This survey was too big and has been split into 2 parts.

This is Part 1

(Part 2 is marked the same survey date as Part 1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536013	A. BUILDING _____ B. WING _____	C 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3120 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: CNA- Certified Nurse Aide DON- Director of Nursing LPN-Licensed Practical Nurse MDS- Minimum Data Set RN-Registered Nurse CAA-Care Area Assessment mg- Milligrams IDT- Interdisciplinary Discipline Team ADL- Activities of Daily Living ADON- Assistant Director of Nursing POA- Power of Attorney Less commonly used abbreviations will be annotated in each deficiency.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 241 SS=E	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, resident and staff interview, and medical record review, the facility failed to ensure effective measures to maintain resident dignity were consistently implemented for 4 of 33 sample residents (#24, #73, #96, #107). The findings were: 1. Review of the 5/30/14 quarterly MDS assessment showed resident #96 was severely	F 241	F241 Corrective Action: Resident #24, #73, #96 and #107 assessed for dignity and hygiene needs and assistance required for completion of activities of daily living. Immediate needs addressed, soiled clothing washed or replaced and plans of care updated as indicated. Food and fluids removed from common areas and appropriately stored. Resident #24 assessed for appropriate dining room placement and needed supervision during meals. Identification of Others: Baseline audit of current residents completed related to dignity, hygiene, ADL (activity of daily living) needs and Care Plans updated as indicated. Current center residents requiring supervision during meals were assessed for appropriate placement and provision of needs during meals.	Sept. 24th, 2014

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

ED 8/25/14

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.

Changes made per the phone call with Carley Applegate, E.D. on 8/29/14 @ 1:17 p.m. POC = 9/24/14. POC accepted. Jeneda Cook, OTR/L

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 241	Continued From page 1 cognitively impaired and required extensive assistance with dressing and personal hygiene. The following concerns were identified: a. Observation of the resident on 7/28/14 at 9:35 AM revealed the resident was seated in the hall outside his/her room. The resident had long, jagged fingernails with chipped nail polish. The nailbeds on both hands were encrusted with thick, brown matter. The resident's t-shirt had visible food debris and stains, and his/her hair was uncombed. b. Observation of the evening meal on 7/28/14 at 5:55 PM showed the resident was seated in a wheelchair in the 3rd floor dining room. The resident continued wearing the same t-shirt with visible food stains, his/her hair remained uncombed, the fingernails continued to have chipped polish and remained long, jagged, and encrusted with thick, brown matter. In addition, the resident had dried food at the corners of his/her mouth. c. Continued observation on 7/28/14 at 5:55 PM showed CNA #6 sat down beside the resident and began feeding him/her. The CNA did not initiate any conversation with the resident. The resident requested to have dessert first and the CNA said "no, you have to eat this first." The CNA proceeded to feed the resident without further conversation. During an interview with the resident on 7/29/14 at 5 PM the resident stated, "can you sit and talk to me? They never talk to me." When asked who "they" were, the resident said, "the staff." d. Observation on 7/30/14 at 3:35 PM showed the resident wore a soiled shirt and over-blouse. The clothing appeared to have spilled food and fluids down the front of both articles of clothing. At 6 PM that same day, the resident wore the same soiled clothing.	F 241	System Change: Education provided to care staff by the SDC/Designee related to dignity, hygiene, assistance with Activities of Daily Living, supervision, engagement and provision of assistance during meals and appropriate storage of food and fluids. Further education will be provided to staff regarding incontinent care, storage of urinals and validating sanitary surfaces prior to serving meals. Monitoring: The ED/Designee will conduct random monitoring rounds associated with resident dignity, hygiene, and ADL needs 3XWeekly. Monitoring for appropriate storage of food and fluids will be completed by the DNS/Designee 3XWeekly. Dining service at random meals will be completed by the ED/Designee 3X Weekly. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Trends identified through monitoring will be brought to the center Performance Improvement Committee monthly and as needed for review by the IDT until a lesser frequency is deemed appropriate.	

8/15/14

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F 241	Continued From page 2 e. Observation on 8/1/14 at 9 AM showed the resident wandering on the unit wearing a soiled sweatshirt. 2. Review of the medical record showed resident #24 had diagnoses including Huntington's Chorea and non-Alzheimer's dementia. Review of the annual MDS assessment dated 7/1/14 identified the resident as cognitively impaired with poor impulse control and required supervision and assistance with eating. Review of the care plan, last updated on 10/8/13, identified the resident as being at risk for nutritional decline related to his/her diagnoses. Interventions included staff providing assistance as needed and monitoring meal intake. The following concerns were identified: a. Observation on 7/28/14 from 4:40 PM until 6 PM revealed the resident was seated in his/her wheelchair in the 3rd floor dining room with 2 other residents. At 6 PM the resident was still seated at the table, alone, waiting to be served the evening meal. At that time the resident was observed reaching across the dining table and eating the remnants of the evening meal left by another resident. The resident began eating off the plate with his/her hands and had consumed one half of the cake left before s/he received his/her meal at 6:05 PM. b. Observation on 7/29/14 from 4:55 PM until 5:15 PM showed the resident was seated in a wheelchair at the nursing station on the 3rd floor. The resident reached up on the nursing station desk and retrieved a bag of potato chips which s/he tore open with his/her teeth and began eating. In addition, the resident was observed going through the trash on the side of the medication cart while LPN's #2 and #3 along with RN #1 walked by but did not assist or re-direct	F 241		

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F 241	Continued From page 3 the resident. The resident consumed the potato chips then placed his/her bare hands into an ice bath where liquids were stored for the evening meal. Finally, observation showed the resident drank from an open container of juice left on a dining table by another resident. 3. Observation on 7/30/14 at 12:30 PM showed resident #107 was wearing a soiled shirt with food and debris on the lower right hand corner. At the time of the observation, the resident was riding the elevator down to the main lobby on first floor. Interview with the resident at the time revealed s/he was embarrassed by the soiled shirt but was unable to change it him/herself and staff was too busy to help. The resident also said staff was supposed to check him/her for incontinence and change the brief when wet or soiled. However, the resident went on to say many times s/he had to visibly see his/her wet clothing and call for staff assistance because staff did not check for incontinence as often as they were supposed to. At the time of this observation and interview the resident smelled of urine. According to the 7/30/14 quarterly MDS assessment, this resident was cognitive but required extensive assistance of 1 for dressing, toileting, and bathing related to his/her diagnosis of multiple sclerosis. 4. Review of the quarterly MDS assessment dated 6/7/14 revealed resident #73 had diagnoses including Parkinson's disease; the resident needed setup assistance with transfers, eating and personal hygiene, and had a physical impairment in an upper extremity which limited the resident's range of motion. The resident was dependent on staff for ADL help. The following concerns were identified: a. Observation on 7/28/14 at 10 AM showed	F 241		

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F 241	Continued From page 4 the resident had a full urinal on the over-the-bed table next to the water jug. Another observation on 7/30/14 at 5:30 PM showed the resident again had a urinal on the over-the-bed table. During this observation an unidentified CNA removed the urinal but did not clean the table before placing the resident's food tray down. b. Observation on 7/31/14 at 9:05 AM revealed the resident's room had a strong smell of urine. Interview with the resident at that time revealed s/he had knocked the urinal over and the urine spilled onto the floor; the resident further said staff had not emptied it "again." Another observation on that same day at 12:30 PM revealed the resident had a partially full urinal placed on the nightstand. Observation showed CNA #2 entered the resident's room to take vital signs, but did not empty the urinal. Interview with the CNA at 12:35 PM that same day revealed she emptied the urinal or not "depending on how much time I have." The CNA did not empty the urinal at that time and left the room. While interviewing the administrator and DON about the quality improvement program on 7/31/14 at 3 PM, the number of concerns and complaints in regard to resident grooming, lack of incontinence care, and overall quality of life was discussed. During the discussion, neither the DON or the administrator made any comments.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be	F 246	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 9/24/14 F246 Corrective Action: The appropriate wheelchair was obtained for Resident #14.	

