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

PRINTED: 11/05/2013
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 10/04/2013

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WY Dept of Health
NOV 06 2013
Health Facility Licensing & Certification Surveys

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	1128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide SDC: Staff Development Coordinator PT: Physical Therapist MDS: Minimum Data Set DNS: Director of Nursing Services RN: Registered Nurse CAA: Care Area Assessment LPN: Licensed Practical Nurse ADL's: Activities of Daily Living Less commonly used abbreviations will be annotated in each deficiency.	F 000	**F241** **Corrective Action:** The Director of Nursing Services (DNS), Unit Managers and Staff Development Coordinator (SDC) provided education to nursing staff regarding: -Timeliness of responding to call lights -Providing prompt assistance to residents -Providing privacy to residents as needed -Utilization of interventions identified in the plan of care for residents **Identification of Others:**	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and medical record review the facility failed to ensure measures to maintain the dignity of residents were implemented for 2 of 2 observed residents (#77, #73). The findings were: 1. Review of the medical record for resident #73 revealed the resident was admitted to the facility on 3/29/2012 with diagnoses including muscular wasting, disuse atrophy, and malaise and fatigue. Review of a significant change MDS dated 8/27/13 showed the resident required extensive	F 241	At a Resident Council Meeting, the residents were asked about concerns regarding timeliness of call light response and/or assistance when requested and if there were any concerns regarding privacy and/or dignity. The facility complaint/concern process will be followed for any identified concerns. The DNS and Unit Managers/designee will conduct call light observations on each shift for 3 days to determine timeliness of response. Following call light response, residents will be interviewed, if interviewable, to determine if their requests were met. Based on the results of the call light observations and	

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

Tonya Sanchez — ED — 11/5/13

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.

11/8/13 POC accepted per telephone call with administrator, Anthony Janusz @ 2PM MW

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F 241	Continued From page 1 assistance to perform ADL's including toileting, and the resident was frequently incontinent of bladder. The MDS also showed the resident was moderately cognitively impaired. The following concerns were identified a. A continuous observation made on 10/2/13 from 3:18 PM until 3:45 PM revealed the resident turned on the call light for assistance at 3:18 PM. CNA #1 was observed near the elevators next to the commons room with a hydration cart, assisting other residents. At 3:25 PM CNA #2 was observed getting on the elevator and leaving the floor and CNA #3 was observed getting off the elevator. At 3:30 PM CNA #3 and #1 were observed at the nursing station reviewing assignments. Nurse #1 went into the resident's room at 3:37 PM, the resident requested, "help to go to the bathroom." Nurse #1 informed the resident he would get a CNA to assist him/her and left the resident's room, the call light continued to be activated. At 3:45 PM, 27 minutes later, CNA #1 entered the resident's room and the resident stated, "Well I had to go to the bathroom, but now I'm wet." CNA #1 assisted the resident to the bathroom. The resident's adult brief, bed pad and clothing were saturated with urine. b. Review of the resident's care plan updated 5/29/13 showed the resident had frequent bladder incontinence related to impaired mobility. Interventions included facility staff needed to assist the resident with toileting as needed. 2. Medical record review showed resident #77 was admitted on 7/8/13 with diagnoses that included dementia, and that s/he required extensive assistance with ADL's, including toileting. a. Observation on 10/2/13 at 3:06 PM showed	F 241	interviews, additional training will be done with staff as needed. The DNS and Unit Managers will conduct rounds twice daily at random times, for two weeks, to observe for privacy and/or dignity concerns and if care plan interventions are utilized by staff. Based on the results of the rounds, additional training will be provided to nursing staff as needed. **Systemic Changes:** Call lights are utilized by residents to request assistance from staff. Staff responds to call lights timely and provide assistance to residents promptly. If a staff member responds to a call light and is unable to provide the assistance needed by the resident, he/she will notify a staff member that can provide assistance. Rounds will be done 3-5 times a week by the DNS and Unit Managers to observe for care provision according to the care plan for residents and to identify potential concerns related to privacy and/or dignity. Immediate training for staff is done as	

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F 241	Continued From page 2 the resident was laying in bed. The bed was near the entrance to the room, the door was open and from the hallway the resident was observed to have had a bowel movement in the bed. The resident's disposable brief was around his/her ankles, and the resident was uncovered and unclothed. The odor was noticeable from two doors down the hall where the surveyor was standing. During this observation CNA #8 was sitting with 6 other residents in the dining/main area of this unit, and CNA #5 was assisting a resident in another room. At 3:20 PM the resident began to move around and wake up, but did not use his/her call light. At 3:22 PM CNA #5 left the unit to go on break leaving one CNA on the unit. CNA #5 walked down the hallway to leave and did not acknowledge the smell or the resident who was visible in the room from the hallway. At that time the resident had propped him/herself up and was looking out the door of the room. As the CNA was leaving, 3 house keeping staff came into the unit to clean and buff the floors. These housekeeping staff observed the resident naked and unclean from the hallway; however, there was no notification to the CNA. The housekeeping staff went about cleaning/buffing the floor in the hallway in front of this resident's room. b. At 3:25 PM the surveyor spoke to CNA #8 to inform her of the dignity issue so the resident could be protected. As the CNA was being informed, a corporate activities representative entered the area, and closed the door so the resident was not in view from the hallway. Interview with CNA #8 on 10/2/13 at 3:30 PM revealed this resident was known to have this behavior. She further stated she had assisted the resident with toileting and laying down not long before. She also stated the other CNA would be	F 241	appropriate. The results of the rounds will be provided to the DNS/designee for trending and to identify further training needs. This will be done weekly for four weeks and then re-evaluated. Residents will be interviewed either individually or as part of Resident Council to determine if there are concerns regarding timeliness of call light response and/or assistance when requested and if there were any concerns regarding privacy and/or dignity. These interviews will be done by the Social Services Director/designee and reported the DNS. The facility complaint/concern process will be followed for any identified concerns. This will be done monthly for three months and then re-evaluated. Education is provided to nursing staff as needed regarding: -Timeliness of responding to call lights -Providing prompt assistance to residents -Providing privacy to residents as needed -Utilization of interventions identified in the plan of care for residents **Monitoring:** The Director of Nursing Services (DNS)/designee will report the results of the rounds and Resident interviews to the	

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F 241	Continued From page 3 on break for 45 minutes, it wasn't easy keeping track of everything, and if she needed assistance she could call the main desk. c. Review of the care plan showed a behavior problem was initiated 10/3/13 showing the resident prefers to sleep without clothes on, and may at times play with feces. There were interventions developed on 10/3/13 to include anticipate needs, provide an opportunity for positive interaction, stop and talk with him/her as passing by, and to provide privacy while in bed without clothing, use privacy curtain and check frequently to ensure safety.	F 241	Performance Improvement (PI) Committee for review. This will be done monthly for three months and then re-evaluated. The PI Committee will review the audits to provide further recommendations and to determine whether or not the deficient practice has been resolved. The PI Committee will make a determination as to the frequency of ongoing monitoring.	
F 279 SS=E	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 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).	F 279	**F279** **Corrective Action:** Resident #75 was discharged from the facility on 08/02/13. The care plan was updated for resident #72 to reflect current interventions related to fall risk. The care plan was updated for resident #70 to reflect current transfer status and interventions related to fall risk. The care plan was updated for resident #54 to reflect current interventions related to fall risk. The care plan was updated for resident #74 to reflect current transfer status and interventions related to fall risk.	

