

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 02/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/20/2012
NAME OF PROVIDER OR SUPPLIER CHEYENNE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 E 12TH STREET 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 MAR- Medication Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and/or execution of the response and plan of correction do 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 the provisions of federal and state law require it.		
F 225 SS-E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	F225 It is the practice of the facility to ensure that all alleged violations are thoroughly investigated and to prevent further potential abuse while the investigation is in progress and to further check beyond the background all abuse registries in which the C.N.A may have obtained the license. Corrective Action: The abuse screening registration has been completed thru the Office of Healthcare Licensing and Survey for the following: C.N.A #1 completed 1/17/12, C.N.A #2 completed on 1/17/12, C.N.A #4 completed on 1/17/12, C.N.A #5 completed on 1/17/12. Identification of Others: Current employed Certified Nursing Assistant files will be audited by the Human Resource Director/Designee for verification of registration of abuse screening with the Office of Healthcare Licensing and survey Any Certified Nursing Assistants not registered will become registered. System Measures:		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Jennifer Reaume

NHA

2/23/12

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.

HEALTHCARE LICENSING
and Surveys

Event ID: CNYV11

Facility ID: WY0006

If continuation sheet Page 2 of 24

HEALTHCARE LICENSING
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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on employee record review and staff interview, the facility failed to verify information with the CNA registry in a timely manner for 4 of 5 CNAs reviewed (CNAs #1, #2, #4, #5). The findings were: Review of employee records showed the following concerns: a. CNA #1 was issued a CNA licensure on 8/11/11. The aide had a date of hire and first resident contact of 9/9/11. However, the facility did not check the state CNA registry until 1/17/12. b. CNA #2 was issued a CNA licensure on 4/7/11. The aide had a date of hire and first resident contact of 11/18/11. However, the facility did not check the state CNA registry until 1/17/12. c. CNA #4 was issued a CNA licensure on 7/16/09. The aide had a date of hire and first resident contact of 8/22/11. However, the facility did not check the state CNA registry until 1/17/12. d. CNA #5 was issued a CNA licensure on	F 225	Newly hired Certified Nursing Assistants will have registration for Abuse screening verified by the Human Resource Director/Designee upon employment. Monitor: Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by Human Resource Director/Designee. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months. Date of Compliance F241 The facility must promote care for residents in a manner and in an environment that maintain or enhances each resident's dignity and respect in full recognition of his or her individuality. Corrective Action: Resident #83 is being provided incontinence care timely. Identification of Others: An audit of residents requiring assistance with incontinence care will be conducted utilizing the facilities care tracker system. NHA/designee will conduct random interviews of residents who utilize the call light system and review responses.	2/28/2012	

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F 225	Continued From page 2 6/5/97. The aide had a date of hire and resident contact of 10/8/11. However, the facility did not check the state CNA registry until 1/17/12. e. During an interview with the human resource coordinator on 1/20/12 at 9:50 AM, she confirmed the state CNA registry was checked for the four aides on 1/17/12, but the registry should have been checked upon hire.	F 225	System Measures: Staff will be educated by the Staff Development Coordinator (SDC)/designee on or before February 28, 2012 regarding dignity and respect to include timely incontinence care, answering call lights and offering fluids.		
F 241 SS-D	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, and staff and resident interview, the facility failed to ensure personal dignity was maintained for 1 of 16 sample residents (#83). The findings were: Observation on 1/17/12 at 4:18 PM showed resident #83 turned on the call light. At 4:30 PM, LPN #1 entered the resident's room and turned the call light off. Interview with the resident at that time revealed his/her sweat pants were wet and s/he needed clean, dry clothes. Observation at the same time showed the resident's sweat pants were soaked through with urine and the resident was visibly upset. Continued observation showed the resident's call light was again turned on at 4:32 PM and at 4:44 PM CNA #1 entered the resident's room. She also turned off the call light then left without providing care to the resident. At 4:47 PM the resident put the call light on a third	F 241	NHA/designee will meet with a group of residents weekly for four weeks then monthly and review call light response and input and plan. DON/designee will round the units 5 to 7 times per week to view dignity and care of residents. Monitor: Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by Director of Nursing/Designee. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months. Date of Compliance: F274 A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined that there has been a significant change in the resident's physical or mental condition. (For the purpose of this section, a significant		2/28/12

