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Healthcare Licensing and Surveys

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

PRINTED: 05/07/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION - RAWLINS	642 16TH STREET RAWLINS, WY 82301

(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: ADL - Activities of Daily Living CNA - Certified Nurse Aide DON - Director of Nursing MDS - Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 252 SS=D	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, resident interview, policy and procedure review and staff interview the facility failed to ensure 3 of 3 random observations of resident bathrooms (rooms 38/39, 23, 21) was maintained in a safe, clean, and homelike manner. The findings were: 1. Observation of the bathroom for room 38/39 on 4/20/15 at 2:20 PM showed there was a raised, dark brown substance, one inch long, located on the toilet riser near the hinge. Observation two days later, on 4/22/15 at 5:36 PM showed the substance remained on the toilet riser. 2. Observation of the bathroom for room 21 on	F 252	**F 252 – Safe/Clean/ Comfortable Environment** **Corrective Action:** Toilet risers in room 38/39 and room 21 and floor in room 23 cleaned and disinfected. **Identification of other patients at risk:** Housekeeping Supervisor completed room checks to ensure sanitation of bathroom and toilet risers. No other issues were identified. **Systemic Changes:** Housekeeping Supervisor/designee educated housekeeping staff on cleaning schedules according to facility policy on 5/13/15 **Monitoring:** Housekeeping Supervisor/ designee will monitor through observation and record review weekly to ensure the facility maintains a sanitary and comfortable interior. Results will be taken to QAPI and reviewed for monthly trends until a lesser frequency has been deemed appropriate.	05/18/2015

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

DNS 5/5/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

POC accepted - Cleared by Naomi King, DNS on 5/21/15 @ 4:12pm.

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F 252	Continued From page 1 4/20/15 at 3:00 PM showed there was a raised, dark brown substance, ¼ of an inch long, on the front left leg of the toilet riser. Observation two days later, on 4/22/15 at 5:30 PM showed the substance remained on the toilet riser. 3. Observation of the bathroom for room 23 on 4/22/15 showed a dark discoloration on the floor and a yellow discoloration around the base of the toilet. 4. Review of the "7-Step Daily Washroom Cleaning" policy dated 1/1/2000 showed the facility should use a germicide solution to wipe every area of the commode. 5. Interview with the Infection Control Nurse on 4/23/15 at 9:35 AM revealed the toilet risers need to be cleaned on a regular basis and fecal matter should be cleaned off by anyone who sees it. 6. Interview with the Housekeeping Manager on 4/23/15 at 10:33 AM revealed the bathrooms should have been cleaned between 4/20/15 and 4/23/15 and confirmed the areas remained soiled at that time.	F 252		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the facility was clean and	F 253	F 253 – Housekeeping and Maintenance Services Corrective Action: Facility will obtain a quote to repair broken tiles in site areas: Sitting area near back nurses station "Plum Street Hall" Activity area Front of exit in activity area Room 49 Near the bathroom in room 23 Kitchen	

Allegra DNS 5/5/15

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F 253	Continued From page 2 well-maintained in 7 random resident areas. The findings were: 1. Observation of the floor in the sitting area near the back nurse's station on 4/22/15 at 5:33 PM revealed 9 (12 inch by 12 inch) tiles which were chipped or cracked and visibly dirty with an uncleanable surface. 2. Observation of the floor on "Plum Street Hall" near the therapy gym on 4/22/15 at 5:38 PM showed 8 (12 inch by 12 inch) tiles which were chipped or cracked and visibly dirty with an uncleanable surface. 3. Observation of the floor in the activity area on 4/22/15 at 5:40 PM showed 13 (12 inch by 12 inch) tiles that were chipped or cracked and visibly dirty with an uncleanable surface. 4. Observation of the floor in front of the exit in the activity area on 4/22/15 at 5:40 PM showed 3 (7 ¾ inch by 12 inch) tiles that were chipped or cracked and visibly dirty with an uncleanable surface. 5. Observation of the floor in room 49 on 4/22/15 at 5:45 PM showed 1 (12 inch by 12 inch) tile with a hole that measured 2 inches by 1 ½ inches by ¼ inch that was visibly dirty with an uncleanable surface. 6. Observation of the floor near the bathroom in room 23 on 4/22/15 at 5:50 PM showed 3 (9 inch by 9 inch) tiles that were chipped or cracked and visibly dirty with an uncleanable surface. 7. Observation of the floor in the kitchen on 4/22/15 at 6:00 PM showed 73 (12 inch by 12	F 253	**Identification of other patients at risk:** Maintenance Director completed rounds of facility to determine other areas of broken tiles. No other areas identified. **Systemic Changes:** Quotes for repairs will be obtained as needed. Education provided to maintenance director and staff relating to identification of areas that are unable to be cleaned and need of repair. **Monitoring:** Maintenance Supervisor/ designee will monitor through observation weekly to ensure the facility maintains a sanitary, orderly and comfortable interior. Results will be taken to QAPI and reviewed for monthly trends until a lesser frequency has been deemed appropriate. 5/30/2015	

