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

PRINTED: 03/31/2016
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
	535032	A. BUILDING _____ B. WING _____	03/17/2016

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

SA 4/12/16

(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 On 03/14/16 - 03/17/16 a recertification survey was conducted at Life Care Center of Cheyenne. The following common abbreviations are used throughout this document: ADON Assistant Director of Nursing CNA Certified Nurse Aide DON Director of Nursing Services MAR Medication Administration Record MDS Minimum Data Set LPN Licensed Practical Nurse RN Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, observation, review of resident council minutes, and review of policies and procedures, the facility failed to ensure a grievance from the resident council was acted upon to resolve a repeated	F 244	F244 When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. A) The facility has ensured that resident #116 received meals in a timely manner and that resident #110's order is taken in a timely manner at subsequent meals. In a resident council meeting on 3/31/16 an appropriate resolution for serving all residents at the same table was identified for implementation.	5/1/2016

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

Executive Director 4/8/16

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.

Spoke with Bryan Merrell, 4/12/16 2:50 pm. PoC accepted with agreed upon changes. SSQD, state surveyor

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 _____	03/17/2016

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

SA 4/12/16

(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 244	Continued From page 1 issue for 2 of 3 months (January 2016, February 2016) reviewed. The findings were: Review of the resident council minutes for January 2016 showed residents had concerns regarding staff not serving everyone at the same table at the same time. Review of the February 2016 minutes showed it was still an issue. Confidential interview with a group of 10 residents on 3/15/16 at 9 AM revealed 6 residents felt the issue was not resolved. They further stated their food would get cold if they waited for everyone else at the table to be served, and they did not like to eat in front of others. Interview with the recreational manager on 3/17/16 at 9 AM revealed when concerns were brought up in resident council, she filled out a concern form and gave it to the administrator for follow-up with the specific department manager. If the concern was not resolved by the next month's resident council, a new concern form was filled out and the process started again. The following concerns were identified: a. Observation of the lunch meal on 3/14/16 at 11:38 AM showed resident #116 was seated at a table with 2 other residents. The 2 other residents received their meals at 11:38 AM. At that time the resident asked staff about his/her meal and was told it was coming. The meal arrived at 11:48 AM and was placed in front of the resident, who stated "You're too late" and wheeled him/herself out of the dining room. At 12:08 PM the resident was wheeled back in to the dining room by another staff member and seated at another table. The resident's meal was retrieved from the first table and brought to the resident at the new table. b. Observation of the lunch meal on 3/14/16	F 244	B) The ED or designee will conduct random audits to ensure meals are received in a timely manner, orders are taken in a timely manner, and grievance cards from Resident Council will show follow-up and/or resolution. C) The ED or designee will conduct an in-service on or before 5/1/16 with dietary staff and other staff assisting in dietary services to ensure the following: meals are received in a timely manner and orders are taken in a timely manner. The ED or designee will conduct in-service on or before 5/1/16 with activity staff regarding resident council grievance process. D) A Performance Improvement tool will be utilized to randomly audit the timeliness of meals served, timeliness of taking orders, and that resident council grievance cards have follow-up or resolution. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by ED or designee. E) The ED will report the results of the 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.	

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 _____	03/17/2016

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

8k 4/12/16

(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 244	Continued From page 2 at 11:35 AM showed resident #110 was seated at a table by him/herself. Staff members were delivering trays to the other residents in the dining room. Continued observation showed at 12:09 PM, 34 minutes later, a dining room attendant approached the table and asked the resident for his/her lunch order. The lunch tray arrived at 12:17 PM. c. Observation of the dining service on 3/16/16 at 5:10 PM showed 6 of 22 tables had some residents that were eating and some residents that had not been served. d. Interview with the dietary manager on 3/17/16 at 9:30 AM verified she was aware the residents wanted each table to be served meals together. She revealed they had been working on a new approach for about a week and it remained a work in progress. e. Interview with the administrator on 3/17/16 at 11:30 AM revealed the concern forms initiated during the resident council did not show follow up or resolution. Review of the policy and procedure titled "Resident Council," undated, showed: "...3. The Recreation Therapy/ Activity Director will facilitate follow-up on all complaints, suggestions, and ideas presented at the council meeting and will report results at the next meeting for the residents' information... 4. Each Department Director will be responsible for filling out a response form prior to the next meeting to provide his or her input..."	F 244		
F 248	483.15(f)(1) ACTIVITIES MEET	F 248	F248 The facility must provide for an ongoing	5/1/2016

