4/1/13 POC accepted Hand-Delivered

p5

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

RECEIVED
WY Dept of Health
MAR 15 2013
Healthcare Licensing and Survey

PRINTED: 03/07/2013
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
	535013	A. BUILDING _____ B. WING _____	C 02/21/2013

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 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 review, staff interview, and review of policy and procedure, the facility failed to ensure all necessary assessments and monitoring were implemented for pain management for 3 of 5 sample residents (#15, #19, #114). The findngs were: 1. Review of the medical record for resident #114 showed s/he had diagnoses including chronic renal disease, hypertension, hypothyroidism, depression, muscle weakness, and history of a fractured arm from a fall at home. Review of the admitting care plan dated 11/17/12 showed the resident was at risk for increased pain secondary to a recent left humerus fracture and decreased mobility. Review of the 11/10/12 physician orders showed Percocet (oxycodone hcl and acetaminophen) 5/325 one, by mouth (po) every 4 hours as needed for pain as well as Tylenol (acetaminophen) 325 mg. (milligrams), two tablets po every 4 hours as needed for pain. During an interview with the 3rd floor nurse manager on 2/19/13 she stated that facility practice was to rate the pain level every shift with 0 to 10 scale for verbal rating or + [positive] or -	F 309	**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-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:**	

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

Kathy Summerville RN DNS 3.15.13

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.

POC accepted as submitted per telephone call with Kathy Summerville 4/1/13 @ 3:10 pm -PPrine

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 02/21/2013

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 309	Continued From page 1 [negative] for non-verbal expression on the MAR (medication administration record). The following concerns with pain management were identified: a. For the month of November, 2012 the resident was not assessed for pain for 13 out of a possible 63 shifts. Review of the November 2012 MAR and pain monitoring flowsheet showed Percocet 5/325 was administered but not assessed for effectiveness on 11/11/12, 11/16/12, 11/22/12, and 11/24/12. Further review showed the Percocet 5/325 was not documented as administered on the MAR, yet was assessed for effectiveness on the pain monitoring flow sheet on 11/19/12 and 11/20/12. b. Review of the 12/3/12 physician orders showed the Percocet 5/325 was discontinued. Review of the December MAR and the pain monitoring flowsheet, showed the effectiveness of the Tylenol was not assessed on 12/2/12. 2. Review of the medical record for resident #15 showed s/he had diagnoses including atrial fibrillation (irregular heart beat), hypertension, chronic renal disease, diabetes, chronic obstructive airway disease, pneumonia, congestive heart failure, and anxiety. Review of the 11/6/12 admission physician orders showed Tylenol 325 mg., 2 tablets po every 4 hours as needed for pain. The following concerns with pain management were identified: a. Review of the November 2012 MAR and pain monitoring flowsheet showed that Tylenol was administered but not assessed for effectiveness on 11/17/12 and for the two doses administered on 11/21/12. b. Review of the 12/28/12 physcian orders showed Flexeril 5 mg. po every 8 hours as needed for pain. Review of the January 2013	F 309	Resident #114 has discharged from the Center. Resident #15 and 19's pain levels will be assessed on the pain monitoring flow sheet with each administration of a prescribed pain medication to confirm the effectiveness of the intervention. **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 pain medications are appropriately documented in the MAR. An audit will be conducted by the RN Unit Manager/Designee to confirm pain levels are assessed on the pain monitoring flow sheet with each administration of a prescribed pain medication to confirm the effectiveness of the intervention.	

