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

PRINTED: 04/06/2017
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 _____	03/23/2017

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 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 3/20/17 through 3/23/17 at Life Care Center of Cheyenne located in Cheyenne, Wyoming. The following common abbreviations are used throughout this document: ADL: Activities of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nurse Aide MDS: Minimum Data Set LPN: Licensed Practical Nurse RAI: Resident Assessment Instrument RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 156 SS=B	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:	F 156	F156 The facility must post, in a form and manner accessible and understandable to resident, resident representatives: A list of names, addresses (mailing and email) and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State Licensure office, adult protective services, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and Medicaid Fraud	5/6/17

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

Director of nursing 4-25-2017

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
APR 24 2017
Healthcare Licensing and Surveys

4/25/17 2:28pm
Spoke c Clint Scearce. POC accepted with agreed upon changes.
Tim Forcum

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F 156	Continued From page 1 (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State	F 156	Control Unit; and a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation. A) The facility has ensured that applicable email addresses for pertinent state agencies was added to posting. The facility has added a statement to show residents may file a complaint with the State Survey Agency. Required positing was relocated to lobby during the course of survey. B) The ED or designee will conduct weekly audits to ensure required positing of pertinent State agencies contact information including email addresses and other necessary statement remain posted in a readily accessible manner. Any problems identified will result in immediate education and/or corrective action. C) The ED or designee will provide education to resident council group at monthly resident council meeting regarding content and location of required posted notices. D) A Performance Improvement tool will be utilized to randomly audit the compliance of required posted notices.	

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F 156	Continued From page 2 and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for	F 156	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 until ongoing compliance has been achieved.	

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F 156	Continued From page 3 information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon	F 156		

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F 156	Continued From page 4 admission and during the resident's stay. (I) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (II) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (I) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(I)(A) and (B) of this section. (g)(18) The facility must inform each resident	F 156		

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F 156	Continued From page 5 before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 156		

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F 156	Continued From page 6 Based on observation and staff interview the facility failed to post the required notices in a form and manner readily accessible to residents and resident representatives. The census was 143. The findings were: Observation of the facility during the survey timeframe showed the names, addresses, and phone numbers of all pertinent State agencies and advocacy groups were listed on an 8 by 11 inch framed document located on a table in the main entrance vestibule. The doors into the vestibule from the facility remain locked at all times and required the manual depression of a red button to open them, which made this document inaccessible to residents. In addition, the document did not contain the required email addresses or a statement to show residents may file a complaint with the State Survey Agency. The administrator declined to comment during an interview on 3/23/17 at 12 PM.	F 156		
F 166 SS=B	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The	F 166	F166 The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights. Upon request, the provide must give a copy of the grievance policy to the resident. A) Facility Grievance Policy and Procedure amended to include contact information of grievance official, expected time frame for completion of the grievance, contact information for independent entities with whom a grievance could also be filed, and right to file grievances	5/6/17

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F 166	Continued From page 7 grievance policy must include: (I) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately	F 166	B) The ED or designee will educate the facility resident council regarding amended grievance policy and procedure on or before 05/06/17. C) The ED or designee will conduct an in-service on or before 05/06/17 with all facility staff regarding changes made to facility grievance policy and procedure. D) The amended Grievance Policy and Procedure will be presented at monthly Performance Improvement Meeting on or before 05/06/17. E) The Executive Director will monitor amended policy for inclusion of required information. The report will include any problems and/or trends noted. Reporting will occur for no less than three months until ongoing compliance has been achieved.	

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F 166	Continued From page 8 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of policy and procedure, the facility failed to ensure the grievance policy contained all the required information. The census was 143. The findings were:	F 166		

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F 166	Continued From page 9 Review of "Grievance Procedures," last revised 11/19/16, showed the policy failed to include required information including the name, address, and phone number of the grievance official, the expected time frame for completion of the grievance, the contact information of independent entities with whom a grievance could also be filed, and did not address the right to file a grievance anonymously. Interview with the administrator on 3/23/17 at 10:10 AM confirmed the policy and procedure did not contain all necessary information.	F 166		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) 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, staff interview, and review of the CMS RAI version 3.0 manual, the facility failed to ensure a significant change assessment was completed for 2 of 5 sample residents (#40, #110) with a significant change. The findings were:	F 274	F274 Comprehensive Assessment after significant change within 14 days after the facility determines, or should have been determined, that there has been a significant change in the resident's physical or mental condition. A) A significant change assessment for resident #40 was completed on 04/10/17. A significant change for resident #110 was completed on 04/10/17. B) The DON or designee will conduct a 100% review of all residents to determine if a significant change assessment required. Required significant change assessments will be completed by MDS coordinators. Any problems identified will result in immediate education and/or corrective action.	5/6/17

