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

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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
	535013	A. BUILDING B. WING	C 06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(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: CNA - certified nursing assistant DON - director of nursing MAR - Medication administration record MDS - Minimum Data Set CAA - Care area assessment Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	**PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE ADMISSION OR 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 EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF STATE AND FEDERAL LAW**	
F 272 SS=E	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 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;	F 272		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D. Stacks
TITLE: Executive Director
(X6) DATE: 07-13-12

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.

This POC accepted between Dug Stacks, Executive Director and Terry [illegible], Surveyor on 7/19/12 [illegible] POC [illegible]
7/19/12

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F 272	Continued From page 1 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 provide comprehensive assessments in a variety of areas for 13 of 19 sample residents (#2, #9, #17, #25, #26, #28, #39, #53, #65, #69, #78, #79, #89). The findings were: According to the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, April 2012, "Review a triggered CAA by doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions...This is also an opportunity to consider any issues and/or conditions that may contribute to the triggered condition, but are not necessarily captured in the MDS data...Use the information gathered thus far to make a clear issue or problem statement." Failure to complete comprehensive assessments of triggered areas was identified as follows:	F 272	**F-272 – Comprehensive Assessments** **This plan of correction is the facility's credible allegation of compliance.** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Case Management Coordinator/MDS Coordinator/Designee will conduct an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions for residents #2, #9, #25, #26, #28, #39, #53, #65, #69, #78, #79, and #89.	

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F 272	Continued From page 2 1. Review of the 4/28/12 initial MDS assessment for resident #17 showed the following areas triggered for comprehensive assessment: ADLs (activities of daily living), psychosocial well-being, activities, nutrition, psychotropic drug use and pain. Review of the care area triggers showed the areas were not comprehensively assessed utilizing the causes and contributing factors to determine the rationale for care planning. Review of the information provided showed no evidence the data in each specified area was analyzed to determine the causes and impact on the resident. 2. Review of the 6/11/12 initial MDS assessment for resident #25 showed the following areas triggered for comprehensive assessment: nutrition, psychotropic drug utilization, and pain. Review of the care area triggers showed the areas were not comprehensively assessed utilizing the causes and contributing factors to determine the rationale for care planning. Review of the information provided showed no evidence the data in each specified area was analyzed to determine the causes and impact on the resident. 3. Review of the 6/3/12 initial MDS assessment for resident #26 showed the following areas triggered for comprehensive assessment: nutrition, ADLs, urinary incontinence, and pain. Review of the care area triggers showed the areas were not comprehensively assessed utilizing the causes and contributing factors to determine the rationale for care planning. Review of the information provided showed no evidence the data in each specified area was analyzed to determine the causes and impact on the resident. 4. Review of the 6/6/12 initial MDS assessment	F 272	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** A facility-wide audit will be conducted by the Case Management Coordinator/MDS Coordinator/Designee to confirm residents that have a triggered CAA had an in-depth, resident-specific assessment of the triggered condition in terms of the potential for care plan interventions. Corrections will be made on the next comprehensive assessment.	

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F 272	Continued From page 3 for resident #79 showed nutrition triggered for comprehensive assessment. Review of the care area triggers showed nutrition was not comprehensively assessed utilizing the causes and contributing factors to determine the rationale for care planning. Review of the information provided showed no evidence the data was analyzed to determine the causes and impact on the resident. 5. Review of the 12/9/11 significant change MDS assessment for resident #39 showed nutrition triggered for comprehensive assessment. Review of the care area triggers showed the area was not comprehensively assessed utilizing the causes and contributing factors to determine the rationale for care planning. Review of the information provided showed no evidence the data was analyzed to determine the causes and impact on the resident.	F 272	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Staff will be educated by the Case Management Coordinator/MDS Coordinator/Designee to confirm they are identifying a triggered area in the CAA with a subsequent in-depth and resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions. The Case Management Coordinator and/or MDS Coordinator will review all triggered areas in the CAA on each comprehensive assessment. This review's focus will be to confirm that an in-depth and resident-specific assessment of the triggered condition was conducted in terms of the potential need for care plan interventions.	
	6. Review of the 4/6/12 initial MDS assessment for resident #53 showed the following areas triggered for comprehensive assessment: cognition, ADLs, behavior, and nutrition. Review of the care area triggers showed the areas were not comprehensively assessed utilizing the causes and contributing factors to determine the rationale for care planning. Review of the information provided showed no evidence the data in each specified area was analyzed to determine the causes and impact on the resident. 7. Review of the 6/19/12 annual MDS assessment for resident #89 showed the following areas triggered for comprehensive assessment: cognition, mood, behavior, and pressure ulcers. Review of the care area triggers			

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F 272	Continued From page 4 showed the areas were not comprehensively assessed utilizing the causes and contributing factors to determine the rationale for care planning. Review of the information provided showed no evidence the data in each specified area was analyzed to determine the causes and impact on the resident. 8. Review of the 5/29/12 significant change MDS assessment showed resident #9 required comprehensive assessments in areas which included nutrition and psychotropic drug use. Review of the information designated as the comprehensive assessment for these areas showed the facility failed to document the impact on the resident, and lacked an analysis of the completed data to form a plan for intervention. 9. Review of the 6/18/12 annual MDS assessment showed resident #28 required comprehensive assessments in areas which included urinary incontinence and nutrition. Review of the information designated as the comprehensive assessment for these areas showed the facility failed to document the impact on the resident, and lacked an analysis of the completed data to form a plan for intervention. 10. Review of the 5/31/12 annual MDS assessment showed resident #65 required comprehensive assessments in areas which included mood state and nutrition. Review of the information designated as the comprehensive assessment for these areas showed the facility failed to document the impact on the resident, and lacked an analysis of the completed data to form a plan for intervention.	F 272	**Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** The Director of Nursing/Designee will report any concerns related to conducting in-depth, resident-specific assessments of the triggered condition(s) in the CAA to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is August 5, 2012.	