Mingo DNS 5/15/15

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F 253	Continued From page 3 inch) tiles that were chipped or cracked and visibly dirty with an uncleanable surface. 8. Interview with the Maintenance Director on 4/23/15 at 10/10/ AM confirmed the chipped or cracked tiles. He further acknowledged the facility did not have a specific plan with a timeframe to complete these repairs.	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure physician orders for sliding scale insulin were followed for 2 of 4 sample residents (#5, #41) receiving sliding scale insulin, and failed to complete neurological assessments as indicated on 1 of 4 sample resident (#20) with falls. The findings were: 1. Review of the 3/21/15 quarterly MDS assessment showed resident #5 had diagnoses that included diabetes mellitus. Review of a physician order dated 9/2/14 showed the resident was to receive insulin on a sliding scale based on fingerstick blood glucose (FSBG) measurements as follows:	F 309	**F 309 – Provide Care/Services for Highest Well Being.** **Corrective Action:** MD was notified of incorrect insulin dosage administration on Rts. #5 and #41. MD notified of failure to complete neurological assessment on Rt. #20. **Identification of other patients at risk:** Director of Nursing Services/ designee will perform baseline audits of residents receiving insulin to validate accuracy of the physician orders. Director of Nursing Services/ designee completed a baseline audit of past 30 days to verify neurological assessments were completed as ordered. MD's notified of any discrepancies orders obtained. **Systemic Changes:** Staff Development Nurse/ designee to educate nursing staff on following physicians orders. In-services scheduled for 5/20/15 and 5/21/15	

Allyson DNS 5/15/15

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F 309	Continued From page 4 FSBS of 201 to 250 = 2 units of Humalog Insulin FSBS of 251 to 300 = 4 units of Humalog Insulin FSBS of 301 to 350 = 6 units of Humalog Insulin FSBS of 351 to 400 = 8 units of Humalog Insulin FSBS of 401 to 451 = 10 units of Humalog Insulin FSBS of 451 to 500 = 12 units of Humalog insulin FSBS of 501 to 550 = 14 units of Humalog Insulin FSBS greater than 550, call physician. Review of diabetic monitoring sheets revealed the following concerns with insulin administration: a. On 1/15/15 at 11:46 AM, the resident's FSBG measurement was 386, and 6 units of Humalog were administered, instead of the 8 units indicated by the physician order. b. On 1/21/15 at 11:30 AM, the resident's FSBG measurement was 324, and 8 units of Humalog were administered, instead of the 6 units indicated by the physician order. c. On 1/24/15 at 12 PM, the resident's FSBG measurement was 335, and 8 units of Humalog were administered, instead of the 6 units indicated by the physician order. d. On 1/26/15 at 9:22 PM, the resident's FSBG measurement was 448, and 12 units of Humalog were administered, instead of the 10 units indicated by the physician order. e. On 2/17/15 at 5 PM, the resident's FSBG measurement was 370, and 6 units of Humalog were administered, instead of the 8 units indicated by the physician order. f. On 2/22/15 at 11:30 AM, the resident's FSBG measurement was 264, and 2 units of Humalog were administered, instead of the 4 units indicated by the physician order. g. On 3/4/15 at 8:46 PM the resident's FSBG measurement was 402, and 8 units of Humalog were administered, instead of the 10 units indicated by the physician order.	F 309	**Monitoring:** The DNS/ designee will conduct monitoring weekly of insulin administration according to physician orders. The DNS/ designee will conduct weekly audits to ensure neurological assessments are completed per Physicians' orders. Results will be taken to QAPI and reviewed for monthly trends until a lesser frequency has been deemed appropriate. 5/30/2015	

