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 02/25/2011

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 The following common abbreviations are used throughout this document: RN - registered nurse LPN - licensed practical nurse CNA - certified nursing assistant DON - director of nursing MDS - Minimum Data Set CAA- Care Area Assessment Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	Preparation and/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.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff maintained dignity for 1 of 15 sample residents (#57). The findings were: Review of the 1/12/11 admission MDS and corresponding care plan for resident #57 showed the resident walked independently, but required extensive assistance with personal hygiene care and toileting due to cognitive impairment. Observation on 2/23/11 at 11:25 AM, revealed the resident wore slacks that were visibly soiled with wet urine that covered the entire posterior and thigh areas of the slacks. Continued observation revealed the resident walked throughout the facility and lobby areas until 12:05 PM (thirty-five minutes) before staff removed the soiled clothing	F 241	F241 It is the practice of the facility to promote care for the residents in a manner and in an environment that maintains or enhances each resident's dignity & respect in full recognition of his or her individuality. **Corrective Action** 1.Resident #57's soiled clothing was removed and she was assisted with pericare and clean clothing on 2/23/11. 2.Resident had a new bladder evaluation completed. 3.An incontinence care plan was placed in the resident's record. **Identification of Others:** Residents who require assist with incontinence care. **System & Measures**: 1.All Staff will be re-educated by the SDC/designee on or before 4/7/11 on providing incontinence care and dignity surrounding incontinent episodes. 2.Ambassador to conduct observations 5 x weekly to monitor for soiled clothing. 3.The DON/Designee will complete random weekly observations 3 – 5 times a week.	

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

RECEIVED
Wyoming Dept of Health
MAR 21 2011
Office of Healthcare Licensing and Surveys

Jennifer Reaume NHA March 19, 2011

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

This POC agreed to with acceptable change between Jennifer Reaume, Administrator and Tony Markey on 3/24/11 4/6/11

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 02/25/2011

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 241	Continued From page 1	F 241	241 continued **Monitor:** QA&A—Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the DON/designee. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. Corrective Date: 4/7/11 F246 It is the intent of the Facility to ensure residents have the right to reside & receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. **Corrective Action:** 1.Resident #65's communication board is in place and within resident's reach. 2.Resident #65's clock battery was replaced on 2/25/11 and re-set to correct time. 3.Speech therapy order received to re-evaluate resident #65 for communication needs on 3/18/2011. **Identification of Others:** 1.Residents who are not able to communicate verbally and require an assistive device. 2.Residents who desire a clock in their room. **Systems / Measure** 1.An audit of all resident rooms with clocks was completed to ensure clock is in working order and set to correct time. 2.All residents with clocks in their rooms will be placed on TELS maintenance log, checked, and reviewed every six months.	4/7/11
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure individual needs for communication and time orientation were accommodated for 1 of 15 sample residents (#65). The findings were: Medical record review for resident #65 showed the resident used a communication board to express his/her needs due to aphasia. Observation on 2/22/11 at 11 AM revealed the resident was in a wheelchair in his/her room holding an empty cup. At that time neither the call light nor communication board were within his/her reach. The resident showed the surveyor the empty cup and by using the communication board the resident communicated that s/he wanted coffee. The resident then attempted to reach the call light, but was unable to do so because s/he could not self propel over the fall mat located between the resident and the call light. Next, the resident went into the hallway and held the empty cup up to the staff, but no one stopped to assist the resident. At 11:10 AM, LPN #1 gave the resident medications and water and departed	F 246		

