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

PRINTED: 04/28/2017
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
	535025	A. BUILDING _____ B. WING _____	C 04/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

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F 000	INITIAL COMMENTS A complaint survey was conducted on 4/12/17 through 4/14/17. Reviewed in the course of the survey were complaint intakes WY00002346, WY00002347, WY00002388, WY00002389, and WY00002391.	F 000		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(l)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(l)(2) or other applicable federal or state laws. §483.70 (l) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 164	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. The plan of correction serves as the facility's allegation of compliance. **F 164 Privacy of Information** **Corrective Action** In-service training was completed by 5/8/17 by the SDC to the nurses regarding closing the laptop computers on the medication carts or locking down the computer each time they walk away from the computer to protect privacy. **Identification of Others** This practice has the potential to affect any resident who has an electronic medical	5/9/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Hancock — TITLE: NHA — (X6) DATE: 5/8/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure privacy and confidentiality of protected health information during three random observations. The census was 95. The findings were: 1. Observation on 4/12/17 from 11:46 AM through 11:52 AM showed the computer screen on the south medication cart was open with resident names visible and was not being used or monitored by nursing staff. 2. Observation on 4/12/17 at 5:30 PM showed the south medication cart was parked outside of resident room #123 and was unattended with the screen open to a resident's information. RN #2 was in a room with a resident at that time. 3. Observation on 4/14/17 from 9:16 AM through 9:22 AM showed the computer screen on the south medication cart was open with resident names visible and was not being used or monitored by nursing staff. During this timeframe nurses, therapy aides, the administrator, and residents passed by the medication cart.	F 164	record, **Systemic Change** In-service training was completed by 5/8/17 by the SDC to the licensed nursing staff regarding closing the laptop computers on the medication carts or locking down the computer each time they walk away from the computer to protect privacy. The Health Information Manager monitors the privacy of the electronic medical record through random computer observations 4 times per week. She observes for unattended laptop computers that have been left open or unlocked that would allow others to see protected health information. Any negative findings are immediately corrected and reported to the Director of Nursing for corrective action with the nurse. **Monitoring** The Health Information Manager reports any patterns or trends identified through her observations to the Quality Assessment and Performance Improvement Committee for their review and resolution. These Health Information observations will continue for 3 months unless the Quality Assessment and Performance Improvement Committee deems it prudent to continue.	

5/9/17 This POC accepted by Brenda Hancock and Tony Madden, State Health Surveyor Administrator

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F 164	Continued From page 2 4. Interview on 4/14/17 at 10:10 AM with LPN #1 and LPN #2 revealed the facility expectation was computers be either locked or the lid shut when the computer was unattended.	F 164		
F 204 SS=D	483.15(c)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG (c)(7) Orientation for Transfer or Discharge A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff and resident interview the facility failed to ensure a safe discharge for 1 of 3 (#97) residents reviewed for discharge to the community. The findings were: 1. Review of the medical record showed resident #97 was admitted to the facility on 5/6/15 and was discharged to the community on 4/11/17 at 5 PM. Review of the 1/7/17 annual MDS assessment showed the resident had a BIMS score of 15/15 (cognitively intact) and had diagnoses which included hemiplegia (paralysis on one side of the body) and bipolar disease. Further review revealed the resident needed the extensive assistance of 2 staff members for bed mobility and transfers and the extensive assistance of 1 staff member for toilet use, personal hygiene, and bathing. The resident used a wheelchair for mobility. The following concerns were identified: a. Review of a doctor's progress note dated	F 204	**F 204 Discharge Planning** **Corrective Action** Resident # 97 no longer resides in the facility. **Identification of Others** An audit was conducted of residents who have been discharged home in the last 30 days from the facility on 5/4/17 by the Social Services Director. Attempts were made to contact identified residents (or families of) by a member of the Social Services Department by 5/8/17 related to discharge outcomes, and the response documented in the medical record. **Systemic Change** In-service training was provided to the Social Service team on 5/5/17 by the Social Services Consultant (LCSW) regarding the elements of discharge planning and following up with the selected agencies to ensure that they are providing the needed services.	5/9/17