8/19/12

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F 272	Continued From page 5 11. Review of the 11/9/11 admission MDS assessment for resident #78 showed the area for nutrition triggered and required additional assessment. Review of the nutrition CAA showed it was not comprehensive and lacked analysis of the data. 12. Review of the 1/26/12 significant change MDS assessment for resident #2 showed the area for nutrition had triggered and required additional assessment. Review of the nutrition CAA showed it was not comprehensive and lacked analysis of the data. 13. Review of the 3/19/12 annual MDS assessment for resident #69 showed the area for nutrition had triggered and required additional assessment. Review of the nutrition CAA showed it was not comprehensive and lacked analysis of the data. Interview with the MDS coordinator on 6/21/12 at 10:35 AM revealed she would re-educate all staff who participated in the CAA process and in the decision making process for care plan development to be more specific in documenting their decision making rationale.	F 272	**F-279 – Develop Comprehensive Care Plans** **This plan of correction is the facility's credible allegation of compliance.** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:**	
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 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279	The care plans for residents #17, #25, and #26 were updated to reflect a measurable goal for managing the resident's pain, evidence of an acceptable individualized pain level, and individualized resident-specific pain management needs.	

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F 279	Continued From page 6 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 staff interview and medical record review, the facility failed to ensure an individualized care plan with measurable goals was developed for 3 of 21 sample residents (#17, #25, #26). The findings were: 1. Review of the 4/23/12 care plan for resident #17 showed pain was identified as a problem. Review of the care plan showed there were no measurable goals; the goal was "Resident's pain will be minimized with interventions over the next 90 days." There was no evidence an acceptable pain level or other parameters were considered for measuring the resident's pain and comfort level. In addition, the interventions were not individualized to meet the resident's specific pain management needs. 2. Review of the 6/11/12 care plan for resident #25 showed pain was identified as a problem. Review of the care plan showed there were no measurable goals; the goal was "Resident's pain	F 279	IDT members will be educated by the Case Manager Coordinator/MDS Coordinator/Designee regarding the development of comprehensive care plans for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit will be conducted by the RN Unit Managers /Designee to confirm the current care plan for all residents reflect measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs.	

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F 279	Continued From page 7 will be minimized with interventions over the next 90 days." There was no evidence an acceptable pain level or other parameters were considered for measuring the resident's pain management and comfort level. Furthermore, the interventions were not individualized to meet the specific pain management needs of this resident. 3. Review of the 5/24/12 care plan for resident #26 showed pain was identified as a problem. Review of the care plan showed there were no measurable goals; the goal was "Resident's pain will be minimized with interventions over the next 90 days." There was no evidence an acceptable pain level or other parameters were considered for measuring the resident's pain management and comfort level. Also, the interventions were not individualized to meet the specific needs for pain management for this resident. 4. Interview with unit manager #1 on 6/21/12 at 9:35 AM and also with the MDS coordinator at 10:35 AM on 6/21/12 verified the goals were not measurable and the interventions were not individualized.	F 279	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Systemic changes will include an on-going audit of care plans by the Case Management Coordinator/MDS Coordinator/ Designee per the MDS schedule to confirm each care plan reflects measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280		

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F 279	Continued From page 7 will be minimized with interventions over the next 90 days." There was no evidence an acceptable pain level or other parameters were considered for measuring the resident's pain management and comfort level. Furthermore, the interventions were not individualized to meet the specific pain management needs of this resident. 3. Review of the 5/24/12 care plan for resident #26 showed pain was identified as a problem. Review of the care plan showed there were no measurable goals; the goal was "Resident's pain will be minimized with interventions over the next 90 days." There was no evidence an acceptable pain level or other parameters were considered for measuring the resident's pain management and comfort level. Also, the interventions were not individualized to meet the specific needs for pain management for this resident. 4. Interview with unit manager #1 on 6/21/12 at 9:35 AM and also with the MDS coordinator at 10:35 AM on 6/21/12 verified the goals were not measurable and the interventions were not individualized.	F 279	**Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is August 5, 2012.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280		

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F 279	Continued From page 7 will be minimized with interventions over the next 90 days." There was no evidence an acceptable pain level or other parameters were considered for measuring the resident's pain management and comfort level. Furthermore, the interventions were not individualized to meet the specific pain management needs of this resident. 3. Review of the 5/24/12 care plan for resident #26 showed pain was identified as a problem. Review of the care plan showed there were no measurable goals; the goal was "Resident's pain will be minimized with interventions over the next 90 days." There was no evidence an acceptable pain level or other parameters were considered for measuring the resident's pain management and comfort level. Also, the interventions were not individualized to meet the specific needs for pain management for this resident. 4. Interview with unit manager #1 on 6/21/12 at 9:35 AM and also with the MDS coordinator at 10:35 AM on 6/21/12 verified the goals were not measurable and the interventions were not individualized.	F 279	**F-280 – Right to Participate Planning Care –Revise CP** **This plan of correction is the facility's credible allegation of compliance.** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #39's physician's order was changed and the ADL care plan was updated to reflect the use of a sit-to-stand lift for all transfers.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** RN Unit Managers/Designee will conduct an audit of all ADL care plans to confirm the correct resident transfer protocol is reflected.	

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F 280	Continued From page 8 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the care plan for 1 of 21 sample residents (#39) was updated to meet the needs of the resident. The findings were: Review of the medical record for resident #39 showed a physical therapy evaluation was completed on 11/5/11. The clinical summary stated the resident was appropriate for a mechanical hoyer lift for transfers due to osteoarthritis, loss of mobility, and pain with minimal movement. The therapist recommended nursing staff use a hoyer lift for the resident's safety and comfort. On 11/12/11, the physician signed a telephone order for a hoyer lift to be used for transfers. The following concerns were noted: a. Review of the ADL care plan last updated on 12/9/11 showed the resident needed extensive assistance with transfers, but did not include that a hoyer lift was to be used. Review of the CNA worksheet last updated on 6/19/12 showed the CNAs were to use a sit to stand lift rather than the	F 280	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** RN Unit Managers/Designee will review all physician orders on a daily basis and update the transfer status on the care plan in accordance with the physician's order. The Staff Development Coordinator/Designee will provide education to nursing staff surrounding the expectation of following the physician's order in relation to a resident's transfer status.	

