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 03/04/2021

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

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 3/2/21 through 3/4/21. The survey was prompted by complaint intakes WY00003064, WY00003080, WY00003084, WY00003101, WY00003102, WY00003186, and WY00003194.. In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted by Healthcare Licensing and Surveys from 3/2/21 through 3/4/21. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining the infection control survey. The following common abbreviations are used throughout this document; BIMS: Brief Interview for Mental Status DON: Director of Nursing MDS: Minimum Data Set mg: milligrams mg/dl: milligrams/deciliter ml: milliliters RCMD: Resident Care Management Director Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 568 SS=B	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's	F 568		4/2/21

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

Electronically Signed | 03/23/2021

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F 568	Continued From page 1 personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on resident representative interview, review of facility documentation, and staff interview, the facility failed to ensure a quarterly statement was provided to the resident's representative for 2 of 3 sample residents (#41, #88) reviewed with personal fund accounts. The facility held personal fund accounts for 53 residents. The census was 88. The findings were: 1. Review of the "AUTHORIZATION AND AGREEMENT TO HANDLE RESIDENT FUNDS" documentation for resident #88 showed the resident's representative had requested the statement of resident funds to be mailed to an address other than the facility's. The document was signed on 6/17/19. The following concerns were identified: a. Interview with the resident's representative on 3/3/21 at 9:10 AM revealed he had not received any resident fund statements from the facility. b. Review of the "Resident Fund Management Service Statement" with a statement period of 10/1/2020 to 12/31/2020 showed the financial statement had been sent to the resident at the facility's address. 2. Review of the "AUTHORIZATION AND AGREEMENT TO HANDLE RESIDENT FUNDS"	F 568	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. The plan of correction serves as the facility□s allegation of compliance. F568 Accounting and Records of Personal Funds CORRECTIVE ACTION The address was corrected for the RFMS quarterly statement for resident # 41 on 3/3/21 by the Business Office Director. A statement was sent out to the correct address on this same date. The address was corrected for the RFMS quarterly statement for resident # 88 on 3/3/21 by the Business Office Director. A statement was sent out to the correct address on this same date.	

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F 568	Continued From page 2 documentation for resident #41 showed the resident's representative had requested the statement of resident funds to be mailed to an address other than the facility's. The document was signed on 2/25/20. The following concerns were identified: a. Review of the "Resident Fund Management Service Statement" with a statement period of 10/1/20 to 12/31/20 showed the financial statement had been sent to the resident at the facility's address. 3. Interview with the business office manager on 3/3/21 at 9:45 AM revealed the previous business office manager had incorrectly entered the facility's address instead of the resident representative's address into the system which caused the statements to be mailed to the facility instead of the representative. Further, the statements were sent to the "designated party" from a bank in Virginia.	F 568	IDENTIFICATION OF OTHERS An audit was conducted by the Business Office Manager on 3/3/21 of all of the RFMS accounts to verify that quarterly statements were being mailed to the correct address on 3/3/21. No additional errors were identified. SYSTEMIC CHANGE Education was provided to the Business Office Manager by the Area Collections Specialist on 3/10/21 ensuring the understanding of entering the correct requested mailing address for the quarterly RFMS statement. For each new RFMS account that is opened, the Business Office Manager requests an address in writing to ensure that the quarterly statement for the account is mailed to the correct recipient and enters the information into the data base. At the end of each week the Business Office Manager verifies that the address was entered into the computer correctly for accurate receipt of the statement. MONITORING The Business Office Manager reports any identified patterns or trends from the address verification audits to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. These audits will continue for	

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F 568	Continued From page 3	F 568	3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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 medical record review and staff interview, the facility failed to follow physician orders for 1 of 7 residents with a diagnosis of insulin-dependent diabetes mellitus (#36) reviewed. The findings were: 1. Review of the 12/16/20 quarterly MDS assessment showed resident #36 had a BIMS score of 14/15 (cognitively intact), a diagnosis of diabetes mellitus, and received insulin injections 7 days of the 7-day look-back period. Review of a physician order dated 9/24/20 showed 60 units of Tresiba FlexTouch solution pen-injector 200 unit/ml (insulin) was to be injected subcutaneously daily. In addition a physician order dated 8/3/20 showed 1.2 mg of Victoza solution pen-injector 18 mg/3ml (insulin) was to be injected one time a day. The orders specified to call the physician if the blood glucose was less than 70 mg/dl or greater than 350 mg/dl. The following concerns were identified:	F 684	F 684 Quality of Care CORRECTIVE ACTION Blood sugar test results for the last 30 days were reviewed for resident #36 with the primary physician by the DON/designee on 3/10/21 IDENTIFICATION OF OTHERS An audit was conducted on 3/10/21 by the DON/designee to identify any residents with blood sugar results outside the physician ordered parameters in which the physician was not notified during the last 30 days. The physician was notified of any results that were identified as not having been reported at the time of occurrence.	4/2/21

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F 684	Continued From page 4 a. Review of the December 2020 medication administration record (MAR) showed the resident had blood glucose levels above 350 mg/dl on 12/16, 12/17, 12/18, 12/26, 12/27, and 12/31. Review of the medical record showed no evidence the physician had been notified. b. Review of the January 2021 MAR showed the resident had blood glucose levels above 350 mg/dl on 1/4, 1/6, 1/24, and 1/25. Review of the medical record showed no evidence the physician had been notified. c. Review of the February 2021 MAR showed the resident had blood glucose levels above 350 mg/dl on 2/1, 2/2, 2/8, 2/9, 2/13, 2/15, 2/18, 2/19, and 2/21. Review of the medical record showed no evidence the physician had been notified. The highest blood glucose level documented was 535 mg/dl on 2/2/21. d. Review of the "Blood Sugar Summary" report from 12/6/20 through 2/27/21 showed 12 blood glucose levels were documented with a range of 139 mg/dl to 329 mg/dl in December 2020; 5 blood glucose levels were documented in January 2021 and ranged from 140 mg/dl to 335 mg/dl and 4 blood glucose levels were documented in February 2021 with a range of 310 mg/dl to 354 mg/dl. e. Interview with the resident on 3/4/21 at 11:40 AM revealed s/he thought his/her blood glucose levels were too high, however the physician had not addressed the levels with him/her. f. Interview with physician #1 on 3/4/21 at 12:30 PM revealed he reviewed the "Blood Sugar Summary" report when reviewing the resident's blood glucose levels. Further he stated he was unaware the resident's blood glucose levels had been greater than 350 mg/dl and it was his expectation the facility contact him as ordered.	F 684	SYSTEMIC CHANGE In-service education was provided to the licensed nurses by the Director of Nursing related to notifying the physician of all blood sugar test results that are outside of the physician ordered parameters and documenting this communication to the physician. This Education was completed prior to 4/1/21. The DON/designee audits the blood sugar results that are outside of the parameters and verifies that the physician was notified and that this notification was documented. Any results identified as outside of the parameters and not reported to the physician and documented results in corrective action with the nurse. MONITORING The Director of Nursing reports any identified patterns or trends from the blood sugar result audits to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. These audits will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	

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F 684	Continued From page 5 g. Interview with the RCMD and DON on 3/4/21 at 10:55 AM stated it was the facility's expectation the physician be notified as specified in the order.	F 684		