RECEIVED
WY Dept of Health
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PC accepted 2/27/13

RECEIVED
WY Dept of Health
FEB 21 2013

PRINTED: 02/13/2013
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
	536036	A. BUILDING _____ B. WING _____	01/31/2013 PP

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

(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 nurse aide DON Director of Nursing MAR medication administration record MDS Minimum Data Set mg milligrams RN registered nurse 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 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/or executed solely because it is required by the provisions of federal and state law.*	
F 170 SS=D	483.10(l)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL. The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record review, the facility failed to ensure 1 of 12 sample residents (#51) received mail unopened. The findings were: Review of the 12/19/12 annual MDS assessment for resident #51 showed s/he had moderate cognitive impairment and functioned independently with all ADLs. Interview on 1/29/13 at 8:30 AM with the resident revealed s/he was upset last year in August when a birthday package that had been mailed to him/her was opened by staff before they delivered it to him/her. Interview on 1/31/13 at 7:40 AM with the	F 170	**F-170 RIGHT TO PRIVACY – SEND/RECEIVE UNOPENED MAIL** **Corrective Action:** Resident #51 has been informed that his/her mail will not be opened by staff members prior to delivery. S/he agreed to open his/her packages while in the presence of a staff member. Resident #51's care plan has been updated to reflect current changes. **Identification of Others:** The Activity Director or Designee has conducted interviews to determine if anyone else had their mail opened without permission and not in their presence. No further incidences were found. **Systemic Changes:** On 2/28/13 the Executive Director educated the staff on compliance with F-170, Right to Privacy-Send/Receive unopened Mail.	3/17/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tony Jamesz LNHA — TITLE: Exec. Dir. — (X6) DATE: 3/7/13

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.

PC accepted per telephone call with Tony James, Administrator, on 2/27/13 @ 4:50 pm — P Pinner, RN

PRINTED: 02/13/2013
FORM APPROVED
OMB NO. 0938-0391

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
	535036	A. BUILDING _____ B. WING _____	01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION - RAWLINS	642 16TH STREET RAWLINS, WY 82301

(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 309	Continued From page 11 pain flowsheet. She stated staff were instructed to use the pain flowsheet, but there were new nurses working in the facility. 5, Review of the facility's "Pain Management" policy (PRO 61016, 4/28/09) revealed "Assess the resident using the Pain Scale...a, Prior to administration of pain medication, b. At an acceptable interval post pain medication administration....c. At each verbalization and/or exhibition of signs and symptoms of pain." Furthermore, "Monitor effectiveness of interventions within the prescribed length of time or within 1 hour as evidenced by controlled, reduced, or elimination of pain until the resident's pain is controlled."	F 309		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe environment for facility staff in the kitchen. The findings were: Observation on 1/30/13 at 1:48 PM revealed the baseboard heater in the facility kitchen was missing protective covering in two areas. The end cover plate was missing on the baseboard heater directly under the "K" fire extinguisher near the exit door exposing approximately five inches of bare metal fins.	F 465	F-465 **SAFE/FUNCTIONAL/SANITARY/ COMFORTABLE ENVIRONMENT** **Corrective Actions:** The two baseboard heaters in the facility kitchen had their protective coverings attached and secured by the Maintenance Director on 1/31/2013. **Identification of Others:** The Maintenance Director or Designee will inspect the base board heaters throughout the facility for compliance and repairs will be made where necessary. **Monitoring:** The Maintenance Director or Designee will monitor the facility base boards daily for safety concerns, repair issues as	3/17/2013

PRINTED: 02/13/2013
FORM APPROVED
OMB NO. 0938-0391

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
	536036	A. BUILDING _____ B. WING _____	01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION - RAWLINS	542 10TH STREET RAWLINS, WY 82301