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F 241	Continued From page 3 time and at 4:50 PM CNA #2 answered the resident's call light and provided incontinence care as the resident had requested at 4:18 PM, 32 minutes earlier.	F 241	change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease - related clinical interventions, that has an impact on one or more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan or both).		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure a significant change MDS assessment was completed for 1 of 4 sample residents (#60) who required that type of assessment. The findings were: Observation on 1/17/12 at 3:15 PM showed resident #60 had bilateral hand and foot contractures. During that observation, the resident was transferred by CNAs #4 and CNA #5 with the use of a transfer belt. Review of the resident's medical record showed s/he had	F 274	clinical interventions, that has an impact on one or more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan or both). Corrective Action: Resident #60's health status has been reviewed by the interdisciplinary team and a significant change of condition assessment has been completed with an ARD of 1/26/2012. Identification of Others: An audit has been conducted of the facility to determine if a significant change of status assessment was indicate, those identified, significant change in status assessment ARD to be set before 2/28/12. System Measures: The Interdisciplinary team will be educated on or before 2/28/2012 regarding identification and review of residents with significant changes of condition conducted by the Regional Care Management Coordinator/Designee. The MDS assessment calendar will be reviewed Monday through Friday in the morning business meeting and residents		

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F 274	Continued From page 4 diagnoses that included muscular weakness. Review of the resident's 4/2/11 annual MDS assessment showed the resident had impairment to one side of the upper extremities, and no impairment to the lower extremities. The assessment also showed the resident required limited assistance of one staff member for walking in his/her room. However, review of a 6/30/11 physician history and physical showed the resident had fingers on both hands that were very contracted with limited mobility. Also, review of the resident's 11/17/11 quarterly MDS assessment showed the resident had bilateral impairment to the lower extremities, and that no walking took place. During an interview on 1/20/12 at 9 AM with the MDS coordinator and RN #4, they stated the facility failed to complete a significant change MDS assessment for resident #60. They further stated that the facility should have completed a significant change assessment for the resident on or around 5/12/11 due to his/her decline in range of motion and loss of ability to ambulate at that time.	F 274	will be reviewed for significant change of condition via discussion. Any resident identified as needing a significant change of status assessment completed will be placed on the electronic care management board with a pending assessment reference date to ensure notification of the team. Monitor Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported to the facility QA & A committee by Resident Care Management Director/Designee. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months. Completed Date :	2/28/2012	
F 278 SS-D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the 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	F 278	The assessment must accurately reflect the resident's status. A registered nurse must conduct and 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		

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F 278	Continued From page 5 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, medical record review, and staff interview, the facility failed to ensure accuracy of the MDS assessments for 1 of 17 sample residents (#60). The findings were: Review of the medical record for resident #60 showed s/he had diagnoses which included muscular weakness. Review of the 11/17/11 quarterly MDS assessment for the resident showed s/he had no upper extremity limitation in range of motion. However, review of a 6/30/11 physician history and physical showed the resident had fingers on both hands that were very contracted with limited mobility. Observations from 1/17/12 through 1/20/12 showed the resident had contractures of both hands. During an interview with the MDS coordinator and RN #4 on 1/20/12 at 9 AM, they verified the MDS assessment was inaccurately coded, and the	F 278	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. Corrective Action: Resident #60's health status has been reviewed by the interdisciplinary team and a significant change of condition assessment has been completed with an ARD of 1/26/12. The assessment will be an accurate reflection of the resident's current status. Identification of Others: An audit has been conducted of the facility to determine if a significant change of status assessment was indicated. The audit will also include any inconsistencies in coding of the MDS assessment. Any inconsistencies or inaccurate coding found will have a modification completed to accurately reflect the resident. System Measures: The interdisciplinary team will be educated on or before 2/28/2012 regarding identification and review of residents with significant changes of condition as well as coding an assessment accurately conducted by the Regional Care Management Coordinator/Designee.		

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F 278	Continued From page 6	F 278	The MDS assessment calendar will be reviewed Monday through Friday in the morning business meeting and residents will be reviewed for significant change of condition. This allow for the interdisciplinary team to review current status of residents to apply to the MDS assessment.		
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 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 1 of 19 sample residents (#80). The findings were: Review of the contractures care plan for resident #80, last updated on 11/15/11, showed s/he had a contracture of the right hand. The plan called	F 280	A draft form of the MDS assessment will be brought to morning business meeting for the interdisciplinary team to review for coding and accuracy by initialing prior to locked completion of the assessment. Monitor: Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by Resident Care Management Director/Designee. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months. Completed Date		2/28/2012
			F280 The resident has the right unless adjudged incompetent or otherwise found to be incapacitated under the Laws of the State, to participate in planning of care and treatment or changes in care and treatment.		

