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 01/31/2019

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

(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 from 1/28/19 through 1/31/19. Also reviewed in the course of the survey were complaint intakes WY00002691, WY00002749, WY00002756, and WY00002763. The following common abbreviations are used throughout this document. ADL: Activities of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a pre-admission screening and resident review (PASARR) Level II was completed for 1 of 5 sample residents (#25) who had a serious mental disorder. The findings were: 1. Review of the medical record for resident #25	F 646	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	2/23/19

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

Electronically Signed | 02/22/2019

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 01/31/2019

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

(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 646	Continued From page 1 showed a PASARR level I was completed at the 9/30/2016 date of admission; however a PASARR level II was not completed at that time because the resident did not have a diagnosis that would trigger the level II review. 2. Review of the 9/10/18 annual MDS assessment showed the resident was not currently considered by the state level II PASARR process to have a serious mental illness and/or intellectual disability or related condition. However, review of the medical record showed the resident was diagnosed with schizoaffective disorder, bipolar type, on 9/11/17 and paranoid schizophrenia on 11/29/17. 3. Interview with the social service manager on 1/30/19 at 10:31 AM revealed she was not aware the resident had psychiatric diagnoses and confirmed a PASARR level II evaluation was indicated.	F 646	of correction serves as the facility□s allegation of compliance. F 646 Significant Change Notification CORRECTIVE ACTION The social worker requested the Pyscho/Social evaluation on 1/29/19. The Social worker requested a LT 101 on 1/29/19. A Level I PASRR was completed on 2/15/19. The completed LT 101 was received back on 2/22/19 and the packet requesting the Level II PASRR was submitted on 2/22/19 for resident #25. IDENTIFICATION OF OTHERS The social workers reviewed a list of diagnosis and medications to a list of residents who have PASRR Level II screens on 2/18/19. The PASRR request process was initiated for any residents identified as needed a PASRR Level II. SYSTEMIC CHANGE In-service training was provided to the Social Service staff related to PASRRs and requirements and triggers for a Level II screen on 2/7/19 by the Social Service Consultant. During the morning meeting the social workers will review any new diagnosis or medication changes that may trigger the need for a Level II screen. Upon	

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 01/31/2019

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

(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 646	Continued From page 2	F 646	identification of the need, the social worker will make the appropriate referrals to imitate the Level II process. The social workers will track all referrals for Level IIs to ensure that the process is completed and the Level II is received by the facility. MONITORING The social workers review the referrals and receipt of the Level IIs and report any identified patterns or trends to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
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 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	F 656		2/23/19

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 01/31/2019

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

(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 3 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 resident and staff interview, the facility failed to ensure the care plan was implemented for 1 of 22 sample residents (#52). The findings were: Review of the quarterly elopement risk assessment dated 12/11/18 showed resident #52 was "at risk" for elopement. Review of the most current physician orders showed the resident was to have a WanderGuard (device to alert staff of possible elopement) placed on his/her wheelchair and verified daily for placement and functionality with a start date of 6/30/17. Review of the safety care plan last revised 7/3/17 showed the resident	F 656	F 656 Develop/Implement Comprehensive Care Plan CORRECTIVE ACTION The wandergard was replaced on 1/30/19 by the nursing staff for resident #52 IDENTIFICATION OF OTHERS The RCMD/designee conducted an audit of all residents care plans to ensure	

