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

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WY Dept of Health
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Healthcare Licensing and Surveys

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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
	535031	A. BUILDING ______ B. WING ______	C 05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER HEALTHCARE & REHABILITATION CENTER	1002 FOREST DRIVE RIVERTON, WY 82501

(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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: RN: Registered Nurse IP: Infection Preventionist ADLs: Activities of daily living CNA: Certified Nurse Aide CAA: Care Area Assessment MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	This plan of correction is the Center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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, staff interview, and medical record review, the facility failed to conduct end-of-life discussions in a dignified and confidential environment for 1 non-sample resident (#76). Further, the facility failed to ensure 1 non-sample resident (#51), and 1 of 13 sample residents (#37) had a comfortable and dignified environment during routine observations of residents' rooms. In addition, the facility failed to honor the request of 1 non-sample residents (#48) and 1 sample resident (#49) to close a bathroom window and prevent cold air from entering their room. The findings were:	F 241	F241 1. Family member of Resident #76 will be shown to a private location for any discussion of health care information relating to Resident #76. All newly admitted Residents and/or family members will be advised regarding the issue of private locations for discussions relating to health care. All Resident family members will be shown to a private location for any discussion of any health care information. Staff will be inserviced relating to privacy of health care information and the need to conduct discussion in a private location. RN #1 will be instructed regarding holding discussions related to health care information with Residents and/or	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ED	6-15-12

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.

Changes per John Aldrich, NHA on 6/27/12 @ 2:54pm.

POC accepted. Janelle Conley, OTR/L

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F 241	Continued From page 1 1. Observation at the front nurses' station on 5/22/12 at 2:40 PM revealed RN #1 was in discussion with a family member of resident #76. The resident was newly admitted and the family member was being questioned about advanced directives and end-of-life decisions; the family member was clearly not understanding his/her role in the process and repeatedly made reference to "...death...morphine...pain...life support...transfer to the hospital..." The location of the verbal exchange was adjacent to the lobby by the front entrance and during the 30 minute observation 2 non-clinical staff and 4 non-staff visitors passed by the nurses' station, well within a distance that the discussion might have been overheard. At 3:10 PM the same day, the social services director intervened and completed the advanced directives process with the family member. The administrator stated in interview on 5/22/12 at 3:25 PM the facility lacked specific policies and procedures for conducting interviews with family members and the need for privacy. She further stated the family member declined the option to move the discussions to a more private location and, per the administrator's interview with the RN, was not being particularly cooperative. The administrator further acknowledged the location of the observed discussion did not afford privacy or confidentiality for the information being exchanged; it was also noted by the administrator that the social services director was "probably better able to handle the situation than the charge nurse" in this specific instance. The administrator stated the maintenance director had discussed the incident with her, clarifying the discussion was	F 241	F241 continued: legal representatives in private location. Staff Development Coordinator (SDC) and/or designee will audit concerning appropriate locations of conversations relating to personal health care one time per week for three weeks then randomly thereafter. Based on the results of the observations, additional training with staff will be done as needed. Audit results will be taken to the Quality Assurance Committee at least quarterly. 2. Window in room of Resident #51 will be closed when the generator is running. In all Resident rooms located near the generator, windows will be closed when the generator is running either during routine testing or when needed for power outage. Maintenance Supervisor will inform all staff caring for Residents in the rooms located near the generator when the generator test will be starting. Staff will be inserviced to ensure the windows are closed prior to generator test being initiated.	