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F 280	Continued From page 7 for notification of the physician if the resident experienced a decline in range of motion (ROM). Also, the plan referred to therapy or restorative as needed, and required staff to apply splints as ordered. The following concerns were noted: a. Observations from 1/17/12 through 1/20/12 showed resident #80 had contractures of hands and feet bilaterally, and revealed the resident was not wearing splints. b. Interview with occupational therapist #1 on 1/18/12 at 1:45 PM revealed the resident was hospitalized on 3/4/11 for weakness, dysphagia, and pneumonia. S/he receive occupational therapy for ROM to the extremities upon return to the facility on 3/11/11 until 8/16/11. The resident refused passive ROM therapy; and therapy relied on electrical stimulation for ROM intervention instead. The resident refused splints, and refused restorative therapy after his/her physician ordered therapy to be discontinued on 8/15/11. Review of the therapy notes at that time showed documentation of the resident's refusal for splints and passive range of motion, and the physician's order to discontinue therapy. c. Interview with the MDS coordinator on 1/20/12 at 9 AM confirmed the care plan was not updated to address bilateral contractures to the resident's upper and lower extremities, or the discontinuation of splints, therapy, and restorative. She further confirmed the plan was not updated to consider possible alternatives in place of splints, therapy, and restorative services.	F 280	A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an 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 of 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. Corrective Action: Resident #60's care plan has been revised to include status of contractures as well as interventions and acceptance of those interventions. Identification of Others: An audit of residents with contractures has been conducted to determine the need for care plan revision. Any care plan found not to be updated to reflect current status of contractures and interventions will be updated. System Measures: Care plans for residents will be reviewed weekly during care conferences with residents and families following the MDS schedule by the Interdisciplinary Team for revisions necessary. Those revisions will be completed at that time.		
F 281 88-D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281			

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F 281	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff followed physician's orders regarding sliding scale insulin management for 1 (#82) of 2 sample residents on sliding scale insulin for diabetes mellitus. The findings were: Review of the 12/2/11 physician's orders for resident #82 showed an order for 7 units of Novolog insulin three times per day at 8 AM, 12 noon, and at 6 PM. The order further instructed to hold the Novolog insulin if the resident's blood sugar reading was less than 140 milligrams per deciliter (mg/dl). Review of the December 2011 MAR showed the resident received Novolog insulin two times when the blood sugar reading was less than 140 mg/dl. Review of the January 2012 MAR showed the resident was administered Novolog insulin three times when the resident's blood sugar was less than 140 mg/dl. In addition, during January 2012, the resident did not receive the ordered Novolog insulin for a blood sugar reading of 147. Interview with the DON on 1/20/12 at 12:15 PM revealed physician orders should always be followed as written and she was unsure why the above noted errors were made. According to the Wyoming Nursing Practice Act of July 2011 and the Administrative Rules and Regulations of November 2011, page 3-6, nursing must function under the direction of a licensed physician.	F 281	RCD/designee to educate the interdisciplinary team on documentation of all pertinent information on the care plans on or before 2/28/2012. DON/designee to conduct random weekly audits of care plans to ensure all pertinent information is on the care plan x 4 weeks and than random audits. Monitor: Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by Director of Nursing/Designee. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months. Completed Date F281 The services provided or arranged by the facility must meet professional standards of quality. Corrective Action: Resident #82 is receiving insulin as ordered following the physician ordered parameters for blood glucose levels. Identification of Others: Residents with parameters for blood glucose level were reviewed for appropriate follow up and intervention for any blood glucose found outside of parameters. Any noted without	2/28/2012			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309					

