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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING _____ B. WING _____	C PP 10/26/2012

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

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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 CAA - Care Area Assessment Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview and medical record review, the facility failed to ensure an interdisciplinary team evaluation for self-administration of medications was performed for 1 of 1 sample resident (#35) who requested self-administration. The findings were: Review of the October 2012 recapitulation of physician's orders for resident #35 showed s/he was admitted with diagnoses including coronary artery disease and chest pain. Further review of physician's orders showed an order dated 4/26/12 for Nitrostat (nitroglycerine) 1/150 0.4 milligrams (mg) sublingual. May repeat every five minutes	F 176	F176 Resident Self-Administer Drugs if Deemed Safe An individual resident may self-administer drugs if the interdisciplinary team has determined that this practice is safe. A) A physician order was written on 11/12/12 for resident #35 requesting self-administration of medication assessment. The request for assessment was denied by the resident's physician and the physician stated, "Not in the patient's best interest as he has poor safety awareness and this medication has the potential to cause severe hypotension if taken improperly. B) Each resident requesting to self-administer medications will have a physician order written to request a medication self-administration assessment. C) The Director of Nursing or designee will conduct an in-service for all licensed nursing	12/11/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 11/20/12

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.

12/6/12 @ 4:40 pm PAC received with revisions via phone conversation with administration and DON, Bryan Merrell and Clint Scearce. P. Prince

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F 176	Continued From page 1 for a maximum of three doses in fifteen minutes as needed for chest pain. Interview with the resident on 10/24/12 at 11 AM revealed s/he told staff s/he would like to keep the nitroglycerine sublingual tablets at the bedside. The resident said s/he had self-administered the nitroglycerine for five years prior to admission to the nursing facility and wished to continue. The resident further said s/he had frequent angina pain and felt s/he needed the medication quicker than the nurse was able to administer it. Review of the 10/19/12 timed at 9:30 AM physician progress notes showed the resident's daughter had recently (exact date not documented) brought his/her nitroglycerine from home and had left it at the resident's bedside. However, staff took the medication away and the resident had to call a nurse to obtain the PRN (as needed) medication. Review of the medical record and interview with the DON on 10/25/12 at 4 PM verified no self-administration of medication evaluation was performed for this resident. The DON further said it was the facility's policy to obtain a physician's order prior to performing an assessment. Review of the facility's policy on self administration of medications, June 2008, showed "Each resident who desires to self-administer medication is permitted to do so if the facilities interdisciplinary team has determined the practice would be safe...If the resident desires to self-administer medication, an order for self-administration will be obtained from the physician, and an assessment is conducted by the interdisciplinary team...." The following concerns were identified: a. Review of the medical record showed no evidence staff asked the physician for an order to evaluate the resident for self-administration therefore no evaluation was performed.	F 176	staff regarding the resident's right to self-administer medications if deemed safe. This in-service will occur on or before 12/11/12. D) A Performance Improvement tool will be utilized to audit residents' requests to self-administer medications. Any problems identified will result in immediate education and/or corrective action will take place. E) The Director of Nursing will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

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F 176	Continued From page 2 b. Review of the physician progress notes from 4/11/12 through 10/19/12 showed no evidence the physician was contacted about writing an order for performing a self-administration of medication evaluation for this resident. Additionally, there was no notation in the physician's progress notes in regard to the resident's desire, and whether or not it was safe for him/her, to keep the nitroglycerine at the bedside. The only notation made in regard to the resident's concern about not receiving the nitroglycerine for his/her chest pain quickly enough was "...re-addressed [his/her] deteriorating heart condition and lack of corrective/definitive treatment. Stressed that this will only worsen over time. Explained that comfort care can be provided here [the facility], as requested, but the immediate attention and individualized care that occurs at hospice will not be available." 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and interviews with residents, family, and staff, the facility failed to provide medically-related social services. This failure resulted in unmet social services needs for 2 of 21 sample residents (#23, #118). The findings were:	F 176		
F 250 SS=D		F 250	F250 Provision of Medically Related Social Service The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. A) Resident #118 and resident #23 have both been discharged back to the community. B) The Social Services Director will receive psychological counseling consents and physician orders to ensure the coordination of services is timely for other residents needing counseling services.	12/11/12

