STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING _____ B. WING _____	C 02/19/2021

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LIFE CARE CENTER OF CHEYENNE	**1330 PRAIRIE AVENUE CHEYENNE, WY 82009**

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F 000	INITIAL COMMENTS A recertification survey which included a COVID-19 focused infection control survey was conducted by Healthcare Licensing and Surveys from 2/16/21 to 2/19/21. Also reviewed in the course of the survey were complaint intakes WY00002896, WY00002994, WY00002996, WY00003022, WY00003035, and WY00003037. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set LPN- Licensed Practical Nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, and policy review, the facility failed to ensure residents were safe to self-administer medication for 1 of 1 sample residents (#19) who self administered. The findings were: Observation on 2/16/21 at 12:13 PM showed an empty medication cup on the over-bed table in	F 554	1. Resident was assessed by nurse on 2/18/2021 and determined to be safe to self-administer medications. The self-administration UDA was completed, care plan was updated, and order was obtained to reflect self-administration on 2/18/2021. 2. A full house audit was conducted on	3/12/21

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

Electronically Signed | 03/12/2021

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F 554	Continued From page 1 front of resident #19 and no staff present. Continued observation showed the resident open a small metal medication pill box, removed a white tablet, and took the tablet. Interview at that time with the resident revealed the tablet was Lomotil. Medical record review showed an order dated 12/5/20 for Lomotil tablet 2.5-0.025 milligrams (mg) to be given in the morning. The following concerns were identified: 1. Review of the 12/11/20 admission MDS assessment showed the resident scored an 11 (moderately impaired cognition) on the brief interview for mental status (BIMS). Review of medical records failed to show an assessment had been completed by the interdisciplinary team (IDT) to determine if the resident was safe to self-administrator medications. 2. Interview on 2/18/21 at 1:03 PM with RN #3 revealed the resident was not safe to self-administer medication. In addition, the expectation was to observe the residents take their medications and not to leave them with the residents to take later. 3. Review of the policy and procedure titled "Self-Administration of Medication" reviewed 4/15/19 showed "Procedure 1. If the resident desires to self-administer medication, an order for self-administration will be obtained from the physician, and an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out the responsibility."	F 554	3/8/2021 by DON and no other residents were found to be affected by the deficient practice. 3. The facility will honor resident preference to self-administer medications as once the resident is considered safe per interdisciplinary team after review. Once a resident is deemed safe and expresses their preference to self-administer medications, the facility will obtain an order for self-administration, complete the self-administration UDA, update the care plan, provide education to the resident as indicated, and provide a lock box for the medications. Nursing staff will be educated by the DON or designee by 4/2/2021 on the facilities self-administration of medication policy. 4. The unit managers will complete weekly audit which will include reviewing new admissions for the potential for self-administration of medication and reviewing 5% of current residents on the units for self-administration of medications. The Director of Nursing will review the weekly audits and present the results to monthly QAPI for review and feedback for a minimum of three months to ensure compliance is achieved and maintained.	
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		3/19/21

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F 582	Continued From page 2 §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's	F 582		

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F 582	Continued From page 3 per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the appropriate Notice of Medicare Provider Non-Coverage (NOMNC) and Advance Beneficiary Notice (ABN) forms were issued correctly for 2 of 3 sample residents (#18, #81). The findings were: 1. Review of the medical record showed resident #18 was discharged from Medicaid Part A services on 2/11/21, and used fewer than the 100 days covered by Medicare Part A. The following concerns were identified: a. Review of the NOMNC form issued to the resident on 2/11/21 for a last covered date of 2/11/21 showed the facility did not meet the requirement of providing the notice two days prior to the last covered day. b. Review of the information presented on the NOMNC form showed there was no contact information provided for the Quality Improvement Organization (QIO), a resource that is necessary for any resident who chooses to appeal to CMS for an extension of their Medicare Part A coverage.	F 582	1. The facility will issue an ABN form to resident #81 on 3/15/2021 by the RN Case Manager. The correct contact number was updated to the forms by RN Case Manager on 2/17/2021. Resident #18 discharged the facility on 2/11/2021. 2. A full house audit will be conducted to identify residents affected by the deficient practice. 3. The facility will issue the NOMNC and ABN forms timely with the correct contact number for the Quality Improvement Organization for any possible appeals for extension. Education will be conducted with the RN Case Managers by the Executive Director or designee by 4/2/2021. 4. A weekly audit of 5% of the residents will be conducted by the RN Case Manager to ensure that NOMNC and ABN forms are issued timely with the correct contact information. The Executive	