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F 246	Continued From page 5 endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interview, and review of facility records, the facility failed to accommodate resident needs with regard to an appropriate wheelchair for 1 of 12 sample residents (#14) who required a wheelchair. The findings were: Review of the quarterly MDS assessment dated 7/2/14 showed resident #14 was cognitively intact. Interview with the resident on 7/28/14 at 2:45 PM revealed the resident was unable to easily propel him/herself in his/her current wheelchair. The resident stated that a different wheelchair was supposed to have been ordered, but it had been a "long time" and s/he did not know why the wheelchair had not yet arrived. Further, the resident stated that s/he might participate more in activities if s/he were able to get to activities independently. Interview with the physical therapist on 7/31/14 at 2:10 PM confirmed the resident's current wheelchair was very difficult for him/her to self-propel. She further revealed the request for a new wheelchair had been submitted "a long time ago" and she did not know what had happened with the request. Review of facility records revealed a capital budget request for a new wheelchair for the resident was submitted on 12/20/13 by a previous executive director who was no longer employed by the facility. However, that was over 7 months ago and the wheelchair was not ordered until 8/1/14. Interview with the current executive	F 246	Identification of Others: Current center residents requiring a wheelchair will be reassessed for seating and positioning needs. Needed equipment will be obtained as indicated and care plans updated as appropriate. Systems Change: Education will be provided by the ED/Designee to care staff and members of the Interdisciplinary team on center process to be followed for requesting and obtaining equipment needed by center residents. Monitoring: The ED/Designee will review requests for purchase of patient equipment and status of previously placed orders, weekly. Identified trends will be brought to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	

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F 246	Continued From page 6 director on 8/1/14 at 11:35 AM revealed she was unable to explain the delay in ordering the wheelchair, stating, "it should have gotten done" and that it was the executive director's responsibility to follow up on capital budget requests.			
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 3 of 4 resident areas (second floor, the Expressions unit, and the third floor) were maintained in a safe, clean and homelike manner. The findings were: Interview and observation on 8/1/14 at 10:15 AM with the maintenance director verified the following items were in need of maintenance or upkeep. The following items were observed in the residents' home during the survey from 7/28/14 to 8/1/14: On the second floor: 1. The thermostat in room 210 had no cover, and the wires were exposed. 2. The vanity in room 201 had broken drawers, and was discolored and splintered. 3. The second floor shower room near the	F 252	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F252 Corrective Action: Rooms 210, 201, 204, 229, 228, 307 have had repairs completed. Shower rooms tiles have been repaired or replaced and the shower rooms deep cleaned. Vendors have been contacted to replace/repair the baseboard heating in rooms 203, 320, hallway between 315 and 317. Vendors have been contacted for removal and repainting of torn and worn wallpaper and chipped door jambs areas indentified in the 2567. Identification of Others: Baseline audit of resident rooms and common areas completed. System Change: Education provided to Maintenance and EVS Director on maintenance schedule of rooms, cleaning schedules and PM practices.	9/24/14

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F 252	Continued From page 7 elevators had broken and missing tiles, and a black, fuzzy-appearing substance on the grout in the shower area. 4. The baseboard near room 203 was pulled out 1/2 inch from the wall, and had sharp edges. 5. The towel rack in the bathroom in room 204 was broken. 6. The doorway into the dining room behind the second floor nurse's station was chipped and scuffed to a height of 20 inches. 7. Wallpaper in the dining room behind the second floor nurse's station was ripped from the wall in an area measuring 7 inches by 82 inches. On the Expressions Unit: 8. The door jamb for room 229 was broken and peeling in an area measuring 8 inches by 4 inches. 9. The baseboard in room 228 was pulled off the wall in an area measuring 44 inches by 7 1/2 inches. On the third floor: 10. The baseboard heater in room 320 was damaged and gaping away from the wall. 11. The hallway baseboard heater between rooms 315 and 317 was pulled away from the wall 2 inches on the left side, with jagged metal edges sticking out. 12. The wall behind the sink in room 307 was damaged, with exposed drywall measuring 23 inches by 7 1/2 inches.	F 252	Monitoring: The Maintenance Director and EVS Director/Designee will conduct random Environmental rounds associated with resident rooms, hallway and common areas. Auditing of resident rooms, hallways and common areas will be completed by the ED/Designee 3X Weekly. Any identified trends will be reported to the Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278	F278 Corrective Action: Resident #96 reassessed for continued use of seatbelt and ability to self release. Care plan updated as appropriate.	9/29/14

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F 278	Continued From page 8 resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to ensure the MDS assessment was accurate for 1 of 33 sample residents (#96). The findings were: Review of the 5/30/14 quarterly MDS assessment showed for resident #96 s/he had diagnoses to include cerebral vascular accident (CVA),	F 278	Identification of Others: No other center residents currently have orders for seatbelt restraints. MDS and care plans for Center residents with potential restraint devices reviewed for accuracy and updated as applicable. System Change: Education provided by the SDC/Designee to center MDS nurses regarding accurate coding of restraint devices on MDS assessments. Monitoring: The DNS/Designee will audit MDS coding accuracy for restraint devices weekly for those with scheduled assessments according to the RAI schedule. Identified trends will be brought to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	

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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 278	Continued From page 9 dementia and osteoarthritis. Observation on 7/30/14 at 3:40 PM showed the resident was sitting in a wheelchair with a fastened seat belt across his/her lap. Interview with the resident on 7/31/14 at 2:55 PM revealed s/he was unable to release the seat belt independently. Interview with CNA #7 on 7/31/14 at 3:05 PM indicated the resident had a seat belt to keep him/her from sliding out of the chair. Review of the care plan initiated on 12/12/13 showed the resident used a supportive device/physical restraint alarming seat belt due to the risk of falls. Further, it showed social services was to be consulted related to the continued use of the restraint due to the resident's inability to release the seat belt independently. Review of the IDT notes for restraint use dated 3/5/14 showed the resident had a restraint and the family was notified. Further, it showed the team recommended the use of the seat belt to ensure safety related to poor body control and posture. Review of the quarterly MDS assessment showed the resident was coded as not having a restraint. Interview with the MDS coordinator on 8/1/14 at 9 AM verified the MDS assessment was not accurately coded for this resident's restraint.	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 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 assessment; prepared by an	F 280	F280 Corrective Action: Oxygen discontinued for resident #96 by the physician prior to survey due to non-use. Care plan for resident #96 updated to reflect current oxygen orders. Care plan meeting and review conducted with resident #73. Resident #89 has been discharged.	9/24/14

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F 280	Continued From page 10 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. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure staff reviewed and revised the care plan to accurately reflect the resident's status for 3 of 33 sample residents (#73, #89, #96). The findings were: 1. Observation of resident #89 on 7/28/14 at 10:25 AM showed a periorbital hematoma (a black eye) on the right side. Review of progress notes showed in the month of July, 2014, the resident suffered falls on 7/3, 7/5, 7/7, 7/12, and 7/30. Review of the resident's care plan for falls, last revised on 5/2/14, showed the resident did not like alarms, and would "out them up if they were placed for safety." The following concerns were identified: a. Review of a physician telephone order dated 7/10/14 showed an order to "DC [discontinue] alarms r/t [related to] resident cutting alarms. Start 15 minute checks reevaluate on 7/14/14 with IDT team." b. Review of a progress note dated 7/14/14, and timed 4:01 PM, revealed "IDT NOTE FOR	F 280	Identification of Others: An audit will be completed for residents with physician orders for oxygen to ensure care plan accuracy. An audit of current center residents will be completed to validate resident/responsible party notification and invitation to attend the next scheduled care plan review meeting. System Change: Education will be provided by the SDC/Designee to nursing staff regarding updating care plans to reflect new or changed physician orders. Education will be provided by the SDC/Designee to Social Services personnel regarding resident right to participate in care plan development and care plan review meetings. Social services personnel educated regarding appropriate process for patient/responsible party notification and invitation to attend care plan review meetings. Monitoring: DNS/Designee will complete audit of new physician orders 3xweekly to validate care plan accuracy. ED/Designee will audit resident records weekly to validate patient/responsible party notification to attend care plan review meetings per schedule and record of participation. Identified trends will be brought to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	

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F 280	Continued From page 11 FALLS - ...Continues Q [every] 15 min. [minute] checks." c. Interview with the RN case manager and the MDS coordinator on 8/1/14 at 9 AM revealed that, while the MDS coordinator formulated the initial resident care plan based on the MDS assessment, the IDT team was supposed to update the care plans with their recommendations. In addition, unit managers received copies of all physician orders and were supposed to make appropriate changes to resident care plans. d. Further review of the resident's care plan showed it was not updated to reflect the physician's order for 15 minute safety checks, or the IDT team's recommendation to continue them. e. Review of Resident Monitoring Tool forms for the dates of 7/10/14 through 7/30/14 showed incomplete and/or missing documentation of 15 minute safety checks for the resident on 7/10, 7/11, 7/12, 7/13, 7/14, 7/18, 7/19, 7/20, 7/22, 7/23, 7/24, 7/25, 7/26, 7/28, and 7/29. In fact, on 7/12/14 and 7/20/14 safety checks were documented only after the resident had already fallen and sustained injury. f. During an interview with the DON on 7/30/14 at 11:25 AM, she confirmed there had been no safety checks done on the resident on 7/29/14, stating, "There are no 15 minute safety checks from yesterday because [s/he] was fine." Later, at 11:45 AM, the DON stated that because 15 min safety checks were not on the resident's care plan "we did not have to do them." 2. Review of the care plan for resident #96, last revised on 7/2/13, showed s/he received oxygen therapy for decreased oxygen saturations. Further, the resident's saturations were to be	F 280		