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(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 309	Continued From page 9 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 staff interview and medical record review, the facility failed to ensure the sliding scale insulin regimen was followed as ordered by the physician for 1 of 2 sample residents (#82) who were on sliding scale insulin for management of their diabetes mellitus. The findings were: Review of physician's orders for resident #82 showed an order dated 12/2/11 for 7 units of Novolog insulin three times per day at 8 AM, 12 noon, and at 6 PM. The order further instructed to hold the Novolog insulin if the resident's blood sugar reading was less than 140 milligrams per deciliter (mg/dl). The following concerns were identified: a. On 12/22/11 at 5 PM the resident's blood sugar was 136 mg/dl, yet the Novolog insulin was administered according to the MAR. b. On 12/23/11 at noon the resident's blood sugar was 129 mg/dl, yet s/he received Novolog insulin according to the MAR. c. On 1/3/12 at 12 noon the resident received the Novolog insulin but his/her blood sugar was 123 mg/dl. d. On 1/5/12 at 7:30 AM, the resident's blood sugar was 147 mg/dl, yet according to the MAR, the Novolog insulin was not given.	F 309	appropriate follow up were reported to the primary care physician. System Measures: An in service will be conducted by SDC/Designee for nursing staff on or before 2/28/2012, for assessment of monitoring of blood glucose parameters per physician orders. The 24 hour report will be monitored by DON/Designee as well to ensure changes in condition for example, blood glucose levels and changes, as well as any insulin order changes. DON/Designee will randomly audit residents with blood glucose parameters to include follow up, physician notification and documentation of results outside of parameters. The audit will include no less than 10 percent of residents receiving insulin. Monitor: Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by Director of Nursing/Designee. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months. Completed Date F309 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable	2/28/2012	

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F 309	Continued From page 10 e. On 1/10/12 at 12:30 PM the resident's blood sugar was 124 mg/dl and the resident received the Novolog insulin. f. On 1/11/12 at 12 noon, the resident's blood sugar was 124 mg/dl but s/he received the Novolog insulin. Interview with the DON on 1/20/12 at 12:15 PM revealed physician orders should always be followed as written and she was unsure why the above noted errors were made. She further stated the resident had no untoward outcome from any of the errors.	F 309	physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Corrective Action: Resident #82 is receiving insulin as ordered following the physician ordered parameters for blood glucose levels. Identification of Others: Residents with parameters for blood glucose level were reviewed for appropriate follow up and intervention for any blood glucose found outside of parameters. Any noted without appropriate follow up were reported to the primary care physician. System Measures: An in service will be conducted by SDC/Designee for nursing staff on or before 2/28/2012, for assessment of monitoring of blood glucose parameters per physician orders. The 24 hour report will be monitored by DON/Designee as well to ensure changes in condition for example, blood glucose levels and changes, as well as any insulin order changes. DON/Designee will randomly audit residents with blood glucose parameters to include follow up, physician notification and documentation of results outside of parameters. The audit will include no less than 10 percent of residents receiving insulin.		
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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the environment was free of safety hazards in resident rooms which involved 4 of 88 doors (rooms #111, #126, #128, #129). The findings were: During an observation on 1/20/12 from 11:15 AM through 11:45 AM, the following concerns were identified: a. The inner front door kick plate for room #111 had a 6 inch by 4 inch corner pulled away from the door, which exposed a sharp pointed	F 323	Data obtained by way of audits will be reviewed and analyzed for patterns and		

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F 323	Continued From page 11 edge. b. The outer front door kick plate for room #120 had a 23 inch by 13 inch corner pulled away from the door, which exposed a sharp pointed edge. c. The inner bathroom door kick plate for room #128 had a 6 inch by 2 inch jagged area that stuck out 1 inch from the door. d. The outer bathroom door kick plate for room #129 had an 18 inch by 12 inch corner pulled away from the door, which exposed a sharp pointed edge. e. During an interview with the maintenance director on 1/20/12 at 11:45 AM, he verified the need to repair the doors and stated he planned to do an inventory of all doors in the building. However, he confirmed the facility failed to have a written plan or specific timeframe for the repairs.	F 323	trends and reported monthly to the facility QA & A committee by Director of Nursing/Designee. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months. Completed Date:		2/28/2012
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy	F 425	F323 The facility must ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Corrective Action: Room #111 outer door kick plate has been repaired. Room #120 outer door kick plate has been repaired. Room #128 inner bathroom door kick plate has been repaired. Room #129 outer bathroom door kick plate has been repaired. Identification of Others: A facility review of all resident room doorway entrances and exits have been conducted to observe for any further doors or kick plates with sharp or jagged edges. Any found to be sharp or jagged have been repaired.		