Mingeau DNS 5/15/15

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F 309	Continued From page 5 h. On 3/11/15 at 1 PM, the resident's FSBG measurement was 402, and 8 units of Humalog were administered, instead of the 10 units indicated by the physician order. i. On 3/29/15 at 5 PM, the resident's FSBG measurement was 296, and 6 units of Humalog were administered, instead of the 4 units indicated by the physician order. 2. Review of the 1/19/15 admission MDS assessment showed resident #41 had diagnoses that included diabetes mellitus. Review of a physician order dated 3/20/15 showed the resident was to receive insulin on a sliding scaled based on FSBG measurements as follows: FSBS of 140 to 200 = 3 units of Humalog Insulin FSBS of 201 to 250 = 6 units of Humalog Insulin FSBS of 251 to 300 = 10 units of Humalog Insulin Review of diabetic monitoring sheets revealed the following concerns with insulin administration: a. On 2/12/15 at 5 PM, the resident's FSBG measurement was 134, and 3 units of Humalog were administered, although the physician's order indicated that no insulin was to be administered. b. On 3/30/15 at 4 PM, the resident's FSBG measurement was 124, and 3 units of Humalog were administered according to the documentation, although the physician's order indicated that no insulin was to be administered. Interview on 4/22/15 at 9:35 AM with LPN #1 revealed she had changed the documentation on 4/22/15 after being asked to make a copy of it, crossing out the insulin administration and stating she had not given the resident any insulin on 3/30/15 at 4 PM, because the resident's insulin coverage did not begin until his/her FSBG was 140. The LPN did not explain why the insulin had	F 309		

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F 309	Continued From page 6 been documented as being administered. 3. Interview with the DON on 4/23/15 at 12:30 PM confirmed the insulin had been administered incorrectly. 4. Review of a fall incident report for resident #20 dated 2/5/15 showed the resident was found on the floor at 6:15 PM. The incident report revealed the resident was assisted up and vital signs were refused by the resident. Further review showed that neurological assessments were not completed. Review of the facility's neurological evaluation procedure revised 5/28/08 showed frequency of the neurological assessment should be obtained from the physician or if a specific order cannot be obtained neurological evaluation should be completed every 15 minutes for an hour, then; every 30 minutes for an hour, then; every hour for 2 hours, then; every 4 hours until physician states it is no longer necessary or in 72 hours if resident's condition is stable and showing no signs and symptoms of neurological injury. Interview with the DON on 4/23/15 at 11:45 AM revealed the facility did not complete a neurological evaluation after the fall and should have continued to attempt to obtain neurological evaluations for the resident.	F 309		
F 323 SS=D	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.	F 323	F 323 – Free of Accident: hazards/supervision/devices Corrective Action: Resident #15- Physicians order obtained to discontinue bolters. Bolsters removed from bed and care plan updated. Resident #9- Nursing staff educated on transfers, care plan updated.	

Allington RN 5/15/15

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F 323	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, review of education documentation, staff interview, medical record review, and policy and procedure review the facility failed to ensure bolsters were assessed for safety for 1 of 1 sample residents (#45) who used bolsters. In addition, the facility failed to ensure a mechanical lift was used for 1 of 3 sample residents (#9) who required a mechanical lift for transfers. The findings were: 1. Review of the 2/26/15 quarterly MDS assessment showed resident #45 was severely cognitively impaired with a brief interview for mental status (BIMS) score of 7/15, and diagnoses that included hydrocephalus and non-Alzheimer's dementia. Observation on 4/20/15 at 2:45 PM showed a bolster was attached to the open side of the resident's bed and the other side was against the wall. The device was designed to be attached to the bed to assist with positioning of a resident during hours of sleep. The following concerns were identified: a. Review of the resident's medical record revealed that a safety assessment of the bolster was not completed. The facility failed to address the safety of bolster and potential for increased risk of injury from fall. b. Review of the resident's care plan showed "[Resident's name] has bolsters pads on bed d/t (due to) [resident's name] will try to get out of the bed and transfer self." c. Review of the policy "Restraint Use," dated 10/31/10, showed "Patients are assessed prior to application of restrictive devices to determine medical symptoms that may require the use of a	F 323	Identification of other patients at risk: Director of Nursing Services/ designee conducted a baseline audit for potential restraints. None identified. Director of Nursing Services/ designee conducted random staff observations to ensure that individual residents are being transferred according to care plan. Systemic Changes: Staff Development Nurse/ designee to educate nursing staff on potential restraints and transfers Monitoring: The DNS/ designee will conduct monitoring of transfers 3 times a week to validate compliance. Results will be taken to QAPI and reviewed for monthly trends until a lesser frequency has been deemed appropriate.	5/30/2015

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F 323	Continued From page 8	F 323		

restraint, to determine how the use of restraints would treat the medical symptom, protect the resident's safety, and assist the patient in attaining or maintaining highest practicable level of physical and psychosocial well-being."

d. Interview with the DON on 4/23/15 at 11:45 AM revealed the facility did not assess the device for safety because the device was "not being used as a restraint."