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F 250	Continued From page 3 1. Review of the medical record for resident #118 showed s/he was admitted on 7/26/12 for rehabilitation after sustaining a hip fracture at home. Interview with a family member on 10/25/12 at 7:08 PM revealed prior to admission, the resident had some problems with depression and anxiety. Because the family member anticipated a difficult adjustment from home to the nursing facility for the resident, upon admission s/he requested psychological counseling. Review of the 8/9/12 CAA for mood showed the resident "has a diagnosis of depression and is receiving the antidepressant Cymbalta. Family requested [name of counseling services] counseling and referral will be made". Review of the 8/21/12 timed at 8:40 AM social services notes showed "MD [physician] order received today for [name of counseling services] to provide psychological services. Referral faxed to [name of counseling services] today. [The resident] has been displaying increased anxiety and tearfulness." It took 24 days for social services to coordinate the requested counseling services for this resident. 2. According to the 5/6/12 physician's progress notes, resident #23 was admitted from the hospital to the facility on 5/6/12 "for rehab" following knee surgery on 5/2/12. Review of the 8/6/12 quarterly MDS showed the resident did not have cognitive impairment and performed all activities of daily living with supervision or independently. During an interview on 10/25/12 at 11 AM, the DON, administrator, social services director and psychological counselor stated the facility had been trying to discharge the resident for the past five months, but the resident's	F 250	The Social Services Director will conduct an audit of residents being seen by psychological services to ensure that suggestions and/or recommendations that pertain to behaviors are being addressed in the interdisciplinary discharge and care planning process. C) The Director of Nursing or designee will conduct an in-service on or before 12/11/12 with nursing, social service regarding the importance of ensuring behavior interventions are in accordance with the residents plan of care. The Executive Director will conduct an in-service on or before 12/11/12 with the psychological counseling service regarding timely coordination of services and provision of recommendations to facility staff. The in-services will take place on or before 12/11/12. D) A Performance Improvement tool will be utilized for random audits. Any problems identified will result in immediate education and/or corrective action will take place. The audits will be conducted by the Social Services Director or designee. E) The Social Service Director will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

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F 250	Continued From page 4	F 250		

responses were "self sabotaging". At that time all agreed that the resident did not need to be in the facility and the administrator stated it was frustrating for some of the nursing staff.

Interview with the social services director on 10/26/12 at 8:20 AM revealed the care management team determined the resident was able to be discharged twenty days after s/he was admitted, but each time plans were made for discharge the resident found a reason to remain at the facility. The social services director also stated the resident exhibited manipulative behaviors and at times reported the same concerns differently to different staff.

Interviews with the resident were conducted on 10/23/12 at 3 PM and 10/25/12 at 5 PM. During the first interview, s/he sobbed and talked about staff's reluctance to administer pain medications, assist with other pain relieving modalities, and help with his/her post discharge planning needs. During the second interview the resident was not sobbing, but stated the facility staff acted like they just didn't care about what happened to him/her after discharge. The following concerns were identified regarding staff's inability to effectively address the resident's behavior to facilitate a successful discharge plan:

a. Interview with CNA #2 on 10/26/12 at 9:50 AM revealed it was very frustrating for the aides when the resident requested something, then later changed his/her mind. The CNA stated the resident did not consistently exhibit this type of behavior, but "you never knew when [his/her] moods changed". The CNA further stated she had not been instructed to use a specific approach when addressing the resident's behaviors.

b. Review of the care plan revealed no

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F 250	Continued From page 5 interventions related to the resident's behavior and discharge planning. c. Review of the weekly progress notes by the psychological services behavioral health organization revealed documentation about the resident's anxiety, worries about housing, overfocus on physical issues and struggles with staff. However, further review of the progress notes and the interview with the psychological counselor on 10/25/12 at 11 AM revealed she did provide suggestions or recommendations for staff regarding approaches to the resident's behavior. d. Interview with the social services director on 10/26/12 at 8:20 AM revealed she was unaware of any attempt to develop and implement a consistent, cohesive plan of approach to be utilized by all staff for addressing the resident's behaviors.	F 250		
F 279 SS=D	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	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 plan for resident #2 to ensure that a comprehensive care plan is developed in regards to the resident's fractured ankle and walking boot use. B) The Director of Nursing or designee will conduct random audits of other residents' care plans to ensure that comprehensive care plans are developed for fractures and walking boots. As a addition to all resident needs according to the residents' current Stryker,	12/11/12

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F 279	Continued From page 6 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 and resident interview and medical record review, the facility failed to ensure care plans were developed as needed for 1 of 24 sample residents (#2). The findings were: Review of the medical record for resident #2 showed s/he had fallen and a visit was made to an orthopedic physician according to a 9/25/12, timed at 10:34 AM nurse's note. The resident returned to the facility with an orthopedic boot for a fibula fracture. The October 2012 recapitulation of physician orders showed the resident was to wear the boot at all times. Interview with the resident on 10/23/12 at 9:45 AM revealed the boot was causing him/her discomfort and s/he had asked nursing staff to remove the boot on several occasions with no results. The resident stated s/he was told the boot needed to remain on. Review of the resident care plan failed to show any plan to care for the resident's fractured ankle or when to remove the boot. Interview with the DON on 10/24/12 at 2:45 PM revealed there was not a specific physician order for the application/removal of the orthopedic boot. He further stated care of the skin under the boot and the wrapping was being provided; however, a care plan was not developed, and there was no documentation of the care and treatments.	F 279	C) The Director of Nursing will conduct an in-service on or before 12/11/12 with nursing staff that review and revise care plans ensuring they are developed and completed appropriately. D) A Performance Improvement tool will be utilized for random audits. Any problems identified will result in immediate education and/or corrective action will take place. The audits will be conducted by the Director of Nursing or designee. E) The Director of Nursing will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	F280 Right To Participate Planning Care-Revise Care Plan	12/11/12

