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	535032	A. BUILDING _____ B. WING _____	C 03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	**1330 PRAIRIE AVENUE CHEYENNE, WY 82009**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 2/27/23 to 3/2/23. Also reviewed in the course of the survey was complaint intake WY00003462. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MAR: Medication Administration Record MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse TAR: Treatment Administration Record	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		4/18/23

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

Electronically Signed | 03/24/2023

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F 656	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, and review of facility policy and procedure, the facility failed to ensure 2 of 26 sample residents (#19, #28) had resident-specific care plans that reflected individual needs in all required areas. The findings were: 1. Review of the medical record for resident #19 showed s/he was admitted to the facility on	F 656	A.) Resident #19 is no longer in the facility as of 3/12/2023. Resident #28 care plan has been updated with patient specific pain interventions on 03/24/2023. B.) The DON or designee will conduct 100% audit of all residents to ensure resident specific pain and behavioral care plan, and care plan will be corrected as needed to meet this requirement.	

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F 656	Continued From page 2 5/11/21 with diagnoses which included major depressive disorder, insomnia, PTSD (post-traumatic stress disorder), dementia with psychotic disturbance, neuroleptic induced Parkinsonism, muscle weakness and lack of coordination. Review of the 2/3/23 quarterly MDS assessment showed the resident had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of the physician's orders, printed 3/1/23, showed orders for Abilify (antipsychotic) 10 milligrams and Cymbalta (antidepressant) 90 milligrams, by mouth, daily for major depression. Interview with the resident on 3/2/23 at 11:30 AM revealed s/he was not verbally or physically aggressive, was dependent on staff for cares, used a wheelchair, and did not walk. The following concerns were identified: a. Review of the care plan, dated 2/15/23, showed the resident had behaviors of pacing, wandering, disrobing, inappropriate response to verbal communication and violence/ aggression towards others. There was no evidence the resident exhibited these behaviors. b. Interview with the DON on 3/2/23 at 3:40 PM confirmed the behaviors listed on the care plan were incorrect. 2. Review of the 11/23/22 quarterly MDS assessment for resident #28 showed the resident had a BIMS score of 15/15 (cognitively intact) and had diagnoses which included non-Alzheimer's dementia, anxiety disorder, depression, and chronic pain. The resident received as needed (PRN) medication and non-medication interventions, and had an opioid administered on 7 days of the 7-day look-back period. Further review showed the resident had frequent pain which interfered with day-to-day activities. Review of the most recent physician orders showed the	F 656	C.) The DON or designee will conduct an in-service on or before 04/18/2023 with all nursing staff and social services for completing resident specific pain and behavioral care plan, and the importance of following the care plan approach for pain management. D.) A performance improvement tool will be utilized to conduct weekly audits of resident pain and behavioral care plans, and to ensure staff is following pain care plan for three months. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the DON or designee. E.) The DON will report results of the audits at the monthly performance improvement meeting, the report will include any problems or trends noted. Reporting will occur for no less than three (3) months or until sustained compliance has been achieved.	

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F 656	Continued From page 3	F 656		

resident was prescribed 0.5 ml of 20 mg/ml morphine sulfate solution every 2 hours, as needed for pain, with a start date of 8/30/21. In addition, the resident was prescribed 650 mg of acetaminophen every 6 hours, as needed for pain, with a start date of 2/23/21. Review of the February 2023 MAR showed an order to assess the resident for pain every shift and to "...Attempt non-med interventions prior to administering PRN pain medications: 1. Reposition 2. Lie down..." Further review of the February 2023 MAR showed morphine was administered on 26 days and acetaminophen on 24 days. The following concerns were identified:

a. Observation on 2/27/23 at 4:06 PM showed the resident was in the hallway asking LPN #3 for morphine. The LPN assessed the resident's pain and administered the medication. After receiving the morphine the resident immediately asked for "Tylenol" and was told by the RN s/he would have to wait for an hour. No non-medication interventions were attempted prior to the administration of the morphine.

b. Review of the resident's pain care plan initiated on 2/9/21 showed "The resident's pain was aggravated by: [left blank]... The resident's pain is alleviated/relieved by: [left blank]...The resident is able to: (SPECIFY: call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increase or alleviates pain)."

c. Interview with the DON on 3/1/23 at 4:24 PM and the MDS coordinator on 3/2/23 at 10:22 AM confirmed the care plan had not been developed to reflect specific resident needs.

