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	535036	A. BUILDING _____ B. WING _____	C 08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 7/25/22 through 8/22/22. The survey was prompted by complaint intakes WY00003444 and WY00003445.	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, staff interview, and review of the facility's neurological evaluation form, the facility failed to follow physician orders, and failed to assess or monitor changes in condition for 2 of 4 sample residents (#1, #2,) reviewed for changes in condition requiring transport to the hospital. This failure resulted in harm to resident #1, whose need for assessment, treatment, and monitoring of his/her diabetes mellitus went unaddressed, and whose change in condition on 7/8/22 was not evaluated in a timely manner. Resident #1 required emergency transport to the hospital, where his/her prognosis was determined to be "bleak". The findings were: 1. Review of the physician orders showed resident #1 was admitted to the facility on 7/5/22 with diagnoses that included acute and chronic respiratory failure with hypoxia, morbid obesity	F 684	Corrective action: Resident #1, no longer resides in Center. Resident #2, no longer resides in Center. ID of others: *Initial audit- to be completed by DNS/Designee of current insulin dependent diabetic residents to ensure others were not affected by deficient practice cited by 9/22/2022 *Initial audit to be completed by DNS/Designee for residents who have experienced a change of condition in the last thirty days to ensure others were not affected by deficient practice cited by 9/22/2022. *Initial audit to be completed by DNS/Designee of falls for the last 30 days to ensure others were not affected by	10/6/22

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

Electronically Signed | 09/16/2022

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F 684	Continued From page 1 due to excess calories, thrombocytopenia, obstructive sleep apnea, hypertension, and diabetes mellitus due to underlying condition with diabetic chronic kidney disease. His/her admission vitals were a blood pressure of 122/60, temperature of 97.5 degrees Fahrenheit, a pulse of 86 beats per minute, and an oxygen saturation of 94% while receiving supplemental oxygen via nasal cannula. Review of a physician's telehealth visit progress note from 7/5/22 at 3:38 PM showed the physician stated the resident was feeling ok, and noted " ... No change in appetite ... no abdominal pains, no bowel habit changes, no emesis ..." Review of physician orders showed 7/5/22 orders for orthostatic vital signs to be performed: lying, sitting, standing, and standing repeated after three minutes. Each order was to be administered " ...one time a day for 3 days". Further review showed a 7/5/22 order stating "blood sugars [in the morning] and [at bedtime] two times a day related to diabetes mellitus ..." Review of the July 2022 medication administration record/treatment administration (MAR/TAR) record showed a 7/5/22 insulin order for "Humalog Solution 100 unit/mL Inject as per sliding scale: if [blood glucose level] 70-150 = 0; 151-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units; 401-501 = 12 units call [doctor] for [blood sugar] over 400, subcutaneously every 12 hours as need for prophylaxis ..." The following concerns were identified: a. Review of the documented blood pressures showed only sitting and lying blood pressures were documented on 7/5/22, only sitting on 7/6/22, no evidence blood pressure readings were taken on 7/7/22, and only a sitting blood pressure was documented on 7/8/22. It was noted that pressures taken on 7/6/22 and 7/8/22	F 684	deficient practice cited by 9/22/2022. Systemic change: *Education to be provided by Executive Director/Designee to current Licensed Nurses and CNAs related to the monitoring of diabetic residents including, following Physician□s orders related to glucose monitoring, appropriate medical record documentation, administration of appropriate sliding scale insulin as ordered, as well as the monitoring, reporting, and documentation of diabetic resident□s meal refusals by 9/22/2022. *Education to be provided by Executive Director/Designee to Licensed Nurses and CNAs on obtaining, assessing, and documenting neuro evaluations and orthostatic vital signs by 9/22/2022. *Education to be provided by Executive Director/Designee to Licensed Nurses and CNAs on appropriate and timely assessment and Physician notification of resident changed of condition by 9/22/2022. *Ongoing audits will be completed weekly times three months by ED/Designee related to diabetic monitoring including following Physician□s order, glucose monitoring, documentation, insulin administration, meal refusals, and Physician notification. *Ongoing audits will be completed twice weekly times three months by DNS/Designee for any residents who have fallen to ensure neuro evaluations and/or orthostatic vital signs have been completed as appropriate. *Ongoing audits will be completed twice	