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F 280	Continued From page 7 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 care plans were updated to reflect the current status for 3 of 21 sample residents (#60, #64, #119). The findings were: 1. Review of a 10/9/12 physician order for resident #60 showed a discontinuation of a merry walker device. Periodic observation throughout the survey showed the resident did not utilize the device. However, review of the care plan for falls, impaired skin integrity, and functional mobility all developed on 4/5/10 showed the care plans had not been updated to show the merry walker	F 280	The care plan is periodically reviewed and revised by a team of qualified persons after each assessment. A) The Director of Nursing or designee will review and revise care plans for resident #60 to reflect the discontinuance of the merry walker and resident #119 to reflect the use of contact isolation precautions. Resident #64 has been discharge to the community. B) The Director of Nursing or designee will conduct random audits of other residents' care plans to ensure that care plans for patients with discontinued merry walkers, MRSA, and C-Diff. are being reviewed and revised appropriately. C) The Director of Nursing will conduct an in-service on or before 12/11/12 with nursing staff that review and revise care plans ensuring they are reviewed and revised appropriately. D) A Performance Improvement tool will be utilized for random audits. Any problems identified will result in immediate education and/or corrective action will take place. The audits will be conducted by the Director of Nursing or designee. E) The Director of Nursing or designee will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

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F 280	Continued From page 8 device was no longer to be used. 2. According to the medical record for resident #64, s/he began to receive antibiotic therapy on 10/11/12 for a pressure ulcer on the heel that tested positive for Methicillan-resistant staphylococcus aureus (MRSA). Periodic observations on 10/23/12, 10/24/12, 10/25/12, and 10/26/12 revealed contact isolation signage was posted on the resident's door. Interview on 10/25/12 at 10:30 AM with the infection control practitioner (ICP) confirmed staff were to use contact precautions when they had contact with the resident's wound. Review of the care plan revealed information regarding the contact precautions was lacking. 3. According to the medical record for resident #119, staff determined the resident should be placed on contact isolation status due to confirmed clostridium difficile infection on 10/21/12. Periodic observations on 10/22/12, 10/23/12, 10/24/12, 10/25/12, and 10/26/12 revealed contact isolation signage was posted on the resident's door. Interview on 10/25/12 at 10:30 AM with the ICP confirmed staff were to use contact precautions when they had contact with the resident's wound. Review of the care plan revealed information regarding the contact precautions was lacking. 4. Interview with the ICP on 10/24/12 at 4:45 PM confirmed the contact precautions information had not been added to the care plans until 10/24/12 after talking with the surveyor.	F 280		
F 284 SS=D	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN	F 284	F284 Anticipate Discharge: Post-Discharge Plan	12/11/12

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F 284	Continued From page 9 When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff and resident interview, the facility failed to ensure effective and timely discharge planning for 1 of 3 sample residents (#23) with discharge planning needs. The findings were: According to the 5/6/12 physician's progress notes, resident #23 was admitted from the hospital to the facility on 5/6/12 "for rehab" following knee surgery on 5/2/12. Review of the 8/6/12 quarterly MDS assessment showed the resident did not have cognitive impairment and performed all activities of daily living with supervision or independently. During an interview on 10/ 25/12 at 11 AM, the DON, administrator, social services director and psychological counselor stated the facility had been trying to discharge the resident for the past five months, but the resident's response was "self sabotaging". The following concerns were identified: a. Interview with the social services director on 10/26/12 at 8:20 AM revealed the care management team determined the resident was able to be discharged twenty days after s/he was admitted (5/6/12), but each time plans were made for discharge it did not take place. b. Review of the weekly care management reviews revealed the following documentation for	F 284	When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. A) Resident #23 was discharged from the facility on 10/26/12. B) The Director of Nursing or designee will conduct random audits of other residents' care plans to ensure that post discharge plans are in place and reflected on the care plan C) The Director of Nursing or designee will conduct an in-service on or before 12/11/12 with licensed nursing and social service staff that review and revise post discharge plans ensuring they are reviewed and revised appropriately and that necessary service are . D) A Performance Improvement tool will be utilized for random audits. Any problems identified will result in immediate education and/or corrective action will take place. The audits will be conducted by the Director of Nursing or designee. E) The Director of Nursing or designee will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

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F 284	Continued From page 10 discharge status: For the week of 5/8/12 to 5/15/12, there was a question mark. For the week of 5/15/12 to 5/22/12 the words "trying to get housing " was documented. For the week of 5/22/12 to 5/29/12 the discharge status was "home (apartment)..." For the week of 6/5/12 to 6/12/12 the discharge status was "apartment in ..." c. Interviews with the resident were conducted on 10/23/12 at 3 PM and 10/25/12 at 5 PM. During the first interview, s/he sobbed and talked about staff's reluctance to help with his/her post discharge planning needs. During the second interview the resident was not sobbing, but stated the facility staff acted like they just didn't care about what happened to him/her after discharge. d. Review of the care plan revealed no interventions related to the resident's discharge planning. e. Interview with the social services director on 10/26/12 at 8:20 AM revealed she was unaware of any attempt to develop and implement a consistent, cohesive plan of approach to be utilized by all staff for addressing the resident's behaviors. She further stated the problems with discharging the resident in a timely manner were due to the resident's indecisiveness and behavior.	F 284		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F309 Provide Care and Services For Highest Well Being Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	12/11/12

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	535032	A. BUILDING _____ B. WING _____	C 10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	1130 PRAIRIE AVENUE CHEYENNE, WY 82009