3/24/11

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 02/25/2011

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 246	Continued From page 2 after pouring water into the resident's empty cup. No attempt was made to communicate with the resident using the communication board, which remained in the resident's room. The resident again held up his/her cup, and the surveyor told the nursing unit manager that the resident wanted coffee. Review of the 10/7/10 significant change MDS and CAA showed staff were to encourage the resident to use the communication board. Interview on 2/24/11 at 1:55 PM with the DON confirmed staff needed training on the use of the communication board, and speech therapy needed to reevaluate the resident's communication devices. Staff's failure to accommodate this resident's need for time orientation was noted during the following observations: On 2/22/11 at 11:30 AM and again on 2/25/11 at 8:30 AM, the time on the resident's clock was 3:20. Interview with the DON on 2/25/11 at 12:05 PM verified the time on the resident's room clock should be set to the correct time.	F 246	F246 Continued 3.An In-service by SDC/designee to educate the staff on the use of communication boards will be conducted on or before 4/7/11. 4.Ambassadors to check clock for operation & correct time, and will make sure communication needs are met 5 x weekly. **Monitoring:** Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the NHA/designee. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. Corrective Date: 4/7/11	4/7/11
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279	F279 It is the practice of the facility to use the results of the assessment develop, review and revise a comprehensive care plan for each resident. **Corrective Action:** 1.Resident #19 behavior care plan was updated on 3/9/2011 to reflect resident #19's action of repeatedly pushing on exit doors and ability to be re-directed. 2.Resident #65's communication care plan was updated on 3/4/2011 to reflect the use of a communication board and instructions for utilizing the communication board. **Identification of Others:** 1.An audit of most recent CAA's (Care Area Assessment) for the last sixty days will be conducted. 2.All CAA's will be compared to care plans and updated to reflect assessment of resident. **System / Measure:** 1.On or before 4/7/11 the IDT will be in serviced by DON/Designee concerning updating care plans with CAA review upon admission, change of condition and annually.	

4/7/11

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 02/25/2011

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 279	Continued From page 3 highest practicable physical, mental, and psychosocial well-being as required under §483.25, and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure the care plans for 1 non-sample resident (#19), and 1 of 15 sample residents (#65) were updated to reflect the current status/needs of the residents. The findings were: Observation on the evening of 2/23/11 revealed resident #19 was wandering in the back hallway in his/her wheelchair. At that time the lights in the west end of the hallway were turned off, and it was very dim. The resident was observed to repeatedly push on the exit doors at each end of the hallway from 7 PM to 8:25 PM. At no time during the observation did the staff working in the area attempt to redirect the resident or intervene in any way. Review of the 2/18/11 annual MDS assessment showed the resident had daily occurrences of wandering that placed the resident at significant risk of getting into a potentially dangerous situation. Review of the behaviors CAA showed pushing on the exit doors was a reoccurring behavior for this resident, and the resident could be easily redirected. Review of the care plan failed to mention this behavior. Interview with the DON on 2/25/11 at 11:55 AM revealed the information from the assessment should be used to develop the care plan.	F 279	**F279 Continued** 2.RCMD/Designee will complete a random ~~weekly audit of comprehensive assessments to~~ ensure care plans are updated to reflect CAA (Care Area Assessment). **Monitoring:** Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the RCMD/designee. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. Corrective Date: 4/7/11	4/7/11

3/24/11

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 02/25/2011

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 279	Continued From page 4 Review of the care plan for resident #65 showed s/he had a communication board, but the plan did not include instructions for use. In an interview on 2/24/11 at 1:26 PM, CNA #7 stated s/he had not been educated on the use of the board and used "common sense" when s/he used it with the resident. Review of the 10/7/10 significant change MDS showed the resident required further assessment for communication needs. Review of the communication CAA showed the resident was to continue to use the communication board and be encouraged by staff to use it. Further, the assessment showed staff were to give the resident time to make him-/herself understood by allowing time to spell out each word. Interview with the DON on 2/24/11 at 1:55 PM confirmed the that the additional information regarding how to use the communication board had not been included in the care plan. She also stated staff still needed to be trained on the use of the communication board.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to follow physician's orders for 2 of 15 sample residents (#28, #37). The findings were: 1. Refer to F318 regarding the facility's failure to provide passive range of motion daily for resident #28 as ordered by the resident's physician.	F 281	F281 It is the practice of the Facility to ensure the services provided or arranged by the Facility meet professional Standards of Quality. **Corrective Action:** 1.Resident #28's physician orders for passive range of motion are being followed. 2.Resident # 37's orders for daily weights are being followed and weights are being obtained daily. **Identification of Others:** 1.An audit of all residents with physician orders for passive range of motion was conducted. 2.An audit of all residents with orders for daily weights was conducted. **System / Measure:** 1.Licensed nurses will be educated by the SDC/Designee on or before 4/7/11 on the importance of following physician orders.	