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F 280	Continued From page 9 hoyer lift as ordered by the physician when transferring the resident. b. Observation on 6/18/12 at 2 PM revealed CNA #1 transferred the resident from the toilet to a wheelchair with a sit to stand lift. During the transfer, the resident put very little weight on his/her lower extremities and stated, "This is torture." When the resident was interviewed on 6/18/12 at 2:10 PM, s/he was unable to explain what s/he meant by the statement "this is torture." c. Interview on 6/20/12 at 11:40 AM with unit manager #2 confirmed the most recent evaluation for transfers completed on this resident was the 11/9/11 physical therapy evaluation. She also confirmed there was a physician order for the hoyer lift and added if the resident was not bearing much weight on his/her lower extremities, the staff should not be using a sit to stand lift for transfers.	F 280	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is August 5, 2012.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and medical record review, the facility failed to ensure staff followed physician's orders regarding disease management for 2 of 21 sample residents (#25, #26) and safe transfer for 1 (#39) of 3 sample residents who required a mechanical lift for transfers. The findings were: 1. Review of the 5/30/12 physician's orders for resident #25 showed an order to notify the	F 281	**F-281 – Services Provided Meet Professional Standards** **This plan of correction is the facility's credible allegation of compliance.**	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 281	Continued From page 10 physician if the resident's blood sugar was above 400 milligram per deciliter (mg/dl). Review of the flow sheet for blood sugar readings showed on 6/1/12 at 6:03 PM the resident's blood sugar was 435 mg/dl. Review of the entire medical record showed no evidence the physician was notified. Further review of the flow sheet showed the next time staff checked the resident's blood sugar was the following morning at 6:58 AM (12 hours later). Interview with unit manager #1 on 6/21/12 at 9:35 AM revealed physician orders should always be followed as written. 2. Review of the list of diagnoses for resident #26 showed s/he was admitted on 5/18/12 with cellulitis, generalized muscle weakness, osteoarthritis, and peripheral vascular disease. Review of the initial 5/31/12 MDS assessment showed the resident had frequent pain which disturbed his/her sleep and limited day to day activities. The resident received physical therapy and occupational therapy which was painful according to an interview with the resident on 6/20/12 at 1 PM. Review of the 5/22/12 physician's order showed the resident should have Percocet (pain medication) administered thirty minutes prior to each therapy session. The following concern with pain management were identified: a. Review of the June 2012 MAR showed no evidence the resident received the pain medication prior to therapy sessions. Review showed the majority of the times the Percocet was administered was at 5 AM and 10 PM which was not prior to therapy. Interview with unit manager #1 on 6/21/12 at 9:35 AM verified receiving the Percocet at 5 AM and 10 PM was not related to therapy sessions. The unit manager	F 281	**Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #25 was discharged home. Resident #26's pain medication order was clarified by the physician to discontinue the "30 minutes prior to therapy" and reflect a PRN pain medication order. Resident #39's physician order was changed and the ADL care plan was updated to reflect the use of a sit-to-stand lift for all transfers. An in-service will be conducted by the Staff Development Coordinator/Designee with nursing staff to educate them on the expectation of following physician orders.	

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F 281	Continued From page 10 physician if the resident's blood sugar was above 400 milligram per deciliter (mg/dl). Review of the flow sheet for blood sugar readings showed on 6/1/12 at 6:03 PM the resident's blood sugar was 435 mg/dl. Review of the entire medical record showed no evidence the physician was notified. Further review of the flow sheet showed the next time staff checked the resident's blood sugar was the following morning at 6:58 AM (12 hours later). Interview with unit manager #1 on 6/21/12 at 9:35 AM revealed physician orders should always be followed as written. 2. Review of the list of diagnoses for resident #26 showed s/he was admitted on 5/18/12 with cellulitis, generalized muscle weakness, osteoarthritis, and peripheral vascular disease. Review of the initial 5/31/12 MDS assessment showed the resident had frequent pain which disturbed his/her sleep and limited day to day activities. The resident received physical therapy and occupational therapy which was painful according to an interview with the resident on 6/20/12 at 1 PM. Review of the 5/22/12 physician's order showed the resident should have Percocet (pain medication) administered thirty minutes prior to each therapy session. The following concern with pain management were identified: a. Review of the June 2012 MAR showed no evidence the resident received the pain medication prior to therapy sessions. Review showed the majority of the times the Percocet was administered was at 5 AM and 10 PM which was not prior to therapy. Interview with unit manager #1 on 6/21/12 at 9:35 AM verified receiving the Percocet at 5 AM and 10 PM was not related to therapy sessions. The unit manager	F 281	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit will be conducted by the RN Unit Managers/Designee to confirm nursing staff are following physician orders. Based on the results of the audits, education will be provided immediately on an as needed basis.	

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F 281	Continued From page 10 physician if the resident's blood sugar was above 400 milligram per deciliter (mg/dl). Review of the flow sheet for blood sugar readings showed on 6/1/12 at 6:03 PM the resident's blood sugar was 435 mg/dl. Review of the entire medical record showed no evidence the physician was notified. Further review of the flow sheet showed the next time staff checked the resident's blood sugar was the following morning at 6:58 AM (12 hours later). Interview with unit manager #1 on 6/21/12 at 9:35 AM revealed physician orders should always be followed as written. 2. Review of the list of diagnoses for resident #26 showed s/he was admitted on 5/18/12 with cellulitis, generalized muscle weakness, osteoarthritis, and peripheral vascular disease. Review of the initial 5/31/12 MDS assessment showed the resident had frequent pain which disturbed his/her sleep and limited day to day activities. The resident received physical therapy and occupational therapy which was painful according to an interview with the resident on 6/20/12 at 1 PM. Review of the 5/22/12 physician's order showed the resident should have Percocet (pain medication) administered thirty minutes prior to each therapy session. The following concern with pain management were identified: a. Review of the June 2012 MAR showed no evidence the resident received the pain medication prior to therapy sessions. Review showed the majority of the times the Percocet was administered was at 5 AM and 10 PM which was not prior to therapy. Interview with unit manager #1 on 6/21/12 at 9:35 AM verified receiving the Percocet at 5 AM and 10 PM was not related to therapy sessions. The unit manager	F 281	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The RN Unit Managers/Designee will conduct routine audits to confirm physician orders are being followed. Based on the results of the audits, education will be provided immediately on an as needed basis. **Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is August 5, 2012.	