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F 279	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to develop, review and revise individualized care plans to meet resident needs for 7 of 15 sample residents (#50, #54, #70, #71, #72, #74, #75). The findings were: 1. Record review for resident #75 showed the resident was admitted to the facility on 7/2/13 with diagnoses including Alzheimer's disease, muscle weakness, and lack of coordination. The MDS assessment dated 7/12/13 showed the resident had severe cognitive impairment, was confused, required extensive assistance with ADL's, and had sustained 2 falls since the prior MDS assessment. The CAA showed the resident triggered for falls and a care plan for fall risk should be implemented. Review of physician orders dated 7/2/13 showed the resident had, "alarms to bed/wheelchair." The following concerns were identified: a. Review of the nursing notes showed the resident had fallen 4 times since his/her 7/2/13 admission. The resident had un-witnessed falls on 7/6/13, on 7/7/13, on 7/16/13, and on 7/24/13. Review of 2 post fall nursing notes dated 7/8/13 showed the resident had, bruises on the legs and abdomen and, had bruised or discolored skin on his/her bilateral arms from the falls. The fall on 7/24/13 resulted in the resident being transferred to the emergency department where it was identified s/he had sustained a transverse fracture of the first lumbar vertebrae. b. Review of the care plan showed no care plan had been developed to address the resident's risk for falls until 8/12/13 even though s/he had experienced 4 falls with injuries (bruises,	F 279	The care plan was updated for resident #71 to reflect current transfer status and interventions related to fall risk. Resident #50 was discharged form the facility on 10/10/13. The District Director of Clinical Operations (DDCO) will provide education to the Interdisciplinary Team (IDT) regarding the following: - Reviewing care plans if a resident experiences a fall to ensure reflective of the current status of the resident, including any new interventions to minimize risk for falls, transfer status changes, etc. - Timeliness of updating care plans related to falls to reflect interventions implemented based on the IDT review after a fall. **Identification of Others:** An audit of care plans for residents will be completed to determine if they were reflective of their current transfer status, fall risk and if reflective of recommended interventions and appropriate measures related to falls. Care plans will be updated as needed.	

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F 279	Continued From page 5 fractures) in July 2013. The goal was the resident would maintain maximum mobility within prescribed restrictions. Interventions were not resident specific and included, "administer medication as ordered, allow to perform tasks, and assess and monitor ability to perform ADL's." Alarms were not listed as interventions on the care plan. c. Review of the interdisciplinary team falls review documentation showed the following recommendations were made. For the fall on 7/15/13; continue with alarms, therapy, and educate staff not to leave the resident alone. For the fall on 7/24/13, the recommendation was to add a tabs monitor. Review of the care plan showed there was no documentation of interventions including alarms, education of staff, therapy or a tabs monitor. d. Interview with the DNS on 10/4/13 at 2:20 PM revealed care plans were supposed to be updated when new interventions were implemented. The interview also revealed fall interventions were supposed to be updated on the care plan during the interdisciplinary team meetings held daily Monday through Friday. 2. Review of the medical record for resident #72 showed s/he was re-admitted to the facility on 9/1/13 and had diagnoses that included rehabilitation and aftercare for the traumatic fracture of his/her hip and arm. The resident was previously admitted on 1/15/13, and review of nursing notes showed the resident had a history of falls. The notes showed the resident had falls in the facility on: 2/25/13, 3/15/13, 3/28/13, 5/21/13, 6/16/13, 7/19/13, 8/30/13, and 9/25/13. Review of the 1/16/13 fall care plan showed the resident was at risk for falls related to de-conditioning/decreased mobility at times,	F 279	**Systemic Changes:** Care plans are initiated by the IDT upon admission, significant change of status and as needed, based on resident status. Comprehensive care plans are reviewed by the IDT upon admission, quarterly and upon significant change of status during care conference. When a resident experiences a fall, the circumstances of the fall are reviewed by the IDT. The fall care plan is updated to reflect the recommendations made by the IDT and any new interventions. Upon admission, quarterly and with a Significant Change of Status (SCOS) residents are assessed for fall risk. Based on the outcome of this assessment, a care plan is developed to reflect the fall risk and interventions, including placing the resident on the Falling Star program. The MDS Coordinator (MDSC)/designee will audit care plans for residents identified at high fall risk upon admission and for residents that experience a fall to determine if current interventions are identified. Care plans will be updated as needed. This will be done monthly for three months and then re-evaluated.	

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F 279	Continued From page 6 occasional incontinence hearing problems, Alzheimer's, use of psychotropic medications, and status post hip fracture. Review of the interventions for falls showed a lip mattress and non-skid socks for both feet at night were added on 2/26/13. Encouraging the resident to request assistance in ambulating were added on 3/16/13, and side rails times two was added to the bed for mobility on 3/20/13. The remainder of the interventions to prevent falls including the use of a bed pressure alarm and wheelchair alarm were developed on 1/16/13 when the care plan was initiated. The care plan failed to show any new or changed interventions to prevent falls after the May, June, July, August and September 2013 falls. 3. Review of the medical record for resident #70 showed s/he had diagnoses that included knee joint replacements, anxiety, muscle weakness, and osteoarthritis. Observation on 10/2/13 at 2:55 PM showed the resident required extensive assistance for transfers. Observation showed CNA #5 assisted the resident with the use of a sit-to-stand lift to transfer from the wheelchair to the toilet. During the observation the resident was noted to be weak and did not have enough strength to participate with the mechanical lift transfer with his/her legs or upper body. The resident made comments during the transfer that it hurt under his/her arms, and the resident was noted to be hanging from the lift sling that was used to help support the body. Review of a physical therapy note dated 4/25/13, and restorative nursing notes dated 6/14/13 showed the resident was not making progress with goals for strengthening and was discontinued from these programs on these dates respectively. Review of the 7/14/12 care plan showed the	F 279	The results of these audits will be provided to the DNS for further review and follow-up. Additional training will be provided to the IDT as needed. Education will be provided to the IDT regarding updating care plans based on fall risk or following a resident fall as needed. **Monitoring:** The DNS/designee will report the results of the care plan audits to the PI Committee for review. This will be done monthly for three months and then re-evaluated. If further issues are identified, additional training will be provided to the IDT. Identified problems will be reported to the PI Committee for further review and recommendations for three months, and then re-evaluated. The PI Committee will review the audits to provide further recommendations and to determine whether or not the deficient practice has been resolved. The PI Committee will make a determination as to the frequency of ongoing monitoring. **Date of Compliance**: 11/05/13	