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F 684	Continued From page 2 triggered as being low, and no follow-up actions were documented. b. Review of the medical record on 7/25/22 showed no evidence the resident's blood glucose levels were measured on the mornings of 7/6/22, 7/7/22, or 7/8/22. However, review of the resident's July 2022 MAR/TAR documentation provided by the facility on 8/16/22 showed registered nurse (RN) #2 documented a blood glucose of 227 for the morning of 7/8/22, with no corresponding administration of insulin. Interview with RN #2 on 8/18/22 at 11:34 AM revealed he did not complete or document the blood glucose check of 227 the morning of 7/8/22. He stated he did not work that morning, and took over caring for the resident at approximately 1:00 PM that afternoon, after licensed practical nurse (LPN) #1 cared for the resident that morning beginning at 6 AM. c. Interview with LPN #1 on 8/17/22 at 3:06 PM revealed she cared for the resident on 7/8/22 from approximately 6 AM to 12 PM, then performed rounds with the physician that afternoon. She stated the resident refused his/her medications that morning, and she did not notify the physician of the refusal since he would be in later that day. However, review of the July 2022 MAR/TAR documentation showed all of the morning medications for 7/8/22 were documented as administered. d. Interview with LPN #1 on 8/18/22 at 11:34 AM revealed she did administer the medications after re-approach, including insulin administration, and did not report to the provider the resident had refused. e. Review of a nursing progress note from 7/8/22 at 1:25 PM showed "Resident did not want [his/her] AM meds, refusal honored ..." However, this was a late entry note, and was not created	F 684	weekly times three months by DNS/Designee to ensure timely assessment and Physician notification has occurred with changes of resident condition. Monitoring: Results of initial and ongoing audits will be reviewed via the QAPI process monthly times three months for further compliance recommendations.	

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until 7/12/22. Review of the medical record showed no documentation the physician was notified of the medication refusal.

f. Review of a nursing progress note from 7/10/22 at 2:30 PM showed "... resident refused to take medications earlier this shift ... Resident refused to eat lunch ..." However, this note was not created until 7/11/22. Review of a progress note showed "Note dated 7/10/22 is late entry report for 7/8/22 day shift;" however, this correction to correct the late entry note was not created until 7/25/22 at 4:56 PM.

g. Review of the the MAR/TAR for July 2022 showed bedtime blood glucose levels of 227 on 7/7//22, and 155 on 7/8/22. According to the physician order for insulin dated 7/5/22, each of these bedtime blood glucose readings was in range for administration of insulin, however, further review of the MAR/TAR showed no evidence insulin was administered to the resident subsequent to these readings, and no documentation to show why no insulin was administered.

h. Further review of the medical record showed insulin was administered to the resident only once during his/her stay at the facility.

i. Review of Fluid and Meal intake documentation showed no dinner intake documented on 7/6/22, refusal of breakfast documented with no lunch or dinner intake documented on 7/7/22, and refusing all three meals on 7/8/22. Further medical record review showed no evidence the physician was notified the resident was not eating.

j. Review of a 7/6/22 nursing progress note timed 4:26 AM showed "Resident appears to display confusion/anxiety with [shortness of breath] this night ..."

k. Review of a physician's telehealth visit

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progress note from 7/7/22 at 3:11 PM showed the resident was struggling with anxiety and frequently requesting staff assistance because s/he was " ...never comfortable." In addition, the physician noted the resident was agitated and angry with staff.

l. Review of a nursing progress note from 7/7/22 at 4:24 PM showed "Resident has obvious anxiety, related to shortness of breath ..." Further medical record review showed no documentation the physician was notified of the change.

m. Review of an untimed physician nursing home visit progress note from 7/8/22 showed the resident " ...has been more somnolent today ..."

n. Review of a Nutrition/Dietary progress note from 7/8/22 at 1:46 PM showed "[Certified Dietary Manager] in to do food preferences eval [evaluation] resident sleeping not easily rousable ..."

o. Interview with the certified dietary manager on 8/19/22 at 3:19 PM revealed she first attempted verbal stimulation to try and rouse the resident for the evaluation on 7/8/22 at 1:46 PM. After unsuccessful attempts, she tried gently shaking the resident, which resulted in no response. She stated after she was unable to wake the resident, she reported the information to LPN #1, who directed her to document a progress note and attempt the assessment later. She further stated she did not report the resident status to the physician, assuming LPN #1 would communicate the information to the physician since LPN #1 was caring for the resident that day and performing rounds with the physician. Further interview revealed when she reviewed the intake documentation for the resident, it showed the resident had very minimal intake, which was worrisome since the resident was " ... a bigger [person]."