3/24/11

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 02/25/2011

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 281	Continued From page 5 2. Review of the medical record for resident #37 showed s/he had diagnoses that included chronic kidney disease and congestive heart failure. Further review showed a 1/25/11 physician's order for daily weights and staff were to report weight gain of ten pounds or more. Review of the "Vital Sign & Weight" flow sheets for January and February 2011 showed no documented weights for 2/3/11, 2/4/11, 2/6/11, 2/12/11, 2/13/11, or 2/17/11. Review of the entire medical record showed no weights were recorded for those dates. Interview with the MDS coordinator on 2/24/11 at 3:30 PM revealed the resident should be weighed daily as ordered. During the interview, the MDS coordinator stated she could not be certain the resident was actually weighed on any days that the weight was not recorded. According to Smith, Duell, and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," 7th Edition, 2008: "Skills and functions that professional nurses perform in daily practice include: ...Administer treatments per physician's order."	F 281	F281 Continued 2.A random weekly audit by DON/Designee of residents receiving passive range of motion will be conducted to ensure documentation and orders are being followed consistently. 3.A daily audit by DON/Designee will be conducted to ensure daily weights are obtained as ordered by physician. **Monitor:** Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the DON/designee. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. Corrective Date: 4/7/11 F285 It is the practice of the facility to coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicate testing and effort. **Corrective Action:** 1.A pre-admission screening has been completed for resident #5 on 12/15/10. 2.A pre-admission screening has been completed for resident #28 on 1/20/2011. 3.A pre-admission screening has been completed for resident #37 on 11/8/10. 4.A pre-admission screening has been completed for resident #57 on 1/11/10. 5.A pre-admission screening has been completed for resident #93 on 11/9/10. **Identification of Others:** 1.Any new resident pending admission with a Dx of Mental Illness or Mental Retardation.	4/7/11
F 285 SS=E	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an	F 285		

3/24/11

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 02/25/2011

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 285	Continued From page 6 independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to ensure the pre-admission screening assessments were completed prior to admission for 5 of 18 sample residents (#5, #28, #37, #57, #93). The findings	F 285	F285 Continued **System / Measure:** 1.NHA/Designee will review pending admission paperwork for diagnosis or medications requiring additional pre-screening. 2.NHA/Designee will review the need for a pre-admission screening with Social Services. 3.Any pending admissions will have a pre-admission screening completed and PASRR I or II if indicated. 4.In-service from the state (ACS) level on PASRR I and II All Dept. Heads will be in serviced on or before 4/7/11. 5.NHA/Designee will discuss all new pending admissions in IDT meeting daily Monday through Friday to review for completed PASRR I or II prior to admission to facility. **Monitor:** Data will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the NHA/designee. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. Corrective Date: 4/7/11	4/7/11

3/14/11

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 02/25/2011

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 285	Continued From page 7 were:	F 285		

1. Medical record review showed resident #5 was re-admitted to the facility on 12/2/10. Due to a new diagnosis, the resident required a new pre-admission screening assessment (PASRR I). This assessment was completed 13 days after the date of admission on 12/15/10. As a result of the PASRR I assessment the resident required a PASRR II assessment to be completed. Review of this PASRR II assessment showed the determination date was 2/10/11, sixty-one days after the date of admission. Interview with the social service director on 2/25/11 at 10:10 AM revealed this case was especially late due to some communication problems between agencies.