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F 281	Continued From page 11 further stated physician orders should always be followed. b. Interview with the resident on 6/20/12 at 1 PM revealed s/he thought s/he received the medication before therapy sometimes, but not always. The patient again reiterated therapy was "very painful and the pain medication helped when it was given prior to therapy." Review of the pain monitoring flow sheet showed the resident usually described the pain at 7 or 8/10. 3. Review of the medical record for resident #39 showed on 11/12/11, the physician signed a telephone order for a hoyer lift to be used for transfers based on a recommendation by physical therapy. However, observation on 6/18/12 at 2 PM revealed CNA #1 transferred the resident from the toilet to a wheelchair with a sit to stand lift. Interview with unit manager #2 on 6/20/12 at 11:40 AM verified there was a physicians order dated 11/9/11 to use a hoyer lift. She further stated staff should not be using a sit to stand lift for transfers. The unit manager verified staff did not follow physician orders. 4. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nursing must function under the direction of a licensed physician. According to Smith, Duell, and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," 7th Edition, 2008: "Skill and functions that professional nurses perform in daily practice include: ... Administer treatments per physician's order."	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	Continued From page 12 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 the care plan was followed as written for 1 of 21 sample residents (#78). The findings were: Review of the medical record for resident #78 showed s/he had diagnoses that included right below the knee amputation, and a history of cerebrovascular accident (CVA). The resident had falls on 3/12/12, 4/13/12, and 5/4/12. Review of the post fall evaluations for each of these falls indicated the falls occurred while the resident was being transferred. Review of the interventions after each fall included the use of a sit to stand lift for all transfers. Review of the 5/7/12 revised care plan for falls showed, "staff will use sit to stand for all transfers...[resident] may have sit to stand in bathroom during voiding d/t [due to] resident stating that [s/he] feels safer with sling and lift attached." Observation on 6/18/12 at 1:40 PM, revealed CNA #2 transferred the resident from the wheelchair to the toilet without the use of any mechanical lift. Interview with the CNA at that time revealed the resident used a sit to stand lift for transferring in and out of bed, but from the wheelchair to the toilet, the resident could use the mobility bar and pivot transfer with the assistance of a CNA. Interview with the DON on 6/21/12 at 7:55 AM verified the lift for transfers was an intervention to reduce falls for this resident, and	F 282	**F-282 – Services by Qualified Persons/Per Care Plan** **This plan of correction is the facility's credible allegation of compliance.** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #78 has a sit-to-stand lift used on her during all transfers. The RN Unit Managers/Designee will conduct an in-service with nursing staff to confirm staff is aware of the lifting protocol for Resident #78.	

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F 282	Continued From page 12 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 the care plan was followed as written for 1 of 21 sample residents (#78). The findings were: Review of the medical record for resident #78 showed s/he had diagnoses that included right below the knee amputation, and a history of cerebrovascular accident (CVA). The resident had falls on 3/12/12, 4/13/12, and 5/4/12. Review of the post fall evaluations for each of these falls indicated the falls occurred while the resident was being transferred. Review of the interventions after each fall included the use of a sit to stand lift for all transfers. Review of the 5/7/12 revised care plan for falls showed, "staff will use sit to stand for all transfers...[resident] may have sit to stand in bathroom during voiding d/t [due to] resident stating that [s/he] feels safer with sling and lift attached." Observation on 6/18/12 at 1:40 PM, revealed CNA #2 transferred the resident from the wheelchair to the toilet without the use of any mechanical lift. Interview with the CNA at that time revealed the resident used a sit to stand lift for transferring in and out of bed, but from the wheelchair to the toilet, the resident could use the mobility bar and pivot transfer with the assistance of a CNA. Interview with the DON on 6/21/12 at 7:55 AM verified the lift for transfers was an intervention to reduce falls for this resident, and	F 282	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit will be conducted by the RN Unit Managers /Designee to confirm resident's lifting protocols are identified and followed. Based on the results of the audits, education will be provided immediately on an as needed basis. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** RN Unit Managers/Designees will routinely audit the lifting protocols for residents which include confirming the correct lifting protocol is identified and implemented. Based on the results of the audits, education will be provided immediately on an as needed basis.	

7/19/12

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F 282	Continued From page 12 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 the care plan was followed as written for 1 of 21 sample residents (#78). The findings were: Review of the medical record for resident #78 showed s/he had diagnoses that included right below the knee amputation, and a history of cerebrovascular accident (CVA). The resident had falls on 3/12/12, 4/13/12, and 5/4/12. Review of the post fall evaluations for each of these falls indicated the falls occurred while the resident was being transferred. Review of the interventions after each fall included the use of a sit to stand lift for all transfers. Review of the 5/7/12 revised care plan for falls showed, "staff will use sit to stand for all transfers...[resident] may have sit to stand in bathroom during voiding d/t [due to] resident stating that [s/he] feels safer with sling and lift attached." Observation on 6/18/12 at 1:40 PM, revealed CNA #2 transferred the resident from the wheelchair to the toilet without the use of any mechanical lift. Interview with the CNA at that time revealed the resident used a sit to stand lift for transferring in and out of bed, but from the wheelchair to the toilet, the resident could use the mobility bar and pivot transfer with the assistance of a CNA. Interview with the DON on 6/21/12 at 7:55 AM verified the lift for transfers was an intervention to reduce falls for this resident, and	F 282	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is August 5, 2012.	

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F 282	Continued From page 13 needed to be followed.	F 282		
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 staff interview, resident interview, medical record review, and facility policies and procedures, the facility failed to ensure all necessary assessments, monitoring, and nursing measures were implemented for disease and pain management for 2 of 21 sample residents (#25, #26), and post operative care for 1 of 1 sample (#106) residents admitted for surgical rehabilitation. The findings were: 1. Review of the 5/30/12 physician's orders for resident #25 showed an order to notify the physician if the resident's blood sugar was above 400 milligram per deciliter (mg/dl). Review of the flow sheet for blood sugar readings showed on 6/1/12 at 6:03 PM the resident's blood sugar was 435 mg/dl. Review of the entire medical record showed no evidence the physician was notified. Further review of the flow sheet showed the next time staff checked the resident's blood sugar was the following morning at 6:58 AM. Interview with unit manager #1 on 6/21/12 at 9:35 AM revealed physician orders should always be followed as	F 309	**F-309 – Provide Care/Services for Highest Well Being** **This plan of correction is the facility's credible allegation of compliance.** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #25 and Resident #106 have discharged from the Center. Resident #26's pain medication order was clarified by the physician to discontinue the "30 minutes prior to therapy" and reflect a PRN pain medication order.	

