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Healthcare Licensing and Surveys

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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
	535025	A. BUILDING _____ B. WING _____	C 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	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: APS-Adult Protective Service CNA-Certified Nurse Aide DON-Director of Nursing POA-Power of Attorney 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 of 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=D	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). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225	F-225 **Corrective Action** Resident #1's alleged incident from December 2013 was immediately investigated. **Identification of Others** The Social Services Director/Designee will conduct a facility-wide survey to determine if residents have experienced, or have witnessed, any abuse and/or neglect. The Social Services Director/Designee will conduct random bi-monthly resident interviews for 3 months to confirm residents are not being treated in an abusive and/or neglectful manner.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

DL Steele — Senior Administrator — 3-18-14 (Amended)

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.

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F 225	Continued From page 1 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 review of facility investigations, medical record review, staff interview, POA interview, APS staff interview, and policy and procedure review, the facility failed to ensure 1 of 3 allegations of resident abuse (for resident #1) was reported as required and was investigated in a timely manner. The findings were: Review of the minutes from a meeting held on 12/27/13 between the administrator, DON, resident #1 and his/her family member, revealed the resident made an allegation of physical abuse stating a staff member "pinched" him/her and also slammed his/her legs against the bathroom door. In addition, the resident alleged verbal abuse by a staff member saying s/he was called a "liar." Interview with the resident's POA on 1/17/14 at 11:35 AM verified the resident made these allegations. Interview with the APS staff #1 on 1/17/14 at 11:30 AM also verified the allegations of physical and verbal abuse were made. Further interview with the APS staff member revealed she had discussed this allegation with the administrator, unit manager	F 225	**Systemic Changes** The Administrator/Designee will contact the State Survey Agency and all other agencies as required by law and/or rule within 24-hours of being notified of an allegation of abuse and/or neglect. The Staff Development Coordinator/Designee will conduct education with facility staff addressing the recognition of abuse and/or neglect, and the protocol for reporting such events. The Staff Development Coordinator/Designee will conduct education with facility staff addressing the reporting requirements regarding an allegation of abuse and/or neglect. The Social Services Director/Designee will conduct quarterly resident interviews addressing the experience of, or witnessing to, abuse and/or neglect. Results of these interviews will be addressed immediately if necessary, and brought to the monthly QA&A meeting for discussion and recommendations.	

2/18/14 - This POC accepted by Kathleen Williams Kathy and Surveyor.

2/18/14

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F 225	Continued From page 2 #1, and DON on 1/15/14 at 11 AM. The following concerns were identified: a. Review of facility documents showed the facility failed to report the allegation of abuse to the state survey agency as required. Additionally, the facility failed to thoroughly investigate the allegation in regard to the pinching, slamming the legs against the bathroom wall, and verbal abuse as evidenced by failure to interview all of the parties involved; specifically CNA #1. Interview with the administrator on 1/17/14 at 12:15 PM verified the allegation was not reported to the state survey agency because he believed it was not a case of abuse and therefore reporting to the state survey agency was not required. b. Review of the facility policy titled, "Abuse and Neglect Prohibition, last revised 6/13, showed the following instructions: Investigation: 1. The facility will conduct an investigation of any alleged abuse/neglect... 2. The facility will report such allegations to the state, in accordance with state regulation. 3. The facility will report all investigation findings to the state in accordance with state regulations."	F 225	**Monitoring** The Administrator /Designee will bring the results of the resident interviews to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is March 3, 2014.	