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F 426	Continued From page 12 services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of facility policy and procedure, the facility failed to ensure residents received the correct medications and doses for 1 of 16 sample residents (#60) and 2 non-sample residents (#43, #23). The findings were: 1. Review of the medical record for resident #60 showed s/he had diagnoses which included senile dementia and depressive disorder. Further review showed a 3/9/11 physician's order for cefexa 40 mg to be administered through the residents percutaneous endoscopic gastronomy tube daily for presenile depression. The following concerns were noted: a. Review of a 9/10/11 fax to the resident's physician stated the resident had missed cefexa 40 mg for five days due to it not being available or provided by the pharmacy. The physician responded the facility should give the medication. Review of the corresponding MAR showed the resident did not receive the medication from 9/4/11 through 9/10/11 (7 days), with "not in stock" and "in process with pharmacy" documented as the reason. b. Review of the facility policy and procedure titled, "Medication Shortages/Unavailable Medications" revised 5/1/10 revealed the following procedure after normal pharmacy hours if a medication was not available from the emergency medication supply: "3.2.1 Emergency	F 425	Staff will re-educated on or before 2/28/2012 on filling out the maintenance cards located at each nurses station for any repair issues identified. Facility ambassadors will round Monday through Friday and will observe for any environmental repairs in assigned rooms. Any observed repair needs will be discussed with the NHA during the morning business meeting. Monitor: Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by NHA/Designee. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months. Completed Date F425 The facility must provide routine and emergency drugs and biologicals to its residents, and obtain them under an agreement described in 483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of the pharmacy services in the facility.	2/28/2012	

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F 425	Continued From page 13 delivery; or 3.2.2 Use of an emergency (back-up) Third Party Pharmacy". c. During an interview with the DON on 1/20/12 at 8:45 AM, she confirmed the procedure for obtaining medication unavailable in the emergency supply was to use the back-up pharmacy or request a different medication order from the physician. She further confirmed she was unaware the facility failed to obtain the medication from a back-up pharmacy, and that not doing so was unacceptable. 2. Observation during medication pass at 2:30 PM on 1/19/12 showed non-sample resident #43 was administered sinemet (for Parkinson's disease) 25/100 mg orally. Review of the physician orders recapitulation for January 2012 showed the order was for 50/200 mg. Review of the pharmacy profile showed it was incorrectly written as 25/100 mg. Interview with LPN #1 on 1/20/12 at 8:03 AM revealed the correct dose according to the physician's order was sinemet 50/200 mg but staff had been administering the 25/100 mg dose at least since December 2011. 3. Observation of a medication pass on 1/17/12 at 4 PM showed RN #1 administered non-sample resident #23 combivent inhaler 2 puffs (a combination medication of albuterol and atrovent). Review of the 1/12/12 admission orders showed the resident was to receive an albuterol inhaler 2 puffs four times a day for chronic obstructive pulmonary disease. Review of the physician orders with the staff development manager on 1/19/12 at 9:15 AM confirmed the medication albuterol was ordered. Inspection of the medication cart at that time with the staff development manager showed only combivent.	F 425	Corrective Action: Resident #60 is being administered Celexa as ordered by the physician. Resident #43's was discharged from the facility on 1/23/2012. Resident #23 was discharged from the facility on 1/27/2012. Identification of Others: An audit of all medication carts has been conducted to review for medications matching the Medication Administration Record and medications available and or needing re-ordered. System Measures: Nursing staff will be educated on or before 2/28/2012 on ordering and receiving medications, transcription of medication orders, comparing medication label with the MAR and review of policy and competency testing. A pharmacy and medication tracking form will be placed at each nurses station for nurses to fill out when notifying the pharmacy of any needed medications. The DON/designee will review the form Monday through Friday at the daily business meeting for any follow up needed. Nursing staff will conduct a medication cart audit twice weekly to observe for medications needing re-ordered, and current medications matching medication administration records. DON/Designee will conduct random medication cart audits weekly to observe for medications needing re-ordered, and		

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F 425	Continued From page 14 was available for the resident. An interview with the staff development manager on 1/19/12 at 4:30 PM revealed that after notifying the physician and pharmacy, it was verified the resident was to receive albuterol.	F 425	current medications matching medication administration records.		
F 441 SS-E	483.85 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 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.	F 441	Nursing/Designee. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months. Completed Date : F441 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish and maintain 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 the 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 lesions from direct contact resident. (2) The facility must prohibit employees with a communicable disease or infected skin with residents or	2/28/2012	