7/19/12

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F 309	Continued From page 14 written and that she was unsure why they were not. In addition, review of the 6/11/12 initial MDS assessment for this resident (#25) showed s/he experienced frequent pain which limited his/her daily activities. Review of physician's orders showed an order written on 5/24/12 for Tylenol 325 milligrams (mg) every six hours as needed for pain. Review of the pain monitoring flow sheet showed the resident complained of pain in his/her back on 6/3/12 at 11:30 AM rated 7 out of 10 on a scale of 0 to 10 with 10 being the worst. The resident was administered Tylenol 650 mg at 11:30 AM on 6/3/12. Further review of the pain monitoring flow sheet showed no evidence a re-assessment was performed to determine the effectiveness of the Tylenol in relieving the resident's pain. Interview with unit manager #1 on 6/21/12 at 9:35 AM revealed her expectation was for pain to be re-assessed within thirty minutes to one hour after administration of a pain medication. Review of the facility policy and procedure on pain management, reviewed 4/28/09, showed instructions to "Monitor effectiveness of interventions within the prescribed length of time or within 1 hour as evidenced by controlled, reduced or elimination of pain ...Document in the resident's medical record on designated form the effectiveness of intervention for pain." 2. Review of the list of diagnoses for resident #26 showed s/he was admitted on 5/18/12 with cellulitis, generalized muscle weakness, osteoarthritis, and peripheral vascular disease. Review of the initial 5/31/12 MDS assessment showed the resident had frequent pain which disturbed his/her sleep and limited day to day	F 309	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit will be conducted by the RN Unit Managers/Designee to confirm nursing staff are following physician orders. An audit will be conducted by the RN Unit Managers/Designee for each new admission to confirm the nursing assessment has been completed on the new resident within four (4) hours of being admitted to the facility. Based on the results of the audits, education will be provided immediately on an as needed basis.	

7/19/12

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F 309	Continued From page 15 activities. The resident received physical therapy and occupational therapy which was painful according to an interview with the resident on 6/20/12 at 1 PM. Review of the 5/22/12 physician's order showed the resident should have Percocet (pain medication) administered thirty minutes prior to each therapy session. The following concerns with pain management were identified: a. Review of the June 2012 MAR showed no evidence the resident received the pain medication prior to therapy sessions. Review showed the majority of the times the Percocet was administered was at 5 AM and 10 PM which was not prior to therapy. Interview with unit manager #1 on 6/21/12 at 9:35 AM verified receiving the Percocet at 5 AM and 10 PM was not related to therapy sessions. b. Interview with the resident on 6/20/12 at 1 PM revealed s/he thought s/he received the medication before therapy sometimes, but not always. The patient again reiterated therapy was "very painful and the pain medication helped when it was given prior to therapy." Review of the pain monitoring flow sheet showed the resident usually described the pain at 7 or 8/10. 3. Review of the admission facesheet showed resident #106 had diagnoses including disorder of muscle ligament and fascia and peripheral vascular disease. Review of the hospital 3/8/12 history and physical showed the resident had a right common femoral endarterectomy with pericardial path angioplasty and a right common iliac and external iliac artery angioplasty and stents performed on February 28, 2012. Continued review showed the right iliac stents were occluded with an ischemic right leg. The	F 309	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The RN Unit Managers/Designee will conduct routine audits to confirm physician orders are being followed. Based on the results of the audits, education will be provided immediately on an as needed basis. The Director of Nursing/Designee will provide education to licensed nurses stating the expectation is that the initial nursing assessment is completed for all new admissions within four (4) hours.	

7/19/12

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F 309	Continued From page 16 resident had a left femoral to right femoral bypass after a right femoral thrombectomy on 3/9/12. The resident was admitted to the facility on 3/14/12 at 5:45 PM for post surgical rehabilitation. The resident had a wound vac to the right wound incision. The following concerns were identified with assessment and monitoring of the resident's post surgical condition: a. Review of the 3/14/12 admission nursing assessment showed it was not performed until 10:05 PM. Review of other nursing documentation including progress notes showed no evidence the resident was assessed during the first four hours and twenty minutes of his/her admission to the unit. Interview with unit manager #1 on 6/21/12 at 9:35 AM revealed the resident should have been assessed "immediately" upon admission to the unit. b. Review of the 3/16/12 nursing notes dated 11 AM showed the wound incision had "slightly" purulent (pus) drainage. Further review of these notes showed the resident said s/he had been vomiting since 4 AM. Review of the March 2012 MAR showed the resident was administered Compazine 25 milligrams suppository for nausea on 3/16/12 but no time was documented. The surgeon's office was notified of the resident's condition on 3/16/12 at 11 AM, however, review of these nursing notes revealed the nurse told the physician's office "I don't see anything urgent..." At 12:05 PM on that same day, 3/16/12, the resident was transported to the hospital where s/he was started on intravenous antibiotics. On 3/17/12 the resident was taken to surgery where the wound was drained and irrigated. On the following Tuesday, 3/20/12, the femoral to femoral graft was removed due to a massive Staphylococcus infection. Interview with unit	F 309	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is August 5, 2012.	