2. Medical record review showed resident #93 was admitted to the facility on 11/4/10. Record review showed the pre-admission screening assessment (PARR I) was completed on 11/9/10. As a result of the PASRR I assessment the resident required a PASRR II assessment to be completed. Review of this PASRR II assessment showed the determination date was 11/23/10, nineteen days after the date of admission.

3. Resident #37 was admitted on 10/21/10, but the resident's PASRR Level I was not completed until 11/8/10 (eighteen days after admission).

4. Resident #28 was admitted on 1/19/11, but the resident's PASRR Level I was not completed until the next day on 1/20/11.

5. Resident #57 was admitted on 1/06/11, but the PASRR Level I was not completed until 1/11/10 (five days after admission).

3/24/11

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 02/25/2011

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) COMPLETI DATE
F 285	Continued From page 8 Interview with the social service director on 2/25/11 at 10:10 AM revealed the staff had difficulty getting the assessments completed prior to admission.	F 285	F312 It is the facilities practice to assist residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure appropriate perineal care was provided during care of 2 of 7 residents whose care was observed. (#52, #61). The facility further failed to ensure oral care was provided during 3 of 6 observations for 2 residents (#51, #56, #87). The findings were: 1. Inappropriate perineal care was noted during the following observations: a. Observation on 2/22/11 at 9:15 AM showed CNA #1 failed to clean resident #52's anterior perineum after the resident was incontinent of urine. While the resident was standing with the assistance of a sit-to-stand lift, the CNA removed the resident's brief, cleaned the posterior perineum and buttocks then reached between the resident's legs from behind to clean the anterior perineum. However, observation showed the skin of abdomen and upper thighs was not cleansed. Review of the annual MDS assessment dated 12/30/10 showed the resident required extensive	F 312	**Corrective Action:** 1.Peri Care has been provided for resident #52 on 2/22/2011 after initial observation and ongoing. 2.Peri Care has been provided for resident #61 on 2/23/2011 and ongoing. 3.Oral care has been provided for resident #51 on 2/24/2011and ongoing. 4.Oral care has been provided for resident #56 on 2/24/2011 and ongoing 5.Oral care has been provided for resident #87 on 2/24/2011 and ongoing **Identification of others**: 1.A review of documentation for residents requiring assistance with peri care and oral care will be completed by DON/designee. **Systemic Changes:** 1.DON/designee will complete random weekly observations of peri – care and oral care and review with IDT at morning meeting Monday thru Friday. 2.Residents assigned ambassador will monitor hygiene to ensure compliance Monday thru Friday. Manager on duty will round the facility on Saturday and Sunday to observe for peri care needs. 3.SDC/Designee to provide education to all licensed staff on or before 4/7/11 on providing proper peri care and oral care. **Monitor:** Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the DON/designee. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. Corrective Date: 4/7/11	4/7/11

3/24/11

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 02/25/2011

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 312	Continued From page 9 assistance with personal hygiene and toileting. b. Review of the 2/18/11 care plan for resident #81 showed the resident was dependent on staff for personal hygiene care and toileting. Observation on 2/23/11 at 12:12 PM revealed CNAs #1 and #5 cleansed the resident after they removed the urine-soiled, disposable brief. Continued observation revealed, the CNAs reached between the resident's legs from behind to cleanse the resident's anterior perineum area, but failed to cleanse the posterior region. Interview with the staff development coordinator on 2/25/11 at 7:55 AM verified that an incontinent resident's skin should be cleaned both posteriorly and anteriorly. 2. Lack of oral hygiene was noted during the following observations: a. According to the 1/7/11 quarterly MDS assessment and corresponding care plan, resident #51 was documented to need extensive assistance with oral hygiene and personal care. Observation on 2/23/11 from 7:23 PM to 7:40 PM revealed neither CNA #1 or #4 provided oral hygiene before or after they transferred the resident to bed. b. Observation on 2/23/11 at 8 PM showed neither CNA #2 or #3 offered oral hygiene to resident #87 before transferring the resident to bed for the night. Review of the quarterly MDS dated 11/26/10 showed the resident required extensive assistance with personal hygiene. c. Observation on 2/23/11 at 8:25 PM showed neither CNA #1 or #4 provided oral hygiene to resident #56 before transferring the resident to bed for the night. Review of the quarterly MDS dated 11/25/10 showed the resident required extensive assistance with	F 312		