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F 241	Continued From page 2 overheard by non-clinical staff that played no role in the decision process or outcome of the advanced directives. 2. On 5/23/12 at 12:50 PM a surveyor was attracted to a resident room by a loud noise; the noise was similar to that of a large engine. Upon approaching the room, the odor of diesel exhaust became distinct. Further observation revealed resident #51 was in his/her bed adjacent to a window. The window was opened 8 1/2 inches and immediately outside the window was the facility's emergency power generator. The generator was running and was identified by the surveyor as the source of the noise and exhaust smell in the resident's room and adjacent hallway. The closest available staff member, the activities director, was asked by the surveyor to intervene. At 1:05 PM the same day he closed the window. At this time he stated he was unaware the window was opened, acknowledged the generator was loud, and was the likely source of exhaust fumes entering the room. Subsequent interview with the activities director on 5/23/12 at 1:10 PM revealed resident #51 "...had a seizure..." the morning of 5/23/12 and was in his/her room to rest. The activities director acknowledged the noise and smell would make resting comfortably difficult in the resident's room. A second staff member, LPN #1 confirmed in interview on 5/23/12 at 1:15 PM that resident #51 had a seizure earlier in the day and was in her room to rest and recover. Interview with hospice nurse, RN #2 on 5/24/12 at 11:25 AM revealed resident #51 was a hospice	F 241	F241 continued: ED and/or designee will conduct rounds of Resident rooms to determine if windows are open/closed per Resident requests and if closed during generator testing. Rounds will be done weekly for three weeks and then re-evaluated. Results of rounds will be taken to the Quality Assurance Committee at least quarterly. 3. The bathroom window in Residents #48 and #49 will be closed unless Residents wish it to be open. The bathroom windows in all Resident room will be closed unless Residents wish them to be open. Staff will be inserviced regarding closing bathroom windows unless the Residents wish them to be open. Audit results will be conducted to ensure bathroom windows are closed unless Residents wish them to be open by SDC and/or designee three times per week for three weeks and randomly thereafter. Audits will be taken to the Quality Assurance Committee at least quarterly.	

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F 241	Continued From page 3	F 241	F241 continued:	

patient. The RN stated the resident's care centered on creating a comfortable environment to minimize agitation. The RN stated in her opinion loud noises, such as running a diesel generator, was not likely to be considered comfortable or reduce the potential for agitation and concern.

The maintenance director stated in interview on 5/24/12 at 9:50 AM that he tested the emergency power generator every Wednesday, a task that required the generator be started and run. He was not aware the windows closest to the generator were opened on 5/23/12, nor did he routinely check if windows were opened during testing.

None of the staff mentioned above, who were interviewed on 5/22/12 through 5/24/12 were aware that windows were opened in resident room adjacent to the emergency generator. Neither did any of the interviewed staff know if the windows were opened at residents' request.

3. Interview on 5/22/12 at 9 AM with residents #48 and #49 revealed staff left the bathroom window open all night and day. The residents stated the room was too cold, noisy and sometimes the air that comes through the open window was "...not good to breathe...it [the incoming air] makes you cough." The residents further stated they asked staff to close the window, but they have not done so. These two residents lived in the room next to resident #51 and their opened bathroom window was also located in close proximity to the facility's emergency power generator.

4. Resident #37 will be assisted to bed after lunch.

All Residents will be assisted to bed per their wishes and/or care plans.

All Staff will be inserviced relating to assisting Residents to bed concerning other staff being available to help.

Audit results of Residents wishing to go to bed after lunch will be completed by the DNS and/or designee three times per week for three weeks then randomly thereafter. Audits will be taken to the Quality Assurance Committee at least quarterly.

7.06.12

F253

1a. The nail/screw holes in the walls of the dining room will be filled and area repainted.

1b. Observed floor tiles in dining room will be replaced.

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F 241	Continued From page 4 4. Review of the 3/31/12 quarterly MDS assessment for resident #37 showed the resident required staff assistance with repositioning and transfers due to limited functional ability. Review of the care plan, updated 2/22/12, showed the resident had pain and discomfort due to neuropathy, contractures, and hemiparesis (weakness on one side of the body). The interventions for this problem included using positioning devices, medication, and non-pharmacological pain relieving interventions. Further review of this care plan showed staff were to encourage activity participation in the morning hours because the resident wanted to go to bed "straight after lunch." On 5/23/12 at 2:45 PM the resident was observed in his/her room sitting in his/her wheelchair. At that time s/he stated s/he was having "a lot of pain" and discomfort from sitting up for over four hours. The resident stated s/he had reported this pain and discomfort to CNA #3 at 2 PM, who told the resident s/he could not be transferred to bed until the second CNA returned from a break. Interview with the resident at 3:05 PM revealed s/he had also talked with RN #1 about wanting to be laid down, and the muscle pain that s/he experienced due to sitting for the prolonged time period. Observation at 3:20 PM (one hour and twenty minutes after the resident's request) revealed two CNAs and RN#1 used a mechanical lift to transfer the resident to bed. During an interview on 5/23/12 at 3:45 PM CNA #3 verified the resident was not transferred to bed at 2 PM due to staff taking breaks and efforts to avoid overtime.			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES			

F 241

F253 continued:

1c. The observed overhead light fixtures in the dining room will be cleaned.

1d. The three observed sprinkler heads will be cleaned.

1e. The observed painted wall surface on the east wall will be repaired.