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 _____	03/17/2016

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

4/12/16

(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 248 SS=D	Continued From page 3 INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record review the facility failed to provide a meaningful program of activities designed to meet resident needs for 1 of 1 sample residents (#31) on isolation precautions. The findings were: Review of 02/24/16 quarterly MDS assessment showed resident #31 was able to make him/herself understood, could understand others, and was cognitively intact with a BIMS (brief interview for mental status) score of 15 out of 15. Continued review showed activity preferences included music, group activities, going outside, and animals. The following concerns were identified: a. Review of a progress note dated 3/9/16 showed the resident was placed on droplet/precautions isolation. Progress notes dated 3/11/16 and 3/12/16 showed the resident was "tearful" about being on isolation and "gloomy" from having to stay in his/her room. b. Interview with the resident on 3/16/16 at 12 PM revealed the resident was "sick to death of puzzles...did nothing all day...watched the cars go by through the window," and wished s/he could go outside. c. Review of the Individual Resident Daily Participation Record for March 2016 showed	F 248	program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychological well-being of each resident. A) Resident #31 was taken off droplet isolation precautions on 3/18/2016. Resident #31 was offered outdoor activities and has since resumed participating in all activities of preference. B) The ED or designee will conduct random audits to ensure any resident on droplet isolation precautions receive a meaningful program of activities designed to meet that resident's needs during the isolation period. C) The ED or designee will conduct an in-service on or before 04/20/16 with activities associates to ensure that any resident on droplet isolation precautions receive a meaningful program of activities designed to meet that resident's needs during the isolation period. D) A Performance Improvement tool will be utilized to randomly audit the provision of meaningful program of activities while a resident is on droplet isolation precautions. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by ED or designee. E) The ED will report the results of the audits at the monthly Performance Improvement meeting.	

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 _____	03/17/2016

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

SA 4/12/16

(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 248	Continued From page 4 visits were recorded during the isolation period. These visits consisted of family/friend visits and reality orientation visits. There were no other activities, such as music or favorite activities documented. d. Review of the Friendly Visit documentation showed 4 visits were made between 3/10/16 and 3/16/16, these visits ranged from 4-5 minutes in length, and included checking to see if the resident needed anything. There were no other activities documented. e. Interview with activities director on 3/17/16 at 9:58 AM confirmed family/friend visits and reality orientation visits lasted approximately 2 minutes and consisted of reading the daily activity sheet. At that time, the director revealed the resident "is usually one of our busiest people, [s/he] loves to be around other people and likes to reminisce."	F 248	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 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	F 279	F279 A facility must use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care. A) The care plan for Resident #74 was updated to reflect current oral intake of fluids and transfer status. B) The DON or designee will conduct a 100% audit of all residents' care plans to ensure ~~oral fluid intake and transfer status~~ they are updated to show current status. C) The DON or designee will conduct an in-service on or before 5/1/16	5/1/2016 SA

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 _____	03/17/2016

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

S+ 4/12/16

(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 279	Continued From page 5 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 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 observation, staff interview, and medical record review, the facility failed to ensure the care plan was updated to reflect the current needs for 1 of 21 sample residents (#74). The findings were: Review of the 1/21/16 significant change MDS assessment showed resident #74 had diagnoses that included dementia, pneumonia, muscle weakness, and oropharyngeal dysphagia (difficulty swallowing). Further review showed the resident was totally dependent for transfers, requiring two people to assist. Additionally, the resident required a mechanically-altered diet and was noted to cough or choke during meals or when taking medications. Review of the physician orders for March 2016 showed intravenous (IV) hydration was discontinued on 2/4/15 and honey-thickened liquids were ordered on 2/5/16. Further review showed the "resident to be 2 person transfer...." Review of the care plan dated 1/26/16 showed the resident was "very high risk for aspiration. No longer safe with any thickness of PO [by mouth] liquids and all liquids received are via IV..." Further, it showed "Extensive to total assist ...transfers... sit to stand lift for transfers." The following concerns were noted: a. Observation on 3/14/16 at 12:26 PM	F 279	with all licensed nursing staff regarding the importance of updating care plans when orders change ~~in regard to oral fluid intake and transfer status~~. D) A Performance Improvement tool will be utilized to conduct random audits. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the DON or designee. E) The DON 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.	SK