3/24/11

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 02/25/2011

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 312	Continued From page 10 personal hygiene. Interview with the DON on 2/24/11 at 11:10 AM revealed staff were expected to provide oral hygiene for all residents at night.	F 312	F318 It is the practice of the facility to ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure restorative care was consistently provided for 2 of 8 sample residents who received restorative services (#28, #64). The findings were: 1. Review of the 2/1/11 admission MDS assessment showed resident #28 had range of motion (ROM) impairment to upper and lower extremities on both sides. Further review showed the resident had a diagnosis of multiple sclerosis. Review of a 1/29/11 physician's order showed the resident was to receive passive ROM exercises from the restorative program daily to all extremities. Review of the restorative care documentation showed the facility failed to provide passive ROM exercises on 2/1/11, 2/2/11, 2/4/11, 2/11/11, 2/12/11, 2/13/11, 2/16/11, 2/18/11, 2/19/11, and 2/20/11, with each of those dates documented with "Activity did not occur"	F 318	**Corrective Action:** 1.Resident #28 has received passive range of motion everyday and is monitored daily Monday through Friday by restorative nurse. If the resident refuses the refusal will be entered into care tracker as such and noted in weekly restorative note by Restorative nurse/designee. 2.Resident # 64 has received Range of Motion and Ambulation restorative program 6 days per week. If the resident refuses the refusal will be entered into care tracker as such and noted in weekly restorative note by restorative nurse/designee. 3.Resident # 64 is being offered a "walk to dine" program daily. **Identification of Others:** 1.DON/Designee will review all restorative programs for the last 30 days to ensure all restorative programs have been implemented and documented as provided. **Systemic changes:** 1.DON/Designee will educate restorative assistants on ensuring restorative programs are completed and documented per nursing order on or before 4/7/11. 2.The restorative nurse will review documentation for restorative programs provided daily Monday through Friday to ensure complete and refusals are documented appropriately. 3.The restorative nurse will review all restorative programs on a weekly basis to ensure appropriateness of program. Restorative nurse will document refusals and if resident continues to refuse the physician and family will be notified.	

3/14/11

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 02/25/2011

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 318	Continued From page 11 "Other"; and three additional days showed "Activity did not occur" and "Refused." Interview with the restorative coordinator on 2/24/11 at 9:35 AM, revealed she was not certain what staff meant when documenting "Other" as a reason why an activity did not occur. Interview with the resident on 2/24/11 at 10:15 AM revealed that s/he never refused passive ROM exercises because they felt good. During an interview with restorative CNA #6 on 2/24/11 at 11:50, she stated that when staff documented "Other" for an activity that did not occur, it usually meant staff could not get to it. 2. Review of the restorative care plan, updated 2/15/11, for resident #64 showed approaches included ambulate with front wheeled walker 250 feet or walk to dine. Review of the 2011 restorative schedule showed transfers/ ROM/ambulation were to be provided for the resident at least six days a week. Review of the rehabilitation/restorative service delivery record showed the resident received restorative services four times and refused twice in the month of January 2011. Further review of the service delivery record showed the services had been provided two times in February and the resident refused two times. Review of the ambulation detail report showed the "Activity did not occur" from 2/17/11 to 2/24/11 (eight days). During periodic observations of the resident from 2/22/11 to 2/24/11, there were no observations of the resident receiving restorative services. Interview on 2/25/11 with CNA #6 at 8:50 AM and the nursing unit manager at 9 AM confirmed the resident had not been receiving restorative services according to the restorative schedule.	F 318	F318 Continued 4.Restorative meetings will occur weekly to review residents on programs and modify programs as needed. **Monitoring:** Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the DON/designee. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. Corrective Date: 4/7/11	4/7/11
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