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F 309	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on staff and resident interview and medical record review, the facility failed to ensure pain and comfort were evaluated and effectively treated for 1 of 13 sample residents (#2) who were identified to have pain/comfort concerns. The findings were: Review of the medical record showed resident #2 had fallen and a visit was made to an orthopedic physician according to a 9/25/12, at 10:34 AM nurse's note. The resident returned to the facility with an orthopedic boot for a fibula fracture. The October 2012 recapitulation of physician orders showed the resident was to wear the boot at all times. Interview with the resident on 10/23/12 at 9:45 AM revealed the boot was causing him/her discomfort and s/he had asked nursing staff to remove the boot on several occasions with no results. The resident stated s/he was told the boot needed to remain on and the boot had not been removed since it was first applied. The resident described the discomfort as "raw and rubbing" on his/her ankle bone. The following concerns were identified: a. Review of the resident care plan failed to show any plan to care for the resident's fractured ankle or when to remove the boot. b. Review of the 10/19/12 timed 5:52 AM nurse's note showed the resident was complaining of discomfort from the boot but agreed to keep it on when the nurse explained how important it was. The note failed to show any attempt to further assess the discomfort or to	F 309	A) The care plan for resident #2 has been revised to reflect care provided to resident's boot use. A physician order was received to remove boot twice a day and apply lotion to alleviate discomfort. B) The Director of Nursing or designee will conduct random audits of other residents' care plans to ensure that comfort/pain is addressed in relation to orthopedic boots. C) The Director of Nursing or designee will conduct an in-service on or before 12/11/12 with licensed nursing staff on obtaining orders for removal of orthopedic ~~boots~~ devices with skin checks. pp D) A Performance Improvement tool will be utilized for random audits. Any problems identified will result in immediate education and/or corrective action will take place. The audits will be conducted by the Director of Nursing or designee. E) The Director of Nursing or designee will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

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F 309	Continued From page 12 provide any relief for the resident. c. Interview with the DON on 10/24/12 at 2:45 PM revealed there was not a specific physician order for the application/removal of the orthopedic boot. He further stated care of the skin under the boot and the wrapping was being provided; however, a care plan was not developed, and there was no documentation of the care and treatments.	F 309		
F 319 SS=G	483.25(l)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview and medical record review, the facility failed to ensure the mental and psychosocial needs were met for 2 of 3 sample residents (#44, #118) who were admitted in the ninety days prior to the survey. The facility's failure to provide appropriate treatment and services to meet resident #118's psychosocial adjustment needs resulted in a continued sense of loss and maladjustment for this resident. The findings were: 1. Review of the medical record for resident #118 showed s/he was admitted on 7/28/12 for rehabilitation after sustaining a hip fracture at home. Interview with a family member on 10/25/12 at 7:08 PM revealed that prior to admission the resident had some problems with	F 319	F319 Treatment/Services For Mental/Psychosocial Difficulties Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. A) Resident #118 was discharged to the community on 11/1/12. Recommendations provided by the neuro-psychologist for resident #44 were implemented on 10/23/12 after consent from the resident's physician was obtained. B) The Social Service Director or designee will conduct random audits of other residents receiving psychological services to ensure they receive timely coordination of services, that psychological counseling service frequency is in accordance with the psychotherapy plan, and recommendations are implements on the care plan.	12/11/12

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F 319	Continued From page 13 depression and anxiety. Because the family member anticipated a difficult adjustment from home to the nursing facility for the resident, upon admission s/he requested psychological counseling. Review of the 8/9/12 CAA for mood showed the resident "has a diagnosis of depression and is receiving the antidepressant Cymbalta. Family requested [name of counseling services] counseling and referral will be made". The following concerns with management of this resident's psychosocial adjustment to the nursing facility were identified: a. Review of the 8/21/12 timed at 8:40 AM social services notes showed "MD [physician] order received today for [name of counseling services] to provide psychological services. Referral faxed to [name of counseling services] today. [The resident] has been displaying increased anxiety and tearfulness." It was 31 days after the resident was identified as having a need for psychological counseling services before a diagnostic assessment was performed by the counseling service on 8/28/12. It was an additional two weeks before the resident received his/her first counseling session on 9/11/12 making a 45 day delay of treatment for an identified concern. b. Interview with the resident's family member on 10/25/12 at 7:08 PM revealed the resident had been depressed for several years but the depression had increased significantly since admission to the nursing facility. The family member said the resident had started making threats to kill himherself in the nursing facility and cried easily since admission which was not part of the resident's behavior prior to admission. The family member said the resident seemed fearful and felt very alone since admission to the nursing	F 319	C) The Executive Director or designee will conduct an in-service on or before 12/11/12 with licensed nursing and social services staff regarding the facility's responsibility to monitor and implement third-party providers' timeliness or treatment, frequency and recommendations. The Executive Director or designee will conduct and in-service on or before 12/11/12 with the psychological counseling service regarding timely coordination of service, frequency, and importance of recommendations. D) A Performance Improvement tool will be utilized for random audits. Any problems identified will result in immediate education and/or corrective action will take place. The audits will be conducted by the Social Services Director or designee. E) The Social Services Director or designee will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

