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	535025	A. BUILDING _____ B. WING _____	02/24/2006

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CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

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F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure immediate family notification after a fall for 1 (#98) of 13 sample residents at risk for falls. The findings	F 157	Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by provision of Federal and State law. This plan of correction is the facility's credible allegation of compliance. F-157 – Immediate: Resident #98 has been discharged. Risk: Incident reports will be reviewed for the last 30 days by the Director of Nurses or designee to ensure timely notification of families regarding change in resident condition. System: Nursing staff will be in-serviced on the need to notify the responsible party when there is an accident involving the resident that results in injury and has the potential for requiring physician intervention.	

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

D L Stacks — Administrator — 3/16/06

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 program participation.

The POC was received on 3/20/06 @ 1600 by Tara Taylor, QDM and Karen Womack RN, Health Surveyor, and accepted.

MAR 16 2006

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F 157	Continued From page 1 were: Review of nursing documentation showed resident #98 fell on 12/26/05 at 6:30 PM and was later sent for an x-ray. However, there was no documentation the facility notified the family until 12/27/05 at 2:50 PM when a family member visited the resident. Interview with the administrator and assistant director of nursing on 2/24/05 at 2:55 PMverified that the family was not notified until the day after the fall. During an interview on 2/27/06 at 5 PM, the administrator reiterated the facility had not attempted to notify the family until the day after the fall.	F 157	Incident reports will be reviewed each day at the morning meeting to assure timely notification of families has taken place. The review will be conducted by the Director of Nurses or designee. Monitor: Results of the incident report review for timeliness of notification will be reviewed at the QA&A committee for trends. Data will be reviewed monthly X3 months. Date of compliance is April 10, 2006.	
F 176 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on medical record review, policy and procedure review, and staff and resident interview, the facility failed to ensure the interdisciplinary team assessed one of one sample residents (#65) who self-administered medications in order to verify it was safe for this resident to do so. The findings were: Medical record review for resident #65 showed the following physician's order dated 11/24/04: "Resident may use Carbamide Peroxide ear wax removal and Lurine [sic] ear gtts [drops] at bedside ...to use as needed qd [everyday]."	F 176	F-176 – Immediate: Resident #65 will be assessed for safe administration of medication and the plan of care will be updated. Risk: Resident orders will be reviewed to ensure any resident with an order for self-administration of medications has been assessed and care planned. This review will be conducted by the Director of Nurses or designee.	

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F 176	Continued From page 2 Interview with the resident on 2/24/06 at 9:15 AM revealed a bottle of eardrops was currently in his/her bedside stand. The resident further stated s/he would periodically "use" the eardrops. Interview with the assistant director of nursing on 2/24/06 at 10:40 AM confirmed one partially full bottle of Murine eyedrops was in the resident's bedside stand. The following concerns with safety were identified: a. According to the 12/9/05 significant change Minimum Data Set (MDS) assessment, the resident had short-term memory problems and moderately impaired cognitive skills for daily decision-making. b. Further review of the medical record revealed no interdisciplinary team assessment to determine if the resident was capable of safely storing and administering the eardrops. In addition, the use of the eardrops was not included in the resident's plan of care, nor was there evidence of staff monitoring the use of the eardrops. c. The lack of assessment, care planning, and monitoring was confirmed on 2/24/06 at 10:20 AM by the MDS coordinator. According to the facility's policy entitled Self Administration of Medication, "Each resident has the right to self administer medications, if able. The interdisciplinary team evaluates each resident who expresses wishes to self administer medications to determine if the resident is safe to do so, and if so provides the education and monitoring necessary to ensure safe administration."	F 176	System: Nursing staff will be in-serviced on the need to evaluate residents that have orders to self-administer medications. This in-service will be conducted by the Director of Nurses or designee. A list of residents who self-administer medications will be generated and placed on the MAR so the licensed staff will monitor these residents. Necessary lock boxes will be provided for residents who self-administer medications. Residents with orders for self-administration of medication will be reviewed on a quarterly basis by the Director of Nurses or designee. Monitor: Results of the review for assessing residents who self-administer medications will be reviewed at the QA&A committee for trends. Data will be reviewed monthly X3 months. Date of compliance is April 10, 2006.	
F 225 SS=B	483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have	F 225		