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 01/31/2019

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

(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 4 was a safety risk related to wandering, exit-seeking, impulsivity, and decreased safety awareness. The following concerns were identified: a. Observation of the resident's wheelchair from 1/28/19 through 1/30/19 showed no evidence a WanderGuard was attached to the wheelchair. b. Interview on 1/30/19 at 8:51 AM with RN #3 and maintenance staff #1 confirmed the WanderGuard device was not attached to the chair. Interview at that time with the resident revealed s/he had changed wheelchairs and had been in the current chair "for a while." c. Interview with the director of physical therapy on 1/30/19 at 9:28 AM revealed the resident's wheelchair had been changed in November or December 2018 because the resident had gained weight and the old one was too narrow. He was unsure if it was therapy or maintenance who had changed the resident's wheelchair and thought, perhaps, the WanderGuard had not been transferred when the wheelchair was changed. d. Review of the January 2019 treatment administration record (TAR) showed the WanderGuard was visually checked for placement and functionality from 1/1/19 through 1/30/19. e. Interview with the administrator on 1/31/19 at 10:06 AM revealed she was unsure when the resident's wheelchair was changed and did not know why the monitoring of the WanderGuard was marked as complete on the TAR.	F 656	wandergards were in place as indicated on the care plan on 2/18/19. Any needed updates were added. SYSTEMIC CHANGES In-service education was provided to the IDT on 2/21/19 by the District Director of Care Management regarding developing care plans that meet the resident need and implementation of the care plan. The RCMD/designee audits 4 resident□'s care plans with wandergards per week for 30 days, then 1 time every other week and then 1 time per month for 3 months to insure the care plan properly reflects the needs of each resident. The district Director of Care Management conducts a second check of these assessments. MONITORING The RCMD reviews these audits monthly and reports any patterns or concerns to the Quality Assessment Performance Improvement Committee monthly for their review and resolution. These audits will continue as planned above unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		2/23/19

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 01/31/2019

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

(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 684	Continued From page 5 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on family and staff interview, and medical record review, the facility failed to ensure appropriate care and monitoring for constipation for 1 of 1 sample resident (#36) reviewed for effective bowel management. The findings were: Review of the 11/23/18 quarterly MDS assessment showed resident #36 had a BIMS score of 0/15 (severe cognitive impairment), required extensive assistance for transfers and toilet use, and was frequently incontinent of urine and continent of bowel. The following concerns were identified: a. Interview with the resident's representative on 1/28/19 at 2:26 PM revealed the resident had problems with constipation and at one time she had been called to the facility because the resident was "in pain" while attempting to have a bowel movement. b. Interview with CNA #4 on 1/31/19 at 8:30 AM revealed the resident had an occasional problem with constipation, however it was not all the time. c. Review of the most recent physician order summary report showed the resident was prescribed Colace (stool softener) 100 mg twice daily for bowel management; Senna (medication for constipation) 8.6 mg 2 tablets at bedtime for constipation; and Dulcolax (medication for	F 684	F 684 Quality of Care CORRECTIVE ACTION A review of the record for resident #36 was conducted on 2/20/19 which indicated his last bowel movement was 2/20/19. IDENTIFICATION OF OTHERS An audit was conducted of current residents to identify any residents who have not had a documented bowel movement in the last 9 shifts on by the DON/designee on 2/21/19. The facility bowel program was implemented for any identified residents and follow up conducted to verify positive results. SYSTEMIC CHANGES In-service education was provided to the licensed nurses by the DON/designee and completed on 2/23/19 regarding implementation of the bowel protocol and the requirement of reviewing the C.N.A. documentation of bowel movement for the	

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 01/31/2019

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

(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 684	Continued From page 6 constipation) delayed release tablet 5 mg daily, as needed, for bowel management. d. Review of the CNA documentation for bowel continence showed the resident had a 5 day gap between bowel movements from 11/17 to 11/23/18; a 5 day gap between bowel movements from 12/2 to 12/8/18; and a 7 day gap between bowel movements from 1/12 to 1/20/19. e. Review of the medical record showed no evidence the gap between bowel movements was addressed. f. Interview with the DON on 1/30/19 at 10:40 AM revealed she thought the gaps between bowel movements was a documentation error. In addition, if a resident had not had a bowel movement in 3 days she would know about it and do an investigation; however the facility did not have a bowel management policy, and no documentation was available. g. Interview with the corporate nurse on 1/30/19 at 3:05 PM confirmed the facility did not have a written bowel management policy.	F 684	last nine shifts and initiating interventions per the protocol. In-service education was provided to the C.N.A. by the DON/designee related to proper documentation of bowel movements and completed on 2/23/19. The IDT reviews any residents who have not had a bowel movement in 9 shifts during the morning meeting to ensure that successful interventions were initiated. MONITORING The DON reviews any patterns or trends related to residents without bowel movements in the last 9 shifts to the Quality Assessment Performance Improvement Committee monthly for their review and resolution. These reviews will continue for 3 months unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		2/23/19

