Hand delivered 12/12/11 KM

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

PRINTED: 12/02/2011
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
	535032	A. BUILDING _____ B. WING _____	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	1330 PRAIRIE AVENUE CHEYENNE, WY 82009

(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 MAR-Medication Administration Record MDS- Minimum Data Set RN-Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 272 SS=E	483.20(b)(1) 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 resident assessment instrument (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;	F 272	F272 Comprehensive Assessments: The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. A) Director of Nursing and/or designee has addressed the CAAs for residents #7, 54, 55, 57, 65 to ensure that the assessments are comprehensive, accurate, standardized, and reproducible. B) The Director of Nursing or designee will conduct random audits of other resident CAAs to ensure they meet the guidelines. If any problems are identified they will be immediately corrected.	12/28/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 12/12/11

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.

Accepted 12/14/11 by

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F 272	Continued From page 1 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the MDS requirements, the facility failed to ensure comprehensive assessments were completed in a variety of areas for 5 of 20 sample residents (#7, #54, #55, #57, #65). The findings were: 1. Review of the 3/2/11 significant change MDS assessment for resident #7 showed s/he required a comprehensive assessment in the following areas: cognitive loss, communication, psychological well-being, and psychotropic drug use. Review of the 3/7/11 care area assessment (CAA) for these areas showed they failed to include sufficient information and analysis to develop measurable goals and meaningful approaches on the resident's care plan. 2. Review of the 2/21/11 significant change MDS assessment for resident #54 showed s/he required a comprehensive assessment in the	F 272	C) The Director of Nursing will conduct in-services for MDS Coordinators, Social Services, Dietary, and Activities staff regarding the development of CAAs according to the guidelines. D) A Performance Improvement audit tool will be utilized for random audits. Any problems identified will be corrected and immediate education and/or corrective action will take place. The audits will be completed by the Director of Nursing or MDS Coordinators. E) The Director of Nursing will report results of these audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. This will occur for a period of no less than three months or until ongoing compliance has been achieved.	

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F 272	Continued From page 2 following areas: communication, dehydration, psychotropic drug use, and mood state. Review of the 2/22/11 CAA for these areas showed they failed to include sufficient information and analysis to develop measurable goals and meaningful approaches on the resident's care plan. 3. Review of the 3/25/11 admission MDS assessment for resident #55 showed s/he required a comprehensive assessment in the following areas: cognitive loss, activities of daily living (ADL) function, urine incontinence, mood state, falls and nutrition. Review of the 3/28/11 CAA for these areas showed they failed to include sufficient information and analysis to develop measurable goals and meaningful approaches on the resident's care plan. 4. Review of the 2/16/11 admission MDS assessment for resident #57 showed s/he required a comprehensive assessment in the following areas: ADL function, psychosocial well-being, falls, nutrition and psychotropic drug use. Review of the 2/18/11 CAA for these areas showed they failed to include sufficient information and analysis to develop measurable goals and meaningful approaches on the resident's care plan. 5. Review of the 11/26/10 annual MDS assessment for resident #65 showed s/he required a comprehensive assessment for cognition, visual function, communication, ADL function and urinary incontinence. Review of the 11/28/10 CAA for these areas showed they failed to include sufficient information and analysis to develop measurable goals and meaningful	F 272		

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F 272	Continued From page 3 approaches on the resident's care plan. 6. Interview with the MDS coordinator and DON on 11/17/11 at 8:10 AM confirmed the assessments were not comprehensive.	F 272		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to develop a comprehensive care plan for 5 of 9 sample residents (#34, #42, #57, #76, #131) who required a care plan for various areas. The findings were:	F 279	F279 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's highest practicable physical, mental, and psychosocial well-being. A) The Director of Nursing will readdress the Care Plans for residents #34, 42, 57, 76, 131 to ensure that a comprehensive care plan has been developed in those various areas. B) The Director of Nursing and/or designee will conduct random audits of other residents' care plans to ensure that comprehensive care plans have been developed and are being revised appropriately. C) The Director of Nursing will conduct an in-service with nursing, social service, dietary, and activity staff that review and revise care plans on ensuring they are developed and completed appropriately. D) A Performance Improvement audit tool will be utilized for	12/28/11