(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 170	Continued From page 1 administrator revealed there were problems with friends mailing alcohol to the resident, so the resident's durable power of attorney requested staff monitor this type of activity. The administrator further stated a better alternative would have been for staff to be present while the resident opened the package instead of opening it prior to delivery.	F 170	The Activity Staff or Designee will receive resident mail daily and will deliver mail and packages to the residents unopened. Residents who require or request assistance in opening their mail and packages will have them opened in their presence. **Monitoring:** The Executive Director or Designee will monitor the delivery of mail/packages and randomly interview residents monthly for compliance. Any non-compliance will be corrected and staff member re-educated on the spot. Non-compliance instances will be reported to the IDT at the Monthly PI meeting for review and corrective actions if necessary until resolved.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 226	**F-225 INVESTIGATION/REPORT ALLEGATIONS/INDIVIDUALS** **Corrective Action:** DFS was notified of CNA #1 involving an allegation occurring on 3/2/2012 regarding resident #58 on 2/1/2013. The Executive Director reviewed Form HLS/CNA-105, 4/12, "Checklist for Reporting and Investigation Allegations of Abuse, Neglect, or Misappropriation of Resident Property", the Wyoming Adult Protective Services Act, W.S. 35-20-103, and Kindred Healthcare, Inc. POL 504-01, 8/31/12 on Abuse on 2/1/2013.	3/17/2013

PRINTED: 02/13/2013
FORM APPROVED
OMB NO. 0938-0391

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
	535035	A. BUILDING _____ B. WING _____	PP 01/31/2013

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

(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 225	Continued From page 2 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on policy and procedure review, staff interview, and review of facility documentation; the facility failed to report 1 of 1 allegation of neglect to law enforcement or the Department of Family Services (DFS) as required by State law. The findings were: Review of facility documentation showed an allegation of neglect dated 3/2/12 involving resident #68 and CNA #1. Facility documentation showed the allegation was reported to the State survey agency, but there lacked evidence law enforcement or DFS was notified. According to Wyoming's Adult Protective Services Act, W.S. 35-20-103, "Any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, exploited or abandoned or is committing self neglect shall report the information immediately to a law enforcement agency or the department." Review of the facility's policy "Abuse" (POL 504-01, 8/31/12) showed all alleged violations involving mistreatment, neglect, or abuse would be "reported immediately to the administrator of the facility and to other officials in accordance with State law..." During an interview on 1/30/13	F 225	**Identification of Others:** The Executive Director reviewed the Abuse and Neglect log and the "Checklist for Reporting and Investigation Allegations of Abuse, Neglect, or Misappropriation of Resident Property" for the last year for compliance. No further non-compliance was identified. **Systemic Changes:** Any abuse, neglect, or misappropriation of resident property allegations will be investigated per Kindred Healthcare, Inc. POL 504-01, 8/31/12 on Abuse. Form HLS/CNA-105, 4/12 , "Checklist for Reporting and Investigation Allegations of Abuse, Neglect, or Misappropriation of Resident Property" will be utilized in conjunction with the investigation tool with notification of all those required, including DFS and/or Law Enforcement, within 24 hours per the Wyoming Adult Protective Services Act, W.S. 35-20-103. **Monitoring:** The Executive Director or Designee will review all investigations of alleged abuse, neglect, and misappropriation of resident property including the Checklist for accuracy, completeness, and notification of DFS and/or Law Enforcement per the Wyoming Adult Protective Services Act, W.S. 35-20-103. Non-compliance will be corrected immediately. The results of the review will be presented to the IDT at the monthly PI meeting for review or corrective action when necessary until resolved.	

