Approved. Notified NHA 5/20/14 @ 9:45 AM Linda Brown RN

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

PRINTED: 05/07/2014
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 04/23/2014

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

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing LPN-Licensed Practical Nurse MDS- Minimum Data Set MAR- Medication Administration Record TAR- Treatment Administration Record mg - Milligrams Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assesement; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	**F-280 Right To Participate Planning Care-Revise CP** **Corrective Action(s) for Those Residents Found to have Been Affected by the Deficient Practice:** The care plan for resident #48 was updated to reflect the weight loss, recent labs, and current interventions. Care plan also included the addition of a nutritional cookie. Education provided to RD and staff regarding updating care plans to reflect current interventions.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D Michele Johnston — TITLE: Executive Director — (X6) DATE: 5/16/14

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.

RECEIVED
WY Dept of Health
MAY 19 2014
Healthcare Licensing and Surveys

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F 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure needed care plan revisions were made for 1 of 12 sample residents (#48). The findings were: Review of the weekly weight records showed resident #48 lost 17.6 pounds from the week of 2/21/14 through 2/24/14. Review of the 2/28/14 IDT (Interdisciplinary Team) weight change notes showed the resident had an 8.4% weight loss in one week. Recommended interventions included adding a nutritional cookie twice daily and to continue on weekly weights. Review of the most current care plan, dated 11/13/13, showed the resident's weight loss was not addressed. The most recent revisions noted on this care plan were dated 8/6/13. Continued review of the care plan showed it did not include the addition of a nutritional cookie twice daily or weekly weights. Interview with LPN #2 on 4/23/14 at 10:30 AM revealed he was unsure why the care plan was not updated to reflect the resident's recent weight loss.	F 280	**Identification of Other Resident's Having the Potential to be affected by the Same Deficient Practice:** RD will audit current care plans of residents with significant weight changes to verify accuracy. Based on the results of the audit, care plans identified Will be updated as needed. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** RD will update care plans weekly for residents that show significant weight changes. IDT Team/RD will review care plans of residents with significant weight changes weekly to ensure appropriate interventions are in place.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff followed physician's orders regarding disease	F 281		

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F 281	Continued From page 2 management for 1 of 12 sample residents (#90).The findings were: Review of the medical diagnosis list showed resident #90 was re-admitted on 4/16/14 with diagnoses including coronary artery disease, hypertension, and atrial flutter. Review of the re-admission orders dated 4/16/14 showed an order for staff to monitor the resident's weight for 3 days. Review of the medical record showed the resident's weight was obtained on re-admission, 4/16/14, however, there were no additional weights obtained and recorded in the medical record after that date. Interview with the DON on 4/23/14 at 11:50 AM revealed she was not sure why the weights were not obtained as ordered. She further said physician orders should always be followed. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nursing must function under the direction of a licensed physician. According to Smith, Duell, and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," 7th Edition, 2008: "Skill and functions that professional nurses perform in daily practice include: ... Administer treatments per physician's order."	F 281	**Identification of Other Residents Having the potential to be affected by the Same Deficient Practice:** An audit of Weight orders of new admissions within the last 30 days were reviewed by unit managers to verify that the weight orders were followed correctly. Physician was notified if weight orders were not properly followed. **Measures Put into Place/Systemic changes Made to Ensure that the Deficient Practice(s) Does not Reoccur** The RNA will be notified of any new admissions/readmissions by the admission coordinator /charge nurse. IDT will review weight orders and to verify residents are weighed according to orders.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	Care Plans were audited by the Unit Managers/ MDS/ SDC and DNS to verify accuracy. Care plans updated as needed to accurately reflect current needs.	

