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 06/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 6/3/24 to 6/6/24. Also reviewed in the course of the survey were complaint intakes WY00003869 and WY00003898. 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 Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657		7/19/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/27/2024

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.

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 06/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 1 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the comprehensive care plan was revised as needed to reflect the resident's current needs for 1 of 23 sample residents (#5). The findings were: 1. Review of the 5/1/24 admission MDS assessment showed resident #5 had a cognitive assessment which determined the resident to be severely impaired. The resident had diagnoses which included traumatic brain dysfunction, Alzheimer's disease, dementia, and anxiety disorder. Review of the physician orders showed the resident was prescribed 25 mg of Seroquel (antipsychotic) daily at bedtime for agitation on 4/27/24 and 25 mg of Zoloft (antidepressant) daily for depression on 5/16/24. Review of the care plan, last revised on 5/30/24, failed to show the care plan had been revised to include goals and interventions related to the diagnosis of depression. 2. Interview with the DON on 6/6/24 at 10 AM confirmed the care plan had not been updated to reflect the use of the antidepressant medication.	F 657	A. Resident #5 discharged the facility on 6/11/2024. B. The DON or designee will conduct 100% audit of all residents to identify individuals with diagnosis of depression, all residents care plans with the diagnosis of depression to ensure the care plan has been revised to include goals and interventions related to the diagnosis of depression, and care plan has been updated to reflect use of antidepressant medication. Care plan will be corrected as needed to meet this requirement. C. The DON or designee will conduct in-service on or before 7/19/2024 with Interdisciplinary Team for completing resident specific care plan for goals and interventions related to the diagnosis of depression, and care plan has been updated to reflect use of antidepressant medication. D. A performance improvement tool will be utilized to conduct weekly audits of resident's depression care plan and updating care plan for antidepressant	

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 06/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 2	F 657	medication for 3 months. Any problems identified will result in immediate corrective action. The audits will be conducted by the DON or designee. E. The DON will report results of audits at the monthly performance improvement meeting. The report will include any problems or trends noted. Reporting will occur for no less than 3 months or until sustained compliance has been achieved.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		7/19/24

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 06/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 3 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure medication-specific target symptoms were identified and monitored for 2 of 5 sample residents (#5, #29) reviewed for unnecessary medication use. The findings were: 1. Review of the 5/21/24 MDS assessment showed resident #29 had a BIMS score of 10 out of 15, which indicated moderate cognitive impairment, and diagnoses which included Parkinson's disease, dementia, anxiety, and depression. Review of the most current physician orders showed the resident received 25 (mg) of Seroquel (antipsychotic) by mouth in the evening	F 758	A. Resident #5 discharged the facility on 6/11/2024. Resident #29 "Behavior Monitoring and Interventions" task has been updated to ensure each psychoactive medication-specific targeted symptom. B. The DON or designee will conduct 100% audit of all resident to identify individuals on psychoactive medications, all residents receiving psychoactive medications "Behavior Monitoring and Interventions" task will be updated to ensure each psychoactive medication-specific targeted symptom.	

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 06/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 4 related to psychotic disorder with hallucinations, 25 mg of Zoloft (antidepressant) by mouth one time a day related to depression, and 34 mg of Nuplazid (atypical antipsychotic) by mouth one time a day for Parkinson's related hallucinations. The following concerns was identified: a. Review of the June 2024 "Behavior Monitoring & Interventions" task showed the resident could be verbally and physically aggressive, exhibited inappropriate sexual behavior, had periods of restlessness, anxious concerns, tearfulness, and had paranoid or delusional thoughts. Further review showed no evidence medication-specific target symptoms had been identified for each of the psychoactive medications prescribed. 2. Review of the 5/1/24 admission MDS assessment showed resident #5 had a cognitive assessment which determined the resident to be severely impaired. The resident had diagnoses which included traumatic brain dysfunction, Alzheimer's disease, dementia, and anxiety disorder. Review of the physician orders showed the resident was prescribed 25 mg of Seroquel (antipsychotic) daily at bedtime for agitation and 25 mg of Zoloft (antidepressant) daily for depression. The following concerns was identified: a. Review of the June 2024 "Behavior Monitoring & Interventions" task for the resident showed agitation, verbal and physical aggression, and resistance to care were identified as behaviors to monitor. Further review showed no evidence medication-specific target symptoms had been identified for each of the psychoactive medications prescribed. 3. Interview with the DON on 6/5/24 at 2:09 PM	F 758	C. The DON or designee will conduct in-service on or before 7/19/2024 with Interdisciplinary Team for completing resident "Behavior Monitoring and Interventions" task to ensure each psychoactive medication-specific targeted symptom. D. A performance improvement tool will be utilized to conduct weekly audits of resident's "Behavior Monitoring and Interventions" task and updating to ensure each psychoactive medication-specific targeted symptom for 3 months. Any problems identified will result in corrective action. The audits will be conducted by DON or designee. E. The DON will report results of audits at the monthly performance improvement meeting. The report will include any problems or trends noted. Reporting will occur for no less than 3 months or until sustained compliance has been achieved.	

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 06/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 5 and again on 6/6/24 at 11:06 AM confirmed the facility did not have medication-specific target symptoms identified on the behavior monitoring and intervention task for the psychoactive medications prescribed. 4. Review of the policy titled "Unnecessary Medication", last reviewed on 8/9/23, showed " ...8. The facility will ensure proper monitoring and accurate documentation to a medication in order to evaluate the ongoing benefits as well as risks of various medications."	F 758		