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F 225	Continued From page 3 been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on policy review, and resident and staff interview, the facility failed in three of three cases to report resident allegations (#5, #31, and #37)	F 225	F-225 – Immediate: Residents #5 and #37 will be reimbursed the lost money. Resident #31 has requested she not be refunded the lost money. Risk: The Administrator or designee will review the last 30 days of grievances to ensure that any misappropriation of funds has been resolved. System: The Facility will ensure that allegations of missing money is properly investigated and reported to the State Survey Agency. The Administrator will review the federal guidelines regarding the misappropriation of personal property. Monitor: Results of the grievances will be reviewed at the QA&A committee for trends. Data will be reviewed monthly X3 months. Date of compliance is April 10, 2006.	

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F 225	Continued From page 4 of missing money, and the results of the investigations, to the state survey agency. The findings were: Interview with resident #5 and resident #31 on 2/22/06 at 10 AM revealed that within the last two months they reported missing money to staff. The residents further commented the money was never found, and they thought it might have been stolen. Interview with the administrator on 2/23/06 at 3:20 PM revealed these two allegations were reported to him and were investigated. The administrator also said it was recently reported that resident #37 had some missing money, and the facility investigated that situation as well. Review of the investigation documentation, and further interview with the administrator on 2/24/06 at 8:30 AM revealed residents #5 and #37 were being reimbursed for the missing money. The administrator said the state survey agency was not notified of these three allegations since the facility could not substantiate whether the money was lost or stolen. Review of the 4/15/01 facility policy titled "Abuse and Neglect Prohibition" revealed, "The facility will report all allegations and substantiated occurrences of abuse, neglect and misappropriation of property to the state agency and law enforcement officials as designated by state law."	F 225		
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		

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F 250	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to ensure one (#82) of two sample residents received follow-up counseling as recommended. The findings were: According to the initial psychological assessment, completed by a licensed, clinical social worker (LCSW) on 11/9/05, during the past two to three months, resident #82 exhibited increased delusions, hallucinations, changes in eating patterns, increased social isolation, and mood and behavior symptoms. The treatment plan that was finalized on 11/17/05 documented the resident would receive weekly psychotherapy sessions by the LCSW to improve and stabilize mood, process loss, decrease anxiety, and increase functional activity, but there was no documentation of the sessions in the medical record. Further review of the medical record showed the resident was placed on Medicare for rehabilitation following a fracture of the right leg sustained on 11/17/05. Interviews with the Minimum Data Set assessment coordinator on 2/23/06 at 3:50 PM, and the administrator on 2/23/06 at 4 PM, revealed the LCSW could not treat residents on Medicare. However, the facility lacked evidence that social services recognized the need for treatment or arranged for an alternate source of treatment. Interview with the social worker on 2/24/06 at 10:40 AM verified that no other arrangements were ever made to meet the resident's needs.	F 250	F-250 – Immediate: Resident #82 will be scheduled to receive further mental health treatment by April 9, 2006. Risk: The Social Services Director will complete a review of residents being seen by the LCSW and ensuring there is a treatment plan in place. System: The current LCSW (outside agency) will meet upon exit with the Social Services Director and/or the Director of Nurses to review residents on caseload, discuss resident visits, care planning, goals, treatment options, and documentation. Monitor: Residents visited by the LCSW will be reviewed monthly X3 by the QA&A committee for recommendations and compliance. Date of compliance is April 10, 2006.	

