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 05/04/2018

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 5/3/18 through 5/4/18 at Cheyenne Health Care Center in Cheyenne, Wyoming. The survey was prompted by complaint intakes WY00002588, WY00002596, and WY00002600.	F 000		
F 573 SS=D	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and	F 573		5/23/18

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

Electronically Signed | 05/24/2018

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.

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F 573	Continued From page 1 (C)Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to respond in a timely manner to requests for copies of health information records for 2 of 2 sample residents (#5, #6) whose representative requested copies of medical records. The finding were: 1. Review of the authorization form for the release of information for resident #5 showed the resident's power of attorney submitted it to the facility on 3/15/18. Interview on 5/3/18 at 4:30 PM with the medical records staff revealed the power of attorney received the copies of the health information on 3/28/18. 2. Review of the authorization form for the release of information for resident #6 showed the resident's power of attorney submitted it to the facility on 2/22/18. Interview on 5/3/18 at 4:30 PM with the medical records staff revealed the copies of the resident's health information were mailed to the power of attorney on 4/13/18.	F 573	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 573 Corrective Action The copies of the health records for resident #5 were received on 3/28/18. The copies of the health records for resident #6 were mailed on 4/13/18. Identification of Others	

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F 573	Continued From page 2 3. Interview on 5/3/18 at 3:50 PM with the administrator revealed she recognized the problem and had developed a system to ensure all health information requests were honored in a more timely manner. She further stated the delay occurred because she had to have approval from the corporate office and they were very slow in responding.	F 573	An audit of record requests was conducted on 5/22/18 beginning 3/1/18 to ensure that all records request have been responded to. All record request have been fulfilled. Systemic Change In-Service education was provided to the NHA and the Medical Records Coordinator on 5/22/18 by the Division Director of Clinical Services related to the new requirements related to the timeliness of response to records requests. The Medical Records Coordinator receives all medical records requests and processes the requests for timely release to the resident. Monitoring The Medical Records Coordinator monitors and tracks requests for Medical Records 5 days per week to ensure timeliness or records release. Any concerns or patterns related to late release of medical records are reported to the Quality Assessment Performance Improvement Committee monthly for their review. This monitoring will continue for 3 months unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	
F 660 SS=G	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix)	F 660		5/23/18

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F 660	Continued From page 3 §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any	F 660		

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F 660	Continued From page 4 referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview and medical record review, the facility failed to develop discharge plans to meet the needs and	F 660	F 660 Corrective Action	

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F 660	Continued From page 5 goals of 1 of 3 sample residents (#2) reviewed for appropriate discharge planning. This failure resulted in significant psychosocial harm, when the resident was discharged to a retirement home that was unable to provide assistance with toileting. The findings were: 1. Review of the medical record showed resident #2 was readmitted to the facility on 11/25/16 with diagnoses that included a below the knee amputation, diabetes, a chronic unstageable pressure ulcer on the ankle of the remaining leg, and peripheral vascular disease. This review showed discharge plans were initiated in February 2018 when the resident refused after multiple attempts to comply with safe smoking practices. Further review showed resident used an electric wheelchair and was discharged from the facility to a retirement home on 4/13/18. The following concerns were identified: a. Interview on 5/3/18 at 3 PM with the administrator revealed the discharge plans for the resident were arranged by a representative of an outside advocacy agency. She further stated the resident was able to perform all activities of daily living independently at the time of the discharge. b.Interview on 5/3/18 with social worker #1 revealed the facility did not communicate with the retirement home staff prior to the discharge because all arrangements were made by the representative of an outside advocacy agency. She stated discharge plans included home health nursing services for pressure ulcer care. The resident was discharged with a bedside commode, sliding board and pill locking mechanism for self medication administration. She further stated the resident had taken care of himself/herself independently prior to discharge. c. Interview on 5/3/18 at 3:45 PM with CNA	F 660	Resident # 2 no longer resides in the facility. Identification of Others The NHA reviewed the facility discharges on 5/22/18 for the last 60 day to identify any concerns related to discharge. No other residents were identified as having concerns related to discharge. Systemic Change In-service education was provided to the Interdisciplinary Team regarding the regulations pertaining to discharge on 5/23/18. Beginning 5/23/18, if the resident is discharging to a specialized living situation such as a SNF, ALF or ILF, the facility social worker will coordinate with the receiving facility directly prior to discharge to ensure that the receiving facility is prepared and able to work within the discharging resident□s abilities. Whenever possible, for residents who are discharging to an independent living situation, the facility will conduct an onsite evaluation of the resident in the new environment. The Social Worker will document the results of the discussions and evaluations related to appropriateness of the discharge location related to the resident□s need. Monitoring	