3. Review of the facility policy titled "Comprehensive Care Plans and Revisions" last reviewed 8/17/22, showed " ensure timeliness of

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F 656	Continued From page 4 each resident's person-centered, comprehensive care plan... should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person -centered plan of care."	F 656		
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's orders for 1 of 26 sample residents (#73) reviewed. The findings were: 1. Review of the 1/13/23 quarterly MDS assessment showed resident #73 had a BIMS score of 99 indicating the resident was unable to complete the interview (severely impaired - never/rarely made decisions) and diagnoses which included diabetes mellitus and long term use of insulin. Further review showed the resident received insulin injections 7 days of the 7-day look-back period. Review of the physician's orders, printed 2/28/23, showed the facility was to check blood sugars before meals and at bedtime. The orders specified to call the physician if the blood glucose was less than 70 mg/dl or greater than 460 mg/dl. The following concerns were	F 684	A.) Resident #73, staff educated on 03/24/2023 to follow physician orders in regards to following the physician orders to notify the physician for blood sugar results below 70mg/dl. B.) The DON or designee will conduct 100% audit for all residents that have blood glucose monitoring that physician orders have been followed notifying physician when blood sugars results are below the parameters. C.) The DON or designee will conduct an in-service on or before 04/18/2023 with all nursing staff regarding notifying physician of low blood sugars per physician orders. D.) A performance improvement tool will	4/18/23

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F 684	Continued From page 5 identified: a. Review of January 2023 MAR showed the resident had blood glucose levels less than 70 mg/dl on 1/12/23 and 1/15/23. Review of February 2023 MAR showed a greater than 460 mg/dl level on 2/2/23 and 2/3/23 and less than 70 mg/dl level on 2/10/23 at two different times. Review of the medical record showed no evidence the physician had been notified. The lowest blood glucose documented was 63 mg/dl level on 2/10/23 and highest blood glucose documented was 480 mg/dl level on 2/3/23. b. Review of the physician progress note dated 1/20/2023 showed "did look at sugar log, there are several low readings" and noted the physician wanted to avoid hypoglycemia. 2. Interview with the DON on 3/1/23 at 4:30 PM revealed the resident's family was very particular about the resident's blood glucose monitoring. The DON confirmed there was no documentation to support the facility had notified the physician when results were out of parameters and stated it was the facility's expectation the physician was to be notified as specified in the order. 3. Review of the facility policy titled "Blood glucose monitoring", dated 9/22/22, showed "If you obtain an extremely high or low blood glucose level on the glucose monitor, retest the resident. If the result is the same, notify the practitioner for review and new orders...and... document the procedure".	F 684	be utilized to conduct weekly audits of residents blood glucose monitoring to ensure physician has been notified of blood sugars below parameters per physician order for three months. The audits will be conducted by the DON or designee. E.) The DON will report results of the audits at the monthly performance improvement meeting, the report will include problems or trends noted. Reporting will occur for no less than three (3) months or until sustained compliance has been achieved.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		4/18/23

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F 689	Continued From page 6 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, resident representative and staff interview, and review of policy and procedure, the facility failed to ensure adequate interventions were in place to prevent accidents for 1 of 4 sample residents (#199) reviewed for accidents. This failure resulted in harm to resident #199, who sustained fractures after a fall. The findings were: Review of the 8/19/22 comprehensive MDS assessment for resident #199 showed the resident was admitted on 8/17/22 with diagnoses that included heart failure, arthritis, malnutrition, muscle weakness (generalized), and unsteadiness on feet. The resident had a BIMS score of 9 of 15, indicating moderate cognitive impairment. Further, the assessment noted the resident was not steady when moving on or off the toilet or during surface-to-surface transfers, and was only able to stabilize with staff assistance. The assessment showed the resident required the extensive assistance of 1 staff member for transfers and toilet use, and utilized a wheelchair. The resident was not coded as using a walker. Review of the resident's care plan, initiated on 8/30/22, showed the resident was at risk for falls and fall-related injuries related to physical deconditioning, weakness, and alterations in gait/balance. Interventions developed at that time	F 689	A.) Resident #199 care plan updated and addressed fall prevention plans, staff education on current transfer status on 03/24/2023. B.) The DON or designee will conduct 100% audit for staff to follow precautions on Kardex, and gait belt use. C.) The DON or designee will conduct an in-service on or before 04/18/2023 for nursing staff to follow precautions on Kardex, and gait belt use. D.) A performance improvement tool will be utilized to conduct weekly audits to ensure staff is following the Kardex, and gait belt use. Any problems identified will result in immediate education and/or corrective action for three (3) months. The audits will be conducted by the DON or designee. E.) The DON will report results of the audits at the monthly performance improvement meeting, the report will include any problems or trends noted. Reporting will occur for no less than three (3) months or until ongoing sustained compliance has been achieved.	