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F 279	Continued From page 4 1. Review of the 4/3/11 significant change MDS assessment, section V, for resident #34 showed s/he required development of a care plan in regard to psychotropic medications. However, review of the 8/11/11 care plan showed the only reference to the antidepressant the resident received was "Administer Remeron for depression/insomnia per MD [physician] order." There was no evidence care plan interventions included monitoring the resident for side effects or adverse reactions. 2. Review of the 10/27/11 significant change MDS assessment, section V, for resident #42 showed a care plan would be developed for psychotropic medications. Review of the 10/31/11 care plan, however, showed no evidence the antidepressant should be monitored for side effects or adverse reactions. The only intervention addressing psychotropic medications was "administer Celexa for diagnosis of Depression as ordered by MD....Administer Ativan for diagnosis of Anxiety as ordered by MD...Administer Risperdal as ordered by MD." 3. Review of the 11/4/11 quarterly MDS assessment for resident #57 showed the resident was frequently incontinent of urine. Review of the resident's care plan last reviewed 5/15/11 showed there was no plan of care for incontinence. 4. Review of the 10/31/11 significant change MDS assessment, section V, for resident #76 revealed s/he required development of a care plan for psychotropic medications. Review of the 10/31/11 care plan showed the only intervention noted in the care plan was "Administer Prozac as	F 279	random audits. Any problems identified will result in immediate education and/or corrective action will take place. The audits will be completed by the Director of Nursing and MDS Coordinators. E) The Director of Nursing will report the results of these audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. This will occur for a period of three months or until ongoing compliance has been achieved.	

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F 279	Continued From page 5 ordered by MD for diagnosis of Depression." 5. Review of the 10/25/11 admission MDS assessment, section V, for resident #131 showed a care plan should be developed for psychotropic medications. However, review of the interventions on the 10/28/11 care plan showed the only reference to the antidepressant was "Administer Effexor as ordered for [resident's name] diagnosis of depression." 6. Interview with the DON on 11/17/11 at 2:30 PM revealed he thought the information on the care plans was adequate.	F 279		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, product label review, and review of sanitizer and maintenance log information, the facility failed to ensure kitchen surfaces were effectively sanitized. In addition, the facility failed to ensure food equipment was cleaned at a frequency to avoid build-up of dried food and other residue. The findings were:	F 371	F371 Food Procure, Store/Prepare/Serve – Sanitary: The facility must Procure food from sources approved or considered satisfactory by federal, state, or local authorities and store, prepare, distribute and serve food under sanitary conditions. A) Sanitizing solution with a concentration of 200-400 parts per million is being used to sanitize all kitchen surfaces. The can opener near the preparation sink was cleaned and sanitized on 11/16/11. The ice machine located in the kitchen was cleaned and sanitized on 11/16/11.	12/28/11

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F 371	Continued From page 6 1. Observation on 11/16/11 at 4 PM showed cook #1 assisted cook #2 to prepare pureed food. On the counter where the two cooks were working was a sanitizer bucket that contained a wet towel but no visible liquid. Cook #2 used the wet towel from the bucket to wipe down the counter. Interview with the dietary manager at that time revealed the bucket should be filled with a sanitizer solution. According to Food Code 2009, U.S. Public Health Service, 4-702.11: "Before Use After Cleaning. UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT shall be SANITIZED before use after cleaning." According to Food Code 2009, U.S. Public Health Service, 3-304.14: "(B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114;" 2. Review of the product label for the "Oasis 146 multi- quat" sanitizer showed a concentration of 200-400 parts per million (ppm) was needed to sanitize surfaces. Observation on 11/17/11 at 7:45 AM revealed, when tested with quaternary sanitizer testing strips, the concentration of chemical in the three compartment sink and two sanitizer buckets in the preparation areas were not adequate. The test strips showed the concentration was less than 100 ppm. Interview with the dietary manager at that time revealed he was not aware the required concentration to effectively sanitize needed to be 200 ppm. Review of the November 2011 logs for testing the sanitizer in the two preparation buckets showed each day it was tested seven times, and each time it was recorded to be 100 ppm. Interview	F 371	B) Weekly audits will occur to ensure that the correct sanitizing solution is being used and that the can opener and ice machine are clean to sight and touch. C) A Performance Improvement audit tool will be utilized for weekly audits. Any problems identified will result in immediate staff education and/or corrective action. The Dietary Manager will conduct the weekly audits. D) The Dietary Manager and/or designee will conduct an in-service regarding the correct concentration of sanitizing solution and cleanliness of food-contact surfaces and utensils. E) The Dietary Manager will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for a period of no less than three months or until ongoing compliance has been achieved.	