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p. Further review of nursing progress notes showed no evidence the resident was assessed by nursing staff after the report from the certified dietary manager the resident could not be awakened.

q. Review of a nursing progress note from 7/8/22 at 9:16 PM showed the resident " ... has been 'unresponsive all day.' Night staff confirm that resident is still unresponsive." Further review showed a temperature of 99.4 degrees Fahrenheit, a blood pressure of 80/46, a pulse of 88 beats per minute, and an oxygen saturation of only 35%. The physician was notified, and orders were given to send the resident to the hospital. Further, " ...Ambulance arrives and notes either emesis or food coming from resident's mouth and black loose stools, EMTs suspect GI bleed and/or sepsis ..."

r. Interview with RN #2 on 8/17/22 at 2:35 PM confirmed the missing blood glucose checks, as well as the lack of recorded insulin administrations with correlating blood glucose checks.

s. Interview with the physician on 8/19/22 at 2:49 PM revealed the resident was somnolent during the visit on 7/8/22. He also stated he did not recall being notified the resident was not eating, or that the resident had refused any medications. He stated staff communicated with him through calls, texts, emails, and in person. Further, he would expect staff to notify him of abnormalities, as well as changes in condition, including lack of intake and medication refusals.

t. Review of a nursing progress note from 7/9/22 at 4:47 AM showed the resident was admitted to the intensive care unit at the hospital and required blood transfusions. Further review showed the resident continued to have very low blood pressure and oxygen levels, and his/her "

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...prognosis is bleak ..." Review of a nursing progress note from 7/9/22 at 10:22 AM showed " ... resident is to be put on comfort measures after family arrives."

2. Review of the physician orders showed resident #2 was admitted to the facility on 2/4/22 with diagnoses that included muscle weakness, congenital renal failure, Type II diabetes mellitus with diabetic polyneuropathy, hypertension, chronic embolism and thrombosis of other specified veins, unsteadiness on feet, and other abnormalities of gait and mobility. Review of the care plan, last revised 5/9/22, showed the resident required assistance with ambulation because s/he " ...wanders and is confused." Further review showed the resident's cognitive function as confused and forgetful; communication was clear. The resident required a wander guard, and was at risk for falls. Review of a 5/6/22 Morse Fall Scale assessment showed any score above 45 was at high risk for falls, and the resident was assessed as having a score of 55. Review of the medical record showed the resident sustained falls on 3/1/22, 5/4/22, 5/5/22, and 5/6/22. The following concerns were identified:

a. Review of the 5/6/22 incident report showed the resident suffered an unwitnessed fall at 12:30 AM. Review of a nursing progress note from 5/6/22 at 12:50 AM showed the resident was found on the floor with " ...a moderate amount of blood everywhere." Further review showed the resident sustained a skin tear to the back of his/her left hand and an injury to his/her suprapubic catheter site. Continued review showed " ... Fall mat placed beside bed." Review of neurological evaluation documentation showed on 5/6/22 neurological assessments were

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performed at 12:30 AM, 12:45 AM, and 1:00 AM. Further review showed no evidence neurological assessments were performed after 1:15 AM.

b. Review of the facility neurological evaluation form showed guidelines for post-fall assessments as "A = Every 15 [minutes] (x8) for first 2 hours, THEN B = Every 30 [minutes] (x4) for 2 hours, THEN C = Every 1 hour (x4) for 4 hours, THEN D = Every 8 hours (x8) for the remaining 64 hours after a fall."

c. Review of a nursing progress note from 5/6/22 at 8:00 AM showed the resident had suffered a seizure, and family had requested the resident return to the hospital for evaluation. Review of a nursing progress note from 5/7/22 at 1:00 PM showed the resident had passed away while at the hospital.

d. Interview with RN #1 on 8/23/22 at 8:33 AM confirmed after the resident suffered the unwitnessed fall on 5/6/22 at 12:30 AM, she did not complete orthostatic vital signs, or complete neurological assessments per protocol.

3. Interview with the administrator and DON on 7/25/22 at 7:07 PM revealed the facility did not have a policy for monitoring changes in condition. However, their expectation was for staff to document and monitor all changes in condition, including labs, vitals, and behaviors. Further, they expect staff to notify the physician and family if the changes worsened and/or a resident needed additional evaluation at the hospital. They stated with any variance from baseline residents are put on "alert charting" that lasts for at least three days and requires at least one assessment to be performed per shift. They confirmed assessments after falls should be completed and documented, including neurological assessments.

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F 684	Continued From page 8 4. Interview with the staff development coordinator on 8/18/22 at 3:04 PM revealed the expectation was for orthostatic vital signs and neurological assessments to be performed with every fall, witnessed or unwitnessed, immediately after the fall. She stated if there were no abnormal findings with orthostatic vital signs, complete once per shift; if abnormal, notify the physician for further orders. Further, if the fall was witnessed and there are no abnormal findings with neurological assessments, complete assessments once per shift. If the fall was witnessed with head impact, or the fall was unwitnessed, neurological assessments were to be completed per guidelines for 72 hours.	F 684		