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F 280	Continued From page 12 monitored each shift. Random observations on 7/30/14 and 8/1/14 showed the resident did not have oxygen available while up in the wheelchair or in his/her room. Review of the physician orders dated 6/30/14 showed the oxygen and oxygen saturation monitoring had been discontinued. An interview with the DON on 8/1/14 at 1:40 PM verified the care plan needed to be updated to show the resident no longer used oxygen and the monitoring was discontinued. 3. Review of the quarterly MDS assessment dated 6/7/14 revealed resident #73 was cognitively intact (alert and oriented). Interview on 7/30/14 at 5:30 PM revealed the resident desired to be involved in the care planning process. The following concerns were identified: a. The resident stated s/he had not been invited to participate in a care plan meeting to plan his/her medical and nursing care or daily and recreational activities. Review of the medical record on 7/31/14 at 8:16 AM verified there was no evidence the resident was invited to care conferences in May, June or July 2014. b. Review of the care plan showed it was revised on the following days: 4/7/14, 4/17/14, 5/23/14, 6/18/14, 6/27/14, and 7/29/14. Review of the care plan showed no evidence the resident was invited to participate in updating the care plan on any of these occasions. c. Interview with the DON on 8/1/14 at 11:55 AM confirmed the lack of documentation related to care conferences in the medical record. Further, she said she was unsure why the resident was not given the opportunity to participate in the discussion and revision of his/her care plan.	F 280		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281		

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F 281 SS=E	Continued From page 13 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 observation, medical record review and staff interview the facility failed to follow physician's orders for 6 of 33 sample residents (#21, #73, #75, #88, #89, #106). In addition, the facility failed to notify the physician of a medication allergy for 1 of 1 sample resident (#106). The findings were: 1. Observation of resident #89 on 7/28/14 at 10:25 AM showed a periorbital hematoma (a black eye) on the right side. Review of progress notes showed in the month of July, 2014, the resident suffered falls on 7/3, 7/5, 7/7, 7/12, and 7/30. Review of the resident's care plan for falls, last revised on 5/2/14, showed the resident did not like alarms, and would "cut them up if they were placed for safety." Review of a physician telephone order dated 7/10/14 showed an order to "DC [discontinue] alarms r/t [related to] resident cutting alarms. Start 15 minute checks reevaluate on 7/14/14 with IDT team." Review of a progress note dated 7/14/14, and timed 4:01 PM, revealed "IDT NOTE FOR FALLS - ...Continues Q [every] 15 min. [minute] checks." The following concerns were identified: a. Review of Resident Monitoring Tool forms for the dates of 7/10/14 through 7/30/14 showed incomplete and/or missing documentation of 15 minute safety checks on the resident on 7/10, 7/11, 7/12, 7/13, 7/14, 7/18, 7/19, 7/20, 7/22, 7/23, 7/24, 7/25, 7/26, 7/28, and 7/29. In fact, on	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 9/24/14 F281 Corrective Action: MD was notified of medications administered outside of ordered parameters for resident #88, #75, #21, and #73. Patients assessed and demonstrate no indication of associated adverse response or negative outcome. Resident #106 assessed and did not demonstrate adverse response associated with administered antibiotic. Physician of resident #106 consulted to clarify drug allergies and medical record updated as appropriate. Resident #89 has been discharged. Identification of Others: Baseline audit of medication administration records completed to validate medications administered in accordance with physician ordered parameters. Baseline audit of medication administration records for patients with orders for insulin, completed to validate administration records reflective of physician ordered parameters.	

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F 281	Continued From page 14 7/12/14 and 7/29/14 safety checks were documented only after the resident had already fallen and sustained injury. b. During an interview with the DON on 7/30/14 at 11:25 AM, she confirmed there had been no safety checks done on the resident on 7/29/14, stating, "There are no 15 minute safety checks from yesterday because [s/he] was fine." During an interview with the DON on 8/1/14 at 12:30 PM, she acknowledged physician orders should be followed as written. 2. Review of the physician's orders showed resident #38 was admitted with diagnoses including atrial fibrillation. A physician's order dated 12/14/12 showed the resident was supposed to receive Lopressor 12.5 mg twice a day. The orders further instructed to hold the Lopressor if the systolic blood pressure (B/P) reading was less than 110, the diastolic B/P was less than 60 or the heart rate (pulse) was less than 60 beats per minute. Review of the July 2014 MAR identified the following concerns: a. Review showed the Lopressor was signed off as administered on 7/2/14 in the evening. However, there was no evidence the resident's B/P or pulse were obtained. b. Review showed the resident's heart rate was recorded as 53 on the evening shift of 7/3/14, and 55 on 7/17/14. However, the Lopressor was signed off as administered despite the heart rates being less than 60. In addition, the resident's heart rate was recorded as 53 on 7/16/14 during the day shift and still the medication was administered. c. Review of the MAR showed no evidence the B/P or heart rate was obtained prior to administering the Lopressor on the morning shift of 7/7/14.	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* System Change: Education provided by SDC/Designee to nursing personnel regarding following physician orders for medication parameters, resident allergies and insulin administration. 281 Monitoring: DNS/Designee will monitor medication administration records for accuracy associated with parameters 3xWeek. DNS/Designee will monitor administration records for residents with insulin for accuracy in administration 3XWeek. Medical Records/Designee will monitor new physician orders and new admission records weekly for accurate recording of current allergies. Any identified trends will be reported to the Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	

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F 281	Continued From page 15 d. Finally, the resident's B/P reading was recorded as 102/ 58 (both the systolic and diastolic ranges indicated the medication should be held) on the evening shift of 7/20/14 yet the Lopressor was administered. 3. Review of the 7/8/13 physician's order showed supplemental resident #75 had an order for Lopressor 12.5 mg twice a day for a diagnosis of hypertension. The order further instructed to hold the medication for a heart rate of less than 50 or a systolic B/P less than 100. Review of the June 2014 MAR showed, on the evening shift of 6/13/14 and 6/29/14, no evidence the resident's B/P or heart rate were obtained to determine whether the Lopressor should be administered or not. However, further review of the MAR showed the medication was administered on both days. 4. Review of the physician's order dated 3/19/13 showed supplemental resident #21 had an order for Lisinopril 40 mg once per day for a diagnosis of hypertension. Further review showed the parameters for administration were to hold the medication for a systolic B/P of less than 100, a diastolic B/P of less than 60 and a heart rate less than 60. Review of the July 2014 MAR identified the following concerns: a. On 7/1/14 the diastolic B/P was recorded as 59, on 7/19/14 it was recorded as 57, on 7/20/14 it was 51 and on 7/30/14 it was recorded as 56. Each of these times showed the diastolic B/P was outside the established parameters yet the medication was signed off as administered. b. On 7/9/14 no heart rate was recorded to determine if the parameters for administration were met, yet the medication was signed off as administered. Interview with the DON on 8/1/14 at 12:30 PM	F 281		

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F 281	Continued From page 16 verified the readings noted above were accurate and outside of the parameters for administration based on physician's orders. She further acknowledged physician's orders should be followed as written. 5. Review of the June and July 2014 MARs showed resident #106 had allergies to include Macrodantin. Review of the Change in Medical Condition document dated 6/24/14 showed the resident had an urinary tract infection (UTI) which was resistant to the medication Bactrim, the antibiotic ordered to treat the infection. The nurse requested another antibiotic and Macrobid was ordered to be given 2 times daily for 10 days. Macrobid and Macrodantin are the same medication. Review of the the June and July MARs showed the resident received the 10 days of Macrobid, twice daily, as ordered and then continued to receive the medication an additional 4 days, once each day, until 7/7/14. A communication from the physician's office dated 7/10/14 showed the resident continued to have the UTI after a second UA was obtained . Further, the antibiotic was changed due to the resident's allergy to Macrobid. During an interview with the DON on 8/1/14 at 1:45 PM, she acknowledged the physician needed to be notified of the resident's documented allergy to the medication. 6. Observation on 7/28/14 at 5:35 PM showed resident #73 (who had a diagnosis of Diabetes Mellitus (DM) and was insulin dependent) was administered insulin Novolog 6 units with a reported BS (Blood sugar level) of 65 mg/dl (milliliters per deciliter) at 4 PM by RN #1. The following concerns were identified: a. Review of the medical record revealed a	F 281		

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F 281	Continued From page 17 new physician order dated 7/28/14 and timed at 3 PM to "hold 6 units of Novolog insulin when BS is < (less than) 70 [mg/dl]". The MAR was not updated to show the new order. b. Review of the facility policy titled Diabetes Mellitus (DM), Guidelines for Management, revealed "the nurse is to compare the results of the blood glucose level with the ranges established by the physician, to notify the physician of blood glucose levels below or above the established ranges and implement any new orders as applicable"; to "monitor [resident] for hypoglycemic episodes (blood sugar results below 70 [mg/dl]) and to notify the physician." c. Interview with LPN #1 on 7/30/14 at 6 PM revealed the expectation for communicating new physician orders is to verbally, and in writing, pass on new physician orders to the next shift; if the nurse who receives the new order is not assigned to the resident, the expectation is to notify the assigned nurse. This was not done at the time the order was received and resulted in the resident receiving insulin when s/he should not have based on physician orders. 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.	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 282 SS=E	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	F282 Corrective Action: RNA program for resident #7, #24, #73, #88, #107, were evaluated, revised as needed and care plans update as appropriate.	9/27/14