PRINTED: 02/13/2013
FORM APPROVED
OMB NO. 0938-0391

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
	535036	A. BUILDING _____ B. WING _____	01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION - RAWLINS	642 16TH STREET RAWLINS, WY 82301

(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 225	Continued From page 3 at 2:20 PM, the administrator confirmed neither law enforcement nor DFS were notified of the allegation of neglect.	F 225		
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: Based on observation, medical record review, and staff interview, the facility failed to complete a significant change MDS assessment for 2 of 3 sample residents (#13, #29) who required that type of assessment. The findings were: 1. Review of the 7/17/12 significant change MDS assessment revealed resident #29 required limited assistance in transfers, dressing, toileting, and bathing, and had not had any falls since the previous assessment. A comparison of the subsequent 10/21/12 quarterly MDS assessment showed the resident had declined, and required extensive assistance in transfers, dressing,	F 274	**F-274 COMPREHENSIVE ASSESS AFTER SIGNIFICNT CHANGE.** **Corrective Action:** Residents #13 and #29 had their MDS assessment reviewed and updated to reflect their specific significant change in condition by the MDS Coordinator on 2/19/2013. The DNS re-educated the MDS Coordinator on the MDS 3.0 guidelines pertaining to Significant Change of Condition on 2/1/2013. **Identify Others:** The MDS Coordinator or Designee will compare the ADL flow sheets for current residents with their most recent MDS assessment for any potential significant change of condition on or before 3/17/2013. 24 hour reports will be reviewed for condition changes. Any resident determined to have a significant change of condition will have a Significant Change of Condition MDS assessment completed by 3/17/13. **Systemic Changes:** The MDS Coordinator/Designee will review information from the ADL flow sheets, communication board, 24 hour	3/17/2013

PRINTED: 02/13/2013
FORM APPROVED
OMB NO. 0938-0391

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
	535036	A. BUILDING _____ B. WING _____	01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION - RAWLINS	542 18TH STREET RAWLINS, WY 82301

(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 274	Continued From page 4 toileting, and bathing. In addition, the resident had one fall since the previous assessment. During an interview on 1/30/13 at 2:25 PM, the MDS coordinator stated she was still new to the position. However, she did agree that a decline in two or more areas would trigger a significant change assessment. 2. Review of the 10/1/12 quarterly MDS assessment for resident #13 showed s/he required extensive assistance with bed mobility, dressing, personal hygiene, and transfers, but only needed limited assistance with walking and locomotion. This review also showed the resident was frequently incontinent of bowel and bladder. Review of the 1/1/13 quarterly MDS assessment showed the resident required extensive assistance with walking and locomotion in addition to bed mobility, dressing, personal hygiene, and transfers. Further review showed the resident's bowel and bladder function declined to always being incontinent. Periodic observations of the resident on 1/28/13 to 1/31/13 revealed staff provided extensive assistance with activities of daily living (ADLs). During an interview on 1/31/13 at 8:40 AM, the MDS coordinator stated the resident had experienced a decline in ADLs, but the significant change in condition assessment that should have been completed had not been done.	F 274	report, and morning staff meetings for any resident who has the potential for a significant change of condition. The Medical Record will be reviewed and the MDS 3.0 Significant Change of Condition guidelines will be followed to determine if a Significant Change of Condition Assessment is necessary. One will be completed as required. **Monitoring:** The DNS or Designee will monitor the Communication Board and the 24 hour shift report in Point Click Care 4-5 times per week for potential significant changes in condition. A change in the condition of a resident will be reviewed to determine if a Significant Change of Condition MDS assessment should be completed. Non-compliance will be reported to the IDT at the monthly PI meeting for review and corrective actions if necessary until resolved.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED 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.	F 282	**F-282 SERVICES BY A QUALIFIED PERSONS/PER CARE PLAN** **Corrective Action:** Resident # 17 had PRN Norco 10/325 mg changed to B.I.D. routinely. The Care Plan was reviewed and updated to reflect these changes.	3/17/2013

PRINTED: 02/13/2013
FORM APPROVED
OMB NO. 0938-0391

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
	535036	A. BUILDING _____ B. WING _____	01/31/2013