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F 279	Continued From page 7 resident was at risk for falls due to limited mobility, dementia and weakness. Another care plan problem related to falls was dated 6/29/12 and showed the resident had an actual fall on 6/29/12 from bed without injury. The interventions for the 7/14/12 fall problem showed the resident was on the falling star program as of 8/22/12. The requirement for a sit-to-stand mechanical lift was added to the care plan on 7/14/12. Further review showed there was nothing added or changed to the residents care plan interventions related to falls or transfers since 8/22/12. 4. Review of the medical record for resident #54 showed s/he was admitted on 5/12/09 and had diagnoses that included difficulty walking, malaise and fatigue, and obesity. Review of a 5/9/13 nursing note showed the resident was being transferred in a sit-to-stand mechanical lift when the resident became unsteady and was lowered to the floor. The resident was transferred back to bed using a Hoyer mechanical lift (full body lift not requiring the resident's strength or support). Review of the resident's care plan showed the resident used a sit-to-stand for transfer status and the goal was to transfer safely. This care plan was initiated on 6/20/12 and the intervention was to "direct [resident's name] while using sit to stand to ensure safety." In addition, review of the care plan related to fall risk showed it was initiated on 1/17/13, and the resident's risk was related to incontinence, decreased mobility, use of antidepressant medications, dementia and history of falls. Several interventions were shown including following the facility fall protocol, and reminding the resident to request assistance. These interventions were all dated 1/17/13, there were no changes or updates made to the care plan related to the 5/9/13 fall.	F 279		

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F 279	Continued From page 8	F 279		

5. Review of the medical record showed resident #74 was admitted on 12/28/11 with diagnoses that included aftercare for a traumatic hip fracture and muscle weakness. Review of the nursing notes showed the resident had a fall on 9/9/13 at 6 PM. Interview with the DNS on 10/4/13 at 9:30 AM revealed the post fall evaluation for this resident's fall was done as a late entry on 10/3/13 due to the recognition that it was initially charted on the wrong resident (#70). Review of the post fall evaluation showed the resident slipped out of the sling while being transferred with a sit-to stand mechanical lift. The fall was in the presence of staff with no injury. The following concerns were identified:

a. Review of the care plan showed the resident was identified as a fall risk on 9/25/12 due to decreased mobility, incontinence, dementia and use of psychotropic medications. The intervention after the 9/9/13 fall from the lift was dated 10/3/13 (almost one month after the fall) and showed: "Resident requires to be transferred with sit-to-stand due to limited mobility and high fall risk."

b. Interview with the unit manager on 10/4/13 at 1 PM verified after the fall the resident continued to be transferred with the sit-to-stand lift. She then stated as of the morning of 10/4/13 an evaluation was completed and a new order was received that the resident needed a full Hoyer lift at all times for safe transfers. She was not aware of why an evaluation for safety was not done or documented after the resident fell from the lift sling on 9/9/13.

6. Review of the medical record for resident #71 showed s/he had diagnoses that included muscle wasting and disuse atrophy. Observation on 10/2/13 at 4:05 PM showed CNA #6 assisted the

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F 279	Continued From page 9 resident using a sit-to-stand mechanical lift to transfer from the bed to the wheelchair. During the transfer the resident was observed to be unable to participate with his/her left side. The resident was unable to hold onto the lift with his/her left arm, it hung at his/her side, the resident wore shoes and his/her feet were appropriately placed on the foot platform. Review of a 3/15/13 post fall evaluation showed the resident had lost his/her footing and slipped off the equipment and onto the floor while being transferred with a sit-to-stand lift. Further record review showed on 5/23/13 (two months after the fall) the resident was evaluated by physical therapy and the therapist trained staff on safe transfer technique and the appropriate lift to be used for this resident. Review of the resident's care plan related to falls showed a revision date of 3/19/13 however, there were no interventions added at that time. The resident was shown to be at risk for falls due to decreased mobility, incontinence, use of antidepressant medication and late effect CVA, and impaired vision. The care plan showed an updated intervention dated 10/3/13 to ensure the resident was wearing the appropriate footwear when ambulating or mobilizing in the wheelchair. However, further review showed the care plan failed to address PT recommendations for the sit-to-stand mechanical lift. 7. Review of the medical record for resident #50 showed the resident was re-admitted to the facility on 9/6/13 with diagnoses including Alzheimer's, pneumonia, and anxiety. Review of the most current MDS assessment dated 9/19/13 showed the resident was cognitively intact but had disorganized thinking (section C1300). Further review showed the resident required	F 279		

PRINTED: 11/05/2013
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
	535013	A. BUILDING _____ B. WING _____	C 10/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 10	F 279		

limited assistance and supervision with ADL's including transferring and walking. The MDS showed the resident had experienced 2 or more falls since admission. The CAA analysis showed the resident was at risk for falls due to decreased mobility, incontinence, use of psychoactive medications, diagnoses of dementia and anxiety, and recent falls. Review of the nursing notes showed the resident had fallen 4 times, 9/12/13, 9/16/13, and twice on 9/17/13. The review further revealed the resident was sent to the emergency room for evaluation of numerous skin tears and complaints of right shoulder pain s/he sustained from the unwitnessed fall on 9/12/13. The following concerns were identified:

a. Review of the care plan showed the resident was high risk for falls related to hearing problems, decreased mobility, incontinence, dementia, anxiety, recent falls, and psychoactive drug use. The care plan for falls was not initiated until 9/25/13, (13 days after the resident's first fall and 19 days after the resident was re-admitted to the facility). The care plan was not updated until 10/2/13 and updated interventions included, "[resident name] often refuses to wear [his/her] shoes, keep adjustable bed in low position for safe transfers, lock bed brakes, and provide non-skid footwear."

c. Review of the facility's policy entitled, "Falling Stars", dated 8/23/13 revealed nursing staff should, "develop the initial care plan addressing fall prevention, develop appropriate interventions, identify resident's that have falling star interventions on the care plan, re-assess after a fall, and revise the care plan as necessary."

d. Interview with the acting administrator on 10/4/13 at 2:20 PM revealed he expected staff to follow the falling stars policy.

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F 315	Continued From page 11	F 315		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and medical record review the facility failed to ensure that 1 of 1 observed residents (#73) were assisted with toileting to reduce incontinent episodes. The findings were: Review of the medical record for resident #73 revealed the resident was admitted to the facility on 3/29/2012 with diagnoses including muscular wasting, disuse atrophy and malaise and fatigue. Review of a significant change MDS assessment dated 8/27/13 showed the resident was moderately cognitively impaired and required extensive assistance to perform ADL's, including toileting, and the resident was frequently incontinent of bladder. The following concerns were identified: a. A continuous observation made on 10/2/13 from 3:18 PM until 3:45 PM revealed the resident turned on the call light for assistance at 3:18 PM. At 3:45 PM, 27 minutes later, CNA # 1 entered the resident's room and the resident stated, "Well I had to go to the bathroom, but now I'm wet".	F 315	**F315** **Corrective Action:** Assistance was provided to resident #73. The DNS, Unit Managers and SDC will provide education to the nursing staff regarding providing prompt assistance to residents when needed. The DNS and Unit Managers will review staffing patterns to ensure staff available to assist residents as needed. **Identification of Others:** Rounds will be conducted by the DNS and Unit Managers/designee 3-5 times a week for two weeks to determine if incontinent care provided timely to residents and if staff available to assist residents as needed. Based on the results of the rounds, additional education was provided to the nursing staff and/or changes to staffing patterns made. **Systemic Changes:** Assistance is provided to residents for use of the bathroom and/or incontinent care as needed.	