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F 582	Continued From page 4 2. Review of the medical record showed resident #81 was discharged from Medicaid Part A services on 1/31/21, and used fewer than the 100 days covered by Medicare Part A. The following concerns were identified: a. Review of the NOMNC form issued 1/31/21 for a last covered date of 1/31/21 showed the facility did not meet the requirement of providing the notice two days prior to the last covered day. b. Review of the medical record showed an ABN form was needed for the resident transitioning to long-term care, but was not completed by the facility. c. Review of the information presented on the NOMNC form showed there was no contact information provided for the Quality Improvement Organization (QIO), a resource that is necessary for any resident who chooses to appeal to CMS for an extension of their Medicare Part A coverage. 3. Interview with RN/case manager #2 on 2/18/21 at 9:11 AM revealed she was unaware of the requirement for providing the NOMNC and ABN forms two days prior to the last covered day of Medicare Part A services, and was unsure of what circumstances were necessary for the use of an ABN form. Further interview revealed she was unaware of the name and contact information of the QIO, and has not provided that information on the NOMNC forms issued to residents.	F 582	Director will review the weekly audits and report results to the monthly QAPI for review and feedback for a minimum of three months to ensure compliance is achieved and maintained.	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity.	F 604		3/19/21

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F 604	Continued From page 5 The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, policy review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure personal alarms were evaluated as potential restraints for 1 of 1 sample residents (#88). The findings were: 1. Review of the quarterly MDS assessment	F 604	1. The chair alarm for resident #88 was discontinued on 2/18/2021. 2. A full house audit was conducted by the DON on 3/8/2021 and it was determined that there were no other residents by the deficient practice.	

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F 604	Continued From page 6 dated 2/3/21 showed resident #88 had a score of 5 of 15 on the brief interview for mental status (BIMS), indicating severe cognitive impairment. Further medical record review showed an intervention note dated 2/11/21 identifying the use of "Alarming monitor at all times." The following concerns were identified: a. Observation on 2/16/21 at 11:53 AM showed the resident triggered an alarm on the resident's wheelchair, which could be heard from the nursing desk at the end of the hall. The resident appeared confused and visibly startled by the alarm, but continued to move around in his/her wheelchair. Further observation revealed CNA #1 responded quickly to ask the resident to sit back in his/her chair. b. Staff interview following the event with CNA #1 and LPN #1 revealed the alarm was meant to prevent falls, and would activate if the resident moved forward in his/her wheelchair. c. Interview with RN#1 on 2/18/21 at 4:27 PM revealed a restraint assessment was not completed for the resident because the chair alarm was not considered a restraint. d. Medical record review showed there was no signed physician order related to the use of a chair alarm or any other restraints. 2. Review of facility policy titled "Restraint & Position Change Alarm Use" updated on 5/12/20 showed "...The use of position change alarms that are audible to the resident may have the unintended consequence of inhibiting freedom of movement...A physician's order is required for the use of the specific type of restraint. The order should include the specific type of restraint, the condition and/or medical symptom that warrants restraint use, where and how the restraint is to be applied and used, and the time and frequency the	F 604	3. Residents will be free from physical restraints. Education will be conducted by DON or designee with nursing on the facility's process in that bed and chair alarms will not be utilized or available. 4. The unit managers will conduct an observation audit weekly of 5% of the residents on each unit to ensure that there are no bed or chair alarms being utilized. The Director of Nursing will review the audits weekly and report the findings to the monthly QAPI for review and feedback for a minimum of three months to ensure that compliance is achieved and maintained.	

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F 604	Continued From page 7 restraint should be released." 3. According to CMS's MDS 3.0 RAI Manual, page p-9: "Individualized, person-centered care planning surrounding the resident's use of an alarm is important to the resident's overall well-being. When the use of an alarm is considered as an intervention in the resident's safety strategy, use must be based on the assessment of the resident and monitored for efficacy on an ongoing basis, including the assessment of unintended consequences of the alarm use and alternative interventions. There are times when the use of an alarm may meet the definition of a restraint, as the alarm may restrict the resident's freedom of movement and may not be easily removed by the resident. When an alarm is used as an intervention in the resident's safety strategy, the effect the alarm has on the resident must be evaluated individually for that resident."	F 604		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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, resident and staff interview, and medical record review, the facility failed to ensure staff provided needed services for 2 of 12 residents (#7, #62) who required assistance to carry out daily living activities of eating. The findings were: 1. Review of the resident care plan last reviewed	F 677	1. Resident #7 changed from an independent diner to an assisted diner on 2/18/2021. Resident #62 assisted dining was resumed on 2/18/2021. Residents #7 and #62 were assessed by the Dietician on 3/12/2021 and no negative outcomes were observed due to the lack of assistance during meal.	3/19/21