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

(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 282	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure care was provided in accordance with the written plan of care for 3 of 12 sample residents (#17, #53, #54). The findings were: 1. Review of the current care plan (printed 1/30/12) revealed resident #17 had chronic pain. Interventions included "Administer medications as ordered. See medication record, Monitor for effectiveness and side effects." Review of the January 2013 MAR revealed the following concerns: a. Review of the back of the MAR and the pain monitoring flowsheet revealed Norco (Hydrocodone-Acetaminophen) 10/325 mg was given PRN (as needed) for pain 14 times. Of those 14 times, only twice was the effectiveness of the medication documented. b. Further review of the MAR showed an additional 17 times that Norco was given PRN, but was not documented on the back of the MAR, nor on the pain flowsheet. Therefore, the effectiveness of the medication was not documented. 2. Review of the 10/13/12 admission MDS assessment for resident #53 showed s/he had frequent pain managed with PRN medications and non-pharmacological interventions. Review of the 1/1/13 quarterly MDS assessment showed the resident continued to receive PRN medications and non-pharmacological interventions for pain, but the resident was unable to answer the pain assessment interview question	F 282	Residents # 53 and #54 had their PRN pain medications reviewed by their physician and appropriate changes were made to their MARs. The Care Plans were reviewed and updated to reflect changes. Identifying Others: On 2/18/2013 the DNS/Designee began a Pain Management audit that included MAR's, quarterly MDS pain assessments, and the following of Care Plans to confirm the completeness, accuracy and the following of Care Plans. Corrective actions were taken as needed. The results will be reported to the IDT during the monthly PI meeting for review and corrective actions if necessary until resolved. Systemic Changes: LN staff has been educated on the Pain Management Procedure and following the resident's Care Plan by the Pain Management Committee through one-on-one training. The SDC, during new hire orientation, will train newly hired LN staff on the Pain Management Procedure and the following of the residents' Care Plans. Monitoring: During the quarterly MDS assessment review, the MDS Coordinator will audit current residents Pain Assessments, their ability to verbalize pain and their care	

PRINTED: 02/13/2013
FORM APPROVED
OMB NO. 0938-0391

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
	535036	A. BUILDING _____ B. WING _____	01/31/2013

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

(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 282	Continued From page 6 during that assessment time period. Review of the care plan, revised 1/4/13, showed the resident had chronic back pain and interventions included monitoring medication for effectiveness, evaluating pain level, completing pain assessments quarterly, and recording interventions tried and results. Review of the December 2012 and January 2013 MARs showed Tramadol 50 mg was ordered for pain as needed every 6 hours and Tylenol 650 mg was ordered for pain as needed every 4 hours. The following concerns were identified: a. Review of the 1/10/13 quarterly pain assessment revealed it was incomplete and contained inaccurate information that the resident did not verbalize pain. b. Review of the December 2012 MAR showed Tramadol was administered 20 times and Tylenol 4 times during that month. Review of the January 2013 MAR showed Tramadol was administered to the resident 4 times and Tylenol was administered 21 times during the month. Further review of both the December and January MARs, pain monitoring flow sheets and nursing notes revealed no documentation regarding post pain assessments and attempted alternatives. 3. Review of the 10/30/12 admission MDS assessment for resident #64 revealed staff assessed the resident as having pain frequently. Review of the care plan, updated 1/11/13, revealed staff were directed to review frequency for pain medication efficacy, assess whether pain intensity was acceptable to the resident, and monitor and document effectiveness of the medications. According to the January 2013 MAR, an order for morphone as needed was discontinued and replaced with a 50 mcg/hr	F 282	plans for accuracy and completeness. Discrepancies will be reported to the DNS for corrective action. The DNS or Designee will audit the MARs and Pain Flow sheets of current residents, including those cited, weekly for one month then 10 MARs and 10 Pain Flow sheets weekly thereafter for documentation of the effectiveness of non-pharmacological and/or PRN pain medications and the following of the resident's Care Plan. Corrective actions will be taken when necessary. Results of audits will be reported to the IDT during the monthly PI meeting for review and direction until resolved.	