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 01/31/2019

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

(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 690	Continued From page 7 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident representative and staff interview, and medical record review, the facility failed to ensure residents were toileted in a timely manner for 1 of 7 sample residents (#36) reviewed for bowel and bladder incontinence. The findings were: 1. Review of the 11/23/18 quarterly MDS assessment showed resident #36 had a BIMS score of 0/15 (severe cognitive impairment); had diagnoses which included diabetes mellitus, non-Alzheimer's dementia, and cognitive communication deficit; required extensive assistance for transfers and toilet use, and was	F 690	F 690 Bowel/Bladder Incontinence Catheter, UTI CORRECTIVE ACTION Resident #36 was assisted to the bathroom at 11:12 AM on 1/29/19. The Director of Nursing contacted the provider for resident #36 to notify him of the resident's urinary urgency on 2/19/19.	

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 01/31/2019

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

(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 690	Continued From page 8	F 690		

frequently incontinent of urine. Review of the 11/23/18 quarterly bowel and bladder evaluation showed the resident was incontinent of urine, was confused at all times, had unclear speech, and required extensive to total physical assistance with toileting. The evaluation showed the resident was not able to participate in a bladder program due to his/her dementia and required "check and change and assist when prompted." Review of the resident's fall care plan last revised on 9/26/18 showed "[resident] has difficulty remembering to use call light for assistance. Anticpate (sic) [resident] needs, make frequent rounds to check on safety & offer toileting with each interaction..." The following concerns were identified:

a. Observation on 1/29/19 at 8:02 AM showed the resident was sitting in his/her wheelchair in the assisted dining room and was then taken to the common room at the front of the facility. At 9:36 AM the resident was taken by the activity manager to the assisted dining room for an activity. At 11:05 AM the resident was moved to a table for the noon meal. At 11:12 AM the resident expressed the need to use the bathroom and was taken to his/her room (an interval of 3 hours and 15 minutes).

b. Interview with CNA #4 on 1/29/19 at 11:22 AM revealed the resident was to be toileted every two hours. Further, she stated the resident would express the need to use the bathroom and often try to stand up at that time; however, s/he would already be incontinent.

c. Interview on 1/28/19 at 2:34 PM with the resident's representative revealed the resident was to be taken to the bathroom every 2 hours, but she did not think that was happening."

d. Interview with the DON on 1/30/19 at 1:53 PM verified that the resident should not go longer

A new base line Bowel and Bladder assessment was conducted on resident #36 on 2/18/19 by the DON.

IDENTIFICATION OF OTHERS

New Bowel and Bladder assessments were completed on current residents on 2/21/19 by the DON to ensure toileting interventions are in place.

SYSTEMIC CHANGES

In-service education was provided to the nursing staff regarding following each resident'□s toileting interventions and completed on 2/23/19 by the DON/designee.

The IDT reviews the initial bowel and bladder assessment for appropriate toileting interventions during the morning meeting on the following business day after admission. The IDT reviews the completed quarterly bowel and bladder assessments weekly for accuracy or change.

The nursing administration team conducts random observations of staff providing timely incontinence management. The nursing management team will conduct observation of 5 residents per week for timely incontinence management.