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F 677	Continued From page 8 2/8/21, showed resident #7 required assistance with ADLs, including the need to encourage and assist at meal times as needed. Review of the quarterly MDS assessment dated 11/18/20 showed the resident had a BIMS score of 4 of 15, indicating severe cognitive impairment, and required limited assistance with eating that included "guided maneuvering of limbs or other non-weight-bearing assistance." Further review showed the resident was 68 inches tall and weighed 158 lbs with no significant weight loss identified at the time of assessment. The following concerns were identified: a. Observation on 2/16/21 at 12:22 PM showed the resident was seated in his/her recliner and was unable to reach his/her food on the tray table, even with assistance from his/her spouse. Further observation at 12:30 PM showed the resident had fallen asleep with what appeared to be less than 10% food consumption. No staff members were observed offering assistance or alternative meal options for the duration of the meal. b. Observation on 2/17/21 at 12:20 PM showed the resident attempted to use a fork to eat his/her food, but could not keep anything balanced on the fork. Further observation showed CNA #3 removed the food at 12:31 PM; the food was almost untouched and no additional assistance was offered. Interview with the CNA at that time revealed she documented 0-25% food consumption, but was aware that there was almost no food consumption. c. Review of the food intake log from 1/20/21-2/18/21 showed the resident consumed 0-25% of the meal for 59 meals, 26-50% for 17 meals, 51-75% for 4 meals, 76-100% for 4 meals, and refused 6 meals.	F 677	2. An observation audit will be conducted of all meal dining areas to observe for needed assistance. 3. The facility will provide assistance to residents as needed during mealtimes and ensure residents have time to finish meals before food is removed. Any change in the resident's ability with eating will be reported to the licensed nurse. Education will be conducted by Dietician or designee on the facility's process for providing assistance during mealtimes to include documenting percentages of intake. 4. The Dietician will perform weekly observation audit of meals at random mealtimes and locations each week to ensure assistance is provided to those residents that require assistance with their meals and intake is documented. The Director of Nursing will review the audits weekly and report the findings to the monthly QAPI for review and feedback for a minimum of three months to ensure that compliance is achieved and maintained.	

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F 677	Continued From page 9	F 677		

2. Review of the resident care plan dated 1/19/21 showed resident #62 was at risk for weight loss due to dementia progression with interventions that included "assisted diner in main dining room for meal set-up and extensive cueing/encouragement." Review of the resident quarterly MDS Assessment dated 1/14/21 showed the resident had a BIMS score of 7 of 15, indicating severe cognitive impairment, and required extensive assistance with eating, which included "one-person weight-bearing support." Further review showed the resident was 65 inches tall and weighed 124 lbs with no significant weight loss identified at the time of assessment. The following concerns were identified:

a. Observation on 2/16/21 at 12:22 PM showed the resident attempted to eat a few bites of food, and consumed what appeared to be less than 10% of his/her meal. Further observation at 12:38 PM showed the resident was asleep with the rest of his/her food untouched.

b. Observation on 02/17/21 at 12:18 PM showed the resident was given his/her meal by a staff member, who left the room after providing the meal. During the period from 12:18 PM to 12:45 PM, the resident did not eat any food, and no assistance was offered.

c. Interview with the resident on 2/17/21 revealed s/he enjoyed meals, but felt the staff frequently removed his/her food before s/he had the chance to eat any of it.

d. Review of the food intake log from 1/20/21 to 2/18/21 showed the resident consumed 0-25% of the meal for 18 meals, 26-50% for 45 meals, 51-75% for 20 meals, 76-100% for 6 meals, and refused 2 meals. Review of the facility weight logs showed the resident had a non-significant weight loss of 8.28% over the previous six-month period.