PRINTED: 02/13/2013
FORM APPROVED
OMB NO. 0938-0391

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
	535039	A. BUILDING _____ B. WING _____	pf 01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION - RAWLINS	642 16TH STREET RAWLINS, WY 82301

(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 282	Continued From page 7 Fentanyl patch every 72 hours. Review of this MAR also revealed Lortab 7.5/500 mg was ordered every 4 hours as needed and 5 to 15 mg of oxycodone was ordered every 4 hours as needed. Review of the pain monitoring flow sheets and January 2013 MAR and nursing notes showed post pain assessments and effectiveness were not documented for the 21 times oxycodone was administered. Further review revealed this documentation was also lacking for the 3 times that Lortab was administered. 4. During an interview on 1/30/13 at 3:45 PM, the DON stated staff should have documented the effectiveness of the PRN pain medications on the pain flowsheet.	F 282		
F 309 SS=E	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 medical record and policy and procedure review, and staff and resident interviews, the facility failed to ensure adequate monitoring for the use and effectiveness of PRN (as needed) pain medication for 3 of 5 sample residents (#17, #53, #54) who were administered PRN pain medication. The findings were:	F 309	**F-309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Corrective Action:** Resident # 17 had PRN Norco 10/325 mg changed to B.I.D. routinely. The Care Plan was reviewed and updated to reflect these changes. Residents # 53 and #54 had their PRN pain medications reviewed by their physician and appropriate changes were made to their MARs. The Care Plans were reviewed and updated to reflect changes. **Identifying Others:** On 2/18/2013 the DNS/Designee began a Pain Management audit that included MAR's, quarterly MDS pain assessments.	3/17/2013

PRINTED: 02/13/2013
FORM APPROVED
OMB NO. 0938-0391

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
	535036	A. BUILDING _____ B. WING _____	01/31/2013

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

(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 309	Continued From page 8 1. Review of the 10/13/12 admission MDS assessment for resident #53 showed s/he had frequent pain managed with PRN medications and non-pharmacological interventions. Review of the 1/1/13 quarterly MDS assessment showed the resident continued to receive PRN medications and non-pharmacological interventions for pain, but the resident was unable to answer the pain assessment interview questions during that assessment time period. Review of the care plan, revised 1/4/13, showed the resident had chronic back pain and interventions included monitoring medication for effectiveness, evaluating pain level, completing pain assessments quarterly, and recording interventions tried and results. Review of the December 2012 and January 2013 MARs showed Tramadol 50 mg was ordered for pain as needed every 6 hours and Tylenol 650 mg was ordered for pain as needed every 4 hours. The following concerns were identified: a. Review of the 1/10/13 quarterly pain assessment revealed it was incomplete and contained inaccurate information that the resident did not verbalize pain. b. Review of the December 2012 MAR showed Tramadol was administered to the resident 20 times and Tylenol 4 times during that month. Review of the January 2013 MAR showed Tramadol was administered 4 times and Tylenol was administered 21 times during the month. Further review of both the December and January MARs, pain monitoring flow sheets and nursing notes revealed no documentation regarding post pain assessments and attempted alternatives. c. Interview with the resident on 1/30/13 at 1:40 PM revealed staff frequently administered pain medications and did not return later to	F 309	and the following of Care Plans to confirm the completeness, accuracy and the following of Care Plans. Corrective actions were taken as needed. The results will be reported to the IDT during the monthly PI meeting for review and corrective actions if necessary until resolved. **Systemic Changes:** LN staff has been educated on the Pain Management Procedure and following the resident's Care Plan by the Pain Management Committee through one-on-one training. The SDC, during new hire orientation, will train newly hired LN staff on the Pain Management Procedure and the following of the residents' Care Plans. **Monitoring:** During the quarterly MDS assessment review, the MDS Coordinator will audit current residents Pain Assessments, their ability to verbalize pain and their care plans for accuracy and completeness. Discrepancies will be reported to the DNS for corrective action. The DNS or Designee will audit the MARs and Pain Flow sheets of current residents, including those cited, weekly for one month then 10 MARs and 10 Pain Flow sheets weekly thereafter for appropriate documentation of the effectiveness of non-pharmacological	