2a. The observed nail holes in the north and east walls in the Purple Sage dinning room will be filled and painted.

2b. The observed six areas with debris on the ceiling in the Purple Sage dinning room will be cleaned.

All nail/screw holes will be filled and area painted; all floor tiles that are cracked, split, or broken will be replaced; all overhead light fixtures will be cleaned; all sprinkler heads will be free of dust and cobwebs; all painted walls with paper underneath will be repaired so wall paper underneath is not away from the wall

F 253

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F 253 Continued From page 5

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to reasonably maintain the appearance of 2 of 4 dining rooms. Further, the facility failed to repair drawers and doors in 3 of 13 sample resident rooms. The findings were:

1. Multiple observations on 5/22/12 from 7:10 AM through 1:15 PM in the facility's main dining room revealed the following:

a. The walls of the dining room exhibited 7 holes in the wall where nails or screws had been removed. The majority of the holes were clustered on the east wall of the dining room.

b. Eighteen floor tiles in the dining room were cracked, split, or broken. The effect was both unsightly as well as creating a surface that was no longer cleanable.

c. Of 16 overhead light fixtures in the dining room, 6 contained dust, debris, and insects.

d. Of 12 ceiling-mounted sprinkler heads, 3 had accumulations of dust and cobwebs; these 3 sprinkler heads were located over resident dining tables.

e. The painted wall surface in two areas on the east wall was peeling away from the wall; it appeared as though a previous layer of wall paper had been painted over and the underlying paper was separating at the seams.

2. Observations on 5/22/12 at 1:45 PM in the assisted, Purple Sage Dining Room, revealed the

F 253 F253 continued:

surface; all ceilings will be free of small deposits of dried material..

All staff will be inserviced relating being aware of nail/screw holes in walls, any cracked, split or broken floor tiles, any light fixtures needing to be cleaned, any sprinkler heads needing to be cleaned, any debris on ceilings. All staff will be inserviced relating to advising Maintenance Supervisor and/or Housekeeping Manager for any of the above observed items in order for items to be cleaned and/or repaired.

Maintenance Supervisor and/or Housekeeping Manager and/or designee will complete audits relating to the above observed items one time per week for four weeks and randomly thereafter. Audit results will be taken to the Quality Assurance Committee at least quarterly.

3. The broken door and drawer fronts on built-in storage areas observed in rooms 39 and 44 will be repaired and/or replaced. The bathroom door

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F 253	Continued From page 6 following: a. The north and east walls contained nail holes. b. Six areas on the ceiling exhibited small deposits, 1 to 1.5 inches in diameter, of dried material. The material varied in color and was peeled off in flakes when scrapped with a thumbnail; the material appeared to be dried food. 3. Routine observation in 13 open sample resident rooms showed 2 rooms (39 and 44) had broken door and drawer fronts on built-in storage areas. In both rooms, the broken material was a composite particle board and was broken along one or more corners. In addition, Room 42 had a deep gouge on the bathroom door, exposing the underlying structural material. 4. Interview with the lead housekeeper on 5/23/12 at 2:50 PM and the maintenance director on 5/24/12 at 10:10 AM confirmed the observations. The lead housekeeper acknowledged the material removed from the ceiling of the assisted dining room was probably food splatter that had been overlooked by the housekeeping staff.			
F 272 SS=F	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at			

F 253	F253 continued: observed in room 42 will be repaired and/or replaced. Staff will be inserviced related to notifying Maintenance Supervisor for any similar observations in other rooms in the facility. Maintenance Supervisor will audit rooms weekly. The Maintenance Director will discuss the findings of the audits with the ED. Items able to be corrected promptly will be addressed; items that may need extensive work or if there are a number of issues, the Maintenance Direction and ED will develop action plans to address. Audit results and any action plans will be taken to the Quality Assurance Committee at least quarterly.			7.06.12
F 272	F272 The CAAs for Residents #6, #8, #9, #13, #14, #18, #29, #32, #37, #49, #60, #64and #69 will be updated to include in the analysis of the findings to include a description of the problem, causes and contributing			

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F 272	Continued From page 7 least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments were completed for 13 of 13 sample residents (#6, #8, #9, #13, #14, #18, #29, #32, #37, #49, #60, #64, #69). The findings were:	F 272	F272 continued: factors and risk factors to the care area. CAAs for all Residents will be reviewed to ensure inclusion in the analysis of the findings to include a description of the problem, causes and contributing factors and risk factors to the care area. Corrections will be made on the next comprehensive assessments for Residents. Case Manager and members of the Interdisciplinary Team will be inserviced relating to the use of comprehensive method of completing the CAAs. The Health Information Manager or designee will audit the CAAs monthly for three months then re-evaluated. Audit results will be taken to the Quality Assurance Committee at least quarterly.	7.06.12