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F 441	Continued From page 16 (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, and review of the facility policy for hand hygiene, the facility failed to ensure staff followed acceptable hand hygiene practices during 2 random observations. The findings were: 1. During an observation on 1/17/12 at 3:05 PM CNA #3 was observed to don a mask and a pair of gloves from the isolation cart located outside the room of resident #21 prior to entering the room. Four minutes later, the CNA came out of the room. She had removed her gloves before exiting but continued to wear the mask. She removed the mask with her ungloved hand and after crushing it, placed it in the trash bag located on the medication cart. The CNA proceeded to assist a resident down the hallway in his/her wheel chair without first cleansing her hands. An interview with the CNA on 1/17/12 at 3:20 PM revealed she had removed her gloves in the room and placed them in a trash can. She did not remove the mask because she was told not to be in the room without a mask and did not know what to do with it. There was not a receptacle outside the room for contaminated personal protective equipment (PPE). Interview with the staff development manager on 1/17/12 at 3:30 PM revealed the resident had methicillin-resistant staphylococcus aureus of the respiratory tract	F 441	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. Corrective Action: Resident #21 is discharged 1/26/12. Resident #83 is now receiving appropriate catheter care. Identification of Others: All residents for hand washing and/or with catheters and/or on isolation were observed for entering and exiting an isolation room on six different occasions for appropriate donning and doffing of Personal Protective Equipment, catheter care and Hand washing. System Measures: Education will be provided to Nursing staff in regard to Infection Control and Prevention by the DON/Designee on or before 2/28/2012 Education will include proper use of personal protective equipment, appropriate catheter care and hand washing when entering and exiting resident rooms and when providing care. DON/Designee will conduct randomly weekly observations of staff entering and exiting isolation rooms for appropriate donning of Personal Protective		

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F 441	Continued From page 16 and was on droplet isolation. He further stated the staff was instructed to remove their PPE and dispose of it before leaving the resident's room. He acknowledged the CNA needed to cleanse her hands after removing the mask. Review of the facility's Patient Care Policies for hand hygiene dated 2009, showed: "If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all clinical situations..." 2. Observation on 1/17/12 at 4:50 PM showed resident #83 had a suprapubic catheter. Further observation showed CNA #2 cleansed the area around the suprapubic catheter with the same soiled gloves she had used to provide incontinence care. Interview with the CNA at the time revealed she should have removed the soiled gloves, washed her hands, and put on clean gloves prior to cleansing the suprapubic catheter area.	F 441	Equipment, hand washing and catheter care. Monitor: Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by Director of Nursing/Designee. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months. Date of Compliance:	2/28/2012	
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to ensure adequate space was available for residents in 2 of 2 dining	F 464	F464 The facility must provide one or more rooms designated for resident dining and activities. These must be well lighted; be well ventilated, with non-smoking areas identified; be adequately furnished and have sufficient space to accommodate all activities. Corrective Action: #46 resident has been discharged on 2/10/12. The facility has two dining areas. The two dining areas have had tables and chairs re-arranged to make maneuvering around the dining tables easier for staff and residents. #31 Sits at the end of the table and has easy access to come and go. Resident #17 does not want to move to another table that maybe easier access. Identification of Others: The NHA/Designee has spoken with resident council to elicit feedback on the structure of the dining rooms.	including #30 jk	