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F 319	Continued From page 14 facility. Review of the nursing notes and social services notes showed the following examples of the resident's distress related to his/her admission prior to having the diagnostic assessment performed by the counseling services therapist. 1. On 7/28/12 timed at 9:31 PM, the resident "is very upset at this time because of being here". 2. On 8/13/12 timed at 9:42 AM, the resident was "...crying this am before breakfast and pleasant afterwards". 3. On 8/15/12 timed at 2:50 AM, the resident was anxious and "...crying at intervals". 4. Review of a social service progress note written on 8/15/12 timed at 9:45 AM showed a family member said s/he thought the resident was "having increased anxiety and tearfulness at night." 5. On 8/15/12 timed at 11:01 PM the resident was "crying without reason and calling out for [his/her daughter] multiple times". 6. On 8/16/12 timed at 2:03 AM the resident was found crawling to the bathroom and was noted to have "nervousness". 7. On 8/16/12 timed at 6:43 PM showed the resident was "...weepy tonight". An antianxiety medication was administered to the resident for anxiety. 8. On 8/17/12 timed at 1:23 AM showed the resident was "anxious". 9. On 8/17/12 at 11:52 AM the resident was "anxious and fidgeting in bed". 10. On 8/17/12 timed at 6:49 PM the resident "...continues to cry out and appears to be very anxious".	F 319		

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F 319	Continued From page 15 11. On 8/18/12 at 2:19 AM the resident was "crying and in pain". 12. On 8/19/12 timed at 2:21 AM the resident was "crying and restless". 13. On 8/20/12 timed at 1:24 PM the resident was "tearful" and "agitated ". 14. On 8/20/12 timed at 10:49 PM the resident wandered the halls in his/her wheelchair, crying out for his/her daughter and "stating [s/he] was not staying here tonight and needed to get to [his/her] car to go home". 15. Review of the 8/21/12 timed at 8:40 AM social services notes showed the resident was "displaying increased anxiety and tearfulness." 16. Review of a social service progress note written on 8/22/12 timed at 1:11 PM showed Xanax (anti-anxiety) medication was ordered but the resident "...continues to have periods of anxiety and tearfulness". 17. On 8/24/12 timed at 5:07 PM, the resident was administered Xanax for increased anxiety and worrying about [his/her] daughter. Resident states, " ...I need to get home...". 18. On 8/24/12 timed at 7:53 PM the resident "began to cry" and required the antianxiety medication Xanax to be administered. 19. On 8/25/12 timed at 6:56 PM the resident stated "I need to find my car, I need to go home". 20. On 8/27/12 timed at 8:58 AM, the night nurse reported the resident "had been up most of the night". Review of the nursing notes and social services notes showed the following examples of the resident's distress and behaviors which continued after the counseling services diagnostic	F 319		

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F 319	Continued From page 16 assessment and development of a treatment plan was performed: 1. On 8/28/12 timed at 3:33 PM, the resident "...received Xanax per signs of anxiety such as attempting to self transfer, having rapid shallow respirations, and an increase in grimacing." 2. On 8/28/12 at 5:24 PM, the resident was "very anxious" and threw a Xanax tablet away stating, "I'm not taking it...I want to go home! Take me to the door so I can leave." The resident kept leaving the dining room and wheeling him/herself down the halls to the doorways and crying. 3. Review of an 8/30/12 timed at 8:59 AM social service note showed the resident "...has had a recent increase in agitation and behaviors. [S/he] has been yelling out and refusing medications, and at times wanders throughout facility...". 4. On 8/30/12 timed at 12:10 PM, the "Resident received Xanax this AM due to increased fidgeting, rapid breaths and inability to focus on taking medications". 5. On 8/31/12 at 6:04 PM, the resident was "...anxious this morning, attempting to self transfer and being sad about not being at home...asked this nurse if [s/he] were to go out the front door if this nurse would stop [him/her]." The resident attempted to leave the facility by going out of the unit 3 door. 6. On 9/1/12 timed at 6:41 AM, the resident was administered Xanax for "increased anxiety about returning to this facility instead of returning home" after a visit to the emergency room. 7. On 9/4/12 timed at 1:06 PM the	F 319		

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LIFE CARE CENTER OF CHEYENNE	1930 PRAIRIE AVENUE CHEYENNE, WY 82009

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resident began to get anxious and attempted to stand to go out the door. Nursing staff was able to get the resident to stay seated and then administered Xanax. The resident "stayed in wheelchair and stared out the side door but not attempting to leave".

8. On 9/9/12 timed at 10:25 AM, the resident was upset, yelling and striking out at staff. The "resident began to go through belongings and throwing them into the trash cans".

9. Review of a social service note written on 9/10/12 timed at 10:28 AM showed the resident "Continues to have periods of increased confusion and statements that [s/he] needs to leave the facility. [The resident] can be verbally and physically abusive and resists care at times".

10. On 9/17/12 timed at 9:05 PM the resident said s/he "just wants to die and kill [him/herself]". The resident's family member requested a psychology consultation.

11. On 9/20/12 timed at 11:59 AM the resident "continues to want to leave" the facility. The resident wanted nursing to call his/her family to come pick him/her up.