3/24/11

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 02/25/2011

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 323	Continued From page 12 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to monitor the effectiveness and safety of equipment used for resident care and reassess the appropriateness of the equipment for 1 of 15 sample residents (#45) and 2 non-sample residents (#52, #87). The findings were: 1. Observation on 2/22/11 at 11:35 AM revealed CNAs #5 and #8 were using the mechanical lift to transfer resident #45 to the shower chair when the resident told them to "stop" because s/he felt pain caused by his/her catheter being pulled. At that time, the CNAs noted the resident's urinary drainage bag was caught on the bed frame and both stated they had forgotten to ensure the drainage bag was positioned properly during the transfer. 2. Observation on 2/22/11 at 9:15 AM showed resident #52, while in a sit-to-stand lift during incontinence care, was unable to hold onto the lift with his/her left hand. CNAs #1 and #5 told the resident to hold onto the lift while they were giving care. The resident used the lift strap around his/her chest for primary support. Review of the resident's care plan showed the staff should not	F 323	F 323 It is the practice of the facility to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. **Corrective Action:** 1.Resident #45's catheter tubing and containment bag are being positioned properly during transfers. 2.Resident #52 was re-assessed for transfer and appropriate lift on 2/22/2011. **ID of Others:** 1.An audit of all residents requiring a mechanical lift will be completed. **Systems/Measurements:** 1.SDC / designee will educate all licensed nurses and C.N.A's on or before 4/7/11 regarding the importance of a safe transfer, positioning of equipment and symptoms of discomfort. 2.DON/designee to random observe 5 transfers a week x 4 and then monthly ongoing. **Monitor:** Data obtained by way of audits/observations will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the DON/designee. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. Corrective Date: 4/7/11	4/7/11 4/7/11

3/24/11

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 02/25/2011

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 323	Continued From page 13 use the lift if the resident was not able to hold on with both hands.	F 323		
F 329 SS=D	3. Observation on 2/23/11 at 8 PM showed CNAs #2 and #3 used the sit-to-stand lift for resident #87, who during transfer continued to tell staff "Hurry up." After the resident was placed in bed, s/he complained of left shoulder pain; Review of the medical record showed the resident had a history of osteoporosis and arthritis. In addition, the resident's pain evaluation dated 2/17/11 showed s/he experienced frequent joint pain. Interview with the DON and nurse administrator on 11/24/11 at 9:15 AM revealed the facility would reassess the residents for the use of the sit-to-stand lift. They stated staff would make sure residents were able to use the lifts before placing them in the devices. 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329	F329 It is the facility's practice to ensure each resident's drug regime is free of unnecessary drugs. An unnecessary drug is any drug when used in an excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. **Corrective Action:** 1.Resident #45 discharged to hospital 2.Resident #82 Hours of sleep are being documented and care plan was updated to reflect non-pharmacological interventions. **ID of Others:** 1.DON / Designee to review all residents on hypnotic/sedative drug therapy for behavior monitoring, care plans for non-pharmacological interventions and tracking hours of sleep.	