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F 282	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on resident and staff and resident interview and medical record review, the facility failed to ensure the care plan was followed for 5 of 33 sample residents (#7, #24, #73, #88, #107). The findings were: 1. Review of the 6/20/14 quarterly MDS assessment showed resident #7 required limited assistance of one person for bed mobility and transfers. For ambulation the resident required only supervision and one person. Further review showed the resident was unsteady during ambulation and utilized a walker. Review of the 4/29/14 restorative care plan showed the resident required lower extremity exercises including utilization of the nu-step (stool) five times per week to improve or maintain the resident's self performance of walking, with or without assistive devices. Review of the 5/4/14 general care plan showed interventions included working with the restorative CNA on the nu-step and therapy bands. The following concerns were identified: a. Review of the June 2014 restorative care flow record showed the resident received restorative services only once per week during the first and second weeks. Restorative was provided three times during the third week of June 2014 then not again until 7/3/14. b. Review of the July 2014 restorative care flow record showed the resident received restorative services two times during the first and second weeks and one time during the third week. The resident received no further restorative services the remainder of July 2014. c. Review of the records showed no evidence the resident refused restorative	F 282	Identification of Others: Baseline review for all patients with orders for restorative nursing program completed. Plans were evaluated, revised as needed and care plans updated as appropriate. System Change: Education provided by SDC/Designee to Restorative Nurse, Restorative Aide, and Therapy Program Manager regarding provision of restorative nursing program, oversight of programs and documentation of provided services. Monitoring: The DNS/Designee will monitor restorative program flow sheets and program review documentation weekly. Identified trends will be brought to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	

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F 282	Continued From page 19 theraples during either month. 2. Review of the 7/25/14 annual MDS assessment showed resident #88 required limited assistance of one person for bed mobility and ambulation, and extensive assistance of two persons to transfer. Review of the 4/23/14 general care plan showed the resident had impaired mobility related to a hip fracture and decreased cognition. Interventions included restorative services as needed. Review of the 5/30/14 restorative care plan showed the resident was to receive lower extremity strengthen exercises and range of motion (ROM) and gait training with a front wheeled walker and caregiver assistance three to five times per week. The following concerns were identified: a. Review of the June 2014 restorative care flow record showed the resident received restorative therapy only one time during the first week and two times during the second week and one timer during the third week. The fourth week in June showed no evidence the resident had any restorative therapy. b. Review of the July 2014 restorative care flow record showed the resident received restorative services one time during the first week, two times during the second week and one time during the third and fourth weeks. c. Review of the records showed no evidence the resident refused restorative therapies during either month. 3. Review of the medical record for resident #107 showed a restorative nursing care referral dated 3/8/14 for restorative services 3 to 5 times weekly to assist the resident with transfers, gait strengthening, nu-step level 3 resistance, increase as tolerated, and if the resident declines	F 282		

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

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F 282	Continued From page 20 to transfer onto the nu-step the program should be completed in parallel bars. Review of the restorative care flow record revealed the restorative program was initiated on 3/13/14. The resident received restorative services on 3/13/14, 3/18/14, 3/20/14, 3/27/14, and 3/31/14, not the recommended 3 to 5 times per week. Review of the April 2014 restorative care flow record showed 2 entries on 4/10/14 and 4/14/14 in which it was documented, "resident refused to work with restorative today." No additional documentation was made available that showed whether staff attempted further restorative therapy or if the restorative program was discontinued. Interview with the resident on 7/30/14 between 10:45 AM and 11:20 AM revealed s/he was supposed to perform exercises with staff but they just quit coming several months ago. 4. Review of the medical record for resident #24 showed a restorative nursing care referral dated 5/14/14 for a functional maintenance program. The program included range of motion and stretching exercises to both lower extremities 3 times a week. Review of the May 2014 restorative care flow record showed entries dated 5/16/14, 5/19/14, and 5/15/14 where the resident refused exercises. Review of the restorative care progress notes revealed the restorative nursing program was discontinued 5/31/14 related to resident refusals. No further documentation was provided indicating staff attempts to perform restorative service 3 times weekly as ordered. 5. Review of the quarterly MDS assessment dated 6/7/14 revealed resident #73 had diagnosis which included Parkinson's, and had a physical impairment in one of his/her upper extremities	F 282		

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F 282	Continued From page 21 that limited range of motion. Review of the medical record for the resident revealed restorative nursing services for maintenance were ordered to begin on 6/5/14 and to include standing hip abduction, heel raises, hip extension, and hip check with fourth resistance (March) 3 times per week. The services were not performed three times a week as ordered on the following dates: the week of 5/5/14 through 5/11/14, the week of 5/26/14 through 6/1/14, the week of 6/9/14 through 6/15/14, the week of 6/23/14 through 6/29/14, the week of 6/30/14 through 7/6/14. 6. Interview with the DON on 8/1/14 at 12:30 PM revealed it is her expectation that staff follow resident care plans.	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, medical record review, and facility policy review, the facility lacked evidence nursing staff provided the necessary assessments, monitoring, and nursing measures to ensure adequate pain management for 4 of 8 sample residents (#25, #33, #58, #106) who had pain or discomfort and for prevention of	F 309	F309 Corrective Action: Residents #33, #58, #106 reassessed for Pain, physician notified, new orders obtained and care plans updated as appropriate. Resident #107: Skin assessment completed, treatment orders clarified with physician and care plan updated as indicated. Resident #73: assessed and demonstrated no adverse response to insulin administration. Medication administration record updated to reflect physician ordered parameters. Resident #105: Respiratory status assessed, physician notified and respiratory treatment orders reviewed. Care plan updated as indicated. Resident #25 was discharged	9/24/14

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F 309	Continued From page 22 skin breakdown for 1 sample resident (#107). In addition, the facility failed to ensure the regimen was followed as ordered by the physician for 1 of 2 sample resident (#73) who were on insulin for management of their diabetes mellitus. Finally, the facility failed to ensure 1 of 2 sample residents (#105) with respiratory problems had their needs addressed. The results of these system failures resulted in harm to these residents. The findings were: In regard to pain management: 1. Review of the medical record showed resident #58 was noted to have a red raised rash on the left side of his/her upper back on 7/1/14. The physician ordered Valtrex 1 mg three times per day for five days on 7/1/14 for a diagnosis of possible shingles. According to Taber's Cyclopedic Medical Dictionary, 20th Edition, 2005, page 990, Shingles is the reactivation of the varicella virus years after the initial infection with chickenpox. Pain often develops and persists for months after resolution of the rash. "This discomfort, which may be severe in patients older than 60, is known as postherpetic neuralgia...and may intensify at night or worsen when clothes rub against the skin." Further, medications such as Valtrex "...are effective in reducing viral shedding and nerve pain damage if administered within 3 days of onset of the rash." However, review of the July 2014 MAR for this resident showed s/he did not receive the first dose until the end of the day on 7/3/14, day three after the onset of the rash, because it was "not available from pharmacy." Review of the July 2014 MAR showed the resident's pain was rated as 6 on a scale of 0 to 10 with 10 being the worst (6/10) on the 6 AM to 2 PM shift of 7/3/14; prior to the	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Identification of Others: A baseline audit of center residents completed to identify those with pain concerns that exceed resident stated acceptable level of pain. Baseline audit of medication administration records for patients with orders for insulin, completed to validate administration records reflective of physician ordered parameters. Skin assessment completed for high risk residents to determine current status of integumentary system. A baseline audit of medication administration records completed for those with orders for inhalers to validate administration as ordered and post treatment assessment System Change: Education provided by SDC/Designee to nursing personnel regarding, pain management, insulin	

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F 309	Continued From page 23 medication being started and 3 days within the onset of the rash. On the 6 AM to 2 PM shift on 7/4/14 the resident's pain was noted to be 5/10. Review of the 6/7/14 quarterly MDS assessment showed the resident had pain on 1 to 2 days during the 7 day look back period of assessment. Further review of the July 2014 MAR showed the resident only exhibited pain 4 other times during the month which was level 2/10. Interview with the DON on 8/1/14 at 12:30 PM revealed the facility should have been able to obtain a back up supply from another pharmacy and was unsure why that did not happen. 2. Review of the physical therapy plan of care (POC) with a 7/26/14 start of care date showed resident #25 had diagnoses to include chronic back pain with thoracic and vertebral compression fractures. Further, the POC showed the resident needed the therapy to reduce pain, improve body mechanics and increase strength and activity tolerance. Review of the July 2014 MAR showed the resident was prescribed Percocet (a narcotic pain medication) 5/325 mg one tablet every 6 hours for pain and Flexeril (muscle relaxant)10 mg as needed 3 times daily. Review of the care plan for pain, initiated on 7/26/14, showed the resident's acceptable pain level was 3-4 on a scale of 0-10 with 10 being at the highest level of discomfort. The following concerns were identified: a. Review of the care plan showed the facility was to assess the resident's pain each shift, record results and any interventions taken. The July 2014 MAR showed the resident's pain was assessed each shift. The resident reported a pain level of 5 or greater 5 of 14 times or 36%. Review of the nurses notes for those days with reported pain did not indicate the pain was addressed to	F 309	administration, prevention of skin breakdown and provision of treatments as ordered. Monitoring: Medication and Treatment administration records will monitor 3 X Week by the DNS/Designee for accuracy of insulin administration, treatment administration, post respiratory treatment assessment and pain monitoring. Identified trends will be submitted to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	