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F 274	Continued From page 10 1. Review of the quarterly MDS assessment dated 2/3/17 showed resident #40 at section 1300 D (Psychomotor retardation) was coded as behavior fluctuates. Further review showed the resident had a depression score of 6 (mild), verbal behavior symptoms directed towards others that occurred 1 to 3 days, other behavioral symptoms not directed at others that occurred 1 to 3 days, no functional range of motion limitations in range of motion in upper extremities, occasional as needed pain medications, occasional pain with a numeric score of 4 out of 10, non-physician prescribed weight loss, use of antipsychotic medication for 6 days, use of antianxiety medication for 7 days, and use of antidepressant medication for 7 days during the assessment period. The following concerns were identified: a. Review of the admission MDS assessment dated 12/2/16 showed the resident had no behaviors present for section 1300 D, had a depression score of 4 (minimal), no verbal behavioral symptoms directed towards others, no other behavioral symptoms not directed at others, functional limitations of both upper extremities, no as needed pain medication, no identified pain, no weight loss, and no antipsychotic, antianxiety, or antidepressant medication use during the assessment period. b. Interview with MDS coordinator #1, MDS coordinator #2, MDS coordinator #3 and the social services director on 3/23/17 at 12:16 PM confirmed a significant change assessment should have been completed. 2. Review of the quarterly MDS assessment dated 3/7/17 showed resident #110 sometimes made self understood, had a BIMS score of 8 (moderately impaired), a depression score of 3	F 274	C) The DON or designee will conduct an in-service on or before 05/06/17 with all MDS coordinators regarding the requirements for significant change assessments. D) A Performance Improvement tool will be utilized to conduct weekly audits to determine if significant change assessments have been completed as required. 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 until ongoing compliance has been achieved.	

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F 274	Continued From page 11 (minimal), was continent of bowel, had scheduled pain medications, had no as needed pain medications, and no falls. The following concerns were identified: a. Review of the admission MDS assessment dated 10/20/16 showed the resident rarely/never made self understood, was unable to interview for BIMS with identified short term memory loss and moderate impairment for daily decisions, had a depression score of 9 (mild), was occasionally incontinent of bowel, had no scheduled pain medication, as need pain medication, and 1 fall with no injury since admission or prior assessment. b. Interview with MDS coordinator #1, MDS coordinator #2, MDS coordinator #3 and the social services director on 3/23/17 at 12:16 PM confirmed a significant change assessment should have been completed. 3. Review of the "CMS RAI version 3.0 manual, October 2016," showed "...04. Significant change in status assessment (SCSA) (A0310A=04)... other conditions may not be permanent but would have such an impact on the resident's overall status for more than two weeks that they would require a comprehensive assessment and care plan revision. For example, a hip fracture may be viewed as a transient condition but it would generally have a major impact on the resident's functional status in more than one area (e.g., ambulation, toileting, elimination patterns, activity patterns)..." Continued review showed "...Decline in two or more of the following...any decline in an ADL (activities of daily living) physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment." Further, the RAI stated a significant change	F 274		

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F 274	Continued From page 12 assessment is appropriate when " ...There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments..."	F 274		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (I) 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 §483.24, §483.25 or §483.40; and (II) Any services that would otherwise be required	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 #85 was updated on 4/10/17 to include an approach for repositioning. B) The DON or designee will conduct a 100% audit of residents at moderate or higher pressure sore risk to ensure repositioning is a care plan approach. . Any problems identified will result in immediate education and/or corrective action. C) The DON or designee will conduct an in-service on or before 05/06/17 with all licensed nursing staff regarding the importance of repositioning as an approach for residents determined to be at moderate or high pressure sore risk.	5/6/17

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F 279	Continued From page 13 under §483.24, §483.26 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative.(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview the facility failed to ensure a comprehensive care plan was developed on resident needs for 1 of 21 sample residents (#85). The findings were: 1. Review of the 1/9/17 quarterly MDS assessment showed resident #85 had diagnoses	F 279	D) A Performance Improvement tool will be utilized to conduct random audits of moderate or high risk residents' care plans to ensure repositioning as an approach. 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 until ongoing compliance has been achieved.	

