POC accept 10/13/08 8:30 Amber telephone conversation Deren Schmidt. Day of Compliance 10/21/08

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

PRINTED: 09/22/2008
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
	535032	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	1330 PRAIRIE AVENUE CHEYENNE, WY 82009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and 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 ensure a urinary catheter was medically necessary for one (#129) of seven sample residents with urinary catheters. The findings were: Medical record review revealed resident #129 was admitted on 8/5/08 to recover from shoulder surgery. Further record review revealed the resident had a urinary catheter in place upon admission. Observation on 9/9/08 at 3:50 PM verified the resident utilized an indwelling urinary catheter at the time of survey. The resident's perineal area was noted to be reddened and excoriated. The following concerns were identified: a. Interview with registered nurse (RN) #1 on 9/9/08 at 3:50 PM revealed the reason for the catheter was that the resident was admitted to the facility with a catheter and because the resident was on Medicare. b. According to the catheter justification worksheet dated 8/5/08 the primary reason for the catheter was skin integrity and wound healing.	F 315	F 315 URINARY INCONTINENCE The facility will ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's cllinical condition demostrates that catheterization was necessary; 1. Resident # 129 was assessed on 9/11/2008 by nurse manager and Director of Nursing to determine if resident had appropriate diagnosis for the use of her foley catheter. It was determined that resident # 129 used the catheter for decreased functional mobility and excoriation. Physician was notified via fax and order was received on 9/11/2008 to discontinue foley catheter. 2. The Director of Nursing or designee will conduct monthly audits of all residents with a foley catheter to determine if residents clinical condition demostrates that the catheterization is necessary. All residents admitted will have audit preformed by medical records by the 15th day post admission to ensure that the foley justification worksheet is completed. 3. Education was provided to all nursing administration on 9/24/2008. Director of Nursing will conduct the re-education of all nursing staff by October 15th, 2008 regarding appropriated use of a foley catheter in LTC setting. 4. A Performance Improvement Audit Tool will be utilized for monthly audits. Any problems identified as a result of the audits	10/21/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DA

Executive Director 10.1.08

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.

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F 315	Continued From page 1 However, record review showed there was no evidence of wounds, just excoriation to the perineal area. An interview with the director of nursing (DON) on 9/11/08 at 9:33 AM, revealed the catheter was used due to the resident's immobility, as well as for wound healing. The DON confirmed the "wound" was actually excoriation, not a wound. She further stated immobility was not a valid reason for continued use of the indwelling catheter. The DON stated a request was made to the physician on 9/10/08 to have the catheter discontinued.	F 315	will result in immediate re-education and/or corrective action 5. The Director of Nursing, designee, and medical records department will report the results of the audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. Reporting will occur for a period of no less than three months or until compliance has been achieved. Overall compliance will be monitored by the PI committee.	
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure kitchen cooking appliances were cleaned often enough to prevent build-up. In addition, the facility failed to ensure various equipment was in good condition and able to be cleaned. The findings were: Observation on 9/8/08 at 7:35 AM and on 9/9/08 at 2:55 PM revealed the outside of two oven doors, the interior of the ovens, and the top of the range were soiled with an accumulation of burned on food residue. In addition, the vents of the hood	F 371	F 371 SANITARY CONDITIONS The facility must store, distribute and serve food under sanitary conditions. 1. The outside of two oven doors, interior of the ovens, vents and the top of the range were cleaned during survey. 2. The complete oven/range was replaced on the monthly cleaning schedule to be completed by the cooks. 3. The Dietary Manager will audit the cleanliness of the oven/range monthly. He will identify, correct and conduct staff education as needed for any issues found. 4. The Dietary Manager will report the results of the audits at the monthly Performance Improvement meeting for a period of three months or until compliance	10/21/08