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F 660	Continued From page 6 (certified nurse aide) #1, RCS (resident care specialist) #1, licensed practical nurse #1, and director of nursing revealed the resident used a sliding board to transfer independently from the bed to wheelchair and to the bedside commode. CNA #1 and RSC #1 also stated the only time staff assisted the resident was when they emptied the commode after use and at times reminded the resident to use the sliding board because s/he did not consistently use it. Review of the discharge plan and summary form, dated 4/13/18, showed the resident could perform activities of daily living independently and arrangements had been made for therapy and home health after discharge. d. Review of the 3/12/18 significant change MDS (minimum data set) assessment showed the resident had a BIMS (Brief Interview of Mental Status) score of 10/15, and required extensive assistance with bed mobility, transfers, personal hygiene and toilet use. Review of the 3/12/18 care area assessment summary for triggered MDS assessed areas showed the resident required supervision while smoking; chose not to use suggested safe transfers with a sliding board; and had a history of driving his/her electric wheelchair across the street in front of oncoming vehicles unsafely. e. Review of the care plan, revised 3/19/18, showed identified problems included safety risk due to operating motorized wheelchair unsafely, requiring supervision with smoking and at risk for falls. Further review of the care plan showed the resident needed assistance with bed mobility, personal hygiene, dressing, and transfers. f. Review of the activities of daily living documentation completed by the CNAs revealed the resident required extensive assistance with toileting 7 times, bed mobility 9 times, transfers	F 660	The NHA/designee will monitor future discharges to ensure that steps are taken to ensure appropriate discharge. Any concerns or patterns related to safety of discharge are reported to the Quality Assessment Performance Improvement Committee monthly for their review. This monitoring will continue for 3 months unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	

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F 660	Continued From page 7 11 times, personal hygiene 7 times, and dressing 8 times during the 4/1/18 to 4/13/18 time period. g. Interview on 5/3/18 at 1:56 PM and again on 5/4/18 at 3 PM with the retirement home assistant manager revealed the resident arrived on 4/13/18 and within hours it was obvious the retirement home was not the appropriate setting for this resident because the resident needed a facility that provided nursing care assistance. The assistant manager stated the representative of an outside advocacy agency made all the discharge arrangements and the retirement home staff did not follow its usual process of pre-admission screening. She stated if the process had been done, they would not have accepted the resident. She stated the following events occurred the day after the resident was admitted: The resident asked for assistance with medications and to go to the bathroom. Both were services not provided by the retirement home. The fire department was called and they were unable to assist the resident to the bathroom. Then emergency medical services was called and the resident was transported to the hospital. h. Interview on 5/10/17 at 11:50 AM with resident #2 revealed the brief stay at the retirement home "did not make me feel good" because when the firemen tried to help him/her to the bathroom, s/he ended up on the floor, and finally they had to call the ambulance. The resident stated the retirement home "was not set up for handicapped people like me" and the facility staff did not tell him/her about "that set up" prior to the discharge. The resident also stated it wasn't a good feeling to have to go the hospital in an ambulance in order to go to the bathroom. i. Review of the facility social services follow up discharge note, dated 4/16/18, revealed social worker #1 had a conversation with the home	F 660		

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F 660	Continued From page 8 health nurse who reported she found the resident at the retirement home on 4/14/18 on the floor covered with urine. Further review revealed the home health nurse also reported the resident was transported by ambulance to the emergency room.	F 660		