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F 279	Continued From page 14 which included heart failure, diabetes mellitus, Parkinson's disease, depression, and difficulty in walking. The resident required the extensive assistance of 2 staff members for bed mobility, transfers, dressing, and toileting. Review of the 1/4/17 Braden scale assessment for predicting pressure sore risk showed the resident scored 14 (moderate risk). The following concerns were identified: a. Observation on 3/20/17 at 2:10 PM showed the resident was in his/her wheelchair in the dining room attending an activity. The resident's right foot was supported by a foot trough, and a left trunk support pad and bilateral arm rest pads were on the wheelchair. At 3:35 PM the resident was brought to his/her room for a blood sugar check. At 4:20 PM CNA #1 returned the resident to the dining room for the evening meal. At 5:32 PM the resident was brought back to his/her room by CNA #2. Continued observation until 6:05 PM showed the resident had not been repositioned for 4 hours. b. Review of the 1/19/17 care plan section "Risk for Pressure Ulcers" showed approaches which included weekly skin assessments, quarterly Braden scale assessments, floated heels while in bed, and pressure relieving or reduction devices to the bed and wheelchair. The care plan failed to address the need for repositioning. c. Interview on 3/22/17 at 3:30 PM with LPN #2 revealed the resident was transferred with a sit-to-stand lift and was totally dependent on staff for mobility. d. Interview with the DON on 3/23/17 at 12:12 PM confirmed the resident's care plan did not include repositioning as an intervention to prevent pressure ulcers and, in addition, it was his expectation that residents at risk for developing	F 279		

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F 279	Continued From page 15 pressure injuries be repositioned every two hours.	F 279		
F 282 SS=D	483.21(b)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must: (II) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview the facility failed to ensure plans of care were followed as written for 2 of 21 sample residents (#66, #27). The findings were: 1. Review of the 1/5/17 quarterly MDS assessment showed resident #66 had moisture associated skin damage, was frequently incontinent, and required extensive assistance with toileting. Review of the resident's care plan for incontinence showed approaches that included instructions for staff to toilet upon rising, before and after meals, at bedtime and as needed. The following concerns were identified: a. Continuous observation on 3/20/17 beginning at 2 PM and ending at 5:30 PM (3 1/2 hours) showed the resident was seated in a wheelchair. The resident was in the dining room from 2 PM until 4 PM. At 4 PM LPN #1 brought the resident to his/her room for medication administration and then returned him/her back to the dining room without toileting him/her. At 4:45 PM the resident was served dinner. At 5:30 PM the resident finished dinner and remained in the	F 282	F282 The services provided or arranged by the facility, as outlined by the comprehensive care plan must be provided by qualified persons in accordance with each resident's care plan. A) The licensed and certified nursing staff for residents #66 and #27 were educated regarding care planned approaches for incontinence. B) The DON or designee will conduct random audits of residents who are incontinent and require extensive assistance with toileting to ensure care planned approaches are followed as directed. Any problems identified will result in immediate education and/or corrective action. C) The DON or designee will conduct an in-service on or before 05/06/17 with all licensed nursing staff regarding the importance of following care planned approaches for incontinence.	5/6/17