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 02/21/2013

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 309	Continued From page 2 MAR and pain monitoring flowsheet showed Flexeril 5 mg. was administered but not assessed for effectiveness on 1/11/13, 1/25/13, 1/29/13, and 1/31/13. 3. Review of the medical record for resident #19 showed s/he had diagnoses including organic brain syndrome, chronic pressure ulcers, and seizure disorder. Review of the 12/22/12 physician orders showed hydrocodone with acetaminophen 5/325, one tablet every 4 hours as needed for pain was ordered. The following concerns with pain management were identified: a. Review of the December 2012 MAR and pain monitoring flowsheet showed that hydrocodone with acetaminophen 5/325, one tablet was documented as administered but not assessed for effectiveness on 12/25/12, 12/26/12, and 12/27/12. b. Review of the 12/28/12 physician orders showed the hydrocodone with acetaminophen 5/325 was increased to 2 tablets every 4 hours as need for pain. Review of the December 2012 MAR and pain monitoring flowsheet showed that the oxycodone with acetaminophen 5/325 was documented as administered but not assessed for effectiveness on 12/29/12, and for two doses given both days on 12/30/12 and 12/31/12. c. Review of the January 2013 MAR and pain monitoring flowsheet showed that oxycodone with acetaminophen 5/325 was documented as administered but not assessed for effectiveness on 1/4/13, 1/5/13, for 2 doses on 1/6/13, for 2 doses on 1/9/13, 1/11/13, 2 doses on 1/13/13, 1/14/13, 2 doses on 1/16/13, 1/19/13, 1/20/13, 1/22/13, 1/26/13, 1/27/13, 1/29/13, and 1/30/13. d. Review of the February 2013 MAR and pain monitoring flowsheet showed hydrocodone with	F 309	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** A comprehensive pain assessment is conducted on all residents upon admission, quarterly, and upon a significant change. The assessment will include an evaluation of the type, location, source of pain, resident pain tolerance, and non-pharmacological interventions to address pain. Based on this assessment, a plan of care to address pain management is developed.	

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 02/21/2013

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 309	Continued From page 2 MAR and pain monitoring flowsheet showed Flexeril 5 mg. was administered but not assessed for effectiveness on 1/11/13, 1/25/13, 1/29/13, and 1/31/13. 3. Review of the medical record for resident #19 showed s/he had diagnoses including organic brain syndrome, chronic pressure ulcers, and seizure disorder. Review of the 12/22/12 physician orders showed hydrocodone with acetaminophen 5/325, one tablet every 4 hours as needed for pain was ordered. The following concerns with pain management were identified: a. Review of the December 2012 MAR and pain monitoring flowsheet showed that hydrocodone with acetaminophen 5/325, one tablet was documented as administered but not assessed for effectiveness on 12/25/12, 12/26/12, and 12/27/12. b. Review of the 12/28/12 physician orders showed the hydrocodone with acetaminophen 5/325 was increased to 2 tablets every 4 hours as need for pain. Review of the December 2012 MAR and pain monitoring flowsheet showed that the oxycodone with acetaminophen 5/325 was documented as administered but not assessed for effectiveness on 12/29/12, and for two doses given both days on 12/30/12 and 12/31/12. c. Review of the January 2013 MAR and pain monitoring flowsheet showed that oxycodone with acetaminophen 5/325 was documented as administered but not assessed for effectiveness on 1/4/13, 1/5/13, for 2 doses on 1/6/13, for 2 doses on 1/9/13, 1/11/13, 2 doses on 1/13/13, 1/14/13, 2 doses on 1/16/13, 1/19/13, 1/20/13, 1/22/13, 1/26/13, 1/27/13, 1/29/13, and 1/30/13. d. Review of the February 2013 MAR and pain monitoring flowsheet showed hydrocodone with	F 309	Pain will be routinely assessed throughout the day. The presence and/or absence of pain will be documented each shift in the MAR. Pain that is reported and/or observed at other times will be documented on the MAR along with the administration of pain medication. Non-pharmacological interventions will be documented on the Pain Management Flow Sheet. Pain will be assessed prior to and after the administration of PRN pain medication and documented on the Pain Flow Sheet. The Staff Development Coordinator /Designee will provide education to licensed nurses upon hire, and as needed, addressing the following areas:	