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F 371	Continued From page 2 above the range/oven unit was soiled with an accumulation of grease and dust. Interview with the dietary director on 9/9/08 at 2:55 PM revealed he did not know when the unit was last cleaned and stated the cleaning schedule was being re-worked. He stated the cooks were responsible for cleaning the ovens and range, and it needed to be done more frequently.	F 371		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to ensure acceptable hand washing techniques were used during one of two meal observations. The findings were: Observation in the main dining room on 9/8/08 from 5 PM to 5:35 PM revealed two instances where certified nurse aide (CNA) #1 bussed the dirty dishes of residents who had finished eating, and wiped down the table. On each occasion, after wiping the table, the CNA proceeded to assist resident #70 by picking up the resident's sandwich with unwashed hands and fed it to the resident. Interview with the CNA on 9/8/08 at 5:37 PM revealed she did not wash her hands because she thought the sani-wipes she used to clean the table were enough to adequately cleanse her hands. However, the facility's policy for hand hygiene instructs staff to wash hands	F 444	F 444 PREVENTING THE SPREAD OF INFECTION The facility will require staff to wash their hands after direct resident contact for which handwashing is indicated by accepted professional practice. 1. Staff member assisting resident was educated on 10/1/2008 of appropriate technique of washing hands after removing soiled dining ware from the assisted table, before feeding other residents 2. The Director of Nursing and/or the Assistant Director of Nursing or designee will conduct monthly audits of various staff members assisting residents during meals to ensure handwashing protocol is followed. 3. Re-education of all nursing staff handwashing will be conducted on or before October 15th, 2008. The Director of Nursing will conduct the re-education of nursing staff. 4. A Performance Improvement Audit Tool will be utilized for monthly audits. Any problems identified as a result of the audits will result in immediate re-education and/or corrective action. 5. The Director of Nursing will report the results of the audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends in inadequate handwashing noted.	10/21/08

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F 444	Continued From page 3 with soap and water whenever the hands become visibly soiled or are contaminated with proteinaceous material.	F 444	Reporting will occur for a period of no less than three months or until ongoing compliance has been achieved. Overall compliance will be monitored by the PI committee.	
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to obtain monthly laboratory tests for 1 (#60) of 22 sample residents who had orders for laboratory tests. The findings were: Review of the September 2008 physician orders for resident #60 revealed an order for a monthly pre-albumin test. The start date for the order was documented as 12/26/06. The following concerns were noted: a. Review of laboratory results revealed a pre-albumin was performed on 1/15/08 with a result of 15.8 (normal range 20-40). On 4/15/08 the pre-albumin was 14.6 and on 7/23/08 it was 15.2. Further record review revealed there were no other reports for pre-albumins for 2008. b. During an interview with the DON on 9/9/08 at 12:45 PM confirmed the monthly pre-albumin tests had not been done as ordered by the physician.	F 502	F 502 LABORATORY SERVICES The facility will provide or obtain laboratory services to meet the needs of its residents. 1. Medical record was reviewed by Director of Nursing and Unit Manager on Resident # 60. A request was then made to have physician review medical record on 9/9/2008. At that time order to have pre-albumin every month was changed to every six months on 9/9/2008, during the survey. 2. Director of Nursing, Assistant Director of Nursing or designee will review all residents in facility with scheduled lab work to ensure lab slips are filled out and placed in the lab book. Scheduled labs have been reviewed and placed on medication administration record by 10/1/2008. 3. Director of Nursing, Assistant Director of Nursing or designee will audit all residents in facility with orders for scheduled lab work to ensure lab slips are filled out and placed in the lab book monthly. All scheduled labs ordered will be audited monthly by nurse managers before the 1st of each month to ensure that labs are on medication administration record. 4. A Performance Improvement Audit Tool will be utilized to conduct the weekly audits. If any problem is noted immediate re-education and/or corrective action will take place. The monthly audits will be conducted by the Director of Nursing, Assistant Director of Nursing, Nurse Managers or designees. 5. The Director of Nursing will report results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of no less than three months or until ongoing compliance has been achieved. Overall compliance will be monitored by the PI committee.	10/21/08