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	**Monitoring the Corrective Action(s) Performance to Make Sure Systems are Maintained.** The DNS/Unit Managers will audit Care plans of at least 5	

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	**F-309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Corrective Actions For Those Found to have been Affected by the Deficient Practice** A new pain assessment was completed on resident #48. Pain meds were reviewed, and q shift pain assessments will be monitored 3xweekly for 2 weeks to verify her	

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F 309	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, medical record review, and review of facility policies and procedures, the facility failed to ensure all necessary assessments, monitoring, and nursing measures were implemented for pain management for 1 of 3 sample residents (#48) who were reviewed for pain. The findings were: Review of the April 2014 recapitulation of physician orders showed resident #48 had diagnoses including osteoporosis. Further review of these orders showed on 2/17/14 the physician ordered Percocet (narcotic) 5/325 mg one tablet every 8 hours as needed for pain. Also ordered on the same date, 2/17/14, was Tizanidine HCL (hydrochlorothiazide) 4 mg for muscle spasms every 8 hours as needed. On 2/18/14 an order for Ibuprofen 400 mg every 6 hours as needed was also ordered for pain. Review of the 11/20/13 significant change MDS assessment showed the resident had almost constant pain daily rated at 9 on a scale of 0 to 10 with 10 being the worst (9/10). Further review showed the pain limited with the resident's daily activities. Review of this MDS assessment showed the resident had moderate cognitive impairment at that time. Review of the 2/17/14 quarterly MDS assessment showed staff assessed the resident's pain as daily based upon protective postures, facial expressions and by the resident's vocal complaints. Review of this quarterly MDS assessment showed the resident was cognitively intact. Review of the 10/13/13 initial and the 4/22/13 revised care plan showed the resident had an acceptable pain goal of 5/10. The following concerns with pain management were identified:	F 309	pain level is consistently at /or below her tolerable pain level. Education was provided to staff regarding pain management and follow-up after administration of pain medication. **Identification of Others affected by the same deficient practice(s)** Audit of pain monitoring flowsheets for current residents was completed. Based on the results of this audit, MD will be notified for new orders for any resident identified as consistently showing pain levels above their acceptable level of pain. **Systemic changes put in place to ensure that the deficient practice (s) does not recur** IDT will review audits in morning clinical meeting 3xweekly for needed follow-up. Unit managers will follow-up with MD for changes to pain management as needed. DNS will provide nursing with post-it flags to use on the	

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F 309	Continued From page 5 a. Review of the 4/3/14 shift assessment for the 2 PM to 10 PM shift (no specific time was identified) showed the resident had a pain level of 6/10. Review of the pain monitoring flow sheet showed no evidence the resident was assessed as to location, duration, intensity and character. In addition, the next pain assessment was not performed until sometime during the 10 PM to 6 AM shift (10 PM 4/3/14 to 6 AM 4/4/14); the resident's pain level was again noted to be 6/10, no change from the previous shift. Review of the April 2014 MAR and TAR, the pain monitoring flow sheet and nursing notes showed no evidence from 2 PM to 6 AM (16 hours) the resident was administered any pain medication or provided any non-pharmacological interventions. Review of the 4/4/14 pain monitoring flow sheet timed at 9 AM showed the resident's pain was 7/10 at which point the resident was administered one Percocet tablet. The resident's pain was rated greater than 5/10 for approximately 18 hours without intervention by staff. b. Review of the 4/7/14 shift report for 6 AM to 2 PM showed the resident's pain level was 6/10. Review of the pain monitoring flow sheet showed the resident was repositioned and received one Percocet at 9:30 AM for the pain. However, continued review showed no evidence the resident's pain was re-assessed to determine the effectiveness of the medication in relieving his/her pain. c. Review of the pain monitoring flow sheet showed on 4/8/14, the resident had pain rated 6/10 at 8:42 AM for which s/he received one Percocet and was repositioned. Continued review showed no evidence the resident was re-assessed to determine the effectiveness of the pain management interventions in relieving the pain.	F 309	MARs. Nurses will verify flagged pain monitoring flow sheets have follow-up completed prior to changing shift. **Monitoring the Corrective Action(s) Performance to Make Sure Systems are Maintained.** Audit of pain monitoring flow sheets will be completed 3Xweekly for 4 weeks. The results of these audits will be brought to the PI Committee for review to determine the frequency of the audits and if the deficient practice has been resolved. **Date of compliance is 5-17-2014.**	

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F 309	Continued From page 6 d. Review of the 6 AM to 2 PM shift pain assessment on 4/10/14 showed the resident's pain level was 6/10. Further, review showed the resident was administered one Percocet at an undocumented time during the same shift. However, there was no evidence the resident's pain was re-assessed to determine the effectiveness of the intervention. e. Review of the 6 AM to 2 PM shift assessment for 4/15/14 showed the resident's pain level was 8/10. Review of the pain monitoring flow sheet showed no evidence the resident was administered any pain medication or provided non-pharmacological interventions during this time period. f. Interview with the resident on 4/23/14 at 10 AM revealed s/he was uncomfortable and in pain much of the time. g. Review of the facility pain management policy dated 8/31/13 showed "Pain is assessed at least every shift, when a patient complains of pain and after an analgesic is given to determine effectiveness of the analgesic.....When pain is identified, assessment and documentation includes pain scale rating, location, duration, intensity and character." Interview with LPN #1 on 4/23/14 at 10:30 AM revealed pain was typically re-assessed within 2 hours after administering a pain medication to determine the effectiveness. The LPN further verified this resident had "lots" of pain and had become "almost bed bound" because of it.	F 309		
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	F 315		

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F 315	Continued From page 7 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 interview and medical record review, the facility failed to ensure 2 of 8 sample residents (#24, #48) who were incontinent of urine received the care and services needed to decrease incontinence episodes. The findings were: 1. Review of the 2/17/14 quarterly MDS assessment for resident #48 showed s/he was incontinent of urine all of the time. Interview with CNA #1 on 4/22/14 at 1:40 PM revealed the resident was mostly incontinent but would sometimes let staff know when s/he needed to be toileted. Review of the 12/19/13 care plan showed the intervention for the resident's incontinence was to assist the resident with incontinent care and brief management. Interview with LPN #2 on 4/23/14 at 10:30 AM revealed the expectation was for staff to check the resident for incontinence every two hours during their rounds. However, observation on 4/21/14 from 12 noon to 4:07 PM showed the resident was seated in the dining room the entire time. Staff did not check the resident for incontinence or offer to toilet the resident at any time during this 4 hour and 7 minute observation. 2. Review of the 12/10/13 and 3/3/14 quarterly	F 315	**F-315 NO CATHETER, PREVENT UTI, RESTORE BLADDER** **Corrective action for those found to have been affected by the deficient practice(s):** Education provided to staff regarding incontinence needs for resident #48 and #24. Education also provided regarding following plan of care. Therapy to evaluate and treat resident #24 for minimizing incontinent episodes. Labs were drawn for res #48 with new orders from MD. **Identify others that might be affected by the same deficient practice:** Observations will be done on incontinent residents to verify they are being toileted in a timely fashion. These observations will be done 3 x week x 4 weeks.	

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F 315	Continued From page 8 MDS assessments showed resident #24 was frequently incontinent of urine. Interview with LPN #1 on 4/21/14 at 4:10 PM verified the resident was incontinent of urine. Interview with CNA #1 on 4/22/14 at 1:40 PM revealed the resident was mostly incontinent but would sometimes let staff know when s/he needed to be toileted. Review of the 5/29/13 care plan showed the resident was on a "prompted voiding schedule." Review of the facility's policy on prompted voiding, revised 10/31/09, showed staff should prompt the resident to try to use the toilet if the resident does not request toileting assistance on his/her own. Further review of the policy showed regular monitoring with encouragement to report continence status; prompting to toilet on a scheduled basis; and praise and positive feedback when the resident was continent and attempted to toilet were the three components of the prompted voiding plan. Observation on 4/21/14 from 12 noon to 4:07 PM showed the resident was seated in the dining room and was not approached by staff to prompt toileting during the entire 4 hours and 7 minutes. Interview with LPN #2 on 4/23/14 at 10:30 AM revealed the resident should have been prompted or asked every 2 hours during rounds. Observation at 4:07 PM revealed the resident was incontinent of urine and required incontinence care and a new incontinence brief.	F 315	**Systemic changes** Residents will be assessed for incontinence upon admission, quarterly, and with a change of condition. Care plan will be updated to reflect current status of incontinence. C.N.A's will be notified of resident needs by Unit Managers as updates are completed. **Monitoring the Corrective Action(s) Performance to Make Sure Systems are Maintained.** Observation rounds will be done 3Xweekly for 4 weeks. The results of these audits will be brought before the PI committee to determine if the duration of these observations and if the deficient practice has been resolved. **Date of compliance is 5-17-2014.**	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and	F 353		