7/19/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	C 06/21/2012

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F 309	Continued From page 17 manager #1 on 6/21/12 at 9:35 AM revealed her expectation was that a resident admitted for post surgical rehabilitation be assessed and monitored at least six to seven times per shift for the first few days and careful attention should be paid to wounds.	F 309	**F-312 – ADL Care Provided for Dependent Residents** **This plan of correction is the facility's credible allegation of compliance.**	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, and staff interview, the facility failed to ensure appropriate incontinence care was provided during 3 of 5 observations of incontinence care that affected 2 sample (#39, #69) and 1 non-sample (#46) residents. The findings were: 1. Medical record review for resident #39 revealed a quarterly MDS assessment dated 5/22/12 that showed the resident was frequently incontinent of urine and stool and needed extensive assistance with toileting. Observation on 6/18/12 at 2 PM revealed CNA #1 removed a wet incontinence brief from the resident and placed the resident on the toilet. After the resident used the toilet, the CNA cleaned the resident's perineum and buttocks, but did not clean the resident's lower abdominal area. 2. Medical record review revealed a quarterly	F 312	**Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #39 will have their perineum care performed correctly which will include attention to the lower abdominal area. Resident #69 will have their perineum care performed correctly which will include attention to their lower abdominal area and buttocks. Resident #46 will have their perineum care performed correctly which will include attention to their lower abdominal area and anterior perineal area.	

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F 309	Continued From page 17 manager #1 on 6/21/12 at 9:35 AM revealed her expectation was that a resident admitted for post surgical rehabilitation be assessed and monitored at least six to seven times per shift for the first few days and careful attention should be paid to wounds.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, and staff interview, the facility failed to ensure appropriate incontinence care was provided during 3 of 5 observations of incontinence care that affected 2 sample (#39, #69) and 1 non-sample (#46) residents. The findings were: 1. Medical record review for resident #39 revealed a quarterly MDS assessment dated 5/22/12 that showed the resident was frequently incontinent of urine and stool and needed extensive assistance with toileting. Observation on 6/18/12 at 2 PM revealed CNA #1 removed a wet incontinence brief from the resident and placed the resident on the toilet. After the resident used the toilet, the CNA cleaned the resident's perineum and buttocks, but did not clean the resident's lower abdominal area. 2. Medical record review revealed a quarterly	F 312	Staff will be in-serviced on the proper procedure to perform perineum care which will include a focus on the lower abdominal area, buttocks, and anterior perineal area.	

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F 309	Continued From page 17 manager #1 on 6/21/12 at 9:35 AM revealed her expectation was that a resident admitted for post surgical rehabilitation be assessed and monitored at least six to seven times per shift for the first few days and careful attention should be paid to wounds.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, and staff interview, the facility failed to ensure appropriate incontinence care was provided during 3 of 5 observations of incontinence care that affected 2 sample (#39, #69) and 1 non-sample (#46) residents. The findings were: 1. Medical record review for resident #39 revealed a quarterly MDS assessment dated 5/22/12 that showed the resident was frequently incontinent of urine and stool and needed extensive assistance with toileting. Observation on 6/18/12 at 2 PM revealed CNA #1 removed a wet incontinence brief from the resident and placed the resident on the toilet. After the resident used the toilet, the CNA cleaned the resident's perineum and buttocks, but did not clean the resident's lower abdominal area. 2. Medical record review revealed a quarterly	F 312	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The RN Unit Managers/Designee will conduct random audits to confirm that perineum care is performed correctly with particular focus on the lower abdominal, buttocks, and perineal areas. Based on the results of the audits, education will be provided immediately on an as needed basis.	

9/19/12

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F 309	Continued From page 17 manager #1 on 6/21/12 at 9:35 AM revealed her expectation was that a resident admitted for post surgical rehabilitation be assessed and monitored at least six to seven times per shift for the first few days and careful attention should be paid to wounds.	F 309	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Staff Development Coordinator/Designee will provide education to nursing staff regarding the correct procedure for performing perineum care which will include additional emphasis on the lower abdominal, buttocks, and perineal areas. The RN Unit Managers/Designee will conduct random audits to confirm perineum care is performed correctly with particular focus on the lower abdominal, buttocks, and perineal areas. Based on the results of the audits, education will be provided immediately on an as needed basis.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, and staff interview, the facility failed to ensure appropriate incontinence care was provided during 3 of 5 observations of incontinence care that affected 2 sample (#39, #69) and 1 non-sample (#46) residents. The findings were: 1. Medical record review for resident #39 revealed a quarterly MDS assessment dated 5/22/12 that showed the resident was frequently incontinent of urine and stool and needed extensive assistance with toileting. Observation on 6/18/12 at 2 PM revealed CNA #1 removed a wet incontinence brief from the resident and placed the resident on the toilet. After the resident used the toilet, the CNA cleaned the resident's perineum and buttocks, but did not clean the resident's lower abdominal area. 2. Medical record review revealed a quarterly	F 312		

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F 312	Continued From page 18 MDS assessment dated 6/12/12 for resident #69 that showed the resident was frequently incontinent of urine and stool and needed extensive assistance with toileting. Observation on 6/18/12 at 5:20 PM revealed CNA #3 removed a wet incontinence brief and wet slacks from the resident. The CNA cleaned the resident's perineal area, but did not clean the resident's lower abdomen or buttocks. 3. Random observation on 6/21/12 at 5:25 AM of non-sample resident #46 revealed the resident was in bed and had on a wet incontinence brief. Licensed practical nurse #1 and CNA #4 removed the wet incontinence brief and turned the resident on his/her side. CNA #4 cleaned the resident's posterior perineal area and buttocks, however, the CNA did not clean the resident's lower abdomen and anterior perineal area.	F 312		
F 323 SS=D	4. Interview on 6/19/12 at 11:20 AM with CNA #1 revealed incontinence care for a resident who has been incontinent included cleaning the lower abdomen, buttocks and perineal area. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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:	F 323	**F-323 – Free of Accident Hazards/Supervision/Devices** **This plan of correction is the facility's credible allegation of compliance.**	