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 _____	03/17/2016

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

84 4/12/16

(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 279	Continued From page 6 showed the resident sitting in a wheelchair in the dining room with a plate of pureed food and a glass of thickened liquids. b. Observation on 3/14/16 at 4:29 PM showed the resident lying in bed, with CNA #1 and CNA #2 assisting the resident to the wheelchair. The CNAs placed a gait belt around the resident's trunk, then lifted the resident into the wheelchair. The resident was not weight-bearing during the transfer. c. Interview with the DON and MDS coordinator on 3/17/16 at 9:30 AM verified the care plan needed to be updated to show the resident's current status of oral intake of fluids. d. Interview with the unit manager RN #1 on 3/17/16 at 10:15 AM revealed the resident usually required a sit-to-stand or full mechanical lift for transfers, although when stronger and weight-bearing would be able to transfer using two staff members and a gait belt.	F 279		
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	F371 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. A) 1a) The Dietary Manager relocated cheese sandwiches on 3/16/16. Employee #1 has been educated by supervisor that he/she is no longer permitted to perform dietary tasks without training.	5/1/2016

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 _____	03/17/2016

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

(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 371	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure safe and sanitary conditions in 2 of 2 kitchens (the main kitchen, the therapy kitchen). The findings were: 1. Observation in the main kitchen on 3/16/16 at 3:40 PM showed the following sanitation issues: a. A cart located in the food preparation area of the kitchen contained rolls of raw ground beef stored on the shelf above a pan of cheese sandwiches. Interview with the dietary manager at that time verified the raw meat needed to be stored on the bottom shelf. She was unaware of how long the food had been out of refrigeration. b. At 3:58 PM employee #1 was observed wearing disposable gloves to sweep up broken glass. With her gloved hands the employee pushed down the trash in the garbage can while disposing of the glass. The employee then removed the gloves and donned a new pair without performing any hand hygiene. With the second set of gloves the employee proceeded to pick up a wet wiping cloth located on the side of the 3 compartment sink. The employee used the towel to wipe pans and then to wipe down a food preparation counter. At 4 PM interview with the employee verified no sanitizer solution had been used when wiping down these items. c. The door between the kitchen and the dining room remained closed and when staff entered the kitchen to retrieve residents' meal trays they had to open the door and then handle it again on the way out to the dining room. There was no hand hygiene performed after contact with the door handle. Observation from the dining room on 3/14/16 at 11:45 AM and on 3/16/16 at 4:30 PM showed there was no hand hygiene	F 371	The door between the kitchen and dining room will remain open during meal service. Dietary staff #1 educated on proper removal of gloves and hand hygiene after coming in contact with soiled surface. Hand towels made available at hand washing sink in therapy kitchen on 3/16/16. B) The Dietary Director or designee, will conduct random audits to ensure that raw meat is not stored near ready prepared foods, employees are performing hand hygiene after disposing of garbage, pans and food preparation counters are sanitized properly, dietary staff is removing gloves and performing hand hygiene after coming in contact with soiled surfaces, and hand towels are available at hand washing sink in therapy kitchen. C) The Dietary Director or designee, will conduct an in-service on or before 5/1/16 with dietary staff to ensure raw meat is not stored near ready prepared foods, employees are performing hand hygiene after disposing of garbage, pans and food preparation counters are sanitized properly, dietary staff is removing gloves and performing hand hygiene after coming in contact with soiled surface, and hand towels are available at hand washing sink in therapy kitchen. D) A Performance Improvement tool will be utilized to conduct random audits. Any problems identified will result in immediate education and/or corrective action.	

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 _____	03/17/2016

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

(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 371	Continued From page 8 performed after contact with the door handle prior to delivering the residents' meals. d. At 4 PM dietary staff #1 entered the walk-in refrigerator to retrieve food items. She handled the door which was visibly soiled while wearing disposable gloves. She then proceeded to load a cart with pans of food to be transported to the therapy kitchen. The staff failed to remove the soiled gloves and perform hand hygiene before leaving the kitchen. 2. Observation on 3/16/16 at 5:25 PM showed there were no hand towels available at the hand washing sink in the therapy kitchen. At that time there were 2 dietary staff cooking food and preparing plates of food for the residents. 3. Interview with the dietary manager on 3/17/16 at 9:30 AM verified the hand washing and glove use required additional education. She further revealed the employee who failed to use sanitizer to wipe the counters was helping out in the kitchen from the maintenance department, and she had not had training related to dietary services. The manager also stated the hand towels for the hand washing sink needed to be better monitored to ensure the supply was available. According to Food Code 2013, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands According to Food Code 2013, U.S. Public Health	F 371	The audits will be conducted by the Dietary Director or designee. E) The Dietary 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.	