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F 273	Continued From page 6	F 273		
F 273 SS=D	483.20(b)(2)(i) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure admission assessments were completed within 14 days of admission for 2 (#75, #94) of 20 sample residents. The findings were: 1. According to the admission face sheet, resident #94 was admitted on 11/21/05. However, the admission Minimum Data Set (MDS) assessment was not completed until 12/8/05, four days after the time allowed by the Centers for Medicare and Medicaid Services. During an interview on 2/23/06 at 3:05 PM, the MDS coordinator confirmed the accuracy of the documented dates. 2. Review of the face sheet showed resident #75 was admitted on 4/20/05. Further review showed the resident was discharged, return anticipated, and readmitted several times until his/her final readmission on 5/23/06. Although the facility completed a Medicare 5 day assessment each time the resident returned to the facility, the required 14 day admission MDS assessment was	F 273	F-273 – Immediate: The Facility will ensure that future MDS' are submitted timely. Risk: The resident's MDS' will be reviewed by the MDS Coordinator for timeliness and corrections if needed. System: The MDS Coordinator will be in-serviced on the RAI guidelines for timely assessments. This will be conducted by the Regional MDS Coordinator. A calendar will be utilized displaying the dates of upcoming MDS assessments. Random weekly reviews of the MDS will be conducted with the Administrator to ensure that MDS' are being completed timely. Monitor: The results of the reviews will be presented monthly X3 at the QA&A meeting for recommendations and continued compliance. Date of compliance is April 10, 2006.	

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F 273	Continued From page 7 not completed until 6/7/05, 16 days after the resident's final return on 5/23/06. During an interview on 2/23/06 at 3:05 PM, the MDS coordinator stated she forgot she did not have the grace period allowed for the Medicare 5 day assessments. 3. According to the December 2002, Centers for Medicare & Medicaid Services Revised Long-Term Care Resident Assessment Instrument User's Manual, Version 2.0, the admission MDS assessment "must be competed no later than day 14 from the admission date." The manual further defined the admission date as day one.	F 273		
F 311 SS=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview with student nurse aide #1 and the certified nurse aide program instructor, the facility failed to ensure one of one sample residents (#78) who had been assessed as requiring restorative dining, received this service during one of two meal observations. The findings were: According to the 12/5/05 quarterly Minimum Data Set (MDS) assessment, resident #78 required "extensive" assistance with eating. This was a decline from the 9/21/05 annual MDS assessment that documented the resident	F 311		

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F 311	Continued From page 8 required "limited" assistance. Review of the care plan dated 1/18/06 showed the resident was to eat in the restorative dining room. Additional care plan interventions dated 12/19/05 documented: "1) Provide set up of meal, 2) encourage resident to feed self, 3) assist with intake as needed from loading spoon to full assistance." The following concerns were identified with the provision of restorative dining services: Observation in the restorative dining room on 2/22/06 from 8:25 AM until 9 AM showed student nurse aide #1 assisted the resident with breakfast. Throughout the observation the student loaded the spoon with pureed food and fed the resident. Although on two occasions the resident grabbed a cup containing liquids from the student and independently drank the liquids, the resident was never encouraged to hold the spoon and feed him/herself. Interview with the student on 2/22/06 at 9:25 AM revealed she did not know if the resident could eat independently if encouraged to hold the spoon. When asked if she was oriented to the resident prior to the meal, the student nurse aide said, "No," and further stated she had been oriented to another resident. Interview with the certified nurse aide instructor on 2/23/06 at 8:25 AM confirmed the student nurse aide was not oriented to the resident prior to assisting him/her with the meal. The instructor further stated, "It was a miscommunication."	F 311	F-311 – Immediate: Resident #78 consumed his meal with no negative effects from the deficient practice. Risk: Care plans for those residents on Restorative Dining have been reviewed for appropriateness and updated to reflect the resident's current status. System: The CNA instructors will be alerted to the structure, goals, and expectations of the Restorative Dining program. The care plans for those residents on Restorative Dining will be available for the instructors to view. The Restorative CNA's will be instructed that students are not to assist residents on Restorative Dining without prior instruction. Random reviews of the Restorative Dining program will be conducted by the Director of Nurses or designee to ensure students are not assisting residents until they are specifically trained. Monitor: The results of the Restorative reviews will be presented monthly X3 at the QA&A meeting for recommendations and continued compliance. Date of compliance is April 10, 2006.	
F 313 SS=D	483.25(b) VISION AND HEARING To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and	F 313		