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1. Review of the various CAAs for the most current full (either initial, annual or significant change) MDS assessments completed for residents #6, #8, #9, #13, #14, #18, #29, #32, #37, #49, #60, #64, #69 showed they were not comprehensive. The area of the CAAs to provide an analysis of the findings was lacking a description of the problem, causes and contributing factors and risk factors to the care areas. Interview with the case manager/MDS coordinator on 5/23/12 at 3:43 PM revealed he was not aware of the level of analysis that was needed to complete the CAAs. In addition, he stated each of the individuals of the interdisciplinary team were responsible to perform specific CAAs were using this same non-comprehensive method.

F 274 SS=D 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE

A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:

F 272 F274

A Significant change
The MDS assessment for Resident #13 was ~~updated to a significant change status.~~ Completed.

A review of all MDS assessments will be conducted to ensure the status of the Residents does not require a significant change of status MDS.

Case Manager will be inserviced relating to capturing the MDS significant change of status.

F 274 DNS or designee will audit the clinical status of Residents weekly for one month and then re-evaluated to ensure the significant change of status is being completed where appropriate. Audit results will be taken to the Quality Assurance Committee at least quarterly.

7.06.12

F279

1. The care plan will be updated for Resident #13 to reflect the changes to the Resident's mobility and interventions put into place for preventing future falls.

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F 274 Continued From page 9

Based on observation, staff interview and medical record review, the facility failed to ensure a significant change MDS assessment was completed for one of one sample residents (#13) who required this type of assessment. The findings were:

Review of the 4/4/12 admission MDS assessment for resident #13 showed s/he was independent or required only supervision for ADLs including transfer, walking, and dressing. On 5/23/12 at 3:10 PM CNAs #1 and #2 were observed providing incontinent and toileting care for this resident. During this observation of transferring, performing personal hygiene care, dressing and undressing, the resident required extensive and total assistance of the two CNAs. Review of a 4/27/12 post fall evaluation showed the resident had fallen while ambulating and sustained a fracture to his/her left upper arm. The resident now used a wheelchair and no longer ambulated, also the resident's arm was in a plaster cast limiting ADLs such as dressing. Interview with the case manager/MDS coordinator on 5/24/12 at 9:35 AM revealed the resident showed a significant change in condition due to the fracture and now having to be in a wheelchair. He then verified a significant change MDS assessment had not been initiated, but was needed.

F 279 SS=D 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable

F 274 F279 continued:

2a. The care plan for Resident #37 will be updated relating to indwelling urinary catheter interventions.

2b. The care plan will be updated to reflect the Resident's (#37) wishes to be in the main dining room for coffee provided by the local restaurant.

3. The care plan for Resident #64 will be updated to reflect the need for intervention for the safety alarm.

MDS Coordinator will audit 10% of care plans each month for three months, the re-evaluate, to determine if it accurately reflects the Resident status.

Audit results will be taken to the Quality Assurance Committee at least quarterly.

7.06.12

F282

F 279

The pressure relieving cushion for Resident #69 will be placed in the wheelchair when Resident is sitting in the wheelchair according to the care plan.

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F 279	Continued From page 10	F 279	F282 continued:	

objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to ensure the care plan was updated to reflect the current needs for 3 of 13 sample residents (#13, #37, #64). The findings were:

1. Review of the falls care plan for resident #13 showed it was initiated on 4/10/12. There was no update shown to reflect the 4/27/12 fall the resident had while ambulating in the secure unit which resulted in a broken arm. The care plan showed the resident was at risk for falls and ambulated with a cane/walker. Observation periodically from 5/21/12 - 5/24/12 showed the resident did not ambulate, s/he was in a wheelchair and had a plaster cast on his/her left arm. Interview with the DON on 5/24/12 at 9:25 AM verified the care plan needed to be updated to reflect the changes to the resident's mobility and the interventions put into place for preventing

DNS and/or designee will conduct rounds to visualize the use of equipment, including wheelchair cushions. Following the rounds, the DNS and/or designee will review the care plans and update as needed. This information will be communicated to the nursing staff.