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 02/21/2013

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 309	Continued From page 2 MAR and pain monitoring flowsheet showed Flexeril 5 mg. was administered but not assessed for effectiveness on 1/11/13, 1/25/13, 1/29/13, and 1/31/13. 3. Review of the medical record for resident #19 showed s/he had diagnoses including organic brain syndrome, chronic pressure ulcers, and seizure disorder. Review of the 12/22/12 physician orders showed hydrocodone with acetaminophen 5/325, one tablet every 4 hours as needed for pain was ordered. The following concerns with pain management were identified: a. Review of the December 2012 MAR and pain monitoring flowsheet showed that hydrocodone with acetaminophen 5/325, one tablet was documented as administered but not assessed for effectiveness on 12/25/12, 12/26/12, and 12/27/12. b. Review of the 12/28/12 physician orders showed the hydrocodone with acetaminophen 5/325 was increased to 2 tablets every 4 hours as need for pain. Review of the December 2012 MAR and pain monitoring flowsheet showed that the oxycodone with acetaminophen 5/325 was documented as administered but not assessed for effectiveness on 12/29/12, and for two doses given both days on 12/30/12 and 12/31/12. c. Review of the January 2013 MAR and pain monitoring flowsheet showed that oxycodone with acetaminophen 5/325 was documented as administered but not assessed for effectiveness on 1/4/13, 1/5/13, for 2 doses on 1/6/13, for 2 doses on 1/9/13, 1/11/13, 2 doses on 1/13/13, 1/14/13, 2 doses on 1/16/13, 1/19/13, 1/20/13, 1/22/13, 1/26/13, 1/27/13, 1/29/13, and 1/30/13. d. Review of the February 2013 MAR and pain monitoring flowsheet showed hydrocodone with	F 309	1. Pain management policy and procedure; 2. Conducting pain assessments to include monitoring for non-verbal signs of pain, identification of pain tolerance, and distractions/non-pharmacological interventions related to pain; 3. Evaluating the effectiveness of PRN medications; 4. Obtaining parameters for varied dosage of pain medications; 5. Monitoring for the presence of applied medicinal transdermal patches; and 6. Documentation.	

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 02/21/2013

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 309	Continued From page 2 MAR and pain monitoring flowsheet showed Flexeril 5 mg. was administered but not assessed for effectiveness on 1/11/13, 1/25/13, 1/29/13, and 1/31/13. 3. Review of the medical record for resident #19 showed s/he had diagnoses including organic brain syndrome, chronic pressure ulcers, and seizure disorder. Review of the 12/22/12 physician orders showed hydrocodone with acetaminophen 5/325, one tablet every 4 hours as needed for pain was ordered. The following concerns with pain management were identified: a. Review of the December 2012 MAR and pain monitoring flowsheet showed that hydrocodone with acetaminophen 5/325, one tablet was documented as administered but not assessed for effectiveness on 12/25/12, 12/26/12, and 12/27/12. b. Review of the 12/28/12 physician orders showed the hydrocodone with acetaminophen 5/325 was increased to 2 tablets every 4 hours as need for pain. Review of the December 2012 MAR and pain monitoring flowsheet showed that the oxycodone with acetaminophen 5/325 was documented as administered but not assessed for effectiveness on 12/29/12, and for two doses given both days on 12/30/12 and 12/31/12. c. Review of the January 2013 MAR and pain monitoring flowsheet showed that oxycodone with acetaminophen 5/325 was documented as administered but not assessed for effectiveness on 1/4/13, 1/5/13, for 2 doses on 1/6/13, for 2 doses on 1/9/13, 1/11/13, 2 doses on 1/13/13, 1/14/13, 2 doses on 1/16/13, 1/19/13, 1/20/13, 1/22/13, 1/26/13, 1/27/13, 1/29/13, and 1/30/13. d. Review of the February 2013 MAR and pain monitoring flowsheet showed hydrocodone with	F 309	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The RN Unit Manager/Designee will conduct routine audits to confirm pain medications are appropriately documented in the MAR and resident's pain levels are assessed on the pain monitoring flow sheet with each administration of a prescribed pain medication to confirm the effectiveness of the intervention. Based on the results of the audits, education will be provided immediately on an as needed basis.	