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F 371	Continued From page 7 with the dietary manager on 11/17/11 at 8:08 AM revealed about thirty days prior, they changed to a new company and had not followed the requirements of the new product being used. According to Food Code 2009, U.S. Public Health Service, 4-702.11: "Before Use After Cleaning. UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT shall be SANITIZED before use after cleaning." According to Food Code 2009, U.S. Public Health Service, 3-304.14: "(B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114;" 3. Observation on 11/16/11 at 3:35 PM showed the can opener mounted to the counter near the preparation sink was not clean. There was a build up of dried food located on the blade. Observation the next morning at 8 AM showed the blade remained uncleaned. Interview with the dietary manager on 11/17/11 at 10 AM revealed the can opener was cleaned at least once per week. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 4. Observation on 11/16/11 at 3:38 PM showed the ice machine located in the kitchen was in need of cleaning and sanitizing. There was a pinkish substance which had built up on the white plastic part where the ice dropped down into the bin. Interview with the dietary manager and the administrator on 11/17/11 at 10 AM revealed the	F 371		

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F 371	Continued From page 8 maintenance department cleaned and sanitized the machine on a routine schedule. Review of the maintenance log showed it was last visually inspected on 11/1/11 and had most recently been cleaned and sanitized on 9/15/11. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch... (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371		12/28/11
F 441 SS=E	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, 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	F 441	F441 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) Virex 256 is being applied to hard nonporous surfaces and being allowed to remain wet for ten minutes. Glucometers are being cleaned with ammonia-based Sani-wipes between use. Infection control nurse has investigated the source of resident #54's upper respiratory track infection. Staff is wearing masks appropriately while on shift. B) The Director of Nursing and/or designee will conduct weekly audits to ensure Virex 256 is used appropriately, glucometers are being cleaned with the appropriate wipes, infections are being	

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F 441	Continued From page 9 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, staff interview, manufacturer representative interview, review of nationally recognized standards for infection control, and review of written manufacturer's recommendations, the facility failed to effectively disinfect resident care equipment during three random observations. In addition, the facility failed to adequately investigate one resident's infection (#54) to determine causative factors and implement preventive measures. Finally, the facility failed to ensure two employees who wore personal protective equipment (activities aide #1, cook #2) were monitored related to possible spread of infection. The findings were: With regard to cleaning equipment: 1. Review of the medical record for resident #54 showed s/he had Methicillin Resistant Staphylococcus Aureus (MRSA) cultured from a buttocks wound on 3/11/11. During an observation on 11/17/11 at 8:40 AM, restorative aide #1 placed the resident in a shower chair to	F 441	investigated, and ill staff is wearing masks appropriately. C) Director of Nursing and/or Infection Control Nurse will conduct an in-service regarding the appropriate use of Virex 256, importance of infection investigation and use of masks. All licensed nursing staff was in-serviced on 11/19/11 regarding the use of ammonia-based Sani-wipes between resident use. D) A Performance Improvement audit tool will be utilized for weekly audits. Any problems will be corrected and immediate education and/or corrective action will take place. The audits will be conducted by Director of Nursing and/or designee. E) The Director of Nursing and/or Infection Control Nurse will report results of these audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. This will occur for a period of no less than three months or until ongoing compliance has been achieved.	