DNS will conduct rounds to visualize the use of equipment, including wheelchair cushions to ensure all pressure relieving devices and/or equipment listed in any care plan are in place. Rounds will be done weekly for four weeks and the re-evaluated, to ensure equipment, including wheelchair cushions, is being used per the care plan. Results of rounds will be taken to the Quality Assurance Committee at least quarterly.

7.06.12

F309

Resident #37 will be assisted to bed after lunch in a timely manner, when requested, to promote comfort.

Residents will be assisted with repositioning and/or transfers due to limited functional ability when requested.

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future falls.

2. Review of the care plan for resident #37 showed the following areas that were not addressed:

a. Periodic observations of resident #37 on 5/21/12- 5/24/12 revealed the resident had an indwelling urinary catheter. Interview with the administrator on 6/1/12 verified the catheter was initiated on 2/18/12. However, interventions regarding the care and monitoring of the urinary catheter were lacking in the care plan.

b. Interview with the resident on 5/23/12 at 11:40 AM revealed s/he liked to get up early and come to the main dining room. The resident explained that prior to breakfast being served, a local restaurant brought in coffee for residents in the dining room and this activity was important to him/her. The resident commented that "..sometimes the staff forgets to wake me up and I miss the early coffee..." The resident closed the interview by reiterating that the coffee activity was one of his/her favorite things to do at the facility. This individualized information regarding the resident's preferences was lacking in the care plan.

3. Review of the 4/16/12 admission assessment for resident #64 showed the resident had severe cognitive impairment and required staff assistance with transfers to and from the wheelchair and bed. Review of the 4/9/12 bed safety evaluation showed the resident had fallen within the past sixty days, was recovering from a fractured hip, and needed a safety alarm attached to wheelchair and bed. Review of the care plan showed the safety alarm had not been added to interventions for maintaining safety. Interview on

F309 continued:

Nursing staff will be inserviced relating to assisting Residents to reposition and/or transfer in a timely manner to promote comfort.

DNS and/or designee will audit Resident repositioning and/or transfer in a timely manner three times per week for four weeks and then re-evaluate. Audit results will be taken to the Quality Assurance Committee at least quarterly.

7.06.12

F314

The pressure relieving cushion for Resident #69 will be placed in the wheelchair when Resident is sitting in the wheelchair according to the care plan.

Resident care plans will be reviewed to ensure all pressure relieving devices, including wheelchair cushions. listed in any care plan are in place.

Staff will be inserviced relating to ensuring pressure relieving devices,

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F 279	Continued From page 12 5/24/12 at 11:40 AM with the MDS coordinator verified this intervention needed to be added to the care plan because the resident needed a safety alarm to alert staff to assist him/her with transfers. F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED SS=D PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure care plan interventions for preventive skin care were consistently followed for 1 of 13 sample residents (#69). The findings were: Review of the 4/23/12 annual MDS assessment and CAA for resident #69, showed s/he was at risk for developing pressure ulcers due to decreased mobility, incontinence and cognitive impairment. Review of the corresponding care plan showed interventions to prevent the development of pressure ulcers included a pressure relieving cushion in the wheelchair. Interview with a family member on 5/22/12 at 2:35 PM, revealed she visited daily and had noticed the pressure relieving cushion had not been in the wheelchair for at least two weeks. Periodic observations on 5/21/12 and 5/22/12 revealed the resident sat in his/her wheelchair without the pressure relieving cushion. When the resident was observed in the wheelchair without the	F 279	F324 continued: including wheelchair cushions, are in place. F 282 Audit of care plans which list pressure relieving devices will be completed weekly for four weeks and then re-evaluated to ensure Residents are using the listed devices. Audit results will be taken to the Quality Assurance Committee at least quarterly. F323 1a,b,c. Resident #64 will have safety alarm attached to wheelchair and bed when Resident is in wheelchair or bed. 2. Safety alarm will be located and attached to wheelchair and bed when Resident is in wheelchair or bed. DNS and/or designee will conduct rounds of Residents identified at risk for falling to determine if appropriate safety measures are in place. DNS or designee will audit all Resident safety alarms to ensure the	7.06.12

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F 282 Continued From page 13

pressure relieving cushion on 5/23/12 at 10:30 AM, the DON was interviewed regarding this issue. At that time she stated she did not know why or how long the cushion had been removed, but it should have been replaced as soon as it was removed.