PRINTED: 02/13/2013
FORM APPROVED
OMB NO. 0938-0391

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
	535036	A. BUILDING _____ B. WING _____	01/31/2013

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

(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 309	Continued From page 9 assess the effectiveness. The resident further stated that the pain medication s/he had received for the past two days for joint pain did not completely relieve this pain. d. In an interview on 1/31/13 at 2:25 PM, RN #1 stated she administered Tramadol at 9:20 AM when resident #53 complained about shoulder pain. She further stated she was not aware of any requirement to complete a post pain assessment or pain monitoring form before and after administering pain medications. Review of the RN's documentation verified a post pain assessent was not completed for the Tramadol administered at 9:20 AM. 2. Review of the 12/7/12 annual MDS assessment revealed resident #17 had frequent pain which affected sleep and activities. The resident rated his/her pain at a level of "6" on a scale of 0 to 10. Review of a 1/26/13 pain assessment showed the resident's acceptable level of pain was "4." The assessment further indicated the resident received routine and PRN medications for pain. Review of physician orders showed the resident had an order for Norco (Hydrocodone-Acetaminophen) 10/325 mg PRN for pain. Review of the current care plan (printed 1/30/12) revealed the resident had chronic pain. Interventions included "Administer medications as ordered. See medication record. Monitor for effectiveness and side effects." Review of the January 2013 MAR revealed the following concerns: a. Review of the back of the MAR and the pain monitoring flowsheet revealed Norco (Hydrocodone-Acetaminophen) 10/325 mg was given PRN for pain 14 times. Of those 14 times, only twice was the effectiveness of the	F 309	and/or PRN pain medications and the following of the residents' care plan, Corrective actions will be taken when necessary. The results of audits will be reported to the IDT during the monthly PI meeting for review and direction until substantial compliance is achieved.	

PRINTED: 02/13/2013
FORM APPROVED
OMB NO. 0938-0391

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
	535036	A. BUILDING _____ B. WING _____	01/31/2013

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

(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 309	Continued From page 10	F 309		

medication documented. Additionally, only six times was the reason for the pain medication given, and only three times was a pain rating documented.

b. Further review of the MAR showed an additional 17 times that Norco was given PRN, but not documented on the back of the MAR, nor on the pain flowsheet. Therefore, there lacked evidence of the reason for administering the medication, including a pain rating, and the effectivness of the medication.

3. Review of the 10/30/12 admission MDS assessment for resident #54 revealed staff assessed the resident as having pain frequently. Review of the care plan, updated 1/11/13, revealed staff were directed to review frequency for pain medication efficacy, assess whether pain intensity was acceptable to the resident, and monitor and document effectiveness of the medications. According to the January 2013 MAR, an order for morphine as needed was discontinued and replaced with a 50 mcg/hr Fentanyl patch every 72 hours. Review of this MAR also revealed Lortab 7.5/500 mg was ordered every 4 hours as needed and 5 to 15 mg of oxycodone was ordered every 4 hours as needed. Review of the pain monitoring flow sheets and January 2013 MAR and nursing notes showed post pain assessments and effectiveness were not documented for the 21 times oxycodone was administered. Further review revealed this documentation was also lacking for the three times that Lortab was administered.

4. During an interview on 1/30/13 at 3:45 PM, the DON stated staff should have documented the effectiveness of the PRN pain medications on the

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
	535035	A. BUILDING _____ B. WING _____	01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION - RAWLINS	642 16TH STREET RAWLINS, WY 82301

(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 465	Continued From page 12 In addition, the end cover plate was also missing on the baseboard heater under the transfer window between the dishwashing room and the kitchen. In both cases, sharp edges of metal were exposed. Interview with the maintenance manager at the time of the observation revealed the exposed metal edges represented an accident hazard to staff.	F 465	needed, then report to the Executive Director for any further corrective actions. The Maintenance Director will present results of inspections of base boards to the IDT at the Monthly PI meeting for review and corrective actions if needed until resolved.	