12. On 9/21/12 timed at 8 PM, the resident "continues to have multiple requests to leave for home".

13. On 9/27/12 timed at 5:45 PM the resident was "anxious and agitated", "wanting to pack up [his/her] things", call his/her family, and go home.

14. On 10/1/12 timed at 9:09 AM the social services staff noted the resident continued to be agitated, and verbally and physically aggressive at times. In addition the resident was sometimes resistive to care and had repetitive concerns. The social worker further noted the

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resident received Klonopin for anxiety and Seroquel for dementia with behaviors.

15. On 10/8/12 timed at 9:32 PM the resident had episodes of behaviors and frequent crying.

16. On 10/8/12 timed at 9:32 PM the resident was "crying frequently" during the shift.

17. On 10/9/12 timed at 10:07 AM the resident was "anxious about the process of getting ready for the day and what time of day it was".

18. On 10/15/12 timed at 8:42 AM the resident had "intermittent episodes of anger" during the shift when staff attempted to interact with him/her.

19. On 10/16/12 timed at 5:45 PM the resident had an "episode of wandering, crying and wanting to leave the facility after dinner".

d. Observation on 10/22/12 at 3:25 PM revealed the resident had his/her face in his/her hands and was sobbing. Interview with CNA #1 at the time revealed the resident had these crying episodes frequently and that s/he verbalized a fear of being left behind and of not being wanted by family anymore. The CNA said the resident was very fearful of being left alone.

e. Review of the 8/28/12 counseling service diagnostic assessment showed "...[the resident] was referred for increased symptoms of depression and agitation including withdrawal, negative statements and irritability." Further review of this document showed the resident presented with symptoms of loneliness and withdrawal. Continued review showed the resident "misses being at home" and gets "confused and easily agitated at the nursing home." The first counseling session occurred on 9/11/12, two weeks after the assessment, and

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F 319	Continued From page 19 showed the resident was depressed, irritable, withdrawn and had issues with grief and loss. Review of the 9/27/12 therapy notes showed the resident stated s/he felt worthless and missed being at home. Review of the 10/16/12 psychotherapy notes showed the resident continued to appear anxious and depressed. Further review of these notes showed the resident needed two counseling sessions per week with a review and update of the care plan scheduled for February 2013 (six months). Interview with the psychotherapist on 10/25/12 at 12:15 PM revealed the resident needed two sessions per week and later on in the conversation said one to two sessions were necessary. However, review of the counseling notes showed the resident was seen only twice in September 2012 and once in October 2012 instead of the one to two times per week as needed. When asked why the resident had not received the planned two counseling sessions per week, the psychotherapist said sometimes she could not "find" him/her because of rehabilitation therapy. Review of the medical record showed no evidence the psychotherapist asked for assistance in locating the resident for sessions. Additionally, there was no evidence the psychotherapist attempted to arrange a schedule that would allow the resident to be seen. F. Review of the nursing noted written on 9/17/12 timed at 9:05 PM showed the family requested a psychological consultation be performed because of the resident's statement that s/he wished s/he could just die and kill him/herself. This consultation was ordered and performed by a different therapy group than the counseling service who performed the 8/28/12 diagnostic assessment. Review of this	F 319		

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neuropsychological evaluation report, dictated 10/24/12 but performed on 10/8/12 and 10/17/12, showed the evaluation was performed based on the belief that the resident had become "increasingly depressed." Further review showed the resident scored in the mild depression range but was likely an underestimate of his/her current mood status. It was felt the resident's responses were more consistent with how s/he thought s/he was supposed to answer or how s/he wished s/he felt but were not consistent with his/her true affective experiences. Review revealed the resident was often "...distraught and making comments indicative of passive suicidal ideation." The psychotherapist who performed the evaluation noted the resident was "experiencing moderate to severe symptoms of depression." Review of the report summary showed the resident was a "distressed woman." Finally, the report indicated "It is vital to note that [the resident] was experiencing a significant degree of depressive symptoms. Mood symptoms, coupled with general confusion, were likely exacerbating the severity of [the resident's] cognitive deficits."

2. Review of the medical record face sheet showed resident #44 was admitted on 8/14/12 with diagnoses including vertebrae fracture, dementia, anxiety, and depression. Observation and interview with the resident on 10/22/12 at 2:40 PM revealed s/he was tearful and appeared to be anxious; the resident asked for help to go to the bathroom and the surveyor had the resident turn on his/her call light. The light was answered at 2:43 PM by RN #1 who had an aide take the resident to the bathroom. Interview with the resident at 2:55 PM revealed the resident again asked for help to go to the bathroom and s/he