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F 323	Continued From page 19 Based on observation, staff interview and medical record review, the facility failed to ensure interventions related to safety were implemented for 2 of 13 sample residents (#39, #78) who were at risk for falls/injury. The findings were: 1. Review of the medical record for resident #78 showed s/he had diagnoses that included right below the knee amputation, and a history of cerebrovascular accident (CVA). The record showed the resident had falls on 3/12/12, 4/13/12, and 5/4/12. Review of the post fall evaluations for each of these falls revealed the falls did not result in injury and had occurred while the resident was being transferred. Continued review of the post fall evaluations showed interventions after each fall included using a sit to stand mechanical lift for all transfers. Review of the 5/7/12 revised care plan for falls showed, "staff will use sit to stand for all transfers... [resident] may have sit to stand in bathroom during voiding d/t [due to] resident stating that [s/he] feels safer with sling and lift attached." The following concerns were identified: a. Observation on 6/18/12 at 1:35 PM showed the resident was seated in his/her wheelchair and did not wear any prosthetic device on the right lower leg. At 1:40 PM, CNA #2 transferred the resident from the wheelchair to the toilet without the use of any mechanical lift. Interview with the CNA at that time revealed the resident used a sit to stand lift for transferring in and out of bed, but from the wheelchair to the toilet, the resident could use the mobility bar and pivot transfer with the assistance of a CNA. b. Interview with the DON on 6/21/12 at 7:55 AM verified the lift for transfers was an intervention to reduce falls for this resident, and	F 323	**Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #78 has a sit-to-stand lift used on her during all transfers. Resident #39 has a physician's order dated 06/20/12 to use a sit-to-stand lift during all transfers. The RN Unit Managers/Designee will conduct an in-service with nursing staff to confirm staff is aware of and in compliance with the lifting protocols for Resident's #39 and #78.	

7/19/12

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F 323	Continued From page 19 Based on observation, staff interview and medical record review, the facility failed to ensure interventions related to safety were implemented for 2 of 13 sample residents (#39, #78) who were at risk for falls/injury. The findings were: 1. Review of the medical record for resident #78 showed s/he had diagnoses that included right below the knee amputation, and a history of cerebrovascular accident (CVA). The record showed the resident had falls on 3/12/12, 4/13/12, and 5/4/12. Review of the post fall evaluations for each of these falls revealed the falls did not result in injury and had occurred while the resident was being transferred. Continued review of the post fall evaluations showed interventions after each fall included using a sit to stand mechanical lift for all transfers. Review of the 5/7/12 revised care plan for falls showed, "staff will use sit to stand for all transfers... [resident] may have sit to stand in bathroom during voiding d/t [due to] resident stating that [s/he] feels safer with sling and lift attached." The following concerns were identified: a. Observation on 6/18/12 at 1:35 PM showed the resident was seated in his/her wheelchair and did not wear any prosthetic device on the right lower leg. At 1:40 PM, CNA #2 transferred the resident from the wheelchair to the toilet without the use of any mechanical lift. Interview with the CNA at that time revealed the resident used a sit to stand lift for transferring in and out of bed, but from the wheelchair to the toilet, the resident could use the mobility bar and pivot transfer with the assistance of a CNA. b. Interview with the DON on 6/21/12 at 7:55 AM verified the lift for transfers was an intervention to reduce falls for this resident, and	F 323	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The RN Unit Managers/Designee will conduct an audit to confirm the correct lifting protocols are identified and implemented for all residents. Based on the results of the audits, education will be provided immediately on an as needed basis.	

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F 323	Continued From page 19 Based on observation, staff interview and medical record review, the facility failed to ensure interventions related to safety were implemented for 2 of 13 sample residents (#39, #78) who were at risk for falls/injury. The findings were: 1. Review of the medical record for resident #78 showed s/he had diagnoses that included right below the knee amputation, and a history of cerebrovascular accident (CVA). The record showed the resident had falls on 3/12/12, 4/13/12, and 5/4/12. Review of the post fall evaluations for each of these falls revealed the falls did not result in injury and had occurred while the resident was being transferred. Continued review of the post fall evaluations showed interventions after each fall included using a sit to stand mechanical lift for all transfers. Review of the 5/7/12 revised care plan for falls showed, "staff will use slt to stand for all transfers... [resident] may have sit to stand in bathroom during voiding d/t [due to] resident stating that [s/he] feels safer with sling and lift attached." The following concerns were identified: a. Observation on 6/18/12 at 1:35 PM showed the resident was seated in his/her wheelchair and did not wear any prosthetic device on the right lower leg. At 1:40 PM, CNA #2 transferred the resident from the wheelchair to the toilet without the use of any mechanical lift. Interview with the CNA at that time revealed the resident used a sit to stand lift for transferring in and out of bed, but from the wheelchair to the toilet, the resident could use the mobility bar and pivot transfer with the assistance of a CNA. b. Interview with the DON on 6/21/12 at 7:55 AM verified the lift for transfers was an intervention to reduce falls for this resident, and	F 323	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Staff Development Coordinator/Designee will provide education to nursing staff to address the expectation that the identified lifting protocol will be implemented for all residents. The RN Unit Managers/Designee will conduct an ongoing audit to confirm the identified lifting protocol for each resident is implemented. Based on the results of the audits, education will be provided immediately on an as needed basis.	

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F 323	Continued From page 20 needed to be used. 2. Review of the medical record for resident #39 showed a physical therapy evaluation was completed on 11/5/11. The clinical summary stated the resident was appropriate for a hoyer lift for transfers due to osteoarthritis, loss of mobility, and pain with minimal movement. The therapist recommended nursing use a hoyer lift for the resident's safety. The following concerns were identified regarding the safe transfer for this resident: a. On 11/12/11, the physician signed a telephone order for a hoyer lift to be used for transfers. Observation on 6/18/12 at 2 PM revealed CNA #1 transferred the resident from the toilet to a wheelchair with a sit to stand lift. During the transfer, the resident put very little weight on his/her lower extremities and stated, "This is torture." b. Interview on 6/20/12 at 11:40 AM with the unit manager confirmed the most recent evaluation for transfers was the 11/9/11 physical therapy evaluation. She added the staff should not be using a sit to stand lift for transfers.	F 323	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is August 5, 2012.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and	F 328		

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F 328	Continued From page 21 Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to obtain, clarify, and follow physician's orders regarding oxygen administration for 1 of 7 sample residents (#26) who required oxygen. The findings were: Review of the medical record for resident #26 showed s/he had diagnoses which included chronic obstructive pulmonary disease (COPD). Review of a physician's order written on 5/19/12 showed the resident required oxygen at two liters per minute via nasal cannula every shift related to the COPD. Periodic observations on 6/18/12 through 6/21/12 revealed the resident did not use the oxygen. Interview with unit manager #1 on 6/21/12 at 9:35 AM verified the resident had not worn the oxygen during these days and was unsure why but said she would check. At the time of survey exit, no information was provided as to why the resident did not use the oxygen or to clarify the physician's order.	F 328	**F-328 – Treatment/Care for Special Needs** **This plan of correction is the facility's credible allegation of compliance.** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #26's physician order has been updated to reflect that oxygen is to be administered as needed to keep the resident's oxygen level greater than 90%.	
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.	F 329		