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F 309	Continued From page 24 include any interventions. b. The care plan for pain showed the facility staff was to assess and document the resident's pain to include location, duration, quality, aggravating/alleviating factors and intensity. Review of the MAR showed on 7/26/14 the resident received the medication Flexeril 3 times for muscle spasms at 9 AM, 4 PM and 11:45 PM. It did not indicate what his/her pain level was at the time the medication was administered, the location of the pain or any aggravating/alleviating factors. It only showed s/he had muscle spasms and that the medication was effective. Review of the pain assessment documentation completed each shift on 7/26/14 showed the resident reported a pain level of 10 during the 6 AM through 2 PM shift only. The remaining two shifts indicated the pain level was within his/her acceptable range. c. Review of the physical therapy note dated 7/30/14 and timed 9:21 AM showed the resident reported severe back pain with a pain level of 10 out of 10. Further, s/he requested to hold the therapy. The therapist assistant noted the nurse was informed. Review of the nurses' notes did not indicate the pain was addressed or the physician notified. d. An interview with the resident on 7/30/14 at 5:45 PM, revealed she received a routine dose of Percocet every 6 hours and the medication only lasted 3 hours. S/he reported his/her pain level would increase to 8 out of 10 at that time. Due to the pain, the resident did not participate in activities provided by the facility and could not always complete the prescribed therapy. The resident further indicated other interventions were effective for his/her pain and discussed with the staff but they were not prescribed. e. Review of the pain m onitoring flowsheet	F 309		

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F 309	Continued From page 25 for July 2014, received after the survey team exited, showed the routine dose of Percocet was assessed for effectiveness 5 times between 7/28/14 and 7/3014. The medication was admministered 19 times during that same time frame. 3. Review of the initial wound care examination dated 4/10/14 showed resident #106 had a stage 4 pressure ulcer to the left hip. Review of the treatment administration record (TAR) for June 2014 showed the dressing was to be changed every 3 days. The frequency of the dressing changes went to twice daily on 7/9/14. Review of the June and July MARs showed the resident was to receive the pain medication Norco 30 minutes prior to his/her dressing changes. The June MAR documentation showed the dressing change was completed 10 times and the resident received the pain medication prior to the dressing change 8 times. In July, the TAR documentation showed the resident had 38 dressing changes completed and the medication record showed s/he only received the pain medication 2 times. There was no documentation to show the resident refused the medication. Review of the 7/8/14 physician orders for the change in wound care did not indicate the pain medication was discontinued. 4. Review of the 7/25/14 admission MDS assessment showed resident #33 had diagnoses to include renal failure, seizure disorder and encephalopathy (brain dysfunction). Review of the June 2014 MAR showed the resident was prescribed the medication Tylenol 3 times daily as needed and received a routine dose of the pain medication Norco (a narcotic pain medication) once daily. Further, the resident's acceptable pain	F 309		

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F 309	Continued From page 26 level was 0 on a scale of 0 through 10 with 10 being the highest level of pain. The pain assessment completed each 8 hour shift showed the resident had a pain level greater than his/her acceptable level 16 times. Fifteen of the pains rating were between 6 and 9. Further, the time of the assessment was not recorded and did not include the location of the pain. Review of the Tylenol doses documented as given showed the medication was given 14 times. It did not show the reason the medication was given, the pain rating prior to the dose or the resident's response after it was given. Review of the July 2014 MAR showed the daily assessment for pain was 0. . Further review showed Tylenol was given 4 times. It did not show the reason the medication was given, the pain rating before or after it was given. Review of the nurses' notes showed Tylenol was given for a headache but pain ratings and assessments were not consistently completed. Review of the policy and procedure for pain management last dated 8/31/13 showed components included: "7. When pain is identified, assessment and documentation includes pain scale rating, location, duration, intensity and character." During an interview with the DON on 8/1/14 at 1:45 PM, she acknowledged the nursing staff needed to give the medication as ordered or indicate why it was not administered. Further, pain medications were to be monitored for their effectiveness. 5. During an interview with the DON on 8/1/14 at 1:45 PM, she acknowledged the nursing staff needed to give the medication as ordered or indicate why it was not administered. Further, pain medications were to be monitored for their effectiveness.	F 309		

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F 309	Continued From page 27 In regards to insulin administration: Observation on 7/28/14 at 5:35 PM showed resident #73 (who had a diagnosis of Diabetes Mellitus (DM) and was insulin dependent) was administered insulin Novolog 6 units with a reported BS (Blood sugar level) of 65 mg/dl (milliliters per deciliter) at 4 PM by RN #1. The following concerns were identified: a. Review of the medical record revealed a new physician order dated 7/28/14 at 3 PM to "hold 6 units of Novolog insulin when BS is < (less than) 70 [mg/dl]", which was not updated on the MAR at the time of insulin administration. b. Review of the facility policy titled Diabetes Mellitus (DM), Guidelines for Management, revealed "the nurse is to compare the results of the blood glucose level with the ranges established by the physician, to notify the physician of blood glucose levels below or above the established ranges and implement any new orders as applicable"; to "monitor [resident] for hypoglycemic episodes (blood sugar results below 70 [mg/dl]) and to notify the physician." c. Interview with LPN #1 on 7/30/14 at 6 PM revealed the expectation for communicating new physician orders is to verbally, and in writing, pass on new physician orders to the next shift; if the nurse who receives the new order is not assigned to the resident, the expectation is to notify the assigned nurse. This was not done at the time the order was received and resulted in the resident receiving insulin when s/he should not have based on physician orders. In regard to skin breakdown: Review of the medical record showed resident #107 was admitted to the facility 2/26/08 with	F 309		

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F 309	Continued From page 28 diagnoses including multiple sclerosis (MS), non-Alzheimer's dementia, and depression. Review of the quarterly MDS assessment dated 4/20/14 showed the resident was always incontinent of bowel and bladder. Review of the care plan updated 1/23/14 identified the resident as having the potential for skin integrity related to multiple sclerosis, decreased mobility, and incontinence. Interventions included staff assessing skin weekly and as needed, apply skin care products to excoriated areas as needed. Review of the treatment administration record showed an order dated 7/29/08 for staff to apply calmoseptine (an ointment to prevent and treat skin irritation) to inner thighs as needed, and an order dated 2/9/12 to apply skin protection cream to abdominal and groin folds as needed. The following concerns were identified: a. During an interview with the resident and his/her POA on 7/30/14 at 10:45 AM through 11:20 AM the resident revealed s/he had, "limited feeling below my waist because of the MS but I have a sore on my leg and it hurts, will you look at it". The resident exposed his/her upper right inner thigh and there was an oblong open area that measured approximately 1.5 cm(centimeters) by 3.5 cm by 0.3 cm deep (length, width, and depth). The resident stated, "it's been that way for about a month but it is worse, and I have told the nurses". The resident denied staff apply any ointment or cream to his/her inner thighs during peri-care. The resident opened his/her bedside table drawers and replied, "see there is no cream in here for them to put on it". The resident stated s/he, "tried to show it to the nurse but they were busy and were supposed to come back and look at it but didn't". The resident further expressed s/he, "feel like I have to beg for help and staff ignore me".	F 309		

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F 309	Continued From page 29 b. Review of weekly skin checks showed a skin check dated 7/26/14 identified the open area as, "irritation from brief on right thigh. Lotion applied with every change". No measurements or description were recorded. c. This surveyor informed nursing staff of open area on the resident's right upper, inner thigh. Review of a nursing note dated 7/30/14 and timed for 11:10 PM revealed measurements were recorded as 3.6cm by 1.7cm and the wound was a partial thickness wound with red, epithelization occurring (no depth was recorded). The physician was notified and wound care was changed and initiated at that time. In regard to respiratory problems; According to the June 2014 MAR, resident #105 received Proventil inhaler 2 puffs every 4 hours as needed for shortness of breath. This order was written by the physician on 5/20/14. Review of the June 2014 MAR showed the resident was provided the inhaler on 6/2/14 at 10:30 AM, on 6/7/14 at 5:30 PM, and on 6/9/14 at 2 PM, however, there was no evidence the resident was re-assessed to determine the effectiveness of the medication in relieving his/her shortness of breath. In addition, review of the June 2014 MAR showed the resident was provided the Proventil inhaler twice on 6/10/14 and one time on 6/29/14 without evidence of an assessment of the resident's shortness of breath, without a re-assessment of the effectiveness of the inhaler in relieving the resident's discomfort, and without documentation of the time of administration. Review of the July 2014 MAR showed resident was provided the Proventil inhaler one time on 7/7/14, 7/19/14, 7/24/14, and 7/30/14	F 309		

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F 309	Continued From page 30 without evidence of an assessment of the resident's shortness of breath, without a re-assessment of the effectiveness of the inhaler in relieving the resident's discomfort, and without documentation of the time of administration. F 311 SS=E 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff and resident interview, the facility failed to ensure restorative nursing exercises were consistently utilized to maintain and/or restore ADL function for 5 of 5 sample residents (#7, #24, #73, #88, #107) who were referred for restorative services. The findings were: 1. Review of the 6/20/14 quarterly MDS assessment showed resident #7 required limited assistance of one person for bed mobility and transfers. For ambulation the resident required only supervision and one person. Further review showed the resident was unsteady during ambulation and utilized a walker. Review of the 4/29/14 restorative care plan showed the resident required lower extremity exercises including utilization of the nu-step (stool) five times per week to improve or maintain the resident's self performance of walking, with or without assistive devices. Review of the 5/4/14 general care plan showed interventions included working with the restorative CNA on the nu-step and therapy	F 311	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F311 Corrective Action: RNA program for resident #7, #24, #73, #88, #107, were evaluated, revised as needed and care plans update as appropriate. Identification of Others: Baseline review for all patients with orders for restorative nursing program completed. Plans were evaluated, revised as needed and care plans updated as appropriate. System Change: Education provided by SDC/Designee to Restorative Nurse, Restorative Aide, and Therapy Program Manager regarding provision of restorative nursing program, oversight of programs and documentation of provided services.	9/24/14