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OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 315	Continued From page 12 CNA #1 assisted the resident to the bathroom. The resident's adult brief, bed pad and clothing were saturated with urine. b. Review of the resident's care plan updated 5/29/13 showed the resident had frequent bladder incontinence related to impaired mobility. Interventions included staff to assist the resident with toileting as needed. c. An interview with CNA #2 on 10/2/13 at 3:55 PM revealed, "sometimes there is not enough help." d. An interview with the DNS on 10/3/13 at 12:40 PM revealed staff were expected to assist residents with toileting as needed.	F 315	Rounds will be conducted to determine if incontinent care provided timely to residents. These rounds will be done by the DNS and Unit Managers/designee 3-5 times a week at various times throughout the day. In addition, the Unit Managers/designee will monitor staffing patterns to ensure staff is available to assist residents as needed. This will be done for 30 days and then re-evaluated. Education will be provided to nursing staff as needed regarding providing prompt assistance to residents when needed and ensuring staff availability to assist residents. **Monitoring:** The DNS/designee will report the results of the rounds and staffing reviews to the PI Committee, along with any corrective actions taken. This will be done monthly for three months and then re-evaluated. The PI Committee will review the audits to provide further recommendations and to determine whether or not the deficient practice has been resolved. The PI Committee will make a determination as to the frequency of ongoing monitoring. **Date of Compliance**: 11/05/13	
F 323 SS=K	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 observation, medical record review, staff and resident interview and review of fall documentation, the facility failed to ensure effective supervision and interventions were implemented to prevent falls for 7 of 8 sample residents (#51, # 54, # 70,# 71, #72, #74, #75). As a result, serious avoidable injuries occurred to sample residents (# 51, #72 , #75). In additon, a determination of immediate jeopardy was identified for 4 of 6 observed sample residents	F 323		

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FORM APPROVED
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F 323	Continued From page 13 who were not being provided safe transfers with mechanical lifts (#54, #70, #71, # 74), and 1 of 4 observed residents with alarms not consistently utilized (#72). The findings were: 1. Review of the medical record for resident #72 showed s/he was re-admitted to the facility on 9/1/13 and had diagnoses that included rehabilitation and aftercare of a traumatic fracture of the hip and arm. The resident was previously admitted on 1/15/13, and review of nursing notes showed the resident had a history of falls. The notes showed the resident had falls at the facility on: 2/25/13, 3/15/13, 3/28/13, 5/21/13, 6/16/13, 7/19/13, 8/30/13, and 9/25/13. Review of a fall action plan showed the 3/15/13 fall resulted in a fractured hip that required surgical intervention. This was an unwitnessed fall, and based on the documentation it was not clear as to what interventions were in place at the time of the fall. Review of the fall evaluation showed the 5/21/13 fall resulted in a fractured arm, the intervention at the time of the fall was a bed and chair alarm that was found to be "not turned on." Review of the 9/25/13 fall evaluation showed the resident fell in the bathroom. The fall was unwitnessed and the resident reported s/he was transferring him/herself to the bathroom and the "chair alarm did not sound." The following concerns were identified related to the resident's continued risk for falls: a. Review of the fall care plan showed it was initiated on 1/16/13. The resident was shown to be at risk for falls related to de-conditioning/decreased mobility at times, occasional incontinence, hearing problems, Alzheimer's, use of psychotropic medications, and status post hip fracture. Review of the care plan interventions for falls showed a lip mattress	F 323	**F323** **Corrective Action:** All residents were evaluated for fall risk and those with sit-to-stand and mechanical lifts were completed. All residents at high risk for falls were evaluated for appropriate fall interventions, which were in place. This was done on 10/03/13. Education was done will all nursing staff. Oncoming staff was education upon arrival to work. Education was conducted on proper transfers and technique, and checking alarms each shift. Education was provided to nurses regarding the facility policy and procedure for fall prevention and assessments. Competencies were done on lifts with staff in the facility. This was done on 10/03/13. A facility-wide audit of alarms was done to ensure all alarms were turned on and functioning properly. Staff was educated on checking the functioning of alarm every shift. This was done on 10/03/13. The alarm was turned on for resident #72 and education was provided by the DNS with the identified CNA. The care plan was updated for resident #72 to reflect current interventions related to fall risk.	

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OMB NO. 0938-0391

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F 323	Continued From page 14 and non-skid socks for both feet at night were added on 2/26/13. Encouraging the resident to request assistance in ambulating was added on 3/16/13, and bed side rails times two was added for mobility on 3/20/13. The remainder of the interventions to prevent falls including the use of a bed pressure alarm and wheelchair alarm were developed on 1/16/13 when the care plan was initiated. The care plan failed to show any new or changed interventions to prevent falls after the May, June, July, August and September 2013 falls. b. Observation on 10/3/13 at 10:20 AM with the RN #3 showed the resident was in bed sleeping and the bed pressure alarm was in the off position. The nurse called in CNA #4 at 10:23 AM who verified the resident had been in bed for about 15 minutes and the alarm should have been turned on. The CNA then turned on the alarm. 2. Review of the medical record for resident #70 showed s/he had diagnoses that included knee joint replacements, anxiety, muscle weakness, and osteoarthritis. The following concerns were identified with the safety of transfers for this resident: a. Observation on 10/2/13 at 2:55 PM showed the resident required extensive assist for transfers. CNA #5 assisted the resident with use of a sit-to-stand lift to transfer from the wheelchair to the toilet. During the observation the resident was noted to be weak and did not have the strength to participate with the mechanical lift transfer with his/her legs or upper body. The resident made comments during the transfer ~~that~~ it hurt under his/her arms, and the resident was noted to be hanging from the lift sling that was	F 323	The transfer status of resident #70 was evaluated by PT on 10/04/13 and a Hoyer lift transfer was initiated and staff training was conducted. The resident was re-evaluated by PT and recommendations were to return to using the Sit-to-Stand lift when transferring the resident. The care plan was updated to reflect current transfer status and interventions related to fall risk. The transfer status of resident #54 was evaluated by PT on 10/04/13 and a Hoyer lift transfer was initiated and staff training was conducted. The care plan was updated to reflect current interventions related to transfer status and interventions related to fall risk. The transfer status of resident #71 was evaluated by PT on 10/04/13 and continued use of sit to stand lift was recommended with using two people. Staff training was conducted and care plan updated to reflect current status and interventions to fall risk. The transfer status of resident #74 was evaluated by PT on 10/04/13 and a Hoyer lift transfer was initiated and staff training was conducted. The care plan was updated to reflect current transfer status and interventions related to fall risk.	