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F 319	Continued From page 21 was unable to remember the assistance that was just provided. Interview with LPN #1 and RN #2 on 10/23/12 at 8:45 AM revealed the resident was new to this room and was not adjusting well and required reassurance, had anxiety, and frequent requests to be taken to the bathroom. The nurses revealed a psychological consult was pending for this resident. Review of the medical record showed a 10/12/12 neuropsychological evaluation was done and the report had been faxed with a fax date of 10/15/12. Review of the recommendations from the report showed specific interventions to possibly reduce the resident's anxiety related to toileting. The following concerns were identified: a. Review of the 8/23/12 care plan for risk of UTI (urinary tract infection) and urinary incontinence showed the recommended interventions related to anxiety and toileting needs were added to the care plan on 10/23/12, eight days after the report was received. b. Interview with the DON on 10/25/12 at 3:40 PM revealed the nursing staff were not aware the neuropsychological report was in the medical record. He further stated this type of consult was new to them and the resident's physician had been out of town. c. Interview with the social service director on 10/26/12 at 10:35 AM verified the resident was being seen by a psychologist weekly; however, she was unaware of the specific recommendations to ease the resident's anxiety.	F 319		
F 327 SS=D	483.25(l) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	F 327	F327 Sufficient Fluid To Maintain Hydration The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health A) Resident #40 expired due to natural causes.	12/11/12

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F 327	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure consistent monitoring of hydration needs for 1 of 5 sample residents (#40) identified at risk for developing dehydration. The findings were: Review of the 9/21/12 CAA summary for resident #40 showed s/he had decreased functional mobility and self care deficit. This review also showed s/he had short term memory loss and his/her mental function varies throughout the day. According to the 9/27/12 care plan, staff were to "increase fluid consumption as appropriate for medical diagnosis." Review of the physician orders showed a diuretic, hydrochlorothiazide 12.5 milligrams was ordered on 10/15/12 and later discontinued on 10/19/12 because it caused a decrease in the resident's blood pressure. Review of the nursing and physician documentation in the medical record showed intravenous fluids were ordered and administered to the resident from 10/10/12 to 10/20/12. Interview on 10/25/12 at 9:45 AM with physician #1 revealed the resident received intravenous therapy due to changes in his/her condition. The physician stated the condition change was related to the blood pressure/diuretic medication and lack of adequate fluid intake. He further stated staff did a good job of encouraging the resident to drink and it was his understanding that they were monitoring the resident's intake. Review of the nursing notes dated 10/20/12, 10/21/12, and 10/22/12 showed the nursing narrative included "encourage fluids".	F 327	B) The Director of Nursing or designee will conduct random observations to ensure fluids are being offered to residents and if fluids are not being offered immediate in-servicing and/or corrective action will take place. C) The Director of Nursing or designee will conduct an in-service on or before 12/11/12 with licensed nursing staff on hydration the importance of offering fluids and documenting fluid intake as order by a physician. D) A Performance Improvement tool will be utilized for random audits. Any problems identified will result in immediate education and/or corrective action will take place. The audits will be conducted by the Director of Nursing or designee. E) The Director of Nursing or designee will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved. 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.	12/11/12

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	535032	A. BUILDING _____ B. WING _____	C pp 10/26/2012

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F 327	Continued From page 23 Interview on 10/25/12 at 8:30 AM with RN #2 revealed the resident needed increased fluids and the system for monitoring fluid intake was the fluid consumption documentation in the intake and output monthly flow record. Interview on 10/25/12 at 10 AM with CNA 4 and CNA #5 revealed the CNAs had not been instructed to give the resident increased fluids. Interview on 10/26/12 at 12:30 PM with the RD (registered dietitian) revealed the estimated daily fluid needs for the resident was 1775 to 2130 milliliters. Review of the intake and output monthly flow record revealed the resident's fluid intake was not documented on ten days in August, twenty-four days in September 2012, and eighteen of twenty-two days in October 2012. Further review revealed none of the recorded amounts equaled more than 500 milliliters a day. Staff were observed providing care for the resident in his/her room on 10/22/12 at 4:50 PM, 10/23/12 at 8:30 AM, and 10/25/12 at 10 AM. Continuous observation during these times revealed staff did not offer or encourage the resident to drink fluids.	F 327	A) The stand mixer located on the preparation counter was cleaned and sanitized on 11/15/12. The electric meat slicer was cleaned and sanitized on 11/15/12. The gas range top was cleaned and sanitized on 10/24/12. The two stainless steal skillets were thrown away during the survey. The kitchen floor was pressure washed on 11/15/12. The ice machine in the kitchen build up of dust was removed on 11/15/12. The walls and ceiling near the ice machine was cleaned on 11/15/12. B) Weekly audits will occur to ensure that the stand mixer, electric meat slicer, gas range top, kitchen floor, ice machine, and walls and ceiling near ice machine remain clean to sight and touch. C) The Dietary Manager or designee will conduct an in-service on or before 12/11/12 regarding cleanliness of food-contact surfaces and cleaning schedule.	
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	F 371	D) A Performance Improvement tool will be utilized for random audits. Any problems identified will result in immediate education and/or corrective action will take place. The audits will be conducted by the Dietary Manager or designee. E) The Director of Nursing or designee will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

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F 371	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of cleaning/maintenance schedules, the facility failed to maintain sanitary conditions in the facility kitchen. The findings were: 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. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." Observation on 10/22/12 at 9:50 AM revealed several items and areas in the kitchen which were in need of cleaning. The following concerns were identified: a. The stand mixer located near the preparation area was noted to have several areas of dried on food splatter. The mixer was observed on 10/24/12 at 10:30 AM to be in the same unclean condition. b. The electric meat slicer located on the preparation counter was noted to have dried on food in many of the crevasses of the equipment, and on the slicer blade. Additionally, the area of the counter underneath the slicer was not clean having evidence of dried food particles. Observation of the slicer on 10/24/12 at 10:30 AM revealed the slicer remained in an unclean condition. c. The gas range top had a thick build-up of burnt-on food. This condition remained on 10/24/12 at 10:30 AM.	F 371		