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F 464	Continued From page 17 rooms. The findings were: 1. Observation of the evening meal in the north dining room on 1/17/12 at 6 PM revealed CNA #2 had to lift a rolling stool over the head of two residents to place it where she needed to sit to assist residents. Interview with the CNA at the time revealed she did not like to have to lift the chair over the residents' heads, but there was no other way to place the stool where it was needed. She said she could not push the stool on the floor through the wheelchairs, because there was no room. 2. During an interview with resident #46 on 1/19/12 at 1 PM, s/he stated that staff sometimes have to "clear a path" and assist him/her to leave the arrowhead dining room because there was not enough room to maneuver the wheelchair. The resident also stated s/he tried to get to dining early because, if s/he was not early, the result was a lengthy wait due to traffic congestion. Observation of the resident at that time revealed s/he was independent with wheelchair mobility. 3. During an interview on 1/18/12 at 3 PM with eight residents, they revealed a concern with getting in and out of the main dining room around meal times. The residents expressed difficulty maneuvering in the dining room due to space limitations once residents were seated at the tables. Resident #31 stated s/he had difficulty getting out of the dining room until after other residents started leaving. Resident #17 stated s/he arrived early for meals due to the difficulty of getting to the table if s/he waited until serving times.	F 464	System Measures: The NHA/Designee will randomly observe the dining areas 3 to 4 times per week during meal service each week to observe for staff having difficulty maneuvering around the dining tables and residents having difficulty maneuvering in and out of the dining area. The NHA/Designee will meet with a group of residents weekly for four weeks then monthly to discuss satisfaction with the dining environment. Will make changes when appropriate. Monitor: Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by NHA/Designee. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months. Date of Compliance: F467 The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. Corrective Action: A bid has been obtained for repair of the bathroom vents by a local vendor in the Northwest Hallway. Identification of Others:	2/28/2012	

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NAME OF PROVIDER OR SUPPLIER CHEYENNE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 E 12TH STREET CHEYENNE, WY 82001		
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F 464	Continued From page 18 4. Observation on 1/19/12 at 12:35 PM during the noon meal showed resident #20 left the main dining room independently in his/her wheelchair prior to finishing the meal. When the resident returned at 12:55 PM to finish eating, s/he needed assistance from the dining room staff to return to the table because of the crowding. The resident was unable to independently maneuver around other residents sitting in their wheelchairs near the dining room entrance and at the end of the tables. An interview with the resident on 1/19/12 at 1:05 PM revealed it was normal for the dining room to be crowded during meals and it was difficult to maneuver in and out.	F 464	All bathroom vents were inspected for proper working condition. System Measures: Maintenance Director/designee will randomly check bathroom vents weekly Monday thru Friday to ensure proper working condition. The random check will include different hallways. Monitor: Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by Maintenance Director/Designee. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months. Completed Date	2/28/2012	
F 467 SS=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation, and family and staff interview, the facility failed to provide adequate ventilation in resident bathrooms for 1 of 8 hallways (northwest hallway). The findings were: Periodic observations from 1/17/12 at 9:30 AM through 1/20/12 at 5 PM, revealed the facility had a noticeable odor of stale urine, particularly in the northwest hallway past the double doors. On 1/17/12 from 3 PM through 3:30 PM, bathroom ceiling vents in the northwest hallway were checked for ventilation adequacy (using a tissue) in resident rooms 129, 130, 30, 132, 133, 134, 135, 136, and 137. In each case, the tissue failed	F 467			
		F496	Before allowing an individual to serve as a nurse aide, a facility must receive a registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819 (c)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/20/2012
NAME OF PROVIDER OR SUPPLIER CHEYENNE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 E 12TH STREET 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 487	Continued From page 19 to cling to the vent, and there was no noticeable air movement. During an interview on 1/17/12 at 8 PM with a family member of a resident who resided on the northwest hallway, the family member stated the northwest hallway had a noticeable odor of stale urine during visits, which included the evening of 12/25/11. During an interview with the maintenance director on 1/19/12 at 2:50 PM, he said he was unaware the vents were not functioning properly. During an interview with the maintenance director on 1/20/12 at 11:45 AM, he confirmed that the motor for the vents in the northwest hallway had not been working, and he exchanged the motor. He also confirmed the ventilation system motors were not on a maintenance schedule checklist.	F 487	If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 months consecutive months none of which the individual provided nursing or nursing related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. Corrective Action: The abuse screening registration has been completed thru the Office of Healthcare Licensing and Survey for the following: CNA #1 completed 1/17/12, CNA #2 completed on 1/17/12, CNA #4 completed on 1/17/12, CNA #5 completed on 1/17/12.		
F 488 SS-E	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1819(e)(2)(A) of the Act the facility believes will include information on the individual.	F 496	Identification of Others: Current employed Certified Nursing Assistant files will be audited by the Human Resource Director/Designee for verification of registration with the Office of Healthcare Licensing and Survey for abuse screening registration. Any Certified Nursing Assistants not registered will become registered. System Measures: Newly hired Certified Nursing Assistants will have registration for Abuse screening verified by the Human Resource Director/Designee upon employment. Monitor: Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/20/2012
NAME OF PROVIDER OR SUPPLIER CHEYENNE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 E 12TH STREET 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 496	Continued From page 20 If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on employee record review and staff interview, the facility failed to verify information with the CNA registry in a timely manner for 4 of 5 CNAs reviewed (CNAs #1, #2, #4, #5). The findings were: Review of employee records showed the following concerns: a. CNA #1 was issued a CNA licensure on 8/11/11. The aide had a date of hire and first resident contact of 9/9/11. However, the facility did not check the state CNA registry until 1/17/12. b. CNA #2 was issued a CNA licensure on 4/7/11. The aide had a date of hire and first resident contact of 11/18/11. However, the facility did not check the state CNA registry until 1/17/12. c. CNA #4 was issued a CNA licensure on 7/15/09. The aide had a date of hire and first resident contact of 8/22/11. However, the facility did not check the state CNA registry until 1/17/12. d. CNA #5 was issued a CNA licensure on 6/5/97. The aide had a date of hire and resident contact of 10/8/11. However, the facility did not check the state CNA registry until 1/17/12.	F 496	facility QA & A committee by Human Resource Director/Designee. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months. Completed Date: F503 If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in 493 of this chapter. If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. laboratory services on site, it must have an agreement to obtain if the facility does not provide these services from a laboratory that meets the applicable requirements of part 493 of this chapter. Corrective Action: The Even Care glucometer open test strips and control solutions as well as Medisense open test strips and control solutions were discarded. New test strips and control solutions were obtained and dated when opened. Identification of Others:		2/28/2012