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F 323	Continued From page 15 used to help support the body. b. Interview with the CNA during the transfer revealed this was the way the resident always transferred with the sit-to-stand lift, and the CNA verified the resident had knee pain and weakness which prevented the resident from being able to participate to the full extent. c. Review of the nursing care plan progress note dated 6/22/13 showed the resident was dependant on staff for all ADLs and required extensive assistance with a mechanical lift for transfers. Review of the 4/11/13 to 4/17/13 physical therapy notes showed the resident was being seen by PT to increase strength and reduce knee pain and was not making good progress with goals. The PT was discontinued on 4/25/13. Review of the 5/14/13 restorative nursing note showed due to complaints of pain with restorative therapy, the resident was not making any progress, and the program was discontinued at that time. d.Review of the medical record showed no evidence the resident was evaluated for use of the sit-to-stand lift for transfers. This resident was identified as having pain and weakness. e. Review of the 7/14/12 care plan showed the resident was at risk for falls due to limited mobility, dementia and weakness. Another care plan problem related to falls was dated 6/29/12 and showed the resident had an actual fall from the bed without injury on 6/29/12. Review of the 7/14/12 care plan for falls showed interventions included use of the sit-to-stand mechanical lift. On 8/22/12 the falling star program was added to the care plan. Further review showed there was nothing added or changed to the residents care plan interventions related to falls or transfers since 8/22/12.	F 323	Resident #75 was discharged from the facility on 08/02/13. Resident #51 was discharged from the facility on 10/08/13. Education was done with the identified staff regarding the proper lift (Hoyer) to use for resident transfers and to use the information from the CNA worksheet and Kardex. Education will be provided to nursing staff by the DNS, Unit Managers and SDC regarding: -Checking alarm placement and functioning for identified residents and reporting if alarms are noted to be turned off or not functioning properly. -Proper use of mechanical lifts and reporting changes in a resident's transfer status for further evaluation and determination of appropriate transfer devices to be used -Use of CNA worksheets and Kardex documentation to identify transfer information for each resident -Referrals to PT for evaluation of resident's related to transfer status as needed The DDCO provided education on 10/14/13 to the DNS, Unit Managers and SDC regarding the facility policy and procedures related to the Fall Management	

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F 323	Continued From page 16 3. Review of the medical record for resident #54 showed s/he was admitted on 5/12/09 and had diagnoses that included difficulty walking, malaise and fatigue, and obesity. Review of a 5/9/13 nursing note showed the resident was being transfered in a sit-to-stand mechanical lift when the resident became unsteady and was lowered to the floor. The resident was transfered back to bed using a Hoyer mechanical lift (full body lift not requiring the resident's strength or support). Review of the 6/20/12 care plan showed the only intervention to address fall prevention was to use the sit-to-stand mechanical lift for transfers. Review of the updated 7/17/13 care plan showed fall interventions included following the fall protocol and reminding the resident to call for assistance. The following concerns were identified: a. No changes or updates were made to the care plan after the 5/9/13 fall. b. Observation on 10/3/13 at 9:55 AM showed CNA #5 was assisting the resident with changing his/her incontinence brief. The resident was up in the sit-to-stand lift and the resident was complaining about the sling hurting under his/her arms. In addition, both of the resident's heels were hanging off of the foot platform, and it appeared as though the resident was supporting him/herself with mimimal strength in the legs. Interview with the resident at that time revealed s/he felt "safe enough, I guess." Interview with the CNA at that time verified the resident's feet should be positioned on the platform and not hanging off. She stated she hadn't noticed until the surveyor asked. c. Review of the medical record showed no evidence a safety assessment was performed to determine the safety and appropriateness of the sit-to-stand mechanical lift for the resident.	F 323	Program, including interventions and documentation. The DDCO will provide education to the DNS regarding tracking fall data, including tracking of falls involving mechanical lifts, trending and analysis of the data, development of action plans, action and re-evaluation to determine effectiveness of corrective action or if changes are needed. **Identification of Others:** A Fall Risk/Intervention review was done by the DDCO, DNS, Unit Managers and SDC. This review was completed on 10/12/13. During this audit the following was reviewed for each resident: -Date of last Fall Risk assessment -Fall Risk score -Current Transfer status, including use of lift, type, and appropriateness based on resident status -Current Interventions related to falls -Date of last fall, if any -If the resident was on the Falling Star Program. Each resident was reviewed to determine if appropriate for the Falling Star Program. Care Plans were updated to reflect this, icons were appropriately placed, the information was placed in POC	

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F 323	Continued From page 17 4. Review of the medical record showed resident #74 was admitted on 12/28/11 with diagnoses that included aftercare for a traumatic hip fracture and muscle weakness. Review of nursing notes showed the resident had a fall on 9/9/13 at 6 PM. Interview with the DNS on 10/4/13 at 9:30 AM revealed the post fall evaluation for this resident's fall was done as a late entry on 10/3/13 due to the recognition that it was initially charted on the wrong resident (#70). Review of the post fall evaluation showed the resident slipped out of the sling while being transferred with a sit-to stand mechanical lift. The fall was in the presence of staff with no injury. Review of the care plan showed the resident was identified as a fall risk on 9/25/12 due to decreased mobility, incontinence, dementia and use of psychotropic medications. The intervention after the 9/9/13 fall from the lift was dated 10/3/13 and showed: "Resident requires to be transferred with sit-to-stand due to limited mobility and high fall risk." The following concerns were identified: a. Review of the medical record failed to show an assessment of the resident's ability to safely transfer with the lift was performed. b. Interview with the unit manager on 10/4/13 at 1 PM verified with the exception of a couple of days after the fall the resident continued to be transferred with the sit-to-stand lift. She then stated as of the morning of 10/4/13 a safety assessment was completed and a new order was received that the resident would use a full Hoyer lift at all times for safe transfers. She was not aware of why a safety assessment was not done or documented after the resident fell from the lift sling. 5. Review of the medical record for resident #71	F 323	for the Certified Nursing Assistants (CNAs) and nursing staff were notified of the residents currently in the program. Based on the results of the audits, the following was done: -Care plans were and CNA worksheets were updated. Additionally, the Point of Care system for CNA documentation was updated with fall risk and transfer information, to include use of mechanical lifts An audit of the Fall Management Program was done by the DDCO, DNS, Unit Managers and SDC. This audit was completed 10/23/13. During this audit, falls for the last 30 days were reviewed for the following: -Date of fall(s) -Presence of Initial Nurses Progress note regarding fall -Clinical assessment complete -Completion of Post-Fall evaluation -Documentation of IDT review of fall -Notification of physician and family -Interventions to help minimize risk for falls identified and implemented -Referral to therapy or restorative nursing made as appropriate -Care plan updated to reflect identified interventions -Changes to plan of care communicated to the nursing staff -Falling Star updated	

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F 323	Continued From page 18 showed s/he had diagnoses that included muscle wasting and disuse atrophy. Observation on 10/2/13 at 4:05 PM showed CNA #6 assisted the resident using a sit-to-stand mechanical lift to transfer from the bed to the wheelchair. During the transfer the resident was observed to be unable to participate with his/her left side. The resident was unable to hold onto the lift with his/her left arm, it hung at his/her side, the resident wore shoes and his/her feet were appropriately placed on the foot platform. The following concerns were identified: a. Review of a 3/15/13 post fall evaluation showed the resident lost his/her footing and slipped off the equipment and onto the floor while being transferred with a sit-to-stand lift. There was no injury noted, and the conclusion to the evaluation showed a lack of appropriate footwear and technique were contributing factors to the fall. b. Further record review showed on 5/23/13 (two months after the fall) the resident was evaluated by physical therapy and the therapist trained staff on safe transfer technique and the appropriate lift to be used for this resident. Review of this education by the therapist showed the resident required a specific model of sit-to-stand lift and the "flaccid leg and arm" needed to be "protected" during transfer. Interview on 10/4/13 at 12:25 PM with the PT who provided the education revealed the way to protect the residents left arm and leg during the transfer was to have two staff members present when the resident was transferred with the lift. She stated this should be included on the care plan but it was not. c. Review of the resident's care plan related to falls showed it was updated on 10/3/13 with an intervention of ensuring the resident was wearing the appropriate footwear when ambulating or	F 323	**Systemic Changes:** Residents are assessed for fall risk using the Morse Fall Risk Assessment, upon admission, quarterly and upon Significant Change in status. Based on the risk score, a care plan is developed to address fall risk and interventions to help minimize the risk for falls. If the Morse Fall Risk score is high, the resident will be placed on the Falling Star program. An icon will be placed on the door to the resident's room. Interventions, such as personal alarms, low bed, etc., will be implemented as appropriate. This information will be reflected on the care plan, on the CNA Kardex in POC and on the CNA worksheets. Physician orders will be obtained for the interventions. A care plan to address fall risk and interventions will be developed within 24-hours of admission and updated following a fall or change in the Morse Fall Risk score. Within 24-72 hours, the Morse Fall Risk Score will be reviewed by the IDT. This will include review to ensure the following: -Morse Fall Risk assessment complete and results reflected on the care plan	