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F 282	Continued From page 16 dining room. At no time during the observation did staff offer to toilet the resident. b. Interview with LPN #1 on 03/20/17 at 4 PM revealed the resident was to be toileted before and after meals and at bedtime. In addition, she stated the resident required total lift assistance from staff. c. Interview on 3/21/17 at 1 PM, with RN #2 revealed "The resident does have stress incontinence and can also tell us when s/he needs to use the bathroom. We take him/her to the bathroom before and after meals and at bedtime." d. Interview on 3/23/17 at 12:12 PM with the DON revealed it was his expectation staff would toilet residents per the care plan. 2. Review of the 3/6/17 significant change MDS assessment for resident #27 showed the resident had diagnoses which included non-Alzheimer's dementia, Parkinson's disease, seizure disorder, periodic paralysis, and had a left lower extremity fracture. The resident required extensive assistance of 2 staff members for transfers, dressing, toileting and personal hygiene. Further review showed the resident was at risk for pressure ulcers and had moisture associated skin damage (MASD). Review of the 3/9/17 Braden scale assessment for predicting pressure injury risk showed the resident scored 14 (moderate risk). Review of the care plan revised on 2/17/17 showed the resident had a knee immobilizer, at minimal flexion, on his/her left leg which required staff stabilization during ADLs. Further review of the care plan showed staff were to "encourage and assist as needed with frequent repositioning when in bed or chair" and "toilet upon rising, before and after meals, at hs (bedtime), upon request and as needed." The following concerns	F 282	D) A Performance Improvement tool will be utilized to conduct random audits of residents who are incontinent and require extensive assistance with toileting to ensure care plan is followed as directed. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the DON or designee. Audits will be performed weekly. 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 until ongoing compliance has been achieved.	

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F 282	Continued From page 17 were identified: a. Continuous observation on 3/20/17 at 2:10 PM showed the resident was in the dining room in his/her wheelchair at an activity. At 3:40 PM the resident was taken to his/her room and remained there until 4:20 PM when CNA #3 took him/her back to the dining room. The resident was returned to his/her room after the evening meal by RN #1 at 4:55 PM. At 5 PM (2 hours and 50 minutes since observation began) 3 staff members entered the room (CNA #1, CNA #4, RN #2) to transfer the resident with a Hoyer lift to his/her bed. The resident resisted the transfer and therapist #1 was called at 5:20 PM. 6 staff members (CNA #1, CNA #3, CNA #4, RN #2, therapist #1, CNA #5) then transferred the resident to his/her bed using the pivot method as they supported his/her leg. At 5:28 PM pericare was performed and CNA #1 confirmed the resident had been incontinent. b. Interview on 3/23/17 at 12:12 PM with the DON revealed it was his expectation that the resident be repositioned every two hours and toileting should be offered as per the care plan.	F 282		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	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.	5/6/17

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F 371	Continued From page 18 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of maintenance records, the facility failed to ensure 2 of 2 ice machines (main, Arrowhead) were maintained in a sanitary condition. The findings were: Observation on 3/20/17 at 9:10 AM of the ice machine in the main kitchen showed the interior of the lid was soiled with discolored debris. Further, the ice machine in the Arrowhead kitchen area showed a build-up of discolored debris on the interior surfaces and the fan/vent was covered in dust. Additional observation on 3/22/17 at 11:05 AM showed the ice machine in the kitchen remained unsanitary with the debris on the interior of the lid and the area around the hinges of the lid. Observation on 3/22/17 at 11:48 AM of the ice machine located in the Arrowhead kitchen showed it remain unsanitary. There was a yellow colored substance which appeared slimy across the surface of the ice-making mechanism located above the ice bin. Interview with the dietary	F 371	A) Ice machine in main kitchen was cleaned of debris around hinges of the lid on 3/22/17. Ice machine in the Arrowhead kitchen was cleaned and substance removed on 3/22/17. B) The Dietary Director, or designee, will conduct weekly audits to ensure all facility ice machines remain free from debris and unsanitary substances. . Any problems identified will result in immediate education and/or corrective action. C) The Dietary Director, or designee, will conduct an in-service on or before 05/06/17 with dietary department staff regarding the importance of regular cleaning and maintenance of facility ice machines. D) A Performance Improvement tool will be utilized to conduct random audits of ice machine cleanliness. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the Dietary Director or designee.	