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F 677	Continued From page 10 3. Interview with the dietitian on 2/18/21 at 3:38 PM revealed resident #62 was an assisted diner prior to COVID-19 restrictions, but no longer needed any assistance with dining. Further interview revealed resident #7 would typically receive encouragement by his/her spouse to help increase food consumption. 4. Interview with RN #1 on 2/18/21 at 4:13 PM revealed staff were expected to offer encouragement or alternative food for residents with low food intake. Further interview revealed the facility had identified that resident #7 needed more support than what his/her spouse could provide, and a plan to provide more assistance for future meals had been put into place.	F 677		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		3/12/21

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F 761	Continued From page 11 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure medications available for use were not expired in 3 of 9 medication storage areas (West long term care cart, 500 hall medication storage room, South long term care medication cart). The findings were: 1. Observation on 2/17/21 at 2 PM with the DON showed a crash cart at the 500 hall nurses desk had 1 bag of 1000 milliliter normal saline that expired on 12/2020. Further observation showed 9 heparin lock flush solutions (500 usp units/5ml) which expired on 9/10/2020. There was also 1 bag of 1000 ml 0.45 sodium chloride which expired Nov 2020. Interview with the DON at that time revealed the medications were for resident use and the medications were expired. 2. Observation on 2/18/21 at 10:08 AM of the west long term care medication room showed 5 containers of Calazime/Nystatin/SSD 1:1:1 cream that had expired with expiration dates between 11/27/20 to 2/5/21. 3. Observation on 2/18/21 at 10:25 AM of the South long term care medication cart showed 4 heparin lock flush solutions 30 USP unit/3 ml (10 USP units/ml) that expired on 7/31/20.	F 761	1. Expired and discontinue medications observed during survey were removed from the crash cart, medication room, and medication cart by the DON on 2/17/2021 and 2/18/2021. 2. An observation audit of all other medications rooms, carts, and crash cart will be conducted. 3. The facility will ensure that medications and biologicals are stored in the medication room, medication cart, and/or treatment cart as appropriate and that expired medications are disposed of properly. Education will be conducted by the DON or designee by 4/2/2021 with nurses and nurse managers on proper disposal of expired and discontinued medications. 4. The unit managers will conduct a weekly audit to include medication carts and medication storage rooms on their units to observe for expired medications. The Director of Nursing will review the audits weekly and report the results to the monthly QAPI for review and feedback for 3 months or until substantial compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING _____ B. WING _____	C 02/19/2021

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F 761	Continued From page 12 4. Review of the policy and procedure "5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" revision date: 4/5/19 showed "17. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications..."	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure cooking/food production equipment was maintained in a sanitary manner in 1 of 1 food preparation areas (kitchen). The census was 88. The findings were: Observation on 2/18/21 at 11:20 AM showed the following items in need of cleaning:	F 812	1. The range was cleaned around the burners and the top surface on 3/11/2021 by cook. The ventilation hood was cleaned along with the pipes of the fire suppression system on 3/11/2021 by cook. The convection oven was cleaned on 3/11/2021 by cook. Quotes were obtained for purchase of a new range.	3/12/21

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F 812	Continued From page 13 1. The range had thick, black, burned on food around the burners and top surface. 2. The ventilation hood above the range showed there was grease build up on the flat surfaces as well as the pipes of the fire suppression system. These pipes had visible droplets of grease. 3. The convection oven had a build up of food/grime on the interior doors and on the outside control panel. Also the doors on the oven did not fully close on the unit. 4. The stand mixer was clean however, there were large areas of scraped off and flaking paint. The grey paint was scrapped and flaked off in several areas including the area above the mixing bowl where the food would be contained. 5. Interview with the Certified Dietary Manager (CDM) on 2/18/21 at 11:50 AM revealed the cleaning of this equipment needed to be done more frequent to prevent the build-up. She also stated the contracted service to clean the ventilation hood was last done in January. The CDM also confirmed the oven and the mixer were in need of repair. They were both at least 10 years old. She said the mixer was used occasionally and staff were aware to watch for flaking paint. The oven was used daily and required staff to turn items while cooking to get the food cooked evenly. 6. According to Food Code 2017, U.S. Public Health Service: 3-305.14 Food Preparation. "During preparation, unPACKAGED FOOD shall be protected from environmental sources of contamination."	F 812	Quote was obtained for a new stand mixer. 2. An audit of the kitchen will be conducted to identify and other issues. 3. The facility will store and maintain food in a clean, safe, and sanitary manner following federal, state and local guidelines to minimize contamination. The Dietary department will be educated by 4/2/2021 by the Registered dietician or designee on cleaning and maintaining kitchen equipment. 4. The dietary manager will conduct a weekly audit to ensure that equipment utilized for preparing and cooking food in cleaned in working condition. The Executive Director will review the weekly audits and report to the monthly QAPI for review and feedback for 3 months or until substantial compliance is maintained.	

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F 812	Continued From page 14 7. According to Food Code 2017, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 812		