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OMB NO. 0938-0391

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

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	535013	A. BUILDING _____ B. WING _____	C 10/04/2013

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F 323	Continued From page 19 mobilizing in the wheelchair. Further review showed the care plan failed to address the PT's recommendations for the sit-to-stand mechanical lift. 6. Record review for resident #75 showed the resident was admitted to the facility on 7/2/13 with diagnoses including Alzheimer's disease, muscle weakness, and lack of coordination. The MDS assessment dated 7/12/13 showed the resident was severely cognitively impaired, confused, required extensive assistance with ADL's, and had sustained 2 falls since the prior MDS assessment. The CAA showed the resident triggered for falls and a care plan for fall risk should be implemented. Review of physician orders dated 7/2/13 showed the resident had, "alarms to bed/wheelchair." The following concerns were identified: a. Review of the nursing notes showed the resident had fallen 4 times since admission on 7/2/13. The resident had an unwitnessed fall on 7/6/13, in which the nurse responded to the bed alarm and found the resident on the floor beside the bed, and no injury was documented. The resident had an unwitnessed fall on 7/7/13; the nurse responded to an alarm and found the resident on the floor. The resident was incontinent of urine, and, "the bed was wet". Review of 2 fall follow-up nursing notes dated 7/8/13 showed the resident had bruises on his/her legs and abdomen and bruised or discolored skin on his/her bilateral arms. Review of a late entry nursing noted dated 7/17/13, showed the resident had, "an unwitnessed fall on 7/16/13 with no injury noted." The resident had attempted to stand and open a drawer. The resident had an unwitnessed fall on 7/24/13 and was transferred to the emergency department	F 323	-Interventions implemented based on risk score -Falling Star Icon placed -Transfer Status of the resident added to POC and on the CNA worksheets and reflected in the care plan -Physician orders for interventions obtained and implemented -Care plan updated The transfer ability of residents is assessed by a nurse upon admission, quarterly and upon significant change of status. Use of mechanical lifts is determined based on this assessment. Referrals to Physical Therapy are made as needed. Information regarding the transfer status of residents is documented on the care plan, in POC, on the CNA worksheets and on the Kardex. Training is conducted to determine competency of staff related to use of mechanical lifts. Competencies are completed upon hire, annually and as needed. If a resident experiences a fall and a mechanical lift is used, the circumstances of the fall will be reviewed. Based on the results of the review, appropriate action will be taken, such as additional training with the CNA or re-evaluation for appropriate transfer. Action taken will be	

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F 323	Continued From page 20 where it was identified s/he had sustained a transverse fracture of the first lumbar vertebrae. b. Review of the care plan showed no care plan had been developed that identified the resident as having fallen or being at risk for falls, until the care plan dated 8/12/13 showed the resident had a lumbar fracture of his/her back related to a fall. The goal was the resident would maintain maximum mobility within prescribed restrictions. Interventions were general and included, "administer medication as ordered, allow to perform tasks, and assess and monitor ability to perform ADL's." Alarms were not listed as interventions on the care plan. c. Review of the interdisciplinary team falls review for July 2013 only listed 2 falls for the resident on 7/15/13 and 7/24/13. Recommendations for the fall on 7/15/13 included, "continue with alarms, therapy, and educate staff not to leave alone". The recommended intervention for the fall on 7/24/13 was to add a tabs monitor. The care plan was not updated to reflect the resident's falls until 8/12/13 and none of the recommended interventions were documented. d. Review of the quality assessment and assurance reports identified the resident as having repeated falls. 7. Review of the medical record for resident #51, showed the resident had numerous recurrent re-admissions to the facility. The most current re-admission was 9/24/13 and a complete MDS was not available. The most current complete annual MDS dated 4/24/13 showed the resident was cognitively intact and able to make decisions independently. The assessment further showed the resident required extensive assistance with ADL's including transferring, and had limited	F 323	documented and trended by the DNS/designee. Personal alarms will be checked by the nurses each shift to ensure proper placement and functioning. This check is documented on the Medication Administration Record (MAR). CNAs will also check to ensure proper placement and function at the beginning of their shift. If alarms are noted to be turned off, this will be reported to the DNS for tracking and follow-up. If the alarms are not functioning properly, they will be repaired and/or replaced as needed. Restorative nursing will also check personal alarms for proper placement and function weekly. If alarms are noted to be turned off, this will be reported to the DNS for follow-up. If the alarms are not functioning properly, they will be repaired and/or replaced as needed. The results of the checks will be documented and provided to the DNS for tracking and follow-up. Additional training will be done with nursing staff as needed. Random rounds will be conducted 3-5 times per week by the DNS, Unit Managers and/or SDC to check personal alarms for proper placement and function. Corrective action will be taken as needed.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 21 range of motion in both lower extremities. Review of a nursing note dated 9/17/13 showed the resident, "is now a Hoyer lift [a mechanical lift with a sling that required no assistance from the resident] due to [his/her] passing out episode in the sit-to-stand [mechanical lift that assist the resident to sit and stand for transfers]." The care plan revealed the resident was at risk for falls related to decreased mobility, incontinence, obesity, and arthritis. Goals showed the resident's risk for falls with injuries would be minimized over the next 90 days. Interventions dated 6/21/13 showed the resident was supposed to be transferred using a,"Hoyer lift [a mechanical lift with a sling not requiring resident strength/participation]." The following concerns were identified: a. Review of the CNA worksheet last updated 7/9/2013 showed the resident was supposed to be transferred using a Hoyer or mechanical sling lift. b. Review of a post fall evaluation dated 9/11/13 revealed the CNA was transferring the resident with a sit-to-stand lift, when the resident became,"unconscious and limp and was lowered to the floor by staff." Review of the nursing notes from 9/11/13 through 9/16/13 showed the resident complained of increasing pain in the right knee on 9/13/13, at which time the resident's pain medication was increased. While the resident refused to go to the emergency department for evaluation, s/he did agree to go for an x-ray of the right leg on 9/16/13 and was found to have sustained a distal femur spiral fracture above the right knee, at which time s/he was admitted to the hospital. c. Interview with the resident on 10/2/13 at 3 PM revealed s/he was able to recall the events of 9/11/13. The resident stated, "the aide was	F 323	The results of these rounds will be documented and provided to the DNS for tracking and follow-up. Additional training will be done with nursing staff as needed. This will be done weekly for 60 days and then re-evaluated. The IDT will review each resident to determine ongoing participation in the Falling Star Program monthly and as needed. Care plans and Falling Star icons will be updated as needed. The MDS Coordinator (MDSC)/designee will audit care plans for residents identified at high fall risk upon admission and for residents that experience a fall to determine if current interventions are identified. This audit will also include identification of transfer status and devices used. Care plans will be updated as needed. This will be done monthly for three months and then re-evaluated. The results of these audits will be provided to the DNS for further review and follow-up. Additional training will be provided to the IDT as needed. The Unit Managers will audit CNA worksheets, the Kardex and POC, to determine if updated with current transfer status and devices used for each resident. The results of the audits will be provided	