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F 313	Continued From page 9 by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to assure one (#82) of one sample residents who had an order for an optometric (eye) examination, received that examination as ordered. The findings were: According to the 12/14/05 significant change Minimum Data Set assessment, resident #82 had impaired vision and did not wear glasses. Review of physician's orders showed an optometric exam was ordered on 12/12/05; the order was noted on 12/13/05. However, there was no evidence in the medical record the exam was ever performed. Interview with the administrator on 2/24/06 at 10:15 AM revealed an appointment for the exam was never made. The administrator stated the administrative assistant made all appointments and she never received the order. Interview with the administrative assistant on 2/24/06 at 10:46 AM revealed nursing was supposed to send her a request for any resident needing an appointment. The administrative assistant confirmed she was not notified of the need for an eye appointment for this resident.	F 313	F-313 – Immediate: Resident #82 went for his optometric examination on March 7, 2006. Risk: A review of medical records will be conducted by the Director of Nurses or designee to determine our compliance in making physician appointments. System: Staff will be in-serviced on the process for appointments and referrals A list of weekday appointments will be provided at each nurse's station by the Administrative Assistant. The Administrative Assistant will maintain a log of referrals and appointments. Monitor: The referrals and subsequent appointments will be reviewed monthly X3 months at the QA&A meeting for recommendations and continued compliance. Date of compliance is April 10, 2006.	
F 319 SS=D	483.25(f)(1) MENTAL AND PSYCHOSOCIAL FUNCTIONING Based on the comprehensive assessment of a	F 319		

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F 319	Continued From page 10 resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to ensure one (#82) of two sample residents received counseling for mental and psychosocial adjustment difficulties. The findings were: Review of the 11/9/05 initial psychological assessment showed, that during the past two to three months, resident #82 exhibited increased delusions, hallucinations, changes in eating pattern, increased social isolation, and mood and behavior symptoms. The treatment plan finalized on 11/17/05 documented the resident would receive weekly psychotherapy sessions by the licensed, clinical social worker (LCSW) to improve and stabilize mood, process loss, decrease anxiety, and increase functional activity. However, there was no documentation of the sessions in the medical record. Further review of the medical record showed the resident was placed on Medicare for rehabilitation following a fracture of the right leg sustained on 11/17/05. Interviews with the Minimum Data Set assessment coordinator on 2/23/06 at 3:50 PM, and the administrator on 2/23/06 at 4 PM, revealed the LCSW could not treat residents on Medicare. However, according to a note written by the LCSW on 11/30/06, she would maintain weekly contact with the resident to develop and maintain a "treatment alliance." Review of that documentation showed the LCSW	F 319	F-319 – Immediate: Resident #82 will be scheduled to receive further mental health treatment by April 9, 2006. Risk: The Social Services Director will complete a review of residents being seen by the LCSW and ensuring there is a treatment plan in place. System: The current LCSW (outside agency) will meet upon exit with the Social Services Director and/or the Director of Nurses to review residents on caseload, discuss resident visits, care planning, goals, treatment options, and documentation. Monitor: Residents visited by the LCSW will be reviewed monthly X3 by the QA&A committee for recommendations and compliance. Date of compliance is April 10, 2006.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 319	Continued From page 11 contacted the resident on 12/5/05, 12/19/05, 1/3/06, 1/10/06, 1/23/06, 1/30/06, 2/6/06, 2/13/06, and 2/22/06. However, psychotherapy sessions were not conducted. Interview with the facility's social worker on 2/24/06 at 10:40 AM verified counseling was not provided by the Medicare approved psychologist who was contracted with the facility, nor was counseling provided under any other arrangement.	F 319		
F 371 SS=F	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must 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 on four of four days of survey to ensure food was stored in a sanitary manner. The findings were: 1. Observation on 2/21/06 at 4:20 PM revealed two Styrofoam containers in the facility 's walk-in refrigerator commingled with resident food. Interview with the dietary manager identified these containers as leftover food from her lunch at a local restaurant. The containers were labeled with the date of 2/21/06 and the name of the dietary manager. Multiple observations on 2/22/06 confirmed the containers remained in the cold storage area. Observation on 2/23/06 at 7:40 AM revealed one of the containers remained in the walk-in refrigerator; however, the lid was no longer sealed. Multiple observations on 2/23/06 and 2/24/06 confirmed the container remained in	F 371		