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F 371	Continued From page 25 d. Two large stainless steel skillets had thick burned-on crust on the interiors and the exteriors. On 10/24/12 at 11:20 AM, one of these skillets was being used to grill sandwiches. e. The kitchen floor was noted to have considerable buildup of grease and dirt in multiple areas. The areas with the most soil accumulation were around the legs of equipment such as the range, steamer, ovens, and preparation tables. The floor and walls in the dish room were also noticed to be soiled with food, grease and mineral deposits. The unclean condition remained on 10/24/12 at 10:30 AM. f. The ice machine in the kitchen was noted to have considerable build-up of dust on both of the side vents. In addition, the walls and ceiling near the ice machine were soiled with dust. The dust was still present on 10/24/12 at 10:30 AM. Review of the weekly cleaning schedule "to be done by 10/29/12" showed the items cited were part of the list, however were not signed off as being cleaned. Interview with the dietary manager on 10/24/12 at 12 PM verified the cleaning needed to be better planned and accomplished more regularly. Additionally, the dietary manager notified the maintenance department in regard to the dusty air filters in the ice machine. When the maintenance log for servicing the ice machine was reviewed, it showed it was serviced on 9/14/12 however, the air filters were ordered and had not yet been received.	F 371		
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	F 441	F441 Infection Control, Prevent Spread, Linens The facility must establish and maintain an infection control program designated to provide a safe, sanitary, and comfortable	12/11/12

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F 441	Continued From page 26 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. (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, medical record review,	F 441	environment and to help prevent the development and transmission of disease and infection A) Resident #119 continues on contact isolation precautions and continues to be monitored for signs and symptoms of infection. Appropriate cleaning solution is available in resident #119's room. B) The Infection Control Nurse or designee will conduct random audits on residents with contact isolation precautions to ensure that proper contact precautions are being implemented. C) The Infection Control Nurse or designee will conduct an in service on or before 12/11/2012 with nursing, therapy, and environmental services staff regarding contact transmission based precautions. D) A Performance improvement tool will be utilized for random audits. Any problems identified will result in immediate education and/or corrective action will take action. The audits will be conducted by the Infection Control Nurse or designee. E) The Infection Control Nurse or designee will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems/trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

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F 441	Continued From page 27 staff interview, and review of facility policies and procedures, the facility failed to ensure infection control measures were consistently implemented on 2 of 5 nursing care units where various resident rooms had posted signage for contact isolation. The findings were: Review of the medical record for resident #119 revealed staff were to use contact isolation precautions during the provision of care due to Clostridium difficile infection. On 10/22/12 at 4:10 PM CNA #3 assisted the resident to the bedside commode in his/her room and the resident defecated. When the CNA cleaned the bedside commode, she used clear water without a disinfectant or cleaning agent. Interview on 10/22/12 at 4:40 PM with the CNA revealed she knew the bedside commode should have been cleaned with a disinfectant but none was in the room, therefore the proper procedure for disinfecting the feces contaminated item was not done. On 10/23/12 at 12:40 PM CNA #4 was observed assisting resident #119 from the wheelchair to the bedside commode in the resident's room. The CNA donned gloves, removed the gait belt from her waist, then secured it around the resident's waist to assist with the transfer. The large amount of fecal incontinence oozed from the resident's disposable brief on his/her clothing, down his/her lower extremities and to the floor. The CNA wore gloves but did not don a gown as she positioned the resident on the bedside commode and removed the resident's soiled clothing. The CNA used the cleansing wipes to clean the resident's skin, then used the same type of cleansing wipes to clean the floor, overbed table and bedside	F 441		

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F 441	Continued From page 28	F 441		

commode. After cleansing the floor, the CNA walked on areas of the floor and moved the bedside commode to other areas of the room. The gait belt remained on the resident as the CNA cleaned the diarrhea stool. During this time the resident was observed touching the gait belt intermittently with his/her hands and arms. When the task was completed the CNA removed the gait belt from the resident and placed it around the CNAs waist without disinfecting it.

In an interview on 10/25/12 at 10:30 AM, the ICP stated the CNAs actions were a breech of infection control practices.

Review of the policy and procedures regarding how to handle patient care items for patients on contact precaution, showed no system for determining which items should remain in the resident's room or which items needed to be disinfected between resident use.

According to Center for Disease Control and Prevention FAQS about Clostridium difficile for Healthcare Providers at http://www.cdc/HAI/organisms/cdiff/Cdiff_faqs_HCp.html (accessed on 11/2/12) the following measures were included in the recommendations:

a. "Use Contact Precautions: for patients with known or suspected Clostridium difficile infection."

b. "Use gloves when entering patients' rooms and during patient care."

c. "Use gowns when entering patients' rooms and during patient care."

d. "Ensure adequate cleaning and disinfection of environmental surfaces and re-useable devices, especially items likely to be contaminated with feces and surfaces that are touched frequently."

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