5/15/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	C 06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 328	Continued From page 21 Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to obtain, clarify, and follow physician's orders regarding oxygen administration for 1 of 7 sample residents (#26) who required oxygen. The findings were: Review of the medical record for resident #26 showed s/he had diagnoses which included chronic obstructive pulmonary disease (COPD). Review of a physician's order written on 5/19/12 showed the resident required oxygen at two liters per minute via nasal cannula every shift related to the COPD. Periodic observations on 6/18/12 through 6/21/12 revealed the resident did not use the oxygen. Interview with unit manager #1 on 6/21/12 at 9:35 AM verified the resident had not worn the oxygen during these days and was unsure why but said she would check. At the time of survey exit, no information was provided as to why the resident did not use the oxygen or to clarify the physician's order.	F 328	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The RN Unit Managers/Designee will audit all residents having a physician's order for oxygen to confirm that the dispensed liters are in compliance with the physician's order; and oxygen is provided/available to the residents in accordance with the physician's order. Based on the results of the audits, education will be provided immediately on an as needed basis.	
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.	F 329		

7/19/12

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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.	F 329		

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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.	F 329		

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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.	F 329	**F-329 – Drug Regimen is Free from Unnecessary Drugs** **This plan of correction is the facility's credible allegation of compliance.**	

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F 329	Continued From page 22 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 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 staff interview and medical record review, the facility failed to ensure unnecessary medications were not administered to 1 of 21 sample residents (#25). The findings were: Review of the June 2012 physician's order recapitulation for resident #25 revealed an order dated 5/24/12 for Ambien 5 milligrams at bedtime for sleep. Review of the medical record revealed no evidence of an assessment to determine the cause of the resident's inability to sleep nor what non-pharmacological interventions were attempted. Interview with the DON on 6/21/12 at 10 AM revealed the assessment that was performed consisted only of the usual waking times and bedtimes which was noted on the initial 6/11/12 MDS assessment, section O "Personal Habits."	F 329	**Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #25 has been discharged from the facility. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The RN Unit Managers/Designee will audit physician orders for the use of hypnotics, confirm an assessment was completed to determine the cause of the resident's inability to sleep, and determine if any non-pharmacological interventions were attempted. Based on the results of the audits, education will be provided immediately on an as needed basis.	
F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428		

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F 329	Continued From page 22 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 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 staff interview and medical record review, the facility failed to ensure unnecessary medications were not administered to 1 of 21 sample residents (#25). The findings were: Review of the June 2012 physician's order recapitulation for resident #25 revealed an order dated 5/24/12 for Ambien 5 milligrams at bedtime for sleep. Review of the medical record revealed no evidence of an assessment to determine the cause of the resident's inability to sleep nor what non-pharmacological interventions were attempted. Interview with the DON on 6/21/12 at 10 AM revealed the assessment that was performed consisted only of the usual waking times and bedtimes which was noted on the initial 6/11/12 MDS assessment, section O "Personal Habits."	F 329	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The RN Unit Managers/Designee will conduct an ongoing audit of all physician orders for the use of hypnotics, confirm an assessment was completed to determine the cause of the resident's inability to sleep, and determine if any non-pharmacological interventions were attempted. Based on the results of the audits, education will be provided immediately on an as needed basis.	
F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428		

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F 329	Continued From page 22 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 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 staff interview and medical record review, the facility failed to ensure unnecessary medications were not administered to 1 of 21 sample residents (#25). The findings were: Review of the June 2012 physician's order recapitulation for resident #25 revealed an order dated 5/24/12 for Ambien 5 milligrams at bedtime for sleep. Review of the medical record revealed no evidence of an assessment to determine the cause of the resident's inability to sleep nor what non-pharmacological interventions were attempted. Interview with the DON on 6/21/12 at 10 AM revealed the assessment that was performed consisted only of the usual waking times and bedtimes which was noted on the initial 6/11/12 MDS assessment, section O "Personal Habits."	F 329	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is August 5, 2012.	
F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428		

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F 428 SS=D	Continued From page 23 IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical records review and staff interview, the facility failed to ensure the pharmacist completed a monthly drug regimen review for 1 of 21 (#53) sample residents. The findings were: Medical record review for resident #53 revealed the resident was admitted to the facility on 3/24/12. Admission orders included physician orders for 16 different scheduled medications and multiple PRN (as needed) medications to be given. The scheduled medications included 2 narcotic, one antipsychotic, and an antianxiety medication. Review of progress notes from 4/2/12 to 4/4/12 revealed the resident was having increased anxiety and agitation and was moved to the secure unit on 4/4/12. At that time the physician ordered Ativan (an antianxiety medication) 0.5 mg to be given three times daily PRN. Review of physician orders showed on 4/5/12, the physician noted the resident may have been experiencing Ativan withdrawal, and	F 428	**F-428 – Drug Regimen Review, Report** **This plan of correction is the facility's credible allegation of compliance** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #53's had a medication regimen review completed by the Pharmacist. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Director of Nursing/RN Unit Managers/Designee will audit the most recent pharmacy consultant report to confirm all residents had a monthly medication regimen review. Based on the results of the audits, communication will be provided to the Pharmacist for resolution.	

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F 428	Continued From page 24 increased the medication to a scheduled dose three times daily rather than PRN. The following concerns were noted: a. Further record review revealed the pharmacist did not complete a medication regimen review (MRR) until 5/12/12, seven weeks after the resident's admission to the facility. Review of the MRR failed to identify the drug withdrawal in April, or the increased dosage. b. Interview on 6/20/12 at 4:40 PM with the corporate pharmacist revealed a pharmacist usually visits the facility every 30 days to perform the MRR, but confirmed the MRR for this resident was not done in a timely manner.	F 428	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Director of Nursing/RN Unit Managers/Designee will conduct ongoing audits to confirm all residents received a monthly medication regimen review. Based on the results of the audits, communication will be provided to the Pharmacist for resolution. **Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is August 5, 2012.	

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