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review, and staff interview, the facility failed to ensure non-pharmacological interventions for pain were implemented in a timely manner for 1 of 9 sample residents (#37) who had pain. The findings were:

Review of the 3/31/12 quarterly MDS assessment for resident #37 showed the resident required staff assistance with repositioning and transfers due to limited functional ability. Review of the care plan, updated 2/22/12, showed the resident had pain and discomfort due to neuropathy, contractures, and hemiparesis (weakness on one side of the body). The interventions for this problem included using positioning devices, medication, and non-pharmacological pain relieving interventions. Further review of this care plan showed staff were to encourage activity

F 282 F323 continued:

alarms are in place for each Resident daily for one week, one time per week for three weeks, then re-evaluate. Audit results will be taken to the Quality Assurance Committee at least quarterly.

F 309 7.06.12

F329

1. The physician for Resident #8 will be contacted to request a response to the GDR or a contraindication request for Seroquel dated 5/3/12.

2. The physician for Resident #29 will be contacted to request a response to the GDR or a contraindication request for Abilify dated 5/8/12.

3.The physician for Resident #69 will be contacted to request a response to the GDR or a contraindication request for Trazadone 25 milligrams dated 5/1/12.

Social Services and nursing staff will be inserviced relating to timely requests/responses to the GDR or contraindication for antipsychotic medications.

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F 309	Continued From page 14 participation in the morning hours because the resident wanted to go to bed "straight after lunch". On 5/23/12 at 2:45 PM the resident was observed in his/her room sitting in his/her wheelchair. At that time s/he stated s/he was having "a lot of pain" and discomfort from sitting up for over four hours. The resident stated s/he had reported this pain and discomfort to CNA #3 at 2 PM, who told the resident s/he could not be transferred to bed until the second CNA returned from a break. Interview with the resident at 3:05 PM revealed s/he had also talked with RN #1 about wanting to be laid down, and the muscle pain that s/he experienced due to sitting for the prolonged time period. Observation at 3:20 PM (one hour and twenty minutes after the resident's request) revealed two CNAs and RN #1 used a mechanical lift to transfer the resident to bed. At 3:30 PM the three staff repositioned the resident in bed and s/he stated the pain and discomfort were beginning to dissipate. During an interview on 5/23/12 at 3:45 PM CNA #3 verified the resident was not transferred to bed at 2 PM due to staff taking breaks and efforts to avoid overtime.			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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	F 309	F329 continued: Social Services and/or designee will audit all Residents who receive psychoactive medications to ensure timely GDR or contraindication request are made to the physician and physician responds timely. Audits will be completed monthly for two months and then re-evaluated. Audit results will be taken to the Quality Assurance Committee at least quarterly. F441 1. Resident #69 will have proper hand washing prior to meals 2. Cups filled with staff beverages will be removed from the back nurses station near the hand washing sink and sharpes container. 3a. CNA's #4 and #5 will perform hand hygiene between glove changes when performing cleaning of diarrhea as well as perform hand hygiene for the involved Resident. 3b. CNA's #4 and #5 will perform appropriate cleansing of the effected wheelchair prior to transferring Resident; perform appropriate cleansing of the gait belt prior to next	F 314	7.06.12

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prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review and staff interview, the facility failed to ensure preventive skin care interventions were consistently implemented for 1 of 5 sample residents (#69) who were at risk for developing pressure sores. The finding were:

Review of the 4/23/12 annual MDS assessment and CAA for resident #69, showed s/he was at risk for developing pressure ulcers due to decreased mobility, incontinence and cognitive impairment. Review of the corresponding care plan showed interventions to prevent the development of pressure ulcers included a pressure relieving cushion in the wheelchair. Interview with a family member on 5/22/12 at 2:35 PM, revealed she visited daily and had noticed the pressure relieving cushion had not been in the wheelchair for at least two weeks. Periodic observations on 5/21/12 and 5/22/12 revealed the resident sat in his/her wheelchair without the pressure relieving cushion. Observation on 5/22/12 at 2:35 PM showed the resident's skin was intact. When the resident was observed in the wheelchair without the pressure relieving cushion on 5/23/12 at 10:30 AM, the DON was interviewed regarding this issue. At that time she stated she did not know why or how long the cushion had been removed, but it should have been replaced as soon as it was removed.

F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

F 314 F441 continued:

use; perform appropriate hand hygiene between glove changes; perform appropriate hand hygiene for the Resident.

3c. CNA's #4 and #5 will inform the Licensed Nurse on duty of episodes of diarrhea.