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F 323	Continued From page 22 getting me up with the sit to stand lift and my blood pressure dropped. I became unconscious, fell out of the lift and broke my right leg". The resident was able to recall that staff were supposed to use the mechanical sling lift to transfer him/her because, "I passed out in the sit to stand lift in June." The resident revealed some of the CNA's used the sit-to-stand or the Hoyer lift, "whatever they felt safe using to get me up." The resident also revealed s/he had worsening pain in the right leg but, "did not feel like I could go to the emergency room in the van so they called the ambulance on 9/16/13 to come and get me." The interview also revealed the facility offered to take the resident to the emergency department for evaluation on 9/13/13/ but the resident refused. The resident revealed s/he had opted not to have surgical repair of the leg fracture due to multiple chronic diseases, including liver cancer. The resident further stated s/he,"a lot of pain and adjustments to pain meds to keep me comfortable." d. Interview with CNA #1 on 10/2/13 at 3:50 PM revealed s/he reviewed the CNA worksheet located at the nursing station to determine the type of assistive devices used to transfer residents. Interview with CNA #2 on 10/2/13 at 4 PM revealed s/he reviewed the CNA worksheet or the care plan book located at the nursing station to determine the type of assistive devices used to transfer residents. Interview with unit manager #1 on 10/2/13 at 4:30 PM revealed CNA's were supposed to check the CNA worksheets located in a file drawer at the nursing station to determine what type of lift to use when transferring residents. e. Interview with the DNS on 10/3/13 at 11:55 AM verified the CNA transferred the resident with the wrong lift on 9/11/13. Interview further	F 323	to the DNS for review and follow-up with corrective action as needed. This will be done weekly for four weeks and then re-evaluated. Education will be provided to the nursing staff regarding fall management, transfer status and use of devices during the new-hire orientation process and as needed. **Monitoring:** The DNS/designee will report on any falls that involved used of a mechanical lift, alarm audit and rounds results, all audits and fall management review and analysis each month to the PI Committee for review. The DNS/designee will report the results of the care plan audits to the PI Committee for review. This will be done monthly for three months and then re-evaluated. If further issues are identified, additional training will be provided to the IDT. The PI Committee will review the audits to provide further recommendations and to determine whether or not the deficient practice has been resolved. The PI Committee will make a determination as to the frequency of ongoing monitoring. **Date of Compliance:** 11/05/13	

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

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F 323	Continued From page 23 revealed the CNA involved was re-educated, however, not all CNA's were re-educated regarding the use of mechanical lifts. The DNS declined a request by the surveyor to review the fall investigations, stating, "they were internal documents". f. Review of the medical record revealed no evidence a transfer assessment had been completed using the sit-to-stand or full sling mechanical lifts. g. Interview with the SDC on 10/3/13 at 10:45 AM revealed CNA's were educated and evaluated about performing safe transfers, including the use of the sit-to-stand and mechanical sling lifts, yearly and as needed on an individual basis. Interview on 10/4/13 at 2:20 PM with the acting administrator, the DNS and the SDC revealed there was information collected in the QAPI program related to falls. The DNS reported the facility had identified an ongoing problem related to increased numbers of resident falls. The DNS and the acting administrator verified interventions and actions taken by the QAPI committee were tracking the numbers of falls, evaluating when and where they were happening, performing alarm audits, and providing staff education known as the 4 P's. The 4 P's included frequent rounding for pain, "potty needs", positioning, and proper placement of items. In the interview the DNS verified the information gathered over the past 90 days had shown a correlation between less staff and higher fall rates. Many of the falls were identified as occurring on Fridays and the weekends. The information also showed many of the resident's falls were being contributed to self transfers. Review of the monthly QAPI summaries showed in June 2013 there were 28 falls throughout the facility. In July 2013 there	F 323		

PRINTED: 11/05/2013
FORM APPROVED
OMB NO. 0938-0391

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

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F 323	Continued From page 24 were 45 falls; one of which resulted in a fracture. In August 2013 there were 39 falls, and in September 2013 the numbers had not yet been calculated, but the fall logs showed 28 falls listed. One of the September 2013 falls resulted in a fracture. In addition, from October 1 through October 4, 2013 there were 3 falls. Although the June, July, and August 2013 monthly "Falls PI" reports showed staff needed to be educated on the 4 P's, there was nothing documented to show this education was completed. Interview with the SDC on 10/4/13 at 10:20 AM verified staff were provided written information on the 4 P's; however, she had not documented to whom or when the information was provided. The following concerns were identified: a. Interview further revealed the incidence of resident falls related to mechanical lift transfers was not being tracked by the facility. During the survey it was found that 5 residents had falls related to lift transfers, one resulted in a fractured hip in the month of September 2013. Interview with the SDC on 10/4/13 at 10:20 AM verified other than for one CNA who had injured her back, she had not provided any additional training related to safe transfers with lifts. She stated CNAs were checked for competency of performing safe lift transfers at orientation and annually. b. Interview with the DNS, SDC, and acting administrator verified alarm audits were being completed; however, the data was not being reported on. When an alarm was identified to be not on or working, it was immediately corrected by the restorative aide who was performing the audit. Interview with restorative aide #1 on 10/3/13 at 11 AM verified the audits were expected to be done daily. However, she said the audits were not always performed daily because	F 323		

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F 323	Continued From page 25	F 323		

she was required to work the floor instead. She stated there were always multiple alarms that were not on or working when checked. Review of the alarm audits for the past two months showed on the days audits were done, an average of 4 to 6 alarms were identified as not working.

c. During the interview the acting administrator stated, "the falling star program is a good program, it just needs to be implemented."