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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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3125 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 311	Continued From page 31 bands. The following concerns were identified: a. Review of the June 2014 restorative care flow record showed the resident received restorative services only once per week during the first and second weeks. Restorative was provided three times during the third week of June 2014 then not again until 7/3/14. b. Review of the July 2014 restorative care flow record showed the resident two times during the first and second weeks and one time during the third week. The resident received no further restorative services the remainder of July 2014. c. Review of the records showed no evidence the resident refused restorative therapies during either month. 2. Review of the 7/25/14 annual MDS assessment showed resident #88 required limited assistance of one person for bed mobility and ambulation, and extensive assistance of two persons to transfer. Review of the 4/23/14 general care plan showed the resident had impaired mobility related to a hip fracture and decreased cognition. Interventions included restorative services as needed. Review of the 6/30/14 restorative care plan showed the resident was to receive lower extremity strengthening exercises and range of motion (ROM) and gait training with a front-wheeled walker and caregiver assistance three to five times per week. The following concerns were identified: a. Review of the June 2014 restorative care flow record showed the resident received restorative therapy only one time during the first week, two times during the second week and one time during the third week. The fourth week in June showed no evidence the resident had any restorative therapy at all. b. Review of the July 2014 restorative care	F 311	Monitoring: The DNS/Designee will monitor restorative program flow sheets and program review documentation weekly. Identified trends will be brought to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	

8/28/14

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	535013	A. BUILDING _____ B. WING _____	C 08/01/2014

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 311	Continued From page 32 flow record showed the resident received restorative services one time during the first week, two times during the second week, and one time during the third and fourth weeks. c. Review of the records showed no evidence the resident refused restorative therapies during either month. 3. Review of the medical record for resident #107 showed a restorative nursing care referral dated 3/8/14 for restorative services 3 to 5 times weekly to assist the resident with transfers, gait length of parallel bars forwards and backwards, nu-step level 3 resistance, increase as tolerated, and if the resident declines to transfer onto the nu-step the program should be completed in parallel bars. Review of the restorative care flow record revealed the restorative program was initiated on 3/13/14. The resident received restorative services on 3/13/14, 3/16/14, 3/20/14, 3/27/14, and 3/31/14, not the recommended 3 to 5 times per week. Review of the April 2014 restorative care flow record showed 2 entries on 4/10/14 and 4/14/14 in which it was documented, "resident refused to work with restorative today." No additional documentation was made available that showed whether staff attempted further restorative therapy or if the restorative program was discontinued. Interview with the resident on 7/30/14 between 10:45 AM and 11:20 AM revealed s/he was supposed to perform exercises with staff but they just quit coming several months ago. 4. Review of the medical record for resident #24 showed a restorative nursing care referral dated 5/14/14 for a functional maintenance program. The program included range of motion and stretching exercises to both lower extremities 3	F 311		

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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 311	Continued From page 33 times a week. Review of the May 2014 restorative care flow record showed entries dated 5/16/14, 5/19/14, and 5/15/14 where the resident refused exercises. Review of the restorative care progress notes revealed the restorative nursing program was discontinued 5/31/14 related to resident refusals. No further documentation was provided indicating staff attempts to perform restorative service 3 times weekly as ordered. 5. Review of the quarterly MDS assessment dated 6/7/14 revealed resident #73 had diagnoses which included Parkinson's, and had a physical impairment in one of his/her upper extremities that limited range of motion. Review of the medical record for the resident revealed restorative nursing services for maintenance were ordered to begin on 5/5/14 and to include standing hip abduction, heel raises, hip extension, and hip check with fourth resistance (March) 3 times per week. The services were not performed three times a week as ordered on the following dates: the week of 5/5/14 through 5/11/14, the week of 5/26/14 through 6/1/14, the week of 6/9/14 through 6/15/14, the week of 6/23/14 through 6/29/14, the week of 6/30/14 through 7/6/14. 6. Interview with the restorative CNA on 7/30/14 at 3 PM showed the restorative nursing department staff were responsible for assisting residents with recommended exercises. The interview further revealed the restorative nursing program had been without a supervising nurse for the last month, since the previous supervisor had resigned. In addition, she revealed residents were not receiving restorative exercises because there was no enough staff and she was required to work on the floor. The interview further revealed	F 311		

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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 311	Continued From page 34 several residents who had previously received restorative exercises had experienced an increased number of falls. 7. Interview with PT #1 on 7/31/14 at 3:30 PM verified residents had not been receiving restorative nursing services as recommended by the therapist for maintenance of ADLs.		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to ensure residents who required extensive assistance performing ADLs received assistance with hygiene for 4 of 27 sample residents (#37, #58, #96, #107) identified as requiring extensive assistance. The findings were: 1. Review of the medical record showed resident #37 was admitted to the facility on 7/30/13 with diagnoses including non-Alzheimer's dementia. Review of the quarterly MDS assessment dated 5/22/14 showed the resident was moderately cognitively impaired and required limited assistance with personal hygiene. Review of the care plan updated 11/20/13 identified the resident as having a self-care deficit. Interventions included nursing staff providing extensive	F 312	F312 Corrective Action: Resident #37, #58, #96, #107 assessed for oral care, personal hygiene needs and assistance required for completion. Immediate needs addressed, soiled clothing washed or replaced and plans of care updated as indicated. Identification of Others: Baseline audit of current residents completed related to Oral care and personal hygiene needs and Care Plans updated as indicated. System Change: Education provided to care staff by the SDC/Designee related to oral care and assistance with personal hygiene.	9/24/14

8/25/14

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

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F 312	Continued From page 35 assistance with dressing, toilet use and bathing. Observation on 7/28/14 at 1:40 PM showed the resident had long fingernails and nailbeds were encrusted with thick, brown matter. Subsequent observations on 7/29/14 and 7/30/14 revealed the resident continued to have long fingernails encrusted with thick, brown matter. Interview with the resident on 7/30/14 at 3:35 PM revealed s/he was unable to clean or trim his/her fingernails, with the resident stating, "I can't see them good enough to do it." 2. Review of the medical record showed resident #107 was admitted to the facility 2/26/08 with diagnoses that included multiple sclerosis, non-Alzheimer's dementia, and depression. Review of the quarterly MDS assessment dated 4/20/14 showed the resident was moderately cognitively impaired and required extensive assistance with ADLs. Review of the care plan updated 1/16/13 identified the resident as having a self-care deficit. Interventions included staff providing extensive assistance with dressing and bathing. Review of the medical record showed dental consultation findings dated 5/21/14 that included, "Homecare is poor! [Resident name] needs assistance with brushing and flossing." The following concerns were identified: a. Observation on 7/28/14 at 9:40 AM revealed the resident had long, jagged fingernails with chipped polish. The nailbeds were encrusted with thick, brown matter. The resident's hair was combed but oily. Subsequent observations on 7/29/14 and 7/30/14 showed the resident continued to have long, jagged fingernails with chipped polish. The nailbeds continued to be unclean and the resident's hair continued to appear oily and limp. Additionally, the resident was observed wearing a t-shirt on 7/29/14, and	F 312	Monitoring: The DNS/Designee will conduct random monitoring rounds associated with resident oral care and personal hygiene 3XWeekly. Trends identified through monitoring will be brought to the center Performance Improvement Committee monthly and as needed for review by the IDT until a lesser frequency is deemed appropriate.	

