POC accepted 3/6/09 JC

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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
	535031	A. BUILDING ______ B. WING ______	C 02/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER HEALTHCARE & REHABI	1002 FOREST DRIVE RIVERTON, WY 82501

(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 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure comprehensive assessments were completed in a variety of areas related to the Minimum Data	F 272	*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.* F272 Comprehensive Assessments This will be met as evidenced by: 1. RN's will complete the following: A comprehensive pain assessment on Resident #19. A comprehensive delirium assessment on Resident #6. A comprehensive delirium assessment on Resident # 76. A comprehensive psychotropic medication assessment on Resident #65. Appropriate assessments will be completed for these residents on a routine basis per state and facility requirements. 2. RN's will complete required assessments on all residents utilizing the MDS Schedule and facility protocols. The MDS coordinator/Designee will routinely audit all charts to assure Required comprehensive assessments are completed timely, signed and dated. 3. All nurses will be inserviced by the SDC related to accurate and timely Completion of required comprehensive assessments. Inservices will also be completed the SDC/Designee on a 1:1 basis with any nurses identified through the audit process outlined in #2 above. 4. Audit results and needed interventions will be presented to	3/21/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Exec Director (X6) DATE 02/28/09

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. Message left for Barrie Deyo, ED on 3/6/09 @ 11 Am Janeece Gorlin, OTR/L

RECEIVED
Wyoming Dept of Health
FEB 28 2009
Office of Healthcare Licensing and Surveys

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F 272	Continued From page 1 Set (MDS) assessments for 4 (#6, #19, #65, #76) of 13 sample residents. The findings were: 1. Observation on 2/3/09 at 6:55 AM revealed resident #19 told certified nurse aide (CNA) #4 that s/he "hurt all over." Review of the 7/7/08 admission Minimum Data Set (MDS) assessment showed the resident had moderate pain (less than daily). Review of the medical record revealed the only pain assessment was an undated, incomplete assessment. During an interview on 2/4/09 at 2:30 PM, the director of nursing (DON) stated there was no comprehensive assessment for pain. 2. Review of the 3/25/08 significant change MDS assessment (section V) for resident #6 revealed further assessment was required for delirium. Review of the attached Resident Assessment Protocol (RAP) detail report for delirium showed it was not a comprehensive assessment. Instead, "not a problem" was written. On 2/4/09 at 2:30 PM, the DON stated there was not a comprehensive assessment for delirium. 3. Review of the 1/22/09 significant change MDS assessment showed resident #76 needed further assessment for delirium. Review of the delirium RAP revealed it was not completed, it showed "addressed in other areas of the care plan." Interview with the DON on 2/4/09 at 6:05 PM confirmed there had not been an assessment done related to delirium for this resident. 4. Review of the 6/26/08 annual MDS assessment and 12/11/08 quarterly MDS assessment showed resident #65 received a daily antianxiety medication. Review of physician's orders showed the medication was first ordered	F 272	*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.* Continued from Page 1 F 272 Comprehensive Asessments This will be met as evidenced by: The Performance Improvement Committee for review and further interventions if indicated.	3/21/09

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F 272	Continued From page 2 for the resident on 5/29/08. Review of the entire medical record revealed, and interview with the MDS coordinator on 2/5/09 at 9:06 AM confirmed, the facility had not completed a comprehensive assessment for psychotropic medications.	F 272	*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 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure nutrition assessments were completed by the qualified professional for 7 (#6, #9, #15, #19, #20, #64, #76) of 7 sample residents who required a nutrition assessment. The findings were: 1. Interview with the DON on 2/4/09 at 6:05 PM revealed she was not aware that it was out of the scope of practice for technical personnel, such as the certified dietary manager (CDM), to complete the nutritional assessments. 2. Interview with the CDM on 2/5/09 at 8:30 AM revealed she had "always" completed the nutrition RAP (Resident Assessment Protocol) assessments, and was not aware they needed to be completed by the RD. 3. Medical record review revealed the following concerns: a. Review of the 7/15/08 significant change Minimum Data Set (MDS) assessment showed resident #15 required an additional evaluation related to nutrition. Review of the nutrition RAP showed the assessment was completed, signed	F 281	F 281 Comprehensive Care Plans This requirement will be met as evidenced by: 1. The registered dietician will complete nutritional assessments on residents #6, #9, #15, #19, #20, #64, #76. 2. The registered dietician will be provided lists of required nutritional assessments by the Health Information Director/Designee on an ongoing basis. The registered dietician will complete those assessments in a timely manner per CMS and facility requirements. The MDS Coordinator will inservice the registered dietician regarding required nutritional assessments and the completion of same. 3. The NSM/Designee, utilizing a performance improvement review tool, will complete routine audits of charts of residents requiring nutritional assessments to assure all nutritional assessments are completed by the registered dietician as required.	3/21/09

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F 281	Continued From page 3 and dated by the CDM. Further record review showed there was no assessment made by the RD during the MDS assessment timeframe. b. Review of the 5/15/08 significant change MDS assessment showed resident #20 had significant weight loss, and required an additional evaluation related to nutrition. Review of the nutrition RAP showed the assessment was completed, signed and dated by the CDM. Further record review showed there was no assessment made by the RD during this MDS assessment timeframe. c. Review of the 1/22/09 significant change MDS assessment showed resident #76 had significant weight loss, and required an additional evaluation related to nutrition. Review of the nutrition RAP showed the assessment was completed, signed and dated by the CDM. Further record review showed there was no assessment made by the RD during this MDS assessment timeframe. d. Review of the 3/25/08 significant change MDS assessment for resident #6 revealed further assessment was required for nutritional status. Review of the attached RAP for nutritional status revealed it was completed by the CDM, and not the RD. e. Review of the 7/7/08 admission MDS assessment for resident #19 revealed further assessment for nutritional status was required. Review of the attached RAP for nutritional status showed it was completed by the CDM. Further review of the medical record showed no comprehensive assessment for nutrition completed by a registered dietitian. On 2/4/09 at 6:05 PM the DON stated there was no nutritional assessment completed by the registered dietitian. f. According to the 7/7/08 MDS assessment	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.* Continued from Page 3 F 281 Comprehensive Care Plans This requirement will be met as evidenced by: 4. Results of the Performance Improvement activities and audit tools will be presented to the Performance Improvement Committee on a quarterly basis for review and further interventions, if indicated.	3/21/09

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F 281	Continued From page 4 (section V), resident #9 required a comprehensive assessment for nutritional status. The nutritional status RAP was completed by the CDM. g. According to the 10/9/08 MDS assessment (section V), resident #64 required a comprehensive assessment for nutritional status. The nutritional status RAP was completed by the CDM. Reference: According to the 2008 Standards of Practice for Registered Dietitians in Nutrition Care, published by the American Dietetic Association, Standard 1: Nutrition Assessment, The registered dietitian (RD) uses accurate and relevant data and information to identify nutrition-related problems. Rationale: Nutrition Assessment is the first of four steps of the Nutrition Care Process. Nutrition Assessment is a systematic process of obtaining, verifying, and interpreting data in order to make decisions about the nature and cause of nutrition-related problems. It is initiated by referral and/or screening of individuals ...for nutrition risk factors. ..It provides the foundation for Nutrition Diagnosis, the second step of the Nutrition Care Process. Further, the 2008 Standards of Practice specifically state: "The RD does not delegate the nutrition care process, but may assign certain tasks for the purpose of providing the RD with needed information (e.g., screens, gathering of data and other information) or communicating with and educating patients." .	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 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309	F 309 Quality of Care This requirement will be met as evidenced by: 1. An RN will complete a comprehensive pain assessment on resident #19.	3/21/09

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F 309	Continued From page 5 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 observation, medical record review, and staff interview, the facility failed to provide timely pain management for 1 (#19) of 6 sample residents with pain. In addition, the facility failed to implement the facility's bowel protocol for one non-sample resident (#58) with documented constipation. The findings were: PAIN 1. Review of the 7/7/08 admission Minimum Data Set (MDS) assessment showed resident #19 had moderate pain less than daily. Review of the physician's orders and the medication administration record (MAR) revealed the resident was ordered Lortab 5/500 milligrams (mg) twice per day (at 9 AM and 7 PM) for pain. In addition, the resident was ordered Tylenol on a PRN (as needed) basis. The following concerns were identified: a. Review of the medical record revealed the only pain assessment was an undated, incomplete assessment. During an interview on 2/4/09 at 2:30 PM, the DON stated there was no comprehensive assessment for pain. b. Observation in the secure care unit (SCU) on 2/3/09 at 6:55 AM revealed the resident was holding his/her hands to the lower back. The resident told certified nurse aide (CNA) #4 that s/he "hurt all over." At 7 AM, the resident told the same CNA that his/her "butt" was hurting.	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.* Continued from Page 5 F 309 Quality of Care This requirement will be met as evidenced by: Based on that assessment, appropriate interventions will be put in place to assure timely pain management. C.N.A #4 will be inserviced by the DNS regarding timely reporting of resident pain concerns to the licensed charge nurse. A daily review of the 'BM List' will be done by the licensed charge nurse for resident #58. Interventions, if indicated, will be provided per facility 'Bowel and Laxative Protocols'. C.N.A's and nurses responsible for the care of Resident #58 will be inserviced on appropriate reporting, review and interventions appropriate for their individual roles. 2. Licensed nurses will be inserviced by the SDC/Designee on the required Completion of comprehensive pain assessments. All clinical staff will be inserviced by the SDC/Designee on the appropriate reporting of a resident's complaints of pain to the resident's charge nurse in a timely manner to assure effective pain management.	3/21/09

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F 309	Continued From page 6 Observation showed the CNA did not report the resident's complaints of pain to the nurse. At 8:25 AM (1 hour 30 minutes after the resident stated he/she had pain), the registered nurse (RN) #5 came back to the SCU to administer routine medications. At that time, the resident denied having pain. During an interview on 2/3/09 at 2:20 PM, RN #5 stated the CNA did not tell her the resident complained of pain. The RN stated the resident was able to verbalize when he/she was in pain, and the CNA should have reported it. On 2/3/09 at 2:35 PM, CNA #4 stated the resident did complain of pain, and she should have reported it to the nurse, but it was ..."crazy in there today." During an interview on 2/4/09 at 2:30 PM, the DON stated the CNA should have reported the pain to the nurse. BOWEL 1. Review of the facility's "Bowel and Laxative Protocol" revealed the following interventions: prunes, prune juice or natural fruit laxative for residents with no bowel movement (BM) for two days; Dulcolax Suppository or Milk of Magnesia for residents with no BM in three days; and Fleets enema for residents with no BM in four days. If no results from the Fleets enema, then a large warm water enema would be given. The following concerns were identified: a. Review of the activities of daily living (ADL) flowsheets showed the last BM resident #58 had was on 1/26/09. Review of the bowel protocol in the front of the ADL flowsheet book on 2/4/09 showed the resident had gone 8 days without a BM. No interventions were listed. Review of the medication administration records (MARs) showed no interventions were given for	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.* Continued from Page 6 F 309 Quality of Care This requirement will be met as evidenced by: All C.N.A's will be inserviced by the SDC/Designee on the completion of unit 'BM list' and ADL sheets as relates to bowel function and reporting of same to the charge nurse. All licensed nurses will be inserviced by the SDC/Designee on the daily review of residents' bowel functions and the required indicated interventions as outlined in the facility 'Bowel and Laxative' protocols. 3. A performance improvement audit tool to assess completion of pain Assessments and effective pain management through MAR review will be completed the DNS/Designee on a routine basis. A performance improvement audit tool to assure compliance with the facility 'Bowel and Laxative protocols' will be completed by the DNS/Designee on a routine basis. 4. On at least a quarterly basis, results of utilization of the PI audit tools for Pain assessment completion and pain management as well as Compliance with 'Bowel and Laxative protocols will be presented to the Performance Improvement Committee by the DNS for review and further PI interventions, if indicated.	3/21/09

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F 309	Continued From page 7 constipation. b. On 2/4/09 at 2:30 PM, registered nurse (RN) #5 (the nurse assigned to the resident) was asked when the resident last had a bowel movement. The nurse replied, "He's not on the bowel list, so in the last two days." The RN confirmed nothing had been given for constipation. c. During an interview on 2/4/09 at 6:05 PM, the DON stated the resident was independent with toileting, and she felt it was a documentation error. However, the DON stated the CNAs filled out the bowel sheet, and they should have reported it to the nurse. The DON stated staff should be following the bowel protocol. The DON further stated she assessed the resident, and there was no evidence the resident was constipated or had a fecal impaction.	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.*	
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING 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, staff interview, and review of policies and procedures, the facility failed to ensure staff provided incontinence care for 1 (#61) of 6 incontinent residents observed during the provision of perineal (incontinence) care. The findings were: Observation on 2/3/09 at 7:30 AM showed certified nurse aide (CNA) #1 assisted resident #61 into the bathroom and removed the resident's	F 312	F 312 Activities of Daily Living This requirement will be met as evidenced by: 1. Resident #61 will routinely receive appropriate perineal care following any incontinent episode. His skin will be assessed on a routine basis to assure prophylactic care for skin breakdown, infection and odor. C.N.A. will complete inservicing and competency testing for perineal care as provided by the SDC.	3/21/09

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F 312	Continued From page 8 urine saturated brief before assisting him/her to the toilet. After the resident used the toilet, the CNA put a new brief on him/her but did not provide perineal care. Interview with the CNA on 2/3/09 at 7:50 AM revealed the CNA did not provide perineal care because the resident's agitation made it difficult for the CNA to provide the care without the assistance of another staff person. The CNA did not say why she did not ask another staff person for assistance. Interview with the DON on 2/4/09 at 2:55 PM revealed staff were expected to provide perineal care after each incontinent episode and if the task required more than one staff person, the staff had been trained to ask for additional staff assistance. Review of the facility's 2007 policy and procedure related to perineal care revealed perineal care was to be performed "to prevent infection, skin breakdown and odor."	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.* Continued from Page 8 F 312 Activities of Daily Living This requirement will be met as evidenced by: 2. All C.N.A.'s will be inserviced by the SDC on the completion of perineal care per facility policies and protocols. Weekly skin assessments will be completed by licensed nurses as well as daily skin review by C.N.A's to assure perineal care is given to maintain maximal skin health. 3. Performance improvement audit tools will be utilized on a routine basis by the DNS/Designee to assure skin assessments and reviews are completed as an indicator of the provision of appropriate perineal care to residents. Random competency reviews of C.N.A.'s providing perineal care to residents will be completed by the SDC/Designee with additional training provided if indicated. 4. Results of performance improvement monitoring tools will be presented to The Performance Improvement Committee by the DNS for review and further interventions, if indicated.	3/21/09