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 _____	03/01/2018

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 2/26/18 through 3/1/17. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		4/12/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/23/2018

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.

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 _____	03/01/2018

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 623	Continued From page 1 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and	F 623		

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 _____	03/01/2018

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 623	Continued From page 2 telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 623	A. The facility has implemented a Notice	

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 _____	03/01/2018

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 623	Continued From page 3 interview, the facility failed to ensure a transfer notice was issued to 4 of 6 sample residents (#58, #87, #99, #138) with hospital transfers. The findings were: 1. Review of the medical record showed resident #99 was transferred to the hospital on 1/27/18 for a fall which resulted in a left hip fracture. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 2. Review of the medical record showed resident #58 was transferred to the hospital for an acute change of condition on 12/4/17 and readmitted to the facility on 12/10/17. Further review showed no evidence the facility issued a written notice of transfer to the resident or resident's representative. 3. Review of the medical record showed resident #138 was transferred to the hospital for an acute change of condition on 1/23/18 and returned to the facility on 1/26/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or resident's representative. 4. Review of the medical record showed resident #87 was transferred to the hospital on 12/28/17 and returned to the facility on 12/30/17. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. Medical record review showed the same resident transferred to the hospital on 2/17/18 and returned to the facility on 2/23/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative.	F 623	of Resident Transfer or Discharge form for all resident transfers to an acute care hospital. B. All residents who transfer from the facility to an acute care hospital are potentially affected. The facility will use the Notice of Resident Transfer or Discharge form when a resident is being transferred to the hospital. C. The ED or designee will conduct an in-service on or before 4/12/18 with all licensed nursing staff regarding the use and importance of the Notice of Resident Transfer or Discharge form. D. A Performance Improvement tool will be utilized to conduct weekly audits to determine whether the Notice of Resident Transfer or Discharge form was completed as required. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the 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 _____	03/01/2018

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 623	Continued From page 4 5. Interview with the DON on 2/28/18 at 4 PM revealed the facility did not issue a written notice of transfer for residents who were sent to the hospital.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 625		4/12/18

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 _____	03/01/2018

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 625	Continued From page 5 Based on medical record review and staff interview, the facility failed to ensure a notice of bed-hold policy was issued to 6 of 7 sample residents (#19, #58, #60, #87, #99, #138) who transferred to the hospital. The findings were: 1. Review of the medical record showed resident #19 was admitted to the hospital on 11/22/17 for left chest pressure, and on 12/14/17 for a urinary tract infection. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative for either stay. 2. Review of the medical record showed resident #60 was admitted to the hospital on 1/30/18 for a scheduled repair of a non-healing fracture. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 3. Review of the medical record showed resident #99 was transferred to the hospital on 1/27/18 for a fall which resulted in a left hip fracture. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 4. Review of the medical record showed resident #58 was transferred to the hospital on 12/4/17 and returned to the facility on 12/10/17. Further review showed no evidence a written notice of the bed-hold policy was provided to the resident or resident's representative upon transfer. 5. Review of the medical record showed resident #138 was transferred to the hospital on 1/23/18 and returned to the facility on 1/26/18. Further review showed no evidence a written notice of the	F 625	A. All residents that were transferred due to hospitalization returned to the facility. The facility has implemented a copy of the facility bed-hold policy to be utilized in the transfer documentation for all resident transfers to an acute care hospital. B. All resident transfers from the facility to an acute care hospital are potentially affected. The facility will use a copy of the facility bed-hold policy to provide notice when a resident is being transferred to the hospital. C. The ED or designee will conduct an in-service on or before 4/12/18 with all licensed nursing staff regarding the use of the facility bed-hold policy upon transfer to the hospital. D. A Performance Improvement tool will be utilized to conduct weekly audits to determine whether the bed-hold policy for was given as required upon transfer. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the 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 _____	03/01/2018