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 _____	03/17/2016

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

(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 371	Continued From page 9 Service: 3-302.11 "(A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(c) below, separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables..." According to Food Code 2013, U.S. Public Health Service: 6-301.12 "Each HANDW- ASHING SINK or group of adjacent HANDW ASHING SINKS shall be provided with: (A) Individual, disposable towels..."	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	F431 Drugs and biologicals used in the facility must be labeled in accordance to currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. A) The two vials that had not been labeled with open dates and the card containing Senna without an expiration date were discarded. New medication were ordered promptly. B) The DON or designee conducted a 100% audit of insulin vials on 3/17/16 to ensure open dates and expiration dates are labeled and medication cards have expiration dates labeled.	5/1/2016

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 _____	03/17/2016

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

st 4/12/16

(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 431	Continued From page 10 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the manufacturers' instructions and policy and procedures, the facility failed to ensure medications were labeled with the expiration date once opened. In addition, the agency failed to ensure medications received from the pharmacy were labeled with the expiration date in 1 of 5 medication storage areas (West medication cart). The findings were: 1. Observation on 3/17/16 at 10:45 AM showed the West medication cart had 2 vials of the insulin Novolog and 1 vial of Levemir opened and available for use. Further, it showed the vials had not been labeled with the date opened. Review of the manufacturers' instructions showed Novolog expired 28 days after it was opened and Levemir expired 42 days after opening. In addition, a medication card containing Senna was found not	F 431	C) The DON or designee will conduct an in-service on or before 5/1/16 with all licensed nursing staff to ensure insulin vials are labeled with open dates and expiration dates and medication cards are labeled with expiration dates. D) A Performance Improvement tool will be utilized to conduct random audits. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the DON or designee. E) The DON 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.	

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 _____	03/17/2016

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

sk 4/12/16

(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 431	Continued From page 11 to be labeled with an expiration date. An interview with RN #2 at that time confirmed the insulin vials needed to be labeled with the dates they were opened. Further, she indicated the medication card needed to show the date the Senna expired. 2. Review of the policy and procedure titled "Medication Storage & [and] Security in the Facility" revised 6/06, showed "16. General Insulin Storage Guidelines... The nurse always dates and initials insulin vials when opened."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	F441 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. A) Resident #127 was discharged from facility on 3/15/2016. CNA #5, #6, & #7 have been educated in regards to keeping catheter bag below the bladder during transfers, keeping catheter bag off the floor, and ensuring a dependent loop is not present in the catheter tubing. CNA #8 was educated on proper cleaning of slings between resident use. Laundry educated on proper PPE and hand hygiene upon entering and exiting a droplet isolation precaution room.	5/1/2016

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 _____	03/17/2016

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

CA 4/12/16

(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 441	Continued From page 12 (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, staff interview, and policy and procedure review, the facility failed to ensure infection prevention practices were followed by staff for 2 of 6 sample residents (#38, #127) with urinary catheters. In addition, the facility failed to use PPE (Personal Protective Equipment) and use appropriate sanitation techniques for multi-resident use equipment during 2 random observations. The findings were: 1. Review of the 2/25/16 quarterly MDS assessment showed resident #127 was severely cognitively impaired and had diagnoses that included UTI (Urinary Tract Infection), obstructive neuropathy, aphasia, and seizure disorder. Further, the resident required extensive assistance of 2 or more persons for bed mobility and transfer, total assistance of 1 person for toilet use, and total assistance of 2 or more persons for personal hygiene. Review of the History and	F 441	B) The DON or designee will conduct random audits of residents with urinary catheters to ensure the catheter is kept below the bladder during transfers, the catheter bag is not placed on the floor, and there are no dependent loops present in the catheter tubing. The DON or designee will conduct random audits to ensure transfer slings are properly cleaned between resident uses. The DON and designee will conduct random audits to ensure laundry dons proper PPE and hand hygiene upon entering and exiting a droplet isolation precaution room. C) The DON or designee will conduct an in-service on or before 4/12/2016 with all nursing staff to ensure the catheter is kept below the bladder during transfers, the catheter bag is not placed on the floor, there are no dependent loops present in the catheter tubing, and proper cleaning of slings between resident use. The DON or designee will conduct an in-service on or before 4/12/2026 with Environmental Services to ensure donning proper PPE and hand hygiene upon entering and exiting a droplet isolation precaution room. D) A Performance Improvement tool will be utilized to conduct random audits. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the DON or designee.	