3e. CNA #2 is no longer employed at the facility.

All CNA staff will be inserviced relating to appropriate hand hygiene when providing care as well as providing appropriate hand hygiene for each Resident prior to meals, after meals and after direct care.

IP will audit for proper hand hygiene for staff as well as Residents three times per week for three weeks, one time per weed for two weeks and then re-evaluate. Audit results will be taken to the Quality Assurance Committee at least quarterly.

4. Culture results relating to the urine analysis for Resident #37 will be
F 323 documented in the medical record and infection surveillance log.

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F 323	Continued From page 16 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure fall safety measures were implemented for 1 of 13 sample residents (#64). The findings were: 1. Review of the 4/16/12 admission assessment for resident #64 showed the resident had severe cognitive impairment and required staff assistance with transfer to and from the wheelchair and bed. Review of a 5/16/12 resident progress note showed physical therapy and occupational therapy continued to work with the resident. Review of the 4/9/12 bed safety evaluation showed the resident had fallen within the past sixty days, was recovering from a fractured hip, and needed a safety alarm attached to wheelchair and bed. A safety alarm was not attached to resident's wheelchair or bed, nor were staff present to assist the resident during the following observations: a. On 6/22/12 at 7:55 AM the resident wheeled him/herself from the dining room to his/her room and transferred himself/herself from the wheelchair to the bed. During the transfer the resident did not lock the wheelchair and it moved when the resident moved, causing him/her to grab the bedside stand to prevent falling.	F 323	P441 continued: Culture results for all urine analysis will be documented in the medical record and infection control surveillance log. Staff will be inserviced relating to ensuring the laboratory test results are documented and IP is notified. IP will audit all laboratory tests for infections performed to ensure results are received, documented in medical record and infection control surveillance log. Audit results will be taken to the Quality Assurance Committee at least quarterly.	7.06.12

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F 323	Continued From page 17 b. On 5/22/12 at 1:05 PM, the resident wheeled him/herself from the dining room to his/her room. The resident made several unsuccessful attempts to rise from the unlocked wheelchair before s/he succeeded in moving to the bed. The resident had an unsteady gait and remained in a sitting position as s/he completed the transfer. c. On 5/23/12 at 1:30 PM, in his/her room, the resident again transferred using the furniture and walls to prevent falling. 2. Interview on 5/24/12 at 11:40 AM with the case manager/MDS coordinator revealed staff checked on the resident routinely and the resident needed a safety alarm to alert staff to assist him/her with transfers. At that time, the case manager/MDS coordinator checked the resident, bed and wheelchair and was unable to locate the safety alarm.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329		

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as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary medications for 3 of 13 sample residents (#18, #29, #69). The findings were:

1. Review of the physician's recapitulation of orders for May 2012 showed resident #18 was ordered a routine dose of the antipsychotic medication Seroquel started on 3/16/11. Further review of the record failed to show any attempt to gradually reduce the dose of this medication in the year since it was initiated. Additionally there was no contraindication by the physician to not attempt a gradual dose reduction (GDR). Interview with the DON on 5/23/12 at 2:35 PM verified the required GDR for some medications were not being done. She then stated a new process was being implemented and they were trying to catch up. Review of a fax to the physician showed a GDR was requested on 5/3/12 for this resident's Seroquel; however, it had not yet been responded to.

2. Review of the physician's recapitulation of

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F 329	Continued From page 19 orders for May 2012 showed resident #29 was ordered a routine dose of the antipsychotic medication Abilify. The medication was started on 9/5/11 when the resident was admitted to the facility. Review of the medical record failed to show any documentation related to a possible GDR or contraindication by the physician to a GDR. Interview with the DON on 5/23/12 at 2:35 PM verified the required GDR for some medications had not been done or were not up to date. She then stated a new process was being implemented and they were trying to catch up. Review of a physician communication form dated 5/8/12 showed the facility was requesting the physician to address the use and possible reduction of this medication; however, the physician had not yet responded. 3. According to the medical record for resident #69, Trazadone 25 milligrams was ordered daily on 6/11/11 for dementia with behaviors, yelling out, and repetitive behaviors. Further review of the medical record failed to show any documentation related to a possible GDR or contraindication by the physician to a GDR. Review of a physician communication form dated 5/1/12 showed the facility was requesting the physician to address the use and possible reduction of this medication; however, the physician had not yet responded.	F 329		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