MONITORING

The DON reviews the bowel and bladder assessments and the incontinence

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 01/31/2019

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

(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 690	Continued From page 9 than 3 hours without toileting.	F 690	observations and reports any patterns or trends to the Quality Assessment Performance Improvement Committee monthly for their review and resolution. These reviews will continue for 3 months unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758		2/23/19

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 01/31/2019

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

(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 758	Continued From page 10 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents were free from unnecessary psychotropic medication for 1 of 5 (#36) sample residents reviewed for medications. The findings were: Review of the 11/23/18 quarterly MDS assessment showed resident #36 was admitted to the facility on 7/5/18 and had diagnoses which included depression and non-Alzheimer's dementia. Further review showed the resident had a BIMS score of 0/15 (severe cognitive impairment) and a mood score of 6/27 (mild depression). Review of the current physician orders showed the resident was prescribed quetiapine fumarate (antipsychotic) 12.5 mg daily on 12/12/18 for dementia with behaviors; and mirtazapine (antidepressant) 15 mg daily on	F 758	F 758 Free from Unnecessary Psychotropic Medication CORRECTIVE ACTION Behavior tracking and potential side effects of the psychotropic medication were added to the TARs for resident #36 on 1/30/19. IDENTIFICATION OF OTHERS The social workers reviewed the TARs of the residents who are administered medication that require behavior tracking and side effects to ensure that associated	

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 01/31/2019

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

(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 758	Continued From page 11 9/28/18 for depression. Review of the behavior care plan last revised 12/13/18 showed the resident had delusions of being chased, fought with, and being shot. Interventions included observing the behavior to determine the underlying cause and to document behavior and potential causes. The following concerns were identified: a. Review of the medical record showed no evidence a behavior monitoring flowsheet had been developed to include specific target behaviors, triggers, or interventions identified for the use of each individual medication. In addition, there was no evidence potential side effects of the psychoactive medications were being monitored. b. Interview with the DON on 1/30/19 at 1:40 PM confirmed a method for monitoring behaviors, interventions, effectiveness and side effects of the psychoactive medications had not been developed for the resident.	F 758	behaviors are tracked and the potential side effects are monitored as required on 2/18/19. Any resident any needed changes were made. SYSTEMIC CHANGES In-service education was provided to the social workers related to the need to track behaviors associated with certain medications and monitoring of side effects by the Social Service consultant on 2/7/19. The social workers review the orders for psychotropic medication in the morning meeting and ensure that the appropriate associated behaviors that are tracked and potential side effects are monitored on the TARs. The social workers monitor for changes in medications and changes in behaviors and ensure that changes are made to the monitoring on the TARs as they occur. MONITORING The social workers report any patterns or trends related to behavior tracking and side effect monitoring to the Quality Assurance Performance Improvement committee monthly for their review and direction. The social workers will continue this monitoring for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
F 801	Qualified Dietary Staff	F 801		2/23/19

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 01/31/2019

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

(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 801 SS=D	Continued From page 12 CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of	F 801		

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 01/31/2019

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

(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 801	Continued From page 13 this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of course certificate, the facility failed to ensure the dietary manager met required qualifications. The findings were:	F 801	F 801 Qualified Dietary Staff	

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 01/31/2019

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

(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 801	Continued From page 14 Interview with the dietary manager on 1/28/19 at 10:42 AM revealed she was new to the position within the past year. She revealed she had graduated from a nutrition and food service professional training program and also had a serve safe certificate. She had no other credentials at that time or education that would meet the qualifications. However, she stated she was scheduled to take the certification exam for dietary managers on 2/8/19. Review of the completion certificate showed she passed the training program on 9/20/17.	F 801	CORRECTIVE ACTION A Certified Dietary Manager is now in place to mentor the current Dietary Manager 25 hours per week until the current dietary manager is able to take the certification exam. The Registered Dietician will provide oversight for an additional 10 hours per week. IDENTIFICATION OF OTHERS All residents have the potential to be affected by qualified dietary staff. SYSTEMIC CHANGES A Certified Dietary Manager is in place. MONITORING The dietary manager report any changes related to certification to the Quality Assurance Performance Improvement committee as they arise for their review and direction.	
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law.	F 808		2/23/19

