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

PRINTED: 11/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 10/28/2010

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 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of incident report documentation, and staff interview, the facility failed to perform a comprehensive assessment for 2 of 2 sample residents (#1, #5)	F 272	Preparation and/or execution of this plan of correction does 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. This plan of correction serves as the facilities allegation of compliance. Tag 272 It is the practice of the facility to conduct initially and periodically comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Corrective Action: Resident #1 transfer assessment has been updated on 11/22/10. Resident #5 discharged 11/19/10. Identification of Others: DON/designee will review all residents at high fall risk; review and update transfer assessments and transfer/fall care plan.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Reaume | TITLE: NHA | (X6) DATE: 11-22-10

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.

This POC accepted on 11/23/10 between Jennifer Reaume, Administrator and Terry Madden. 11/23/10

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F 272	Continued From page 1 who were at risk for falls. The findings were: 1. Review of the nurses' notes and the incident report documentation for resident #1 showed s/he fell during a transfer from the bed to his/her wheelchair on 7/21/10, which resulted in a sub-dural and sub-arachnoid bleed (bleeding of and around the brain) and hospitalization. The review showed CNA #2 transferred the resident alone at that time and did not use a gait belt as called for on the resident's transfer care plan. Review of the 6/10/10 significant change MDS assessment for the resident showed two staff members were required to provide extensive assistance with transfers. The 8/26/10 quarterly MDS assessment showed the resident required extensive assistance with transfers. Review of 7/21/10 and 8/11/10 interdisciplinary post fall reviews showed intervention recommendations that included adding a floor mat by the resident's bed and an alarm to the resident's wheelchair. However, the assessments failed to determine the method to be used for transfers such as the need for a mechanical lift, or a two person assist. 2. Review of the 8/24/10 admission MDS assessment for resident #5 showed two staff members were required to provide extensive assistance with transfers. Review of the resident's 9/28/10, 10/18/10, 10/20/10, 10/21/10, 10/24/10, and 10/28/10 interdisciplinary post fall reviews showed staff assessed the falls, and intervention recommendations included re-education of the resident to use the call light for assistance, adding a floor mat by the resident's bed, and use of a gait belt during resident transfers. Review of a physical therapy evaluation dated 10/1/10 showed assistance varies with all transfers & ambulation, minimal assistance to moderate to maximum	F 272	System/Measurements: SDC / designee will provide in-service education to License nursing staff regarding policy and procedure for transferring residents on or before 12/12/10. All residents who have a fall will be reviewed next business day during the morning business meeting and the IDT will review the transfer status with the post fall review. Monitoring: DON/designee will track and trend falls and interventions and will report findings to the QA&A committee monthly. 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 four months then will reassess the need for further monitoring based on compliance. Date of Completion: 12/12/10. TAG 274 It is the practice of the facility to conduct a comprehensive assessment for a resident within 14 days after the facility determines, or should have	

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F 272	Continued From page 2 assistance. However, the above mentioned assessments failed to determine the method (lift or number of staff required) for the safe transfer of the resident. 3. During an interview with the DON and MDS coordinator on 10/29/10 at 11 AM, the DON stated that resident care plans did not address staff numbers required for transfer, and no assessments were done for residents #1 and #5 to make that determination.	F 272	determined that there has been a significant change. This plan of correction serves as the facilities allegation of compliance. Corrective Action: Resident #2 comprehensive assessment for significant change has been completed 11/17/10.	
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 medical record review and staff interview, the facility failed to complete a significant change MDS assessment for 1 of 3 sample residents (#2) who required such an assessment. The findings were: Review of the medical record showed resident #2	F 274	Identification of Others: RCMD / designee will review and compare residents last MDS with current status for significant changes. Those identified will be scheduled with ARD's and completed within 14 days of the identification. System / Measures: Residents that have been discharged and returned will be reviewed for significant changes in morning business meeting and the IDT will determine if a significant change of condition is needed. RCMC will educate RCMD/and MDS coordinator on identification of significant changes and completing the assessment within 14 days of the identification of the significant change on or before 12/12/10.	

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F 274	Continued From page 3 had a fall on 9/24/10 that resulted in a hip fracture and subsequent surgery. The resident returned to the facility on 9/30/10. Further review showed the last MDS assessment for the resident was a quarterly assessment on 7/16/10. The review showed the facility completed an interdisciplinary post-fall assessment on 9/24/10, and referred to the care plan for revision. Revised changes to the care plan upon the resident's return to the facility showed staff was required to assist the resident with transfers and activities of daily living, including toileting. The resident could complete these tasks with minimal supervision prior to 9/24/10. In addition, staff was required to place an abductor pillow between the resident's legs when the resident was in bed. During an interview with the MDS coordinator on 10/29/10 (29 days since a significant change had been determined) at 2 PM, it was revealed that the resident required a significant change MDS assessment related to his/her fall. However, the MDS coordinator verified the assessment had not been completed. According to the September 2010 MDS RAI Version 3.0 Manual, page 2-15, a significant change MDS assessment is required on the 14th calendar day after determination that significant change in the resident's status has occurred.	F 274	NHA will receive MDS tickler weekly and review for assessment timeliness. Monitoring: NHA/designee to track and trend MDS assessment timeliness and report findings to the QA & A committee monthly. 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 4 months then reassess the need for continued monitoring based on compliance Date of Completion: 12/12/10	

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