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 625	Continued From page 6 bed-hold policy was provided to the resident or resident's representative upon transfer. 6. Medical record review showed resident #87 was transferred to the hospital on 12/28/17 and re-admitted on 12/30/17. Further review showed the facility failed to provide written notice of the bed-hold policy to the resident or resident's representative upon transfer. Further medical record review showed the same resident transferred to the hospital on 2/17/18 and returned to the facility on 2/23/18. Further review showed no evidence a written notice of the bed-hold policy was provided to the resident or resident's representative upon transfer. 7. Interview with the DON on 2/28/18 at 3:12 PM revealed the facility did not issue written notice of the bed-hold policy when residents were transferred to the hospital.	F 625		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F 640		4/12/18

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 _____	03/01/2018

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 640	Continued From page 7 §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview the facility failed to ensure a discharge MDS assessment was completed as required for 2 of 3 (#2, #3) sample residents reviewed for late transmissions. The findings were:	F 640	A. Discharge MDS assessments were completed on 3/1/18 for residents #2 and #3. B. The DON or designee will conduct a 100% audit of all discharges within a 120	

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 _____	03/01/2018

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 640	Continued From page 8 1. Review of the medical record for resident #2 showed s/he was admitted to the facility on 8/24/17 and discharged to the community on 10/23/17. Further review showed no evidence a discharge MDS assessment was completed (129 days post discharge). 2. Review of the medical record for resident #3 showed s/he was admitted to the facility on 9/5/17 and discharged to the hospital on 11/1/17. Further review showed no evidence a discharge MDS assessment was completed (120 days post discharge). 3. Interview with MDS coordinator #1 on 3/1/18 at 9:44 AM confirmed the discharge MDS assessments had not been completed.	F 640	day look back period. Residents missing discharge MDS assessments will be completed by MDS Coordinators. C. The DON or designee will conduct an in-service with all MDS Coordinators on or before 4/12/18 regarding the requirements for discharge MDS assessments. D. A Performance Improvement tool will be utilized to conduct weekly audits to determine if discharge MDS 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 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.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(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	F 656		4/12/18

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 _____	03/01/2018

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 656	Continued From page 9 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 under §483.24, §483.25 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 the care plan was implemented as planned for 1 of 32 sample residents (#46). The findings were: Review of the care plan showed resident #46 had decreased physical mobility related to "...weakness, rom [range of motion] difficulties, knees, trauma wound right knee, pain." The interventions included "2/15/17 transfer with 2	F 656	A. CNA #1 and LPN#1 were educated by Unit Manager on 3/23/18 regarding the use of a pivot disc for all transfers for resident #46. B. The DON or designee will conduct a 100% observation audit of other residents that use a pivot disc for transfers to ensure it is used as directed by the resident care plan. Audit will be completed on or before 4/12/13.	

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 _____	03/01/2018

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 656	Continued From page 10 person pivot disc for all transfers." The following concerns were identified: 1. Observation on 2/26/18 at 10:16 AM showed 2 staff members (CNA #1 and LPN #1), used a gait belt to transfer the resident from wheelchair to bed. During the observation the resident was moving slowly and it appeared the staff performed most of the work with weight bearing. Further observation showed a posted sign above the resident's bed that read: "Never Transfer PT without the Pivot Disc." Interview with CNA #1 at the time revealed she wasn't aware of the need to use the pivot disc, and LPN #1 offered no comment. 2. Interview with unit manager #1 on 2/27/18 at 11:50 AM verified the expectation was for staff to follow the care plan, which included using the pivot disc.	F 656	C. The DON or designee will conduct an in-service on or before 4/12/18 with all nursing staff regarding the importance of following the care planned approach for resident transfers. D. A Performance Improvement tool will be utilized to conduct weekly audits of residents using a pivot disc for transfers to ensure the care planned approach for transfers is followed 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 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.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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 safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		4/12/18