2. Review of the 3/11/15 admission MDS assessment showed resident #9 had wounds to his/her bilateral lower extremities, required the total assistance of 2 or more persons for transfer, and had diagnoses that included chronic pain, edema, and anxiety. Observation on 4/20/15 at 3:47 PM showed the resident was in the hallway propelling her/himself in a wheelchair.

Observation on 4/20/15 at 4:00 PM showed the resident was transferred by 3 staff members with the use of a mechanical lift. The following concerns were identified:

a. Observation of care for the resident on 4/21/15 at 11:19 AM showed the resident was partially in bed with a gait belt around his/her trunk. CNA #1, CNA #2, and LPN #1 finished positioning the resident in the bed by utilizing the gait belt to move the resident in the bed. No mechanical lifting device was utilized or present in the resident's room. The resident was verbalizing pain at that time.

b. Interview with the resident on 4/22/15 at 5:40 PM revealed the resident transferred with both the mechanical lift and a gait belt, was transferred with the gait belt prior to the observation on 4/21/15, and had pain when transferred with the gait belt. Further interview at that time revealed the resident was usually transferred with a gait belt following a shower, but a mechanical lift had been used before.

Mingo DNS 5/15/15

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F 323	Continued From page 9 c. Review of progress notes for April 2015 showed notes on 4/4/15, 4/5/15, 4/7/15, 4/12/16, 4/20/15, and 4/21/15 that revealed the resident was a 2-person assist with transfers using a "Hoyer" or mechanical lift. Further review of the progress notes showed a note on 4/21/16 at 3:16 PM that revealed the resident "transfers very well for 3 staff and a gait belt this am to the shower chair." d. Review of undated education documentation provided by therapy on 4/23/15 related to transfers for resident #9 showed therapy had trained five staff members to complete the transfers. CNA #1 and CNA #2 were not listed as being trained. Further review of the education showed that some staff were not able to transfer the resident with a gait belt due to body size and a Hoyer must be used. e. Interview with the Rehab Manager on 4/23/15 at 12:50 PM revealed she would not be comfortable with a gait belt transfer being performed, on that resident, by anyone who had not been trained.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	**F 441- Infection Control, Prevention Spread, Linens** **Corrective Action:** Infection control nurse provided education on proper infection control during wound care as it applies to Resident #9. Wound culture obtained. **Identification of other patients at risk:** Infection Control Nurse/ designee will conducted a random audit and assess for proper infection control technique during wound care rounds.	

Wingard DNS 5/15/15

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F 441	Continued From page 10 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure staff followed acceptable infection control practices during 1 of 2 observed dressing change procedures which affected resident #9. The findings were: 1. Review of the 3/11/15 admission MDS assessment showed resident #9 had wounds to their bilateral lower extremities and had diagnoses that included chronic pain, edema, and anxiety. Observation on 4/20/15 at 4:00 PM showed the resident had personal protective equipment available for staff to use for	F 441	Systemic Changes: Infection Control Nurse/ designee will educate appropriate nursing staff on infection control as it relates to wound care. In-service scheduled for 5/20/15 and 5/21/15. Monitoring: Infection control Nurse/ designee will monitor for appropriate infection control practices during wound cares weekly. Results will be taken to QA and reviewed for monthly trends until a lesser frequency has been deemed appropriate.	05/30/2015

Wingard DNS 6/16/15

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION - RAWLINS	542 16TH STREET RAWLINS, WY 82301

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F 441	Continued From page 11	F 441		

precautions when providing care. The following concerns were identified:

a. Observation of a dressing change for the resident on 4/21/15 at 11:19 AM showed LPN #1 donned personal protective equipment (PPE) including a gown, face mask, and gloves prior to dressing change. Continued observation showed the LPN sprayed the wound with cleanser and then patted the area dry. The LPN then applied honey-saturated adaptic dressing to the wound bed and covered with cast batting followed by coban wrap. The nurse did not change gloves prior to applying the cast batting or coban wrap.

b. Interview with the Infection Control Nurse on 4/23/15 at 9:45 AM revealed she would expect gloves to be changed after applying the adaptic dressing and prior to applying the batting to prevent cross contamination of bacteria. Further interview revealed the resident was on contact isolation precautions for cellulitis that was positive for Pseudomonas and precautions had not been removed at that time because of a pending culture of the wound.

5/15/15