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F 312	Continued From page 36 during an interview with the resident and his/her POA on 7/30/14 at 10:45 AM, the resident continued wearing the same purple t-shirt. b. During an interview with the resident and his/her POA on 7/30/14 at 10:45 AM through 11:20 AM, the resident confirmed s/he was wearing the same t-shirt as the day before. The resident revealed when staff assisted him/her to bed the night before, they were supposed to return and assist him/her with changing clothing, however s/he had fallen asleep before they returned. The resident further revealed s/he had "not had a bath or hair washed in a week," and that his/her fingernails had been polished by staff about 2 weeks ago, but s/he could not recall the last time they had been trimmed and cleaned. The resident stated, "I have to ask them to trim and clean my fingernails and usually they will tell me they don't have time and will do it later or I can do it myself, but I don't have strength in my hands and it doesn't get done." c. The resident reported that facility staff did not assist him/her with toileting every couple of hours. They changed the resident's brief in the morning and before the evening meal and sometimes the resident would notice that his/her clothing was wet with urine and would tell staff s/he needed to be changed. Interview further revealed the resident refused showers "only if I feel really bad and I asked if they can do it later, but they never come back." d. The resident also revealed that s/he was supposed to perform exercises with staff, but that staff had quit coming to do this several months ago. e. The resident stated s/he felt "like I have to beg for help and staff ignore me." f. Also during this interview, the resident's POA revealed the resident's dentist had written	F 312		

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

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F 312	Continued From page 37 an order for staff to assist the resident with brushing and flossing his/her teeth, but it was not being done. 3. Observation on 7/30/14 at 3:35 PM showed resident #96 had a soiled shirt and over-blouse. The clothing appeared to have spilled food and fluids down the front of both articles of clothing. At 6 PM that same day, the resident had the same soiled clothing on. Observation on 8/1/14 at 9 AM showed the resident was wandering on the unit wearing a soiled sweatshirt. Review of the 5/30/14 quarterly MDS assessment showed the resident was severely cognitively impaired and required extensive assistance with dressing and personal hygiene. 4. Review of the 9/17/13 annual and the 3/11/14 and 6/17/14 quarterly MDS assessments showed resident #68 required extensive assistance with personal hygiene and grooming. Observation on 7/28/14 at 2:05 PM showed the resident's hair was uncombed. Interview with the administrator and DON on 8/1/14 at 3 PM revealed they had no comments to make regarding resident grooming.	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 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	F 315	F315 Corrective Action: Assessment completed for resident #14 to determine current bowel and bladder status and elimination needs. Care Plan updated to reflect status. Identification of Others: Baseline audit of high risk residents for bowel and bladder control and elimination needs completed and care plans updated as appropriate. Systemic Change: Education provided to care staff regarding incontinence care and toileting.	9/27/14

8/28/14

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3126 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 316	Continued From page 38 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, and review of facility policy and procedures, the facility failed to provide appropriate and timely toileting to restore as much normal bladder function as possible for 1 of 12 sample residents (#14) with incontinence. The findings were: Review of the quarterly MDS assessment dated 7/2/14 for resident #14 showed the resident was cognitively intact, was frequently incontinent, and required the extensive assistance of 2 or more persons for toilet use. Review of the resident's care plan for incontinence, last revised on 10/23/13, showed a goal of "[resident] will be continent during waking hours through the review date," with a target date of 10/15/14. Interventions included "Prompted schedule as required for incontinence" and "Nrsg [nursing] staff to provide extensive assistance with toilet use." During interview with the DON on 8/1/14, beginning at 11:55 AM, she was unable to define what "Prompted schedule as required for incontinence" meant for this resident. Review of facility policy and procedure titled "Prompted Voiding," provided by the facility on 8/1/14 showed that prompted voiding involved a resident being prompted to toilet on a scheduled basis. The policy did not define that schedule. Continuous observation of the the resident on 7/28/14 from 2:30 PM to 4:52 PM showed the resident was not toileted in that time period. Further observation in that time period showed	F 315	Monitoring: DNS/designee will perform random monitoring rounds associated with incontinent residents 3XWeekly. The ED/Designee will conduct random satisfaction interviews with residents and/or responsible party weekly. Trends identified through monitoring will be brought to the center Performance Improvement Committee monthly and as needed for review by the IDT until a lesser frequency is deemed appropriate.	

8/25/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3123 BOXELDER DRIVE CHEYENNE, WY 82001

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F 315	Continued From page 39 access to the bathroom in the resident's room was obstructed by the bed, making it impossible to take a wheelchair into the bathroom. During an interview on 7/28/14 at 2:45 PM the resident stated that s/he could feel "a little" when s/he needed to void, but was "never toileted" and that s/he wore an incontinence brief that was changed by staff after incontinent episodes.	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 323 SS=J	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, resident and family interview, review of fall documentation, and review of facility policy and procedure, the facility failed to ensure effective supervision and interventions were implemented to prevent falls for 3 of 9 sample residents (#24, #70, #89). As a result, serious avoidable injuries occurred to sample resident #89 and the potential for serious injury occurred with resident #24. In addition, a determination of immediate jeopardy was made for 1 of 9 observed sample residents (#24) with preventative measures not consistently utilized, and 1 resident (#89) who required direct staff supervision to prevent falls. The findings were:	F 323	F323 Corrective Action: Assessment completed on Resident #24, during the survey for fall risk in relation to the immediate jeopardy citation. Resident was found to have safety devices in place as ordered and no adverse affects associated with safety device placement or function. Resident #70 reassessed during the survey for fall risk. Both residents were re-evaluated with regard to interventions to prevent falls, new orders obtained and care plans updated as appropriate. Resident #89 is discharged.	9/24/14

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

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F 323	Continued From page 40 1. Review of the medical record showed resident #24 was admitted to the facility on 1/11/13 with diagnoses including non-Alzheimer's dementia, Huntington's disease, and arthritis. Review of the quarterly MDS assessment dated 4/12/14 and the annual MDS assessment dated 7/11/14 identified the resident as being at risk for falls. The quarterly MDS assessment dated 4/1/14 also showed the resident had experience 2 or more falls since the previous assessment had been completed. Review of the CAA dated 7/11/14 showed the resident was at risk for falls due to decreased mobility, incontinence, dementia, disease processes, pain, medications, and history of prior falls. Review of the care plan updated on 5/19/14 identified the resident as being at risk for falls secondary to decreased mobility, decreased cognition, and history of falls, incontinence, Huntington's chorea, pain and medications. Dated interventions included encouraging the resident to request assistance as needed (7/5/13), tab alarm when in wheelchair (7/5/13), educate/remind him/her to request assistance prior to transferring (7/16/13), monitor medication side effects and report to physician (7/16/13), refer physical therapy to evaluate and treat as needed (7/16/13), half side rails X 2 to aid with positioning in bed (10/4/13), bed in low position, alarming pressure pad in bed, gray floor pad and lip mattress (10/16/13). In addition, anti-tip bars and rollbacks were supposed to be applied to wheelchair and maintenance were supposed to check for proper positioning (10/16/13). The most current intervention dated 5/7/14 was placing the resident on the falling star program. Review of the falls documentation from 1/4/14 through 7/30/14 showed the resident had experienced unwitnessed falls on 1/18/14, 5/7/14, 5/13/14, 6/7/14, and 7/24/14. Review of the fall dated	F 323	Identification of Others: A baseline audit of center residents with safety devices was completed during the survey. Patients identified as high risk for falls and those experiencing falls in the prior 30 days were reassessed, physician orders validated and care plans updated. System Change: Education provided by the SDC/Designee to care staff regarding application of safety devices, validation of placement and fall prevention measures. Monitoring: The ED/Designee will monitor safety devices for placement according to physician orders 3Xweekly. A Fall Committee Meeting will be conducted weekly to review fall trends and interventions. Identified trends will be brought to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	

8/25/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536013	A. BUILDING _____ B. WING _____	C 08/01/2014

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 323	Continued From page 41 1/18/14 revealed the resident had been transported to the emergency department for evaluation. Review of a physician's progress note dated 3/18/14 showed "recommendations - Always have a medical assistant accompany the patient for office visits. Pt [patient] suffers from dementia, agitation, and is prone to falls!" The following concerns were identified: a. Observation on 7/30/14 at 11:30 AM revealed the resident was seated in his/her wheelchair beside the low bed. The resident's tab alarm clothing clip was clipped to the cord and the unit was turned off. Also, there was no pressure pad alarm in the wheelchair. The resident self-transferred from the wheelchair to the low bed using unsteady, jerky movements. LPN #4 was notified and verified the resident should have had the tab alarm clipped to his/her shirt and a pressure pad alarm in the wheelchair. LPN #4 was unaware the tab alarm was not turned on or in place, and stated the resident "probably took the [tab] alarm off." Interview at the time of the observation revealed nursing staff were responsible for making sure fall prevention interventions were in place on each shift. However, restorative was supposed to check alarms to ensure batteries were replaced and the alarms were working properly weekly. She also revealed CNAs were responsible for making sure alarms were in place when they assisted residents with ADLs. b. Review of fall documentation revealed findings of the unwitnessed fall on 5/7/14 included the resident had removed the tab alarm monitor from his/her shirt. In addition, the resident's wheelchair was supposed to have been equipped with anti-tippers, which were not in place, and anti-rollbacks, which did not touch the floor (anti-tippers prevent the wheelchair from flipping	F 323		

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F 323	Continued From page 42 over, and anti-rollbacks prevent the wheelchair from rolling back if their rubber-tipped stoppers contact floor surfaces). The anti-tippers and anti-rollback devices had been implemented as fall prevention measures on 10/18/13. c. Interview with the restorative CNA on 7/30/14 at 3 PM showed the restorative nursing department staff were responsible for checking resident alarms to ensure they were in place and functioning properly daily. However, the last time the alarms were checked was on 6/29/14 because she was required to work the floor instead. The interview further revealed the restorative nursing program had been without a supervising nurse for the last month, since the previous supervisor resigned. In addition, she revealed residents were not receiving restorative exercises or showers, and several residents who had previously received restorative exercises had experienced an increased number of falls. The CNA verified there were 3 notebooks which contained documentation for the restorative program and daily alarm documentation that were located in the restorative nursing office. However, when the CNA went to retrieve the notebook containing the daily alarm check documentation, the notebook was "missing." d. Interview with the DON on 7/30/14 at 6:55 PM verified facility staff were aware the resident often removed his/her tab alarm. She also verified the tab alarm continued to be utilized as a preventative fall intervention for the resident and should have been attached to his/her clothing and turned on. e. Review of the fall care plan initiated on 7/16/13 identified the resident as being at risk for falling, however, the resident was not placed on the falling star program until 6/7/14. The care plan further showed no new fall prevention	F 323		

