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

PRINTED: 06/19/2014
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 _____	R-C 06/05/2014

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 000}	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADLs - Activities of Daily Living CNA- Certified Nurse Aide DON- Director of Nursing LPN-Licensed Practical Nurse MDS- Minimum Data Set NHA - Nursing Home Administrator Less commonly used abbreviations will be annotated in each deficiency.	{F 000}		
{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 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.	{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.** Interviews were conducted with residents #38, #42 to determine preference on number of times per week to shower. Residents #103, #60, #10, #62, #17, #78 were not interviewable. Care plans and shower schedules were updated to reflect current preference. Education was provided to staff regarding completion and documentation of showers and following care plan. **Identify others with the same deficient practice:** An audit of residents was completed to verify showers were given as scheduled. Showers found not to be as per scheduled were completed and documented.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D. Michele Johnston | TITLE: Executive Director | (X6) DATE: 6/27/14

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
JUN 27 2014
Healthcare Licensing and Surveys

7/1/14 Plan of correction accepted w/ 7/16/14 date of compliance. Administrator notified by telephone at 4pm. J. VanDyke, RN

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

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(F 353)	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review and resident and staff interview, the facility failed to ensure there was a sufficient number of staff members to provide the needed care for 6 of 45 non-sample residents (#10, #17, #38, #60, #62, #103) who reside on the second floor. In addition, 2 of 33 non-sample residents (#42, #78) who live on the third floor did not receive their routine showers per the established schedule. The findings were: 1. Review of the 2/26/14 quarterly MDS assessment showed resident #38 had diagnoses including past cardiovascular accident, non-Alzheimer's dementia, paraplegia, and multiple sclerosis. Further review of this MDS assessment showed the resident required extensive assistance upon staff for bathing. Review of the shower/bath schedule showed the resident was scheduled for a bath on Mondays and Thursdays during the day shift. However, review of the bath documentation in the medical record showed the resident received only one shower during the weeks of 5/18/14 through 5/24/14 and 5/25/14 thru 5/31/14. There was no evidence the resident refused any baths. 2. Review of the 3/23/14 quarterly MDS assessment showed resident #103 had severe cognitive impairment and required extensive assistance with bathing. Review of the shower/bath schedule for this resident showed s/he was scheduled for a shower/bath on Mondays and Thursdays on the day shift. Continued review of the schedule showed the resident received only one shower during the weeks of 5/18/14 through 5/24/14 and 5/25/14	(F 353)	**Systemic changes** Education provided to nursing staff regarding shower schedule, Communication Tool and required documentation. **Monitoring:** Nursing supervisors will bring Shower binders to IDT meeting for verification of shower completion as scheduled. Monitoring will be done 3 X weekly until substantial compliance is achieved. Results of this audit will be brought to PI committee for further review and recommendations monthly until a lesser frequency is deemed appropriate. **Date of compliance is:** July 16, 2014	

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{F 353}	Continued From page 2 through 5/31/14. The resident was not interviewable due to severe cognitive impairment. However, there was no evidence the resident refused any baths. 3. Review of the 3/11/14 quarterly MDS assessment showed resident #60 had moderately impaired daily decision making skills and was totally dependent upon staff for bathing. Review of the schedule for this resident showed s/he was scheduled for a shower on Mondays and Thursdays on the evening shift. Continued review of the schedule showed the resident received only one shower during the week of 5/25/14 through 5/31/14. There was no evidence the resident refused any baths and the resident was not interviewable. 4. Review of the 3/4/14 quarterly MDS assessment showed resident #10 had severe cognitive impairment and required extensive assistance with bathing. Review of the shower/bath schedule for this resident showed s/he was scheduled for a shower on Mondays and Thursdays on the day shift. Continued review of the schedule showed the resident received only one shower during the weeks of 5/18/14 through 5/24/14 and 5/25/14 through 5/31/14. The resident was not interviewable due to severe cognitive impairment. However, there was no evidence the resident refused any baths. Additionally, there was no family available for interview.	{F 353}		
	5. Review of the 3/5/14 quarterly MDS assessment showed resident #62 had severe cognitive impairment and required extensive assistance with bathing. Review of the shower/bath schedule for this resident showed			

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{F 353}	Continued From page 3 s/he was scheduled for a shower on Mondays and Thursdays on the day shift. Continued review of the schedule showed the resident received only one shower during the week of 5/25/14 through 5/31/14. There was no evidence the resident refused any baths. Additionally, the resident was not interviewable because of severe cognitive impairment and no family was available for interview. 6. Review of the 5/2/14 significant change MDS assessment showed resident #17 had severe cognitive impairment and required extensive assistance with bathing. Review of the shower/bath schedule for this resident showed s/he was scheduled for a shower on Mondays and Thursdays on the evening shift. Continued review of the schedule showed the resident received only one shower during the week of 5/25/14 through 5/31/14. There was no evidence the resident refused any baths. The resident was not interviewable due to severe cognitive impairment, and no family was available for interview. 7. Review of the 5/2/14 quarterly MDS assessment showed resident #78 had severe cognitive impairment and required extensive assistance with most ADLs including personal hygiene. Review of the shower/bath schedule for this resident showed s/he was scheduled for a shower on Wednesdays and Saturdays on the night shift. Continued review of the schedule showed the resident received only one shower during the week of 5/25/14 through 5/31/14. The resident was not interviewable due to severe cognitive impairment, and there was no family available to interview. However, there was no evidence the resident refused any baths.	{F 353}		

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{F 353}	Continued From page 4 8. Review of the 3/28/14 quarterly MDS assessment showed resident #42 was occasionally incontinent of urine and always incontinent of bowel. Further review showed the resident required extensive assistance for most ADLs. Review of the shower/bath schedule for this resident showed s/he was scheduled for a bath on Tuesdays and Sundays during the day shift. However, review of the May 2014 bath documentation in the medical record showed the resident received only one bath during the week of 5/25/14 through 5/31/14. There was no evidence the resident refused any baths. Interview with the resident on 6/5/14 at 4:25 PM revealed the facility needed more staff. 9. Interview with LPN #1 on 6/4/14 at 1:30 PM revealed the facility was short staffed and not all residents received the care they need. Interview with the DON, NHA, and corporate clinical nurse consultant on 6/5/14 at 5:07 PM revealed they were actively recruiting more CNA staff, however, staffing was based on a ratio, not on acuity.	{F 353}		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535013	A. Building B. Wing	6/5/2014

Name of Facility	Street Address, City, State, Zip Code
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 05/17/2014	ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC	Correction Completed 05/17/2014	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 05/17/2014
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 05/17/2014	ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 05/17/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By 7/25/14	Date:	Signature of Surveyor: Lynda Brown	Date: 7/25/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor: 53[illegible]71905 7-34	Date:

Followup to Survey Completed on: 4/23/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO