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 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	**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 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 12/20/18 to 12/21/18. The survey was prompted by complaint intake WY00002752. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CNA- Certified Nurse Aide DON- Director of Nursing Services LPN- Licensed Practical Nurse MAR- Medication Administration Record MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and hospital record review, the facility failed to ensure pain associated with a change in condition was treated effectively for 1 of 5 sample residents (#2) with a change in condition. This failure resulted in harm to resident #2, whose pain was not assessed or treated for an extended period of	F 697	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Wind River Rehabilitation and Wellness Center does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts, or	1/17/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/17/2019

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F 697	Continued From page 1 time. The resident was transferred out to the hospital and found to have hip and clavicle fractures. The findings were: Review of the 12/5/18 quarterly MDS assessment showed resident #2 required supervision for bed mobility, transfer, and locomotion on and off the unit. The resident required limited assistance for walking in room and extensive assistance with dressing and toileting. According to this MDS assessment the resident's brief interview for mental status (BIMS) score was not completed; however, on the 9/18/18 annual MDS assessment the resident was cognitively intact with a BIMS score of 15/15. Review of the interdisciplinary team (IDT) note dated 12/17/18 at 8:43 AM showed the resident had an unwitnessed fall in his/her bathroom on 12/16/18 at 6:07 PM. The resident reported falling onto his/her right side while attempting to close the door. The 12/16/18 timed at 7:07 PM nursing note showed the resident was alert and able to make needs known, and was moving all extremities. The resident was assisted to bed with assist of 2, "stance was weak and had unsteady balance." There was no mention of pain in the note, there were injuries which included a skin tear to the right elbow, and abrasion to the right ear, and a bump to the right upper side of the head. The physician and family were notified and neurological (neuro) checks were initiated. Review of a 12/16/18 pain evaluation timed at 6:29 PM showed the resident was interviewable and denied any pain or discomfort. Review of the neuro checks showed they were within normal limits. The following concerns were identified: a. Review of the 12/17/18 timed at 6:53 AM nursing notes showed, "...Complained of pain on right leg. Administered pain medication with	F 697	conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. Corrective Actions: Resident #2 has been discharged from the facility. Immediate review of Pain Monitoring for all residents via pain audit via interview and observation. It was noted that Residents and families were satisfied with their Pain regiment. This was conducted by RCM and DNS on 1/10/19 and again on 1/17/19. Licensed nursing staff was immediately educated by SDC on 12/27/18 regarding the documentation requirements when administering pain interventions to include follow up for its effectiveness. Licensed Nursing staff were given intensive re-education on 1/15-16/2019, which included documentation expectations and new tracking tool for each shift regarding pain monitoring and PRN medications by DNS. LPN #1 and LPN #2 were given Intensive training on Pain Policy and Procedure and will be meeting weekly with the DNS for on-going monitoring. Identification of Others Residents were observed for Pain by ECR rounds on 1/15-16/2019 any unsatisfied with their pain management were addressed.	

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F 697	Continued From page 2 expected outcomes. Neuro checks continued and is WNL [within normal limits]. Resident didn't sleep well last noc [night]. Will continue to monitor for changes." b. Review of the December 2018 MAR showed an order for acetaminophen tablet 325 mg, give 2 tabs by mouth every 6 hours as needed for chronic pain. This pain medication was administered on 12/17/18 at 5:30 AM. There was no documentation to show the pain level or the effectiveness of the medication was assessed. The MAR showed no additional dates or times when pain medication was administered. c. Review of the resident's functional performance record for December 2018 showed the resident declined in bed mobility, transfers, ambulation, and locomotion after the fall on 12/16/18. The resident had been supervision or limited assistance in these areas and declined to extensive assistance beginning on 12/17/18. d. Interview with CNA #1 on 12/21/18 at 9:53 AM verified he worked with the resident on 12/17/18 during the day shift (6 AM to 6 PM) and the resident was up and was able to transfer to the toilet, and had gotten up for the noon meal. The CNA stated the resident required more help than usual, and had no complaints of pain. e. Interview with CNA #2 on 12/21/18 at 10:05 AM revealed she had worked with the resident on 12/18/18 during the day shift (6 AM to 2 PM). She recalled the resident required extensive assistance and was "sore from falling" but she did not remember specific complaints of pain. f. Interview with LPN #1 on 12/20/18 at 6:27 PM revealed she had cared for the resident the night shift (6 PM to 6:30 AM) on 12/17/18 to 12/18/18. She recalled helping the aides provide care to the resident in bed at approximately 5:30 AM on 12/18/18, and the resident stated s/he	F 697	Systemic Changes The pain subcommittee IDT reviewed and made recommendation for those residents stating they have moderate to severe pain upon admission, MDS assessments, and per nurse's referral to review. The subcommittee will meet weekly to review and implement interventions for pain relief as needed for those residents identified to be at risk. Licensed nurses were re-educated on the facility pain management policy and procedure and shift report documentation on 1/15-16/19 by DNS. Monitoring for Compliance Pain Audits have been completed by RCM, and DNS on 1/10/19; 1/16/19 and will continue weekly. Shift to shift report documentation will be monitored daily by IDT at the clinical meeting, starting January 17th, 2019. Results of the audits will be brought to the Monthly QAPI meeting for review, recommendations and need for ongoing monitoring. An Ad Hoc QAPI meeting was held on January 15th, 2018 to discuss this POC and it adaptation.	

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"hurt really bad, a 10 out of 10" the nurse stated when she raised the resident's right foot slightly off the bed s/he "screamed out in pain." The nurse also revealed she saw noticeable bruising to the right leg and shoulder area. The nurse stated she had not documented this; however, she passed it onto the oncoming day shift nurse. She further stated the resident was treated for the pain at 5:30 AM, however, review of the December 2018 MAR showed no evidence pain medication was administered on 12/18/18.

g. Interview with LPN #2 on 12/21/18 at 9:35 AM revealed she was made aware on the morning of 12/18/18 the resident had a "bad night." She stated after breakfast around 9 AM the resident was complaining of pain saying his/her leg hurt. She also stated she saw the bruising at that time. However, the LPN confirmed she had not documented a pain assessment or administered any pain medication. Review of the 12/18/18 timed at 12:08 PM nurses note showed LPN #2 documented "resident c/o [complaint of] right leg and knee pain purplish discoloration on back of leg...requested an order for x-ray of hip and leg..." The next note dated 12/18/18 at 1:15 PM showed LPN #2 documented the resident was up for lunch and was having difficulty eating. The note showed the resident voiced moving the arm in upright position hurt, and there were "multi purple discoloration around the shoulder area."

h. Interview with the DON on 12/21/18 at 8:36 AM verified the resident was experiencing pain on the morning of 12/18/18. The DON stated she was made aware the resident was having a change in condition and LPN #2 was requesting to have the resident sent out for x-rays. The DON completed the change in condition assessment. She confirmed there was no evidence in the medical record to show an assessment of the

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resident's pain level, or any pain treatment was provided after 12/17/18 at 5:30 AM.

i. Review of the DON's note dated 12/18/18 timed at 1:04 PM showed she was informed of the x-ray results which showed "abnormality in Right Hip." Orders were received to transfer the resident to the hospital of the family's choice in a nearby town for further evaluation.

j. Review of the hospital record physician note dated 12/18/18 at 3:40 PM showed the resident had complaints of pain in the right hip and was not able to ambulate or bear weight.

k. Review of the hospital radiology report dated 12/18/18 showed 2 views of the right shoulder revealed a clavicle fracture with minimal displacement.

l. Review of the hospital nurse's notes dated 12/18/18 at 6:55 PM showed the resident was transferred to another hospital for orthopedic services.

m. Review of the receiving hospital's physician notes/assessment on 12/18/18 at 10:49 PM showed the resident was admitted to the intensive care unit (ICU) with diagnoses of Septic shock, secondary to urinary tract infection, right sided hip fracture, acute kidney injury, and right-sided clavicular fracture.