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F 353	Continued From page 9 individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, and review of facility policy and procedure, the facility failed to ensure there was a sufficient number of staff members to provide the needed care for 2 of 4 sample residents (#24, #48) and for an additional 18 non-sample residents (#1, #6, #8, #9, #14, #19, #28, #30, #37, #38, #44, #68, #75, #76, #91, #93, #95, #105) residing on the third floor, excluding the locked unit. The findings were: 1. Review of the 2/17/14 quarterly MDS assessment for resident #48 showed s/he was incontinent of urine all of the time. Interview with CNA #1 on 4/22/14 at 1:40 PM revealed the resident was mostly incontinent but would sometimes let staff know when s/he needed to be toileted. Review of the 12/19/13 care plan showed the intervention for the resident's incontinence	F 353	**F-353 SUFFICIENT 24- HR NURSING STAFF PER CARE PLANS** **Corrective action(s) for those residents found to have been affected by the deficient practice.** Residents # 1,#6, #8, #9,#14,#19,#28, #30, #37, #38, #44, #68,#75, #76, #91, #93, #95, and#105 were bathed. Therapy to evaluate and treat resident #24 for minimizing incontinent episodes. Labs were drawn for res #48 with new orders from MD. Education provided to staff regarding documentation of showers upon completion. **Identify others with the same deficient practice:** Observations of residents being toileted according to plan of care will be done 3 x week x 4 weeks. Showers will be audited 3 x week x 4 weeks by the SDC, DNS, and unit managers.	

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F 353	Continued From page 10 was to assist resident with incontinent care and brief management. Interview with LPN #2 on 4/23/14 at 10:30 AM revealed the expectation was for staff to check the resident for incontinence every two hours during their rounds. However, observation on 4/21/14 from 12 noon to 4:07 PM showed the resident was seated in the dining room the entire time. Staff did not check the resident for incontinence or offer to toilet the resident at any time during this 4 hour and 7 minute observation. In addition, review of the shower/bath schedule for this resident showed s/he was scheduled for a bath on Tuesdays and Fridays during the evening shift. However, review of the April 2014 bath documentation in the medical record showed the resident received only one bath during the weeks of 4/6/14 through 4/12/14, and 4/13/14 through 4/19/14. Interview with the resident on 4/23/14 at 10 AM revealed the facility needed more staff. The resident said s/he had been waiting to get up for a long while that morning but staff had not yet come to assist him/her. 2. Review of the 12/10/13 and 3/3/14 quarterly MDS assessments showed resident #24 was frequently incontinent of urine. Interview with LPN #1 on 4/21/14 at 4:10 PM verified the resident was incontinent of urine. Interview with CNA #1 on 4/22/14 at 1:40 PM revealed the resident was mostly incontinent but would sometimes let staff know when s/he needed to be toileted. Review of the 5/29/13 care plan showed the resident was on a "prompted voiding schedule." Review of the facility's policy on prompted voiding, revised 10/31/09, showed staff should prompt the resident to try to use the toilet if the resident does not request toileting assistance on his/her own.	F 353	**Systemic changes** **CNAs assigned to floors will be responsible for completing and documenting showers and incontinence care per shift. Unit manager/designee will verify documentation is present prior to shift change. Unit managers will assist with showering and toileting of residents on an as needed basis.** **Monitoring:** **Observations of toileting and showers audits will be brought before the PI committee. The frequency of these observations/ audits will determine the frequency of these observations/audits, and if the deficient practice has been resolved.** **Date of compliance is 5-17-2014**	

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Further review of the policy showed regular monitoring with encouragement to report continence status; prompting to toilet on a scheduled basis; and praise and positive feedback when the resident was continent and attempted to toilet were the three components of the prompted voiding plan. Observation on 4/21/14 from 12 noon to 4:07 PM showed the resident was seated in the dining room and was not approached by staff to prompt toileting during the entire 4 hours and 7 minutes. Interview with LPN #2 on 4/23/14 at 10:30 AM revealed the resident should have been prompted or asked every 2 hours during rounds. Observation at 4:07 PM revealed the resident was incontinent of urine and required incontinence care and a new incontinence brief.