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F 441	Continued From page 10	F 441		

transfer the resident to the shower room located by the nurses' station on the 200 hall. The shower chair was framed with plastic tubing, and a porous netting was attached as a seat and back support. Just before the transfer, RN #1 removed a dressing from the resident's buttock wound. A rolled up towel was placed between the resident's wound and the shower chair. During the observation, as the resident received a shower in the chair, the resident's wound oozed bloody drainage on the towel, over the chair (including the porous netting), and onto the shower floor. The aide then placed another towel under the resident to prevent further contamination. After the resident was transported to his/her room in the shower chair, the chair was brought back to the shower room, and the aide sprayed the chair and shower area with a disinfectant cleaner (Virex 256). Within one minute, the aide washed the disinfectant off with water from the shower hose. When asked at that time concerning the appropriate method to disinfect equipment, the aide said she should follow the manufacturer's instructions; then she read the manufacturer's label for use on the Virex 256 bottle. The following concerns with disinfection of the shower area and shower chair were noted:

a. Review of the manufacturer's instruction for use, located on the bottle, showed that Virex 256 should be applied to "hard nonporous surfaces" and allowed to remain wet for ten minutes, then wiped dry or allowed to air dry. During a phone interview on 11/18/11 at 10 AM with a manufacturer's representative, she stated that Virex 256 was not effective for MRSA unless the disinfectant remained on a "hard nonporous surface for ten minutes".

b. During an interview with the DON and

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F 441	Continued From page 11 infection control coordinator (ICC) on 11/17/11 at 1 PM they produced the facility's infection control log, which showed resident #54 had a current MRSA infection in his/her wound. They confirmed that the facility expectation was for staff to follow the manufacturer's instructions when using disinfection solution. 2. According to recently released guidance by the Food and Drug Administration at http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/InVitroDiagnostics/ucm227935.htm (accessed 9/29/11) for cleaning and disinfecting of blood glucose meters, "...The disinfection solvent you choose should be effective against HIV, Hepatitis C, and Hepatitis B virus." Further, "Please note the 70% ethanol solutions are not effective against viral bloodborne pathogens." The following concerns regarding disinfection of glucometers were noted: a. During a random observation on 11/14/11 at 4:45 PM, licensed practical nurse #1 cleaned the 500 hall medicine cart glucometer with alcohol (not effective against viral bloodborne pathogens) before and after she used the glucometer for resident #132. The nurse confirmed at that time that each medicine cart had a single glucometer available to use for multiple residents. b. An observation on 11/15/11 at 11:25 AM showed RN #2 did a blood glucose test on non-sample resident #52. Immediately after the test was complete, the nurse cleaned the glucometer with an alcohol wipe instead of an effective disinfectant. c. During an interview with the DON and ICC on 11/17/11 at 1 PM, they confirmed that staff were trained to use Sani-Wipes (ammonia based)	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING _____ B. WING _____	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 12 to clean glucometers. After the interview a copy of that training, dated 11/17/11, was provided. With regard to infection control program analysis: Review of the medical record for resident #54 showed s/he had diagnoses which included muscular atrophy and multiple sclerosis. Further review revealed the resident had a positive culture on 10/28/11 for Escherichia Coli of the tongue. Periodic observations during the survey from 11/14/11 through 11/17/11 showed the resident utilized an oral nursing call light due to inability to use his/her arms or hands bilaterally. Use of the call light required the resident to put his/her mouth over the straw-like endpiece. During an interview with the DON and ICC on 11/17/11 at 1 PM, they were aware that the resident had a tongue infection diagnosed on 10/28/11. However, the DON revealed that the facility failed to investigate the resident's infection for the source, and did not consider the resident's call light. He also confirmed that the facility failed to place the resident's call light on a cleaning list, and he could not be certain if it had ever been cleaned since use. With regard to staff illness: During an observation on 11/16/11 at 11:35 AM, activities aide #1 pushed a resident via wheelchair to the main dining area. The aide was wearing a mask and was coughing. The mask covered the aide's mouth, but not her nose. During an interview at that time, she stated that she had been coughing intermittently for several days and did not want to expose residents or	F 441		

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F 441	Continued From page 13 staff. During an observation on 11/16/11 at 1:25 PM, cook #2 pushed a food cart to the nurses' station by the 200 hall. He was wearing a mask that covered his mouth, but not his nose. During an interview at that time, the cook lowered the mask below the mouth and stated that he had a sore throat. During an interview with the DON and ICC on 11/17/11 at 1 PM, both confirmed they were aware that the activities aide had a cough, but were unaware that the cook had a sore throat. They both confirmed that the correct way to wear a respiratory mask is over the mouth and nose, and not to lower it.	F 441		