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/20/2012
NAME OF PROVIDER OR SUPPLIER CHEYENNE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 E 12TH STREET 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 498	Continued From page 21 a. During an interview with the human resource coordinator on 1/20/12 at 9:50 AM, she confirmed the state CNA registry was checked for the four aides on 1/17/12, but the registry should have been checked upon hire.	F 498	Medication carts and medication rooms were audited for all glucometers and associated test strips and control solutions. Any found to be without an open date were discarded.		
F 503 SS=D	488.75(D)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of manufacturer instructions, the facility failed to ensure laboratory test strips and control solutions were not outdated in 2 of 4 medication carts. The	F 503	System Measures: Licensed Nurses were educated on or before 2/28/2012 on dating new vials of control solutions for glucometers as well as test strips when opened for the first time. The facility has moved to using only EvenCare G2 glucometers. A weekly audit by the DON/designee of control solution and test strips will be conducted to ensure proper date identified when product opened and to monitor for expiration. Monitor: Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by Director of Nurses/Designee. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months. Date of Compliance:	2/28/2012	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 638025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/20/2012
NAME OF PROVIDER OR SUPPLIER CHEYENNE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 E 12TH STREET CHEYENNE, WY 82001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY(IES) (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 503	Continued From page 22 findings were: Observation of the southwest medication cart on 1/20/12 at 12:30 PM with RN #2 showed the ReliOn glucometer test strips and the EvenCare glucose control solutions were opened, but not labeled with a date. The RN at that time verified the bottles were not dated and were available for use. In addition, she acknowledged she did not know what the expiration date of the test strips and glucose control solutions were once they were opened. An observation of the northeast medication cart on 1/20/12 at 1 PM with LPN #2 showed the MediSense and EvenCare glucose control solutions were opened but not labeled with a date. The LPN confirmed at that time the solutions were not dated and they were available for use. In addition, the LPN acknowledged she did not know when the solutions expired once they were opened. An interview with the DON on 1/20/12 at 2:25 PM acknowledged she did not know what the expiration dates of the test strips and control solutions were once they were opened. Further, she was unable to locate the instruction manuals or package inserts for the ReliOn or MediSense glucometers and control solutions. Review of the EvenCare glucose control solutions package insert showed the solutions expired 90 days after they were opened. A telephone interview on 1/23/12 at 10:20 AM with a representative at Abbott Diabetes Care, the company that provided the MediSense control solutions, revealed the control solutions expire 90 days after they are opened. Review of the instruction manual found on line for the ReliOn glucometer on 2/3/12 at 9AM showed the test strips were not to be used more than three months after they had been opened to ensure	F 503			

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NAME OF PROVIDER OR SUPPLIER CHEYENNE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 E 12TH STREET 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)	(X6) COMPLETION DATE	
F 503	Continued From page 23 accuracy.	F 503			