3. Review of the 2/19/14 annual MDS assessment showed resident #95 had severe cognitive impairment and was totally dependent upon staff for bathing. Review of the shower/bath schedule showed the resident was scheduled for a bath on Mondays and Thursdays during the evening shift. However, review of the bath documentation in the medical record showed the resident received no bathing from 3/30/14 through 4/20/14 (3 weeks). There was no evidence the resident refused any baths.

4. Review of the 1/13/14 annual MDS assessment showed resident #1 had moderate cognitive impairment and required extensive assistance of staff for bathing. Review of the shower/bath schedule showed the resident was scheduled for a bath on Monday and Thursday evenings. However, review of the April 2014 bath documentation in the medical record showed the resident received only one bath during the week

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F 353	Continued From page 12 of 4/6/14 through 4/12/14. In addition, there was no evidence the resident received a bath at all during the week of 4/13/14 through 4/19/14. According to this bath record the resident did not receive a bath/shower from 4/7/14 through 4/21/14 (13 days). There was no evidence the resident refused a bath during those weeks. 5. Review of the 1/24/14 annual MDS assessment showed resident #8 required limited assistance with bathing. Review of the shower/bath schedule for the resident showed s/he was scheduled for bathing on Wednesdays and Saturdays during the day shift. Review of the April 2014 bath documentation showed the resident received only one bath during the weeks of 4/6/14 through 4/12/14 and 4/13/14 through 4/19/14. There was no evidence the resident refused a bath during those weeks. 6. Review of the 3/11/14 initial MDS assessment showed resident #8 had severe cognitive impairment. Review of the shower/bath schedule showed the resident was scheduled for one bath a week, day not specified, on the day shift. However, review of the bath documentation in the medical record showed the resident received no bathing from 3/31/14 through 4/14/14 (14 days). There was no evidence the resident refused a bath during that time. 7. Review of the 8/7/13 initial MDS assessment showed resident #9 required extensive assistance with bathing. Review of the 2/7/14 quarterly MDS assessment showed during that assessment period, the resident received no bathing. Review of the shower/bath schedule showed this resident was scheduled for bathing on Tuesdays and Thursdays during the day shift.	F 353		

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Review of the bath documentation in the medical record showed the resident received only one bath during the weeks of 4/6/14 through 4/12/14 and 4/13/14 through 4/19/14. There was no evidence the resident refused a bath during those weeks.

8. Review of the annual 1/10/14 MDS assessment showed resident #14 required extensive assistance with bathing. Review of the shower/bath schedule showed the resident was scheduled for a bath on Mondays and Thursdays. However, review of the bath documentation in the medical record showed the resident received only one bath during the week of 4/6/14 through 4/12/14. There was no evidence the resident refused a bath during that week.

9. Review of the 2/17/14 quarterly MDS assessment showed resident #19 required extensive assistance with bathing. Review of the shower/bath schedule showed the resident was scheduled for a bath on Tuesdays and Fridays. Review of the bath documentation in the medical record showed during the week of 4/13/14 through 4/19/14, the resident received only one bath. There was no evidence the resident refused a bath during that week.

10. Review of the 4/1/14 initial MDS assessment showed resident #30 had severe cognitive impairment and required extensive assistance with most ADLs. Review of the shower/bath schedule showed the resident was scheduled for bathing one time per week. However, further review of this documentation showed the resident received no bathing from 4/7/14 through 4/20/14 (13 days). There was no evidence the resident refused bathing during that time frame.

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11. Review of the 7/16/13 initial MDS assessment showed resident #28 had moderate cognitive impairment and required extensive assistance with bathing. Review of the 1/21/14 quarterly MDS assessment showed the resident did not have a bath during that review period but required extensive assistance with other ADLs. Review of the shower/bath schedule showed the resident was scheduled for a bath on Mondays and Thursdays. However, review of the bathing documentation in the medical record showed during the weeks of 4/6/14 through 4/12/14 and 4/13/14 through 4/19/14 the resident received only one bath. There was no evidence the resident refused a bath during that week.

12. Review of the 1/8/14 quarterly MDS assessment showed resident #37 was moderately cognitively impaired and required extensive assistance with bathing. Review of the shower/bath schedule showed the resident was scheduled for a bath on Wednesdays and Saturdays. Review of the bath documentation in the medical record showed the resident received a bath on 4/5/14 and then not again until 4/19/14 (13 days). There was no evidence the resident refused a bath during that time.