3/24/11

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 02/25/2011

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 329	Continued From page 14 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 2 of 15 sample residents did not receive unnecessary medications (#45, #82). The findings were: Review of the February 2011 recapitulation of physician orders for resident #82 revealed a 8/20/10 physician's order for Ambien daily at bedtime for sleep. Review of the February 2011 recapitulation of physician orders for resident #45 revealed a 10/27/10 physician's order for Ambien [hypnotic] at bedtime for sleep as needed. Review of the medical records for the two residents revealed no evidence there had been a formal assessment of the causes and contributing factors for their insomnia. In addition, there was no evidence that any non-pharmacological interventions had been attempted. Interview on 2/25/11 at 9:15 AM with the nursing unit manager confirmed the lack of a sleep assessment for these residents.	F 329	F329 Continued **Systems/ measures:** 1.The DON/Designee will re-educate the license nurses on the proper assessment for the use of hypnotic/sedative medications on or before 4/7/11. 2.The DON/Designee will re-educate the license nurses on offering non-pharmacological approaches to sleep and to record their effectiveness on the behavior tracking form on or before 4/7/11. 3.The DON/Designee will re-educate the licensed nurses to accurately record the number of hours of sleep on the behavior tracking sheets for residents receiving hypnotics/sedatives and to document follow up results of medication given on or before 4/7/11. 4.The DON/Designee will review physician orders and the 24 hour report for orders for hypnotics to ensure the behavior monitoring forms, care plans, non pharmacological approaches to sleep and tracking hours of sleep are in place. The DON/Designee will complete random weekly audits of medication documentation, hours of sleep on behavior tracking form. 5.Any resident requesting the use of a hypnotic/sedative or physician order to initiate a new sedative/hypnotic will be reviewed daily Monday through Friday in morning meeting to initiate a study of hours of sleep prior to initiation of medication. **Monitoring** Data obtained by way of audits/observations will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the DON/designee. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. Corrective Date: 4/7/11	4/7/11
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371		

3/24/11

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 02/25/2011

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 371	Continued From page 15 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure food equipment and ventilation hoods located in the kitchen were maintained in a sanitary manner. In addition, the facility failed to ensure wiping cloths were properly stored. The findings were: a. Observation on 2/23/11 at 10:50 AM showed the meat slicer, a blender, and the table mounted can opener located in preparation areas of the kitchen were not clean. Food preparation was not taking place at that time of the observation, and none of the pieces of equipment were being used. The outside of the blender was noted to be splattered with dried food on the operation buttons and the base of the unit. The counter below the meat slicer had an accumulation of dried food and liquid, and the can opener blade was soiled with a build up of food and debris. In addition, the hood baffles above the range and griddle were observed to have a thick accumulation of grease and dust. Interview with the dietary supervisor on 2/23/11 at 10:50 AM revealed the hood system was cleaned by an outside company, and this was last done on 12/20/10. The dietary supervisor verified the equipment was in need of more thorough cleaning. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment	F 371	F371 It is the facilities practice to procure food from sources approved or considered satisfactory by Federal, State and local authorities; and store, prepare, distribute and serve food under sanitary conditions. **Corrective Action-** 1.Hood Vents washed and free of grease and dust on 2/23/11. 2.Wiping cloths are properly stored in sanitizer solution. 3.Meat grinder, blender and table mounted can opener were cleaned on 2/23/11. **ID of Other:** 1.DM to review all Sanitation audits for the last 30 days and correct to ensure cleaning and storage of any identified areas has been completed. **Systems/Measures:** 1.DM to re-educate all dietary staff on or before 4/7/11 and train on sanitation assignments, proper cleaning techniques after each use of equipment, proper storage of sanitation cloths. 2.DM/designee to do daily sanitation checks Monday through Friday to ensure proper cleaning of equipment and storage of cloths is being done. The DM/Designee will report findings in morning meeting Monday through Friday for the next 8 weeks. 3.RD/designee to do weekly sanitation checks to ensure proper cleansing techniques and storage of sanitation cloths. 4.NHA/designee to do random observations monthly. **Monitoring:** Data obtained by way of audits/observations will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the NHA/designee. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. Corrective Date: 4/7/11	4/7/11

3/24/11

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 02/25/2011

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 371	Continued From page 16 food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." b. Observation on 2/23/11 at 12 PM showed three wet wiping cloths lying on the side of a three-compartment sink. Interview at that time with the dietary supervisor revealed the cloths should be in the sanitizer solution. He stated he was unsure what the cloths were being used for. According to Food Code 2009, U.S. Public Health Service: 3-304.14. "...(B) Cloths in-use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114;"	F 371		

3/24/11