On 10/3/13 at 1:25 PM, the acting administrator and DON were notified of the immediate jeopardy. The facility's plan showed immediate changes as follows:

a. 100% of residents had been re-evaluated for fall risk and those with sit-to-stand and mechanical lifts had been evaluated by a physical therapist for safety with lift transfers. Any changes had been documented and 100% of nursing staff had been educated prior to their shifts on these changes.

b. 100% of high risk fall residents had been re-evaluated by professional licensed staff for appropriate fall interventions which were put into place.

c. 100% of residents will be monitored and evaluated daily by direct care and professional licensed staff and any changes in transfers communicated with the DNS and SDC for evaluation and intervention.

d. Education was done by professional licensed staff with 100% current nursing staff in the building. Education was conducted on proper transfers and technique, checking safety alarms every shift, and on the facility's policy and procedures for fall assessments and prevention. Competencies on lifts were done with 100% of nursing staff in the building. Specific transfer training with sit-to-stand and mechanical lifts was

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

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F 323	Continued From page 26 done by a physical therapist for 100% of residents identified as high risk. Competencies were performed on 100% of nursing staff prior to their next shift. e. 100% of alarms utilized in the facility were audited to ensure all alarms were turned on and functioning properly. The action plan was accepted on 10/4/13 at 1:26 PM, and the immediate jeopardy was removed at that time. However, the scope and severity level will remain an "H".	F 323		
F 493 SS=B	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on staff interview and review of licensing agency documentation, the facility failed to	F 493	**F493** **Corrective Action** It is the policy of this facility to have a governing body which has legal authority and responsibility to operate the Nursing Care Facility. The facility will appoint a full-time, on premise, administrator qualified by education, training and experience by the Wyoming Board of Nursing Home Administrators. **Identification of Others:** Staff, residents, and family members have	

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F 493	Continued From page 27 ensure the acting administrator was licensed by the state of Wyoming. The findings were: a. Interview with the administrator on 10/2/13 at 4:30 PM revealed he had been acting as the intermittent administrator for the facility for, "about the last 4 weeks." The interview further revealed he had submitted an application to be licensed as the administrator but had not completed the application process. b.Verification of the acting administrator's license on 10/3/13 at 10:00 AM confirmed the Wyoming Board of Nursing Home Administrators had received the administrator's application, however, the application process had not been completed and the administrator was not licensed by the state.	F 493	the potential of being affected by not having an administrator qualified by education, training and experience by the Wyoming Board of Nursing Home Administrators. **Systemic Changes:** The District Vice President of Operations will monitorand follow up with the administrator of the facility licensed by the Wyoming Board of Nursing Home Administrators.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the	F 520	**Monitoring:** The PI Committee will review the audits to provide further recommendations and to determine whether or not the deficient practice has been resolved. The PI Committee will make a determination as to the frequency of ongoing monitoring. **Date of Compliance:** 11/05/13 **F520** **Corrective Action:** The District Vice President of Operations (DVPO) will conduct training for the IDT regarding the QAPI process, including	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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(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 520	Continued From page 28 requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of facility quality assurance and performance improvement (QAPI) documentation, the facility failed to ensure effective measures were taken to ensure QAPI actions were timely and effective in resolving identified concerns related to resident falls. The findings were: Interview on 10/4/13 at 2:20 PM with the acting administrator, the DNS, and the SDC revealed there was information collected in the QAPI program related to falls. The DNS reported the facility had identified an ongoing problem related to increased numbers of resident falls. The DNS and the acting administrator verified interventions and actions taken by the QAPI committee were tracking the numbers of falls, evaluating when and where they were happening, performing alarm audits, and providing staff education known as the 4 P's. The 4 P's included frequent rounding for pain, "potty needs," positioning, and proper placement of items. In the interview the DNS verified the information gathered over the past 90 days had shown a correlation between less staff and higher fall rates. Many of the falls were identified as occurring on Fridays and the weekends. The information also showed many of the resident's falls were being contributed to self transfers. Review of the monthly QAPI summaries showed in June 2013 there were 28	F 520	data gathering, analysis and taking appropriate action related to fall management, appropriate transfers, care plans, etc. This will be done on 10/28/13. **Identification of Others:** Review of QAPI minutes for the last 90 days was done to determine method in which data was gathered, tracked/trended, analyzed, and if action taken was evaluated for effectiveness in order to identify specific training needs for IDT. Based on this review, the information will be included in the training for the IDT by the DVPO. **Systemic Changes:** A Fall Management subcommittee was developed to review fall risk scores, falls, residents in the Falling Star Program, etc. This subcommittee is comprised of the DNS, Unit Managers, SDC, Therapy and Social Services designees. Fall data is tracked and reviewed to determine trends. Based on this data, an action plan is developed and implemented to correct identified quality deficits. The QAPI committee works to identify root causes, which led to the identified deficient areas.	

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

PRINTED: 11/05/2013
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 10/04/2013

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KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 520	Continued From page 29 falls throughout the facility. In July 2013 there were 45 falls; one of which resulted in a fracture. In August 2013 there were 39 falls, and in September 2013 the numbers had not yet been calculated, but the fall logs showed 28 falls listed. One of the September 2013 falls resulted in a fracture. In addition, from October 1 through October 4, 2013 there were 3 falls. The following concerns were identified with lack of corrective measures: a. Although the facility identified days of the week when falls were high, there was no evidence that staffing patterns were changed. During the 10/4/13 interview with the DNS, she verified the number of CNAs allowed to work per shift was based on a defined ratio of staff to residents. Acuity was not taken into consideration in the staffing pattern. b. Although the June, July, and August 2013 monthly "Falls PI" reports showed staff needed to be educated on the 4 P's, there was nothing documented to show this education was completed. Interview with the SDC on 10/4/13 at 10:20 AM verified staff were provided written information on the 4 P's; however, she had not documented to whom or when the information was provided. c. The incidence of resident falls related to mechanical lift transfers was not being tracked by the facility. During the survey it was found that 5 residents had falls related to lift transfers, one resulted in a fractured hip in the month of September 2013. Interview with the SDC on 10/4/13 at 10:20 AM verified other than for one CNA who had injured her back, she had not provided any additional training related to safe transfers with lifts. She stated CNAs were checked for competency of performing safe lift transfers at orientation and annually.	F 520	Appropriate corrective action plans are developed and implemented to address identified issues. Action plans may include, but are not limited to: -The development or revision of clinical protocols based on current standards of practice -Revision of policies and procedures -Training of staff concerning changes Education is provided to the IDT regarding the QAPI process during the new-hire orientation and as needed. **Monitoring:** The DDCO/designee will attend the PI Committee meetings to assist in determination of effective a QAPI process. This will be done for three months and then re-evaluated. If concerns are identified, additional training will be done with the IDT. **Date of Compliance**: 11/05/13	

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F 520	Continued From page 30 d. Further, interview with the DNS, SDC, and acting administrator verified alarm audits were being completed; however, the data was not being reported on. When an alarm was identified to be not on or working, it was immediately corrected by the restorative aide who was performing the audit. Interview with restorative aide #1 on 10/3/13 at 11 AM verified the audits were expected to be done daily. However, she said the audits were not always performed daily because she was required to work the floor instead. She stated there were always multiple alarms that were not on or working when checked. Review of the alarm audits for the past two months showed on the days audits were done, an average of 4 to 6 alarms were identified as not working. e. The action plan for the past three months remained the same with no shown improvements or achievement of reaching the goal of reducing falls by 15%. f. During the interview the acting administrator stated, "the falling star program is a good program, it just needs to be implemented." While these interventions were appropriate, the lack of timeliness and implementation of further interventions may have contributed to 28 falls in June 2013, 45 falls in July 2013, 39 falls in August 2013, 28 falls in September 2013, and 3 falls as of October 4th 2013, of which three residents sustained serious injuries involving fractures.	F 520		