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(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to ensure residents received hand hygiene prior to eating during 2 of 2 meal observations. The facility further failed to ensure

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staff complied with accepted hand hygiene practices and policies that prevented food and drink in areas with a potential for contamination with blood-borne pathogens. In addition, the facility failed to verify culture results for 1 of 7 sample residents (#37) with cultures ordered within the last 30 days. The findings were:

1. Observation of meals on 5/22/12 at 7:20 AM and 5/23/12 at 11:45 AM failed to show that staff assisted residents with hand hygiene prior to eating. A mix of open sample and non-sample residents were observed. The 5/23/12 observation included a focus on resident #69; this resident had experienced a two-day bout of diarrhea and ate in the assisted dining room. Staff were not observed to assist the resident to wash his/her hands. The IP stated in interview on 5/23/12 at 2:45 PM that resident hand hygiene prior to meals was a facility's policy and her expectation of staff members. She did not have monitoring data to show staff compliance with the policy.

2. Observation on 5/23/12 at 10:15 AM showed 2 uncovered plastic drink cups located next to the hand washing sink on the back nurses' station at the Owl Creek unit. One cup was 1/3 full with an orange drink and the other was filled with a clear liquid. Both cups were pushed up to, and touching, a sharps disposal container bearing a biohazard label. The sharps container was half full and contained, among other items, used needles and lancets. Interview with LPN #1 on 5/23/12 at 10:28 AM revealed his opinion that the drink cups belonged to staff members. He stated drinks should not be placed next to the hand washing sink or a sharps disposal container.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535031	A. BUILDING _____ B. WING _____	C 05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER HEALTHCARE & REHABILITATION CENTER	1002 FOREST DRIVE RIVERTON, WY 82501

(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
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Subsequent interview with the IP on 5/23/12 at 2:40 PM confirmed that food or drink should not be located in an area with the potential for contamination.

3. Multiple observations of resident cares performed by facility staff revealed the following lapses in acceptable hand hygiene practices:

a. On 5/22/12 at 2:35 PM CNA #4 and #5 were observed as they provided personal hygiene and toileting assistance for resident #69 due to an episode of diarrhea. The resident's family member cleaned the wheelchair while the CNAs cleaned the resident, the floor, bathroom commode, and wall fixtures contaminated by feces. During this task the CNAs did not perform hand hygiene between glove changes and they completed the task without providing hand hygiene for the resident.

b. On 5/23/12 at 9:35 AM CNAs #4 and #6 were observed providing the same care for the resident due to another episode of diarrhea. During this observation staff did not cleanse the resident's wheelchair before they transferred him/her from the bathroom to the wheelchair. After they transferred the resident from the wheelchair to bed CNA #6 placed the gait belt in the seat of the wheelchair, washed her hands, then secured the unwashed gait belt around her waist and left the room. The CNAs did not perform hand hygiene between glove changes; nor did they provide hand hygiene for the resident.

c. Interviews on 5/23/12 at 10 AM with LPN #1 and at 10:30 AM with the DON verified they had not received any information from the CNAs about the resident's diarrhea episodes. Both stated this was the type of issue the CNA were

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expected to report to the charge nurse.

d. On 5/23/12 at 3:10 PM CNAs #1 and #2 were observed providing personal hygiene and toileting care for resident #13 due to urine and fecal incontinence. Both CNAs wore gloves during the provision of care; however, CNA #2 performed the following tasks without removing his gloves and without hand hygiene: removed soiled clothing, washed the resident's legs, dressed the resident in clean clothes, groomed the resident, and washed the resident's hands.

e. The IP stated in interview on 5/23/12 at 1:40 PM her expectation that staff wash their hands or use hand sanitizer when appropriate. She acknowledged toileting as an example when hand washing would be expected.

4. Record review for resident #37 showed a physician's order dated 5/2/12 for a urine analysis and culture. There was no further documentation to show if a culture was performed and, if so, what results were reported by the laboratory. The resident had a history of urinary tract infections and antibiotic therapy; the resident was started on an antibiotic prophylactically pending culture confirmation and antimicrobial sensitivities. Interview with the IP on 5/22/12 at 4:05 PM revealed she was not aware a culture was pending for resident #37. On 5/22/12 at 5:20 PM she provided a report from the laboratory stating the resident's culture included >100,000 colony forming units (CFUs) of Klebsiella pneumoniae per milliliter of urine. She acknowledged the laboratory culture report was absent from the medical record and should have been part of her infection surveillance log.