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F 689	Continued From page 7	F 689		

were non-specific, and included "Assist with ADLs as needed ...Call light within reach...Complete fall risk assessment ...Orient resident to room ..."

Review of the 2/14/23 quarterly MDS assessment showed the resident had a BIMS score of 6 of 15, indicating severe cognitive impairment. Additionally, the assessment showed the resident continued to be unsteady when moving on or off the toilet or during surface-to-surface transfers, and was only able to stabilize with staff assistance. The resident was coded as utilizing a wheelchair. The resident was not coded as using a walker. Further, the assessment showed the resident had increased assistance needs, requiring the extensive assistance of 2 or more staff members for transfers and toilet use.

Further review of the resident's care plan showed interventions related to the resident's risk for falls were updated on 2/27/23 and included the following: "Anticipate and meet The [sic] resident's needs ...Educate the resident/family/caregivers about safety reminders and what to do it a fall occurs ...Provide activities that minimize the potential for falls while providing diversion and distraction ...Provide adaptive equipment or devices as needed ...Provide appropriate footwear when mobilizing in w/c [wheelchair] ...Pt [physical therapy] evaluate and treat as ordered or PRN [as needed]". The updated care plan lacked interventions that addressed the resident's need for increased staff assistance with transfers and toilet use.

Review of the resident's Visual/Bedside Kardex Report, provided by the facility on 3/2/23, instructed staff who provided care to the resident that the resident required the following assistance

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F 689	Continued From page 8	F 689		

with transfers: "TRANSFER: 1 person stand pivot front wheel walker from bed to wheelchiar [sic] or wheelchiar to bed Grab bar for the restroom".

Observation of the resident's room on 3/2/23 at 12:35 PM showed a wheelchair positioned in front of the bed. There was no front wheel walker observed at that time.

The following concerns were identified:

1. Review of the progress note dated 2/25/23 at 7:31 PM showed "Event note, Resident was being transferred to bed from wheelchair and slid to the floor in front of [his/her] bed."

2. Interview with CNA #1 on 3/2/23 at 12:45 PM revealed on 2/25/23 the resident was in bed and needed to go to the toilet. The CNA transferred the resident to the toilet, and on return to the resident's bed she and the resident " ...were going to stand and pivot back to bed ...we got halfway back and [s/he] tried to sit down, I couldn't hold [him/her] and [s/he] fell, kinda hard." The CNA confirmed she did not use a gait belt while transferring the resident, and she believed the resident only required a 1 person assist. She further stated she had checked the resident's Kardex to confirm the resident's transfer requirements after the fall. The CNA also stated the DON had a conversation with her about gait belts after the fall, and she would be using a gait belt "from now on."

3. Review of the progress note dated 2/26/23 at 11:22 PM showed "Health Status Note, Resident requesting to the [emergency room] for [evaluation] and treat on right leg pain from fall ..."

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F 689	Continued From page 9	F 689		

4. Review of the progress note dated 2/27/23 at 1:15 AM showed "Health Status Note, resident admitted to [local hospital] due to femur fracture."

5. Interview with the resident's representative on 3/2/23 at 11:45 AM revealed the facility had notified her of the fall. She stated, "I was told there was a CNA with [him/her] and it was a soft fall." She was informed the resident was not hurt, but was complaining of pain. She stated she did go to see the resident on 2/26/23 and told the facility staff the resident was in pain and the resident's right leg was swollen. The representative added she received a call from the hospital on 3/1/23, and was informed the resident had a hairline fracture to the left leg in addition to the fractured right femur.

6. Review of the facility policy titled "Fall prevention, long-term care" revised 2/20/23 showed " ...If the resident is at risk for future falls, take steps to reduce the danger based on the factors creating the risk. Assess the resident for gait disturbances, and identify and correct improper use of ambulation devices as needed ..."