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F 204	Continued From page 3 3/30/17 revealed the resident was working with an outside advocacy group for discharge to the community in April 2017, was mostly wheelchair bound, and self-transferred. Further review revealed "...HH [home health] order for [outside advocacy group] to get working on it early HH for PT/OT/CNA/RN 6x/wk x 8 wks [5 times a week for 8 weeks] or more." b. Review of the "Physician Face-To-Face Encounter Form" showed the physician had a face-to-face encounter with the resident on 3/30/17. The section entitled "Medical Condition" showed the resident was in need of home care services due to cerebrovascular accident, hemiplegia, weakness, and being wheelchair bound. The section entitled "Medical Necessity" showed nursing, physical therapy, occupational therapy, home health aide, and RN were all marked for "medical necessary home care services." c. Review of the "Home Visit Worksheet" dated 4/5/17 and completed by the facility's physical therapist showed areas that needed to be addressed prior to resident discharge included toileting and self-care/hygiene, and transfers to and from the toilet or commode. Observations of "simulate bathroom transfers and activities to ensure safety" showed "not ideal setup" was documented in reference to "transfer safely on/off toilet" and "difficult in 20 inch chair" was documented in reference to "Maneuver AD [assistive device] into bathroom." Review of the section entitled "Additional noted challenges/obstacles" showed "laundry-home health?, groceries?, and money?" was documented. d. Review of a letter addressed "To whom it may concern" and signed by the facility's physical therapist and the resident's physician, but not	F 204	In-service training was completed with the IDT on 5/4/17 by the NHA regarding the elements of discharge planning. A discharge care conference meeting is offered to each resident when the discharge date is approaching. This meeting is held to ensure all services are arranged prior to discharge home. If an agency chooses not to attend the meeting the Social Worker calls the agency to verify that services are arranged and confirm the discharge date. The information is then documented in the medical record by the social worker. A follow up call is placed to the resident/family on the next business day after discharge to ensure all services are in place post discharge. The social worker calls the appropriate agency if any concerns arise during this follow up call. The results of this call are documented in the medical record by the social worker. **Monitoring** The Social Services Director tracks all discharges to ensure that services were arranged and implemented. The Social Services Director reports any negative patterns or trends to the Quality Assurance and Performance Improvement Committee monthly for their review and resolution. The Social Service Director will track discharges for 3 months unless the Quality Assurance and Performance Improvement Committee deems it prudent to continue.	

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F 204	Continued From page 4	F 204		

dated; included the following: [Resident's name] had a physical therapy home evaluation with [his/her] current wheelchair, [s/he] is unable to navigate [his/her] current apartment due to the width restrictions for the hemi-drive system. [S/he] is able to use a 20-inch wide wheelchair for all mobility and transfers within [his/her] apartment."

e. Review of a fax transmission report dated 4/7/17 showed orders, medications, and diagnosis codes were sent to a home health agency. Further information was faxed on 4/11/17 and 4/13/17.

f. Review of an undated and unsigned document provided by the facility revealed a representative of the [outside advocacy agency] "was not happy with resident's discharge from the facility" and wanted "home health to be set up prior to resident leaving the facility." Further review showed no confirmation was made with the home health agency prior to the resident's discharge to ensure services were going to be provided.

g. Review of fax transmission reports dated 4/13/17 and timed 11:13 AM and 12:34 PM showed information was sent to a second home health agency two days after the resident was discharged from the facility.

h. Interview on 4/14/17 at 9:35 AM with occupational therapist #1 revealed the electric wheelchair the resident had was too big for the apartment. In addition she stated the resident used a manual wheelchair from the facility when the home visit evaluation was done.