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 01/31/2019

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

(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 808	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure residents received food in the appropriate form as prescribed by the physician during 1 random observation which affected resident #36. The findings were: Review of the 11/23/18 quarterly MDS assessment showed resident #36 had a BIMS score of 0/15 (severe cognitive impairment); had diagnoses of dysphagia (difficulty swallowing) and non-Alzheimer's dementia; required extensive assistance for eating; and was prescribed a mechanically-altered diet. Review of the most current physician orders showed the resident was prescribed a pureed diet and nectar-like thickened liquids on 10/24/18. The findings were: Observation on 1/29/19 at 11:05 AM showed the resident was in his/her wheelchair at a table in the assisted dining room. At that time LPN #1 offered the resident a snack of graham crackers, a sandwich, or pears. The resident did not respond to the question and was given a small container of pear chunks and a fork. Interview with RN #2 at that time confirmed the pears were not appropriate. Further observation showed the pears were removed before the resident ate them, and a thickened-liquid beverage was provided instead.	F 808	F 808 Therapeutic Diets CORRECTIVE ACTION A list of therapeutic diets in available for residents with altered diets with the snack tray including the diet for resident #36. IDENTIFICATION OF OTHERS All residents on altered diets have a potential to be affected by this practice. SYSTEMIC CHANGES In-service education was provided to the staff related to altered diets and offering snacks to residents on altered diets and the risks associated with this completed on 2/23/19 by the DON/designee. A list of residents with altered diets has been developed to accompany the cart tray so that staff members can easily identify residents who require alter diets. The Unit Manager maintains this list and conducts random observation of snack passing 3 times per week observing for correct texture of snack offered. MONITORING The DON/designee reports any patterns or concerns related to observations of the snacks that are passed to the Quality	

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 01/31/2019

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

(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 808	Continued From page 16	F 808	Assessment Performance Improvement Committee monthly for their review and resolution. These reviews will continue for 3 months unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		2/23/19

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 01/31/2019

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

(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 880	Continued From page 17 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure infection control standards were met during 3 random observations involving	F 880	F 880 Infection Prevention and Control	

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 01/31/2019

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

(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 880	Continued From page 18 residents #7, #37, #66. The findings were: 1. Observation on 1/28/19 at 2:27 PM showed, after performing care to resident #37 who had been incontinent of bowel, CNA #1 removed her gloves. However, the CNA failed to wash her hands prior to leaving the resident's room. 2. Observation on 1/29/19 at 8:47 AM showed, after performing care to resident #66 who had been incontinent of bowel, CNA #2 kept soiled gloves on and touched the resident's blanket and the bed control. 3. Observation on 1/30/19 at 4:25 PM showed RN#1 went into the room of resident #7 to test his/her blood sugar. There was a urinal with urine on the nightstand, and a banana next to the urinal. The RN placed her clipboard which held the glucometer, test strips and papers on the nightstand. When finished with resident care she picked up her items and left the room. Continued observation showed she cleaned the glucometer, but nothing else. 4. Interview with the infection preventionist on 1/31/19 at 8:37 AM revealed it was her expectation for staff to wash their hands after providing care and to be aware of any measures that could be taken to prevent cross-contamination of a potential infection.	F 880	CORRECTIVE ACTION In-service education was provided to the facility staff by the SDC and completed on 2/23/19 related general infection control practices with emphasis on removal of gloves and washing hands, changing gloves after dirty tasks and placement of clean items/food items near unclean items. 1:1 education was provided to the nurse who placed the clean items next to the dirty items on 1/31/19 by the SDC. IDENTIFICATION OF OTHERS All residents have the potential to be affected by this practice. SYSTEMIC CHANGES In-service education was provided to the facility staff by the SDC and completed on 2/23/19 related general infection control practices with emphasis on removal of gloves and washing hands, changing gloves after dirty tasks and placement of clean items/food items near unclean items. Random rounds are conducted by the SDC with a minimum of 5 observations per week of infection control practices with an emphasis on use of glove use, hand washing and placement of clean items. These rounds will also observe the environment for the locations of	

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 01/31/2019

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

(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 880	Continued From page 19	F 880	clean/food items and dirty items. Findings are reported to the DON. MONITORING The DON/designee reports any patterns or concerns related to infection control observations to the Quality Assessment Performance Improvement Committee monthly for their review and resolution. These reviews will continue for 3 months unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	