7. Review of the facility policy titled "Gait belt use" revised 5/20/22 showed " ...A gait belt is a safety device ...The device provides a secure grasping surface to aid with patient transfer and ambulation. A gait belt is commonly used for patients who are at risk for falling and can help lower a patient safely to the ground if the patient begins to fall or loses balance during transfer or ambulation ..."

8. Interview with the DON on 3/2/23 at 2:17 PM revealed it was the facility's expectation for staff

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F 689	Continued From page 10 to follow residents' care plans.	F 689		
F 761 SS=D	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 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, policy and procedure review, and professional standard review the facility failed to ensure medications were labeled in accordance with professional standards in 1 of 4 medication storage units (Therapy South medication cart). The finding were:	F 761	A.) Audit all insulin pens in medication carts for open dates on 03/24/2023, discarded insulin pens without an open date. B.) The DON or designee will conduct 100% audits for all medication carts for	4/18/23

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F 761	Continued From page 11 1. Observation on 3/2/23 at 9:45 AM of the Therapy South medication cart showed 2 insulin glargine 100 unit/milliliter flex pens with no open date, and 1 insulin lispro 100 unit/milliliter kwikpen with no open date. Interview at that time with RN #1 confirmed the medications were for resident use. Further, the RN stated she was unaware when the medications would expire. 2. Interview with the DON on 3/2/23 at 10:31 AM revealed it was the facility's expectation for the insulin containers to be dated with an open date when they come out of the refrigerator for use. 3. Review of policy "Guidance for Using Insulin Products dated 2021 Omnicare, showed "1. Storage of Product ...b. ...Storage of unopened insulin products outside of the refrigerator is permissible, but results in an earlier expiration date. ...After opening may be used for: Up to 28 days" included insulin Lispro, and Lantus (insulin glargine brand name). 4. Review of the web page "American Diabetes Association" accessed 3/14/23 showed "...Insulin kept at room temperature will last approximately one month..."	F 761	insulin pens being dated, and will discard any insulin pens without open date. C.) The DON or designee will conduct an in-service on or before 04/18/2023 for all nursing staff regarding dating insulin pens upon removal from the refrigerator and opening. D.) A performance improvement tool will be utilized to conduct weekly audits of nursing carts to ensure insulin pens are dated for three months. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the DON or designee. E.) The Don will report results of the audits at the monthly performance improvement meeting, the report will include any problems or trends noted. Reporting will occur for no less than three (3) months or until sustained compliance has been achieved.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		4/18/23

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 03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 12 except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-	F 842		

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F 842	Continued From page 13 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure 1 of 2 medical record storage areas (Therapy West) were safeguarded from unauthorized use. The findings were: 1. Observation on 2/27/23 at 1:58 PM of the Therapy West hall showed resident medical records were kept in a cabinet. Both doors of the cabinet were observed to be off the hinges. At that time 12 resident medical records were seen. The storage area was across from the nurses' desk, and a restroom. Further observation showed throughout the four days of the recertification survey the medical records were easily accessible and were available for unauthorized use. 2. Interview with LPN #2 on 2/28/23 at 11:13 AM	F 842	A.) On 03/06/2023 Cabinet doors were repaired. B.) 100% audit will be conducted by the ED to ensure resident record storage area cabinet doors are on hinges and able to close. C.) In-service staff on notifying maintenance if cabinet doors are unhinged and unable to close, as well as closing cabinet doors when not accessing records. D.) A performance improvement tool will be utilized to conduct weekly audits of cabinet doors ensuring they are able to close and are being closed when not accessing medical records for three	

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F 842	Continued From page 14 confirmed the records were available for anyone to access. Further, the LPN stated she was unsure of the how long the doors had been broken. 3. Interview with the DON on 2/28/23 at 4:59 PM revealed it was the facility's expectation for the residents' medical records to be kept in a secure cabinet with the doors closed. Further, the DON stated she was aware the cabinet was broken and thought it was okay since it was in an alcove. In addition, she acknowledged that someone could get into the records. 4. Review of the policy and procedure "Safeguarding and Storage of Medical Records" revised 3/22/22 showed "...Procedure...Protect all medical records from damage, loss, destruction, or unauthorized use. Do not leave clinical records unattended in public areas. Limit viewing access by unauthorized personnel and visitors by returning records to their designated storage location and closing them when not in use."	F 842	months. E.) The ED will report results of the audits at the monthly performance improvement meeting, the report will include any problems or trends noted. Reporting will occur for no less than three (3) months or until sustained compliance has been achieved.	