i. Interview on 4/14/17 at 9:55 AM with social service director #1 revealed social services was not involved in setting up home health for the resident. In addition she stated the resident left the facility with his/her electric wheelchair and a

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F 204	Continued From page 5 manual wheelchair that had been modified to accommodate his/her lower extremity hemiplegia, neither of which was compatible with maneuvering through the apartment. j. Phone interview with resident #97 on 4/14/17 at 8:45 AM confirmed s/he was discharged from the facility to an independent apartment on 4/11/17. The resident also confirmed that s/he required a wheelchair for locomotion. The resident stated that s/he was unable to navigate the hallway, bathroom, or bedroom of the apartment because the motorized wheelchair was too large. Further, the resident stated that s/he had to sleep in the living room area in his/her wheelchair the first night at the apartment due to the wheelchair size issue. The next day, an outside advocate brought the resident a smaller wheelchair on a temporary basis. The resident stated the facility was aware the electric wheelchair was too large to fit in some areas of the apartment, and gave him/her a prescription for a different wheelchair upon discharge. However, the resident stated the facility failed to assist him/her to obtain that wheelchair prior to discharge. The resident stated that from discharge on 4/11/17 through the phone conversation on 4/14/17 s/he had not received home health services, and the facility had failed to ensure those services were set-up for specific services and timeframes for visits. S/he was not sure when home health services would start. k. Phone interview with the ADON on 4/14/17 at 11 AM confirmed she had been in communication with an outside advocacy group to assist with discharge of resident #97 to an independent apartment. The ADON had faxed information and left voice-mail messages for a local home health agency concerning home service needs for the resident prior to discharge.	F 204		

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F 204	Continued From page 6 The ADON had discussed these plans with the representative for the outside advocacy group, and believed the required services had been set-up. However, the ADON revealed the facility failed to ensure specific services with a timeframe for those services to start were confirmed with the home health agency prior to the resident's discharge from the facility.	F 204		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview the facility failed to ensure timely delivery of meals during 2 of 2 meal services observed (noon, evening). The findings were: 1. Interview with resident #16 on 4/12/17 at 5:05 PM revealed, "I waited an hour last night for dinner. I gave up and went to my room and they brought me a tray." 2. Observation on 4/12/17 at 5:15 PM revealed resident #12 was wheeled into the dining room by staff. At 6:04 RN #1 asked resident what s/he wanted to eat. At 6:11 PM the resident was served dinner (54 minutes). 3. Interview on 4/14/17 at noon with the DON revealed that prolonged meal times were unacceptable and she would look into it.	F 241	**F 241 Dignity** **Corrective Action** Residents #16, #12 and #19 were interviewed by the NHA on 5/8/17 to determine if they had any concerns about the meal times. All voiced that they were satisfied currently. Meal times were posted on 5/3/17 for both dining rooms. **Identification of Others** All residents have the potential to be affected by this practice. **Systemic Change** A Resident Council Meeting was held regarding what types of activities they would like to have available in the dining room for entertainment prior to the meal. Using the input from the Resident Council Meeting the Activity Director developed activity boxes that are kept in the dining rooms for the residents who choose to come	5/9/17

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F 241	Continued From page 7 4. Observation in the main dining area on 4/13/17 at 10:55 AM showed a staff member brought resident #19 to the dining room in his/her wheelchair. The resident was with no other residents or staff. The resident was not served until 11:49 AM (54 minutes) after s/he was brought to dining, and no other activities occurred.	F 241	to the dining room prior to the meal. An all staff in-service was completed on with the activity boxes if they choose to participate. **Monitoring** 5/8/17 regarding resident preference as to when they would like to go to the dining room, and how to effectively engage residents The Dining Room Managers continue to monitor the dining room with special attention to timeliness and activity. Any identified negative findings are reported to the NHA. The NHA will report any negative patterns or trends to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This monitoring will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	

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