13. Review of the 2/13/14 significant change MDS assessment showed resident #38 had moderate cognitive impairment and required extensive assistance with ADLs. This MDS showed the resident had not bathed during the review period. Review of the shower/bath schedule showed the resident was scheduled for one bath each week during the day shift. However, review of the April 2014 bath documentation in the medical record showed the

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resident received a bath on 4/7/14 then not again until 4/20/14 (13 days). There was no evidence the resident refused a bath during that week.

14. Review of the 4/21/14 initial MDS assessment showed resident #44 was admitted on 4/8/14 with a diagnosis of Alzheimer's disease, had severe cognitive impairment and required extensive assistance with all ADLs. Review of this same MDS assessment showed the resident had no bathing during the review period. Review of the shower/bath schedule showed the resident received his/her first bath 6 days after admission. There was no evidence the resident refused any baths.

15. Review of the 1/15/14 quarterly MDS assessment showed resident #68 had moderate cognitive impairment and required extensive assistance with ADLs. Review of this same assessment showed the resident had received no bathing during the review period. Review of the shower/bath schedule showed the resident was scheduled for a bath on Mondays and Thursdays. Review of the bath documentation showed the resident received a bath on 4/3/14 and not again until 4/14/14 (10 days). There was no evidence the resident refused a bath during that time.

16. Review of the 1/28/14 annual MDS assessment showed resident #75 had severe cognitive impairment and required extensive assistance with ADLs. Review of this same MDS assessment showed the resident received no baths during the review period. Review of the shower/bath schedule showed the resident was scheduled for a bath on Wednesdays and Saturdays during the evening shift. Review of the bath documentation in the medical record showed

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F 353	Continued From page 16 during the weeks of 4/6/14 through 4/12/14 and 4/13/14 through 4/19/14 the resident received only one bath instead of two. There was no evidence the resident refused a bath during those weeks. 17. Review of the 1/21/14 quarterly MDS assessment showed resident #76 had moderate cognitive impairment and required limited assistance with ADLs. Further review showed the resident had no baths recorded during the review period. Review of the shower/bath schedule showed the resident received a bath on 3/30/14 but not again for 14 days later on 4/14/14. There was no evidence the resident refused a bath during those weeks. 18. Review of the 7/24/13 initial MDS assessment showed resident # 91 had moderate cognitive impairment and required extensive assistance with bathing. Review of the 1/30/14 quarterly MDS assessment showed the resident had no baths during the review period. Review of the shower/bath schedule showed the resident had no bath from 3/31/14 through 4/13/14 (14 days). There was no evidence the resident refused a bath during that time. 19. Review of the 1/8/14 quarterly MDS assessment showed resident #93 had moderate cognitive impairment and required extensive assistance with bathing. Review of the shower/bath schedule showed the resident was scheduled for a bath on Mondays and Thursdays. However, review of the bath documentation in the medical record showed during week of 4/6/14 through 4/12/14 the resident received only one bath. There was no evidence the resident refused a bath during that week.	F 353		

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 04/23/2014

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 353	Continued From page 17 20. Review of the 1/23/14 annual MDS assessment showed resident #105 had moderate cognitive impairment and required extensive assistance with bathing. Review of the shower/bath schedule showed the resident was scheduled for baths on Wednesdays and Saturdays during the day shift. Review of the bath documentation in the medical record showed the resident received only one bath during the weeks of 4/6/14 through 4/12/14 and 4/13/14 through 4/19/14. There was no evidence the resident refused a bath during either of these weeks. 21. Interview with CNA #1 and LPN #2 on 4/22/14 at 1:40 PM revealed there were times when there was not enough staff to provide for the needs of residents. CNA #1 stated when the facility was short staffed, it was usually the baths that were not provided. During an interview on 4/23/14 at 10:30 AM, LPN #2 again reiterated staffing was short. 22. Interview with the administrator and DON on 4/22/14 at 4:20 PM revealed they were aware of the staffing shortage and had been working aggressively to address the facility needs. They further said managers and floor nurses had been assisting with bathing and resident care needs to assist the CNAs, however, there was no evidence of such. Interview with the clinical nurse consultant on 4/23/14 at 12:50 PM revealed she too was aware of the short staffing but the facility had been actively recruiting.	F 353		