops of the dryers daily while the area behind the dryers is cleaned monthly. Interview also revealed the covering on the back of the dryer had been removed several days ago to make repairs. The director stated the job was interrupted and the dryer back covering was not replaced.	F 465	F-465: The Maintenance Director will ensure that the area behind the dryers is clean and free of lint and equipment components for the dryers remain attached to the piece of equipment until the repair parts(s) have been received. The Maintenance Director or designee will clean the lint behind the dryers 2 times per month. Results will be reviewed monthly at the QA&A committee for trends. Recommendations will be followed to ensure continued compliance monthly X 3 months and then revaluated. Date of compliance is February 19, 2005.	

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

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 535025	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 1/6/2005
NAME OF PROVIDER OR SUPPLIER: CHEYENNE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE: 2700 E 12TH STREET CHEYENNE, WY		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 241	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interviews, and medical record review, the facility failed to assure laundry staff replaced clothing correctly in each residents closet. Another resident's clothing was hung in the closet of one (#69) of nine sample residents who required assistance with dressing. Findings were: Review of the 11/9/04 significant change Minimum Data Set (MDS) assessment revealed resident #69 had severely impaired cognition, required extensive assistance with dressing, was five feet tall, and weighed 98 pounds. On 1/4/05 at 4:05 PM observation showed certified nurse aide (CNA) #53 assisted the resident to change clothing. The CNA removed a very large shirt from the closet. After checking the initials inside the shirt, the CNA stated it did not belong to the resident. Interview with a family member on 1/4/05 at 7:35 PM revealed s/he often found the resident wearing other residents' clothing. The family member stated this was upsetting as the resident had several sets of marked clothing which kept "disappearing." The family member further stated when reporting the missing items to the facility, s/he was told they were probably in the laundry. On 1/5/05 at 3:00 PM interview with the person in charge of laundry confirmed the facility was aware resident clothing items were being lost or misdirected. Applying the reasonable person scenario, a person would prefer to wear his or her own clothing.

JAN 31 2005

Health Svg Pgs
Pgs 1-11

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

The above isolated deficiencies pose no actual harm to the residents

031099

Event ID: NXYX11