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 02/21/2013

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 309	Continued From page 2 MAR and pain monitoring flowsheet showed Flexeril 5 mg. was administered but not assessed for effectiveness on 1/11/13, 1/25/13, 1/29/13, and 1/31/13. 3. Review of the medical record for resident #19 showed s/he had diagnoses including organic brain syndrome, chronic pressure ulcers, and seizure disorder. Review of the 12/22/12 physician orders showed hydrocodone with acetaminophen 5/325, one tablet every 4 hours as needed for pain was ordered. The following concerns with pain management were identified: a. Review of the December 2012 MAR and pain monitoring flowsheet showed that hydrocodone with acetaminophen 5/325, one tablet was documented as administered but not assessed for effectiveness on 12/25/12, 12/26/12, and 12/27/12. b. Review of the 12/28/12 physician orders showed the hydrocodone with acetaminophen 5/325 was increased to 2 tablets every 4 hours as need for pain. Review of the December 2012 MAR and pain monitoring flowsheet showed that the oxycodone with acetaminophen 5/325 was documented as administered but not assessed for effectiveness on 12/29/12, and for two doses given both days on 12/30/12 and 12/31/12. c. Review of the January 2013 MAR and pain monitoring flowsheet showed that oxycodone with acetaminophen 5/325 was documented as administered but not assessed for effectiveness on 1/4/13, 1/5/13. for 2 doses on 1/6/13, for 2 doses on 1/9/13, 1/11/13, 2 doses on 1/13/13, 1/14/13, 2 doses on 1/16/13, 1/19/13, 1/20/13, 1/22/13, 1/26/13, 1/27/13, 1/29/13, and 1/30/13. d. Review of the February 2013 MAR and pain monitoring flowsheet showed hydrocodone with	F 309	The Director of Nursing/Designee will provide education to licensed nurses regarding the expectations addressing documenting the administration of pain medications in the MAR and addressing the resident's pain levels on the pain monitoring flow sheet with each administration of a prescribed pain medication to confirm the effectiveness of the intervention. The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction a s needed. Date of compliance is April 7, 2013.	

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 02/21/2013

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 309	Continued From page 3 acetaminophen 5/325 was documented as administered but not assessed for effectiveness on 2/17/13. Review of the Pain Management policy dated 4/28/09 showed the pain assessment should included the evaluation of the effectiveness of the intervention. Interview with the director of nursing on 2/21/13 at 10 AM revealed that every as needed dose of pain medication should be evaluated and the evaluation documented.	F 309		
F 323 SS=E	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: Based on medical record review and staff interview, the facility failed to ensure 1 of 4 sample residents (#115) who was at risk for falls received an accurate post fall assessment. The findings were: Review of the admission nursing evaluation for resident #115 showed the resident was admitted to the facility on 1/25/13. This review also revealed the resident was alert and oriented, ambulated with a cane, had a history of falling prior to admission; and required supervision and limited assistance with most activities of daily	F 323	**F-323 – Free of Accident Hazards/Supervision/Devices** **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 #115 has discharged from the Center.	

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 02/21/2013

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 323	Continued From page 4 living. Review of the documentation written by RN #1, dated 2/1/13 at 1 AM, showed the resident was found lying face down on the floor by the sink. At that time the resident complained of left ankle pain when staff moved him/her from the floor to the bed. The resident also complained of pain when staff touched his/her ankle. According to the 1/25/13 documentation, RN #1 completed a neurological assessment at 1:20 AM, 1:35 AM, 1:50 AM, 2:20 AM, 3:20 AM, 3:50 AM, 4:50 AM and 5:50 AM. Review of each timed assessment showed the resident moved both lower extremities without difficulty and no changes in condition were noted. Review of the January 2013 medication administration record showed RN #1 assessed the resident's pain as zero from 1/31/13 at 10 AM to 2/1/13 at 6 AM. However, the RN had documented the resident "said" his/her ankle was "sore" at 6:15 AM and there were "no orders for pain med [medication]." Review of the 2/1/13 documentation by licensed practical nurse (LPN) #1 at 7:40 AM and RN #2 at 8 AM revealed their assessments of the resident's pain and injury were not the same as documented by RN#1. Review of the nursing note completed by LPN #2 showed she assessed the resident at 7:40 AM and noted the resident's ankle was "swollen and bruised" and there was "increased pain with movement and touch." Review of the assessment completed by RN #2 showed she assessed the resident at 8 AM and the resident complained of left ankle pain. This review also showed the resident's ankle was swollen, purple and "lying laterally on a pillow with obvious deformity." According to the medical record the resident was transferred to the hospital on 2/1/13 at 9AM for treatment and care of a fractured left ankle.	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 residents have a post fall evaluation completed, assessed for pain, confirm the availability of pain medications, and administer the pain medications in accordance with the physician's order. Based on the results of the audits, education will be provided immediately on an as needed basis.	