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F 371	Continued From page 19 manager on 3/22/17 at 12:48 PM verified the machines were in need of cleaning. She stated the maintenance department was responsible for the sanitation. Interview with the maintenance director on 3/23/17 at 9:40 AM verified the ice machines were sanitized every 3 months. Review of the maintenance record showed the machines were last sanitized on 12/15/16 and due again on 3/31/17. The record did not show separate entries for when maintenance/cleaning was done, it referred to "Ice Machines." According to the director the schedule was to clean/sanitize both at the same time. He further verified the machines should be kept sanitary and there may be times when sanitization/cleaning was needed between the scheduled times. According to Food Code 2013, U.S. Public Health Service: 4-602.11 "...(E) Except when dry cleaning methods are used as specified under § 4-603.11, surfaces of UTENSILS and EQUIPMENT contacting FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cleaned: (4) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold."	F 371	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 until ongoing compliance has been achieved.	
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 20 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in	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 bottles of Simethicone, one bottle of Selenium, and one bottle of Nystatin were removed from cart and destroyed on 3/23/17. B) The DON or designee will conduct a 100% audit of medication carts to ensure no expired medications are available and medications have expiration dates labeled. Any problems identified will result in immediate education and/or corrective action. C) The DON or designee will conduct an in-service on or before 05/06/17 with all licensed nursing staff to ensure expired medications are not available on medication carts and that medications are labeled with expiration dates.	5/6/17

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F 431	Continued From page 21 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) 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 and staff interview, the facility failed to discard expired medications for 3 of 7 medication carts (Hall 400 medication cart, Southwest medication cart, Therapy Center medication cart). The findings were: 1. Observation on 3/23/17 at 10:51 AM of the medication cart in hall #400 with RN #3 revealed the following: a. A bottle of the medication Simethicone 80 milligrams (mg) had an opened date of 8/16/16 and had an expiration date of 2/17. b. A bottle of the medication Selonium 200 micrograms had an opened date of 8/11/16 and an expiration date of 1/17. 2. Observation of the Southwest medication cart on 8/23/17 at 10:25 AM revealed a bottle of Simethicone 80 mg had an expiration date of 06/16. The medication was available for use. 3. Observation of the Therapy Center West cart on 8/23/17 at 11 AM revealed a bottle of liquid Nystatin 100,000 u/ml had no expiration date	F 431	D) A Performance Improvement tool will be utilized to conduct weekly audits to ensure expired medications are not available and all medications are labeled with expiration dates. 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 until ongoing compliance has been achieved.	

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PRINTED: 04/06/2017
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OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING _____ B. WING _____	03/23/2017

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 431	Continued From page 22 written on the label and was available for use. 4. Interview on 3/23/17 at 10:51 AM with RN #3 and RN #4 revealed the nurses were responsible for ensuring there were no expired medications in the medication carts. They further confirmed the medications Simethicone and Selonium were expired and still available for use.	F 431		
F 502 SS=E	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and manufacturer instructions, the facility failed to ensure the accuracy of finger stick blood sugar levels obtained by staff. The findings were: 1. Observation on 3/23/17 at 10:59 AM revealed a medication cart in the 400 hall had a Medisense glucose control solution box which had an opened date of 11/19/16. 2. Observation on 3/23/17 at 11:20 AM revealed a medication cart in the 500 hall had a Medisense glucose control solution box which had an expiration date of 2/17. 3. Interview on 3/23/17 at 10:59 AM and 11:20 AM with RN #4 revealed the night shift nurses check the glucometers on each medication cart and stated the nurses used the Medisense glucose control solution for calibrating the	F 502	F502 The facility must provide or obtain laboratory services to meet the needs of its residents The facility is responsible for quality and timeliness of the services. A) All bottles of expired Medisense glucose control solution was discarded on 3/23/17. B) The DON or designee will conduct 100% audit of Medisense glucose control solution to ensure solution is not expired. Any problems identified will result in immediate education and/or corrective action.. C) The DON or designee will conduct an in-service on or before 05/06/17 with licensed nursing staff regarding the importance of discarding expired Medisense glucose control solution.	5/6/17

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

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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 _____	03/23/2017

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F 502	Continued From page 23 glucometers. She further confirmed the control solutions in the box with the opened date of 11/19/16 and the control solutions with the expiration date of 2/17 were expired and should have been discarded and not used for calibrating the glucometers. 4. Review of the Medisense glucose control solutions instructions (pdfstream.manualsonline.com/1/1818548d-6671-4107-a798-c13026569edc.pdf pg 56, retrieved 3/23/17) showed "Do not use the control solution if the expiration date has passed. Check the expiration date printed on the control solution bottle. When you open a control solution bottle for the first time, count forward 90 days and write this date on the control solution... Throw away any remaining solution after this date.".	F 502	D) A Performance Improvement tool will be utilized to conduct weekly audits of Medisense glucose control solution to ensure solution is not expired. 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 until ongoing compliance has been achieved.	