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

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F 323	Continued From page 43 Interventions were initiated after 5/7/14. 2. Observation of resident #89 on 7/28/14 showed a periorbital hematoma (a black eye) on the right side. Review of progress notes showed in the month of July, 2014 the resident suffered falls on 7/3/14, 7/5/14, 7/7/14, 7/12/14, and 7/30/14. Review of the resident's care plan for falls, last revised on 5/2/14, showed the resident did not like alarms, and would "cut them up if they were placed for safety." Review of a physician telephone order dated 7/10/14 showed an order to "DC [discontinue] alarms r/t [related to] resident cutting alarms. Start 15 minute checks reevaluate on 7/14/14 with IDT [interdisciplinary team] team." Review of a progress note dated 7/14/14, timed 4:01 PM, revealed "IDT NOTE FOR FALLS - ...Continues Q [every] 15 min. [minute] checks." Interview with LPN #2 on 7/30/14 at 10:50 AM revealed safety checks were the nurse's responsibility, and were not delegated to CNAs. The following concerns were identified: a. Review of Resident Monitoring Tool forms showed incomplete or missing documentation of safety checks. On 7/10/14, there was no documentation indicating that safety checks were performed between 6:15 PM and 7:45 PM. b. On 7/11/14, there was no documentation indicating that safety checks were performed between 10:45 PM and 11:45 AM. c. On 7/12/14, there was no documentation indicating that any safety checks were performed during the entire day until the resident fell at approximately 10:15 PM, at which time the resident was found on the floor in his/her room. Progress notes dated 7/12/14, timed 11:25 PM, showed "Beginning of shift resident seen in bed watching tv @ [at] 2215 [10:15 PM] cna got this nurse, entered room to find resident on floor lying	F 323		

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

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F 323	Continued From page 44 right side by bed. When asked if anything hurts states my head. Resident has bruise right forehead with raised lump. Sm [small] abrasion right cheek from eyeglasses which broke (frame)..." d. On 7/13/14, there was no documentation indicating that safety checks were performed between 3:15 PM and 9:45 PM. e. On 7/14/14, there was no documentation indicating that safety checks were performed between 2:30 PM and 9:45 PM. f. On 7/18/14, there was no documentation indicating that safety checks were performed between 6:15 AM and 1:45 PM. g. On 7/19/14, there was no documentation indicating that safety checks were performed between 6 AM and 1:45 PM. h. On 7/20/14, there was no documentation indicating that safety checks were performed between 6 AM and 9:45 PM. i. From 7/22/14 to 7/26/14, there was no documentation of safety checks at all. j. From 7/28/14 through 7/29/14, there was no documentation of safety checks at all. k. Documentation of safety checks began again on 7/30/14 at 12 AM. Review of progress notes dated 7/30/14, timed at 12:29 AM, revealed "Seen in bed at 2330 [11:30 PM] remains on Q [every] 15 min [minute] safety checks. At 11:45 AM CNA called this nurse to room resident on floor lying on right side. Resident alert states head hurt. Body audit reveals blood and laceration 1.5 cm posterior left head...Sent to [hospital] ER [emergency room] via emergent ambulance at 0015 [12:15 AM]." l. An interview with the DON on 7/30/14 at 11:25 AM, she confirmed there had been no safety checks done on the resident the evening prior to the fall with injury on 7/29/14, stating,	F 323		

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F 323	Continued From page 45 "There are no 15 minute safety checks from yesterday because [s/he] was fine." 3. Review of the medical record showed resident #70 had been admitted to the facility on 1/20/06 with diagnoses including non-Alzheimer's dementia and stroke. Review of the quarterly MDS assessment dated 7/9/14 revealed the resident was cognitively impaired, made poor decisions, required cues and supervision, and had impaired communication. The resident was also identified as requiring extensive assistance from staff for wheelchair mobility, and had experienced 2 or more falls since the prior MDS assessment. Review of the care plan updated 7/23/14 showed s/he was at risk for falls related to confusion/dementia, poor communication, decreased mobility, incontinence, diminished safety awareness and a history of falls. Dated interventions included using bedside impact absorbing floor mat while in bed (5/23/12), tipped mattress (5/23/12), bed and chair alarm (5/23/12), using a mechanical lift for transfers (6/21/12), therapy screen for wheelchair positioning (6/11/14), wheelchair cushion to be replaced with pommel cushion (7/23/14), tilt-space wheelchair in place, cushion with Velcro to prevent sliding (7/23/14). Review of falls documentation additionally revealed the resident experience an unwitnessed fall on 7/12/14 and a witnessed fall on 7/18/14, however, no IDT post-fall follow-up was documented for either incident until 7/23/14, at which time the IDT recommended using a pommel cushion in the resident's wheelchair. On 7/29/14 at 5:30 PM the DON provided an order form for a flip down pommel cushion dated 7/29/14 and timed 4:58 PM (6 days after the IDT recommendation was made). The following concerns were identified:	F 323		

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F 323	Continued From page 46 a. Review of fall documentation dated 3/29/14 showed the resident was found on the mat on the floor beside his/her bed. The alarm was turned on, however, the alarm had not been sounding and the batteries had to be replaced. b. Observations on 7/28/14 at 9:40 AM and 3 PM, and 7/29/14 at 4:20 PM revealed the resident was asleep in a low bed, and the gray mat was rolled up and leaning against the footboard of the resident's bed, instead of being on the floor beside the bed. c. Review of the physical therapy note dated 6/11/14 showed the "resident's positioning in wheelchair assessed, properly positioned, wheelchair and cushion are appropriate ...staff education ongoing. " Review of a staff training documentation form with the same date showed 4 staff members were educated on wheelchair positioning (2 LPNs and 2 CNAs). d. Interviews with CNA #11 and CNA #12 on 7/29/14 at 5 PM revealed they did not recall any in-services related to positioning the resident properly in his/her wheelchair. CNA #11 stated, "[the resident] has had several wheelchairs over the past couple of months but we've never had any in-services, and some of them have been difficult to figure out, one of them the brakes were in a different place." e. Review of nursing documentation dated 7/11/14 revealed the resident was observed sliding out of his/her wheelchair " 8 " times and required staff intervention to prevent falling. Additional nursing notes showed physical therapy was not notified until 7/16/14 when the resident was again observed sliding out of his/her wheelchair and staff had to intervene to prevent the resident from falling. No documentation was made available to show the resident had been referred to and evaluated by physical therapy.	F 323		

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KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3123 BOXELDER DRIVE CHEYENNE, WY 82001

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F 323	Continued From page 47 Additionally there was no documentation relating to the various types of wheelchairs until a nursing note dated 7/29/14 indicated the resident was currently utilizing a tilt in space wheelchair which reclined in an attempt to reduce the risk of the resident falling forward and sliding out of the wheelchair. Review of the care plan did not reflect the wheelchair changes. f. Interview with PTA #1, who also acts as the rehabilitation director, on 7/31/14 at 1:30 PM revealed not all facility staff were in serviced on positioning the resident in his/her wheelchair, usually several staff members were educated, then they educated other staff during shift report when on shift went off duty and another shift came on duty. She also revealed she had evaluated the resident several times and several different types of wheelchairs had been used to improve the resident's posture and reduce sliding from the wheelchair. She further disclosed she did not document every time she performed a physical therapy screening assessment for residents. No additional documentation was made available related to physical therapy screening and recommending different types of wheelchairs or staff education related to the operation and positioning of the resident in the different wheelchairs. On 7/30/14 at 3:05 PM the acting administrator was notified of the immediate jeopardy. The facility's plan showed immediate changes as follow: a. Staff education was performed by professional licensed staff for proper application and placement of fall intervention equipment prior to starting on shift. b. 100% audit by floor of all 216 safety devices to validate placement in accordance with physician orders.	F 323		

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F 323	Continued From page 48 c. Reassessment of Morse Fall risk initiated for 100% of the 18 high-risk residents based on falls in the last 30 days. d. Interview of floor staff on monitoring safety devices/equipment throughout the day. e. Assessment completed on the resident in immediate jeopardy, with no adverse outcome. Further, the facility validated the resident had physician ordered safety devices in place. The action plan was accepted on 7/30/14 at 9:27 PM and the immediate jeopardy was removed at that time. However, the deficient practice remained at a level G.	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record review and resident and staff interview, the facility failed to ensure residents received the necessary treatment for respiratory care for 1 non-sample resident (#63). The findings were: During an interview with resident #63 on 7/30/14	F 328	F328 Corrective Action: Resident #63 respiratory status assessed, physician notified and respiratory treatment orders reviewed. Care plan updated as indicated. Identification of Others: A baseline audit of medication administration records completed for those with orders for inhalers to validate administration as ordered and post treatment assessment System Change: Education provided by SDC/Designee to nursing personnel regarding provision of treatments as ordered.	9/24/14

8/25/14