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 02/21/2013

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 323	Continued From page 5 Interview on 2/21/13 at 11:40 AM with the director of nursing revealed the facility investigated and reviewed the above events and determined RN #1 needed education and training regarding assessments and identifying fall related injuries. Review of the education training records showed only RN #1 and four additional nurses had received the inservice and training. Further review of the information revealed no evidence of competency evaluations to ensure all staff who did not receive the education and training had the skills and knowledge to complete a post fall assessment accurately. Interview on 2/21/13 with LPN #2 at 9:35 AM and LPN #3 at 11:20 AM revealed they had not received the inservice training. During an interview at 11:40 AM, the director of nursing also confirmed all licensed nurses were responsible for post fall assessments, but efforts to ensure all nurses had the necessary skills and knowledge to complete accurate post fall assessments was lacking.	F 323	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Residents are assessed immediately following a fall to determine the presence/absence of pain and/or injury. The findings of this assessment are documented. If abnormal findings are noted during the assessment, appropriate interventions are initiated, including the need for further assessment, measures to manage pain, etc. Residents are assessed each shift for 72 hours to follow a fall to determine if any adverse effects have resulted from the fall. Additional interventions are taken as needed. Education is provided to nurses regarding the policy and procedure related to post-fall assessment and intervention, upon hire as needed.	

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 02/21/2013

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 323	Continued From page 5 Interview on 2/21/13 at 11:40 AM with the director of nursing revealed the facility investigated and reviewed the above events and determined RN #1 needed education and training regarding assessments and identifying fall related injuries. Review of the education training records showed only RN #1 and four additional nurses had received the inservice and training. Further review of the information revealed no evidence of competency evaluations to ensure all staff who did not receive the education and training had the skills and knowledge to complete a post fall assessment accurately. Interview on 2/21/13 with LPN #2 at 9:35 AM and LPN #3 at 11:20 AM revealed they had not received the inservice training. During an interview at 11:40 AM, the director of nursing also confirmed all licensed nurses were responsible for post fall assessments, but efforts to ensure all nurses had the necessary skills and knowledge to complete accurate post fall assessments was lacking.	F 323	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Staff Development Coordinator/Designee will provide education to licensed nurses to address the necessary skills and knowledge to complete the post-fall evaluation, the appropriate protocol for assessing pain, contacting the physician, administering the pain medications in accordance with the physician's order, determining the effectiveness of the pain medication, and documenting in the MAR the administration of the pain medication.	

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 02/21/2013

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 323	Continued From page 5 Interview on 2/21/13 at 11:40 AM with the director of nursing revealed the facility investigated and reviewed the above events and determined RN #1 needed education and training regarding assessments and identifying fall related injuries. Review of the education training records showed only RN #1 and four additional nurses had received the inservice and training. Further review of the information revealed no evidence of competency evaluations to ensure all staff who did not receive the education and training had the skills and knowledge to complete a post fall assessment accurately. Interview on 2/21/13 with LPN #2 at 9:35 AM and LPN #3 at 11:20 AM revealed they had not received the inservice training. During an interview at 11:40 AM, the director of nursing also confirmed all licensed nurses were responsible for post fall assessments, but efforts to ensure all nurses had the necessary skills and knowledge to complete accurate post fall assessments was lacking.	F 323	The RN Unit Managers/Designee will conduct an audit to confirm the completion of the post-fall evaluation, as assessment for pain was conducted pre and post pain medication administration, the physician was contacted if needed, and validate the MAR reflected the administration of the pain medication in accordance with the physician's order. Based on the results of the audits, education will be provided immediately on an as needed basis. 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 April 7, 2013.	