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 _____	03/01/2018

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 812	Continued From page 11 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 2 kitchens (main kitchen, Arrowhead kitchen) were maintained in a sanitary manner related to food preparation areas and food and equipment storage. The findings were: 1. Observation on 2/26/18 at 9:18 AM and on 2/27/18 at 4 PM showed floors and walls around the kitchen, dry food storage area, and dish room were in need of cleaning. These areas included: a. The floors near the walls in the preparation areas had a build-up of grease/food debris which was dark in color. b. The walls behind the food preparation counters in the back of the kitchen were soiled with food splatter and debris. c. The floors in the dry food storage area appeared grimy with debris around the edges of the room underneath the shelving. There were also areas on the walls where the paint was damaged and marred. d. The walls and floor around the dish machine had a build-up of food grime. 2. Observation on 2/27/18 at 4:20 PM showed there were at least 21 dish machine racks available for use which were in poor condition. The racks were discolored and damaged and could not be effectively cleaned. Two of these racks were being used to store clean bowls and 1 was being used to store clean pan lids.	F 812	A. Floors near the walls in the preparation areas cleaned and free of grease/food debris on 3/23/18. The walls behind the food preparation counters in the back of the kitchen were cleaned on 3/23/18. The floors in the dry storage were cleaned and free of grime and debris on 3/23/18. The walls in the dry storage area were repaired and painted on 3/23/18. The walls and floor around the dish machine were cleaned and free of debris on 3/23/18. Dish machine racks were replaced on 3/23/18. Plastic hose that extended from the chemical dispenser on the wall into a wash sink was shortened on 3/23/18. The wall mounted AC unit was repaired and free from water drips on 3/2/318. B. The Dietary Director or designee will conduct weekly audits to ensure that the floors near walls in the preparation areas, dry storage and around the dish machine are clean and free of debris, that the walls in preparation and dish machine areas are free of food debris, that the walls in the dry storage are in good repair, that the dish machine racks are in good condition and effectively being cleaned, and that the wall mounted AC unit is free of damage. C. The Dietary Director or designee will conduct an in-service on or before 4/12/18 with dietary staff regarding the importance	

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 _____	03/01/2018

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 812	Continued From page 12 3. Observation on 2/27/18 at 4:17 PM showed there was a plastic hose that extended from a chemical dispenser on the wall into a wash sink. The interior of the hose had brownish debris clumped to the sides. The sink was not in use at that time. 4. Observation on 2/27/18 at 4:46 PM showed staff were working in the Arrowhead kitchen to serve the evening meal. The kitchen included a wall-mounted air-conditioning (AC) unit. The unit was located near the top of a wall over a food preparation table. The drain from the AC unit was damaged and the drip pan with a drain hose attached was coming away. Water was observed to be dripping into the drip pan at that time. 5. Interview with the regional registered dietitian (RD), facility RD, dietary manager, and assistant dietary manager on 2/28/18 at 9:35 AM revealed they were in the process of revamping the assignments related to cleaning in the department. The regional RD verified the cleaning was not acceptable and more time was required weekly to ensure cleaning was being completed. She was also aware the AC unit in the Arrowhead kitchen was not in working order and stated it needed to be repaired or replaced. The dry storage room was discussed and the team verified the floors and walls needed to be cleaned and any damaged areas on the walls repaired. The regional RD then verified the dish racks were worn and could no longer be cleaned, and the dispenser hose would need to be replaced.	F 812	of ensuring that the floors and walls in preparation, storage, and dish machine areas are free of debris and damage. In-service will also include importance of ensuring that dish machine racks are in good condition and being effectively cleaned, and ensuring that the plastic hose does not extend into sink and AC unit is not damaged. D. A Performance Improvement tool will be utilized to conduct weekly audits to ensure the floors and walls in preparation, storage, and dish machine rooms are free of debris and damage, that dish machine racks are in good condition and being effectively cleaned, that plastic tubing does not extend into sinks, and that the AC unit is maintained in good repair. E. The Dietary Director 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.	