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 _____	02/24/2006

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F 371	Continued From page 12 the resident food storage area with an open lid. Interview with the dietary manager on 2/24/06 at 9:10 AM, and observation in the walk-in refrigerator, confirmed the container remained in the food storage area. Further interview with the dietary manager revealed kitchen staff did, on occasion, use the walk-in refrigerator to store personal food. The dietary manager further commented that dietary staff " ...might eat part of a sandwich and leave the reminder in the refrigerator until later." The dietary manager further stated the facility failed to specify in writing a policy for commingling of staff food in resident food storage areas. 2. Observation on 2/24/06 at 10:40 AM revealed food stored in a pan inside a small undercounter refrigerator located adjacent to the rehabilitation area. The pan contained what appeared to be potato salad, but was not labeled with the date or contents. Further observation at that time revealed multiple containers of staff food items and drinking cups were also stored in the refrigerator. Interview with the rehabilitation manager revealed residents prepared the potato salad the morning of 2/23/06. These same residents were to return on 2/24/06 to eat a portion of the salad. According to the interview, staff were not routinely monitoring time or temperature conditions in the observed refrigerator, and the rehabilitation manager was unaware of the need to maintain such controls. When asked if time/temperature controls were monitored by dietary services, the rehabilitation manager stated that she did not know. 3. Interview with the staff development specialist on 2/24/06 at 11:10 AM, in the presence of the assistant director of nursing, established the	F 371	F-371 – Immediate: The food identified was removed and disposed. Risk: The Facility will ensure that resident food is not co-mingled with employee food. System: The Dietary Manager or designee will in-service dietary employees on the requirement that other foods are not to be co-mingled with resident foods. The Dietary Manager or designee will monitor the walk-in cooler to ensure that other foods are not co-mingled with resident food. This review will be conducted daily for four (4) weeks and then weekly X3 months. The Dietary Manager or designee will in-service the Rehabilitation Department regarding co-mingling foods and properly dating food items. The Rehabilitation Manager will ensure that food is properly stored, dated, and that daily temperatures are recorded for the refrigerator. Monitor: Compliance will be reviewed monthly X3 months at the QA&A meeting for recommendations and continued compliance. Date of compliance is April 10, 2006.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 13 rehabilitation staff was responsible for maintaining and monitoring the refrigerator in their work area. It was further revealed the facility failed to specify in a written policy the commingling of staff food in resident food storage areas. Both the facility staff development specialist, and the assistant director of nursing, stated staff were instructed during initial orientation that personal food was not to be commingled with resident food. The expectation was for staff to label their personal food (name and date) and store it in one of the refrigerators provided specifically for the staff. When asked to reiterate the facility policy regarding commingling of staff and resident food, the staff development specialist stated, " ...staff do not store their personal food with resident food. " 4. According to the Food Code 2005, U.S. Public Health Service, Food and Drug Administration, 3-307.11: Miscellaneous Sources of Contamination. " FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301-3-306."	F 371		