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 _____	03/17/2016

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

SK 4/12/16

(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 441	Continued From page 13 Physical dated 3/14/16 showed the resident "appeared to have a grand-mal seizure" and UTI in October 2015. Further, it showed the seizure was most likely caused by a UTI. Review of a physician note dated 2/21/16 showed the resident was being treated for UTI and epididymitis (inflammation of the tube at the back of the testicle). The following concerns were identified: a. Observation on 3/14/16 at 4:20 PM showed CNA #3 and CNA #4 entered the resident's room to assist the resident to get up in the wheelchair. After performing catheter care to the tubing and insertion point, a gait belt was applied to the resident's trunk to assist with transfer. CNA #3 lifted the catheter collection bag above the resident's bladder and secured it on the gaitbelt. Urine was visible in the tubing and flowed backwards toward the resident's bladder. The resident was assisted to stand and pivot, then lowered into the wheelchair. While in the wheelchair the collection bag was above the bladder, resting on the resident's trunk. b. Interview with the Medical Director on 3/16/16 at 3:06 PM revealed that having a catheter can increase the risk of UTI and epididymitis. Further, a UTI could increase the risk of seizures for the resident. c. Interview with the DON and ADON on 3/17/16 at 10:28 AM revealed the drainage bag should have been kept below the resident's bladder. d. Review of the "Clinical Services Policy and Procedure, Nursing Volume II" titled "Genitourinary, Chapter 9", provided by the facility on 3/17/16 at 10:28 AM, showed "Infection Control:...6. Keep the collecting bag below the level of the bladder..." e. Review of the CDC's "Guideline for Prevention of Catheter-Associated Urinary tract	F 441	E) The DON 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.	

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 _____	03/17/2016

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

sk 4/12/16

(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 441	Continued From page 14 infections 2009" showed "...Category IB-A strong recommendation supported by low quality evidence suggesting net clinical benefits or harms or an accepted practice (e.g. aseptic techniques) supported by low to very low quality evidence...B. Maintain unobstructed urine flow. (Category IB)...2. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the flow. (Category IB)..." 2. Observation on 3/16/16 at 2:35 PM showed CNAs #5, #6, and #7 transferred resident #38 from the wheelchair to the bed using a full mechanical lift. The resident had a Foley catheter and urine collection bag. During the transfer one of the CNAs hung the bag from the lift transfer bar, above the level of the bladder allowing urine to potentially flow back into the bladder. While the resident was in bed, perineum care was provided. The resident was turned to his/her side and the Foley catheter bag was placed directly on the floor during repositioning. The bag was then placed in a pouch hanging off the side of the bed with a dependent loop extending below the level of the urine bag. Interview with CNAs #5 and #7 following the observation revealed they were aware the urine bag should not have been placed on the floor. Further, a dependent loop should be avoided in order to ensure proper urine flow. 3. Observation on 3/14/16 at 4 PM showed CNA #8 took a lift sling used during a transfer from resident room #301 to resident room #310 and placed it on the sink for use. The sling dropped to the floor. The CNA then retrieved another sling from resident room 314 to use to transfer the resident in room 310. During an interview with CNA #9 on 3/14/16 at 4:40 PM, she indicated slings were sent to the laundry when they were	F 441		

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 _____	03/17/2016

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

(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 441	Continued From page 15 soiled, particularly with urine and stool. Further, she was uncertain of any schedule for cleaning the slings to include between residents. Interview with the DON on 3/16/16 at 6:20 PM revealed slings were to be sprayed down with "virex" (a disinfectant) prior to use for another resident. 4. Review of the care plan showed resident #31 had a potentially active infection in the lungs, and was to be on droplet precautions/isolation as of 3/9/16. Review of the facility policy entitled, "Chapter 4: Standard and Transmission-based Precautions; Isolation Procedure" showed visitors to the room of a resident on droplet precautions were "instructed to wear a mask and wash hands when entering and leaving room." The following concerns were identified: a. Observation on 3/14/16 at 4:05 PM showed housekeeper #1 entered the resident's room without donning any PPE or washing her hands to deliver laundry. The housekeeper then exited the room without washing her hands and walked down the hall. The housekeeper was then observed entering another resident's room. b. Interview with the staff development coordinator on 3/14/16 at 4:30 PM confirmed all staff, including housekeeping, were expected to don the appropriate PPE before entering the room of a resident on isolation precautions. c. Interview with the DON and ADON on 3/17/16 at 10:28 AM verified staff should don PPE when performing tasks in an isolation room.	F 441		