PRINTED: 11/03/2014
FORM APPROVED
OMB NO. 0938-0391

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
	535026	A. BUILDING _____ B. WING _____	C 10/23/2014

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 159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the	F 159	Preparation and execution of this response and plan of correction does not constitute an admission or agreement be 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 it is required by the provisions of the state and federal law. For the purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of allegation of compliance in accordance with the State Operations Manual. F159 1. Resident #13 will be educated about signing for funds by 11/21/2014. 2. Business Office Director or designee will complete an audit by 11/21/2014 to ensure current Resident Trust Accounts have an	11/21/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/13/2014

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.

RECEIVED
WY Dept of Health
NOV 13 2014
Healthcare Licensing and Surveys

POC accepted. Cert to Jen Wong, DHA on 11/14/14 @ 3:59pm. Janeece Conn, ONLC

FORM CMS-2567(02-99) Previous Versions Obsolete — Event ID: UCA811 — Facility ID: WY0005 — If continuation sheet Page 1 of 4

PRINTED: 11/03/2014
FORM APPROVED
OMB NO. 0938-0391

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 10/23/2014

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 159	Continued From page 1 SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure and resident account review, the facility failed to safeguard the personal funds of 1 of 3 sample residents (#13) reviewed for accounting of personal funds. The findings were: Review of the quarterly 10/2/14 MDS assessment for resident #13 revealed the resident had diagnoses that included bipolar disorder and anxiety. The review revealed the resident had a legal guardian appointed. Review of the Resident Account Family Member Statement revealed the resident had personal funds available. Further review of the statement revealed the resident was advanced cash on 10/14/14 and 10/17/14. The following concerns were identified: a. Review of the withdrawal receipts dated 10/13/14 and 10/16/14 revealed the resident did not sign for the funds. Interview with staff member #1 on 10/23/14 at 11 AM revealed the receipts dated 10/13/14 and 10/16/14 were signed by a person the resident identified as a "friend". b. Review of the facility policy titled, "Resident Trust Accounts", revised April 2012 revealed, "Only the resident or authorized individual can make a cash withdrawal. Authorized individuals are Power of Attorney (POA), Legal Guardian or	F 159	authorization form with copies of the POA, Guardian or Rep Payee documents. 3. Business Office Director or designee to educate the Administrative Assistant by 11/21/2014 regarding the purpose of maintaining a binder for identifying residents/ authorized persons whom are able to withdrawal funds. 4. Business Office Director or designee to review all resident trust disbursements monthly for 90 days to ensure the resident or authorized individual made the withdrawal. Results of monitoring will be reported to the facility QAPI committee monthly for 90 days or until substantial compliance has been achieved and sustained as determined by the committee.	

PRINTED: 11/03/2014
FORM APPROVED
OMB NO. 0938-0391

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 10/23/2014

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 159	Continued From page 2 Rep Payee (excluding facility)."	F 159		
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 medical record review and staff interview, and policy and procedure review, the facility failed to ensure adequate supervision for 1 of 13 sample residents (#13). The findings were: Review of the quarterly 10/2/14 MDS assessment revealed resident #13 had diagnoses that included bipolar disorder and anxiety. Medical record review revealed the resident was appointed a legal guardian. The following issues were identified: a. Review of the "Out Of Facility Release Of Responsibility" form revealed the resident had signed him/herself out on 10/13/14 at 1:30 PM. However, the facility failed to ensure the resident signed back in upon return to the facility. b. Interview with staff member #1 on 10/23/14 at 11 AM revealed the resident had left the facility on 10/13/14 and 10/16/14; however, the facility failed to ensure the responsible person signed the resident out either day. c. Review of the policy titled, "Resident On Pass," last revised on June 2007 revealed, "The	F 323	F323 1. Resident #13 will be educated about signing the "Out of Facility Release of Responsibility" form by 11/21/2014. 2. Director of Nursing or designee will complete an audit by 11/21/2014 to ensure each resident whom has a "Out of Facility Release of Responsibility" form in the last 30 days is reviewed to ensure the resident or POA has signed out and in. 3. Director of Nursing or designee to educate Nursing Staff by 11/21/2014 regarding the purpose of the "Out of Facility Release of Responsibility" form to ensure the resident or authorized individual is signing out and in. 4. Director of Nursing or designee to review all	11/21/14

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

PRINTED: 11/03/2014
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 10/23/2014

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 323	Continued From page 3 sign out register must indicate who is responsible for the resident while he or she is signed out." Further review revealed, "Residents must be signed in upon return to the facility."	F 323	"Out of Facility Release of Responsibility" forms monthly for 90 days to ensure the resident or authorized individual signed out and in. Results of monitoring will be reported to the facility QAPI committee monthly for 90 days or until substantial compliance has been achieved and sustained as determined by the committee.	