STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	**05/04/2018**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0573 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Let each resident or the resident's legal representative access or purchase copies of all the resident's records.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on medical record review and staff interview, the facility failed to respond in a timely manner to requests for copies of health information records for 2 of 2 sample residents (#5, #6) whose representative requested copies of medical records. The finding were: 1. Review of the authorization form for the release of information for resident #5 showed the resident's power of attorney submitted it to the facility on [DATE]. Interview on 5/3/18 at 4:30 PM with the medical records staff revealed the power of attorney received the copies of the health information on 3/28/18. 2. Review of the authorization form for the release of information for resident #6 showed the resident's power of attorney submitted it to the facility on [DATE]. Interview on 5/3/18 at 4:30 PM with the medical records staff revealed the copies of the resident's health information were mailed to the power of attorney on 4/13/18. 3. Interview on 5/3/18 at 3:50 PM with the administrator revealed she recognized the problem and had developed a system to ensure all health information requests were honored in a more timely manner. She further stated the delay occurred because she had to have approval from the corporate office and they were very slow in responding.
F 0660 **Level of harm -** Actual harm **Residents Affected -** Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on staff and resident interview and medical record review, the facility failed to develop discharge plans to meet the needs and goals of 1 of 3 sample residents (#2) reviewed for appropriate discharge planning. This failure resulted in significant psychosocial harm, when the resident was discharged to a retirement home that was unable to provide assistance with toileting. The findings were: 1. Review of the medical record showed resident #2 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. This review showed discharge plans were initiated in (MONTH) (YEAR) when the resident refused after multiple attempts to comply with safe smoking practices. Further review showed resident used an electric wheelchair and was discharged from the facility to a retirement home on 4/13/18. The following concerns were identified: a. Interview on 5/3/18 at 3 PM with the administrator revealed the discharge plans for the resident were arranged by a representative of an outside advocacy agency. She further stated the resident was able to perform all activities of daily living independently at the time of the discharge. b.Interview on 5/3/18 with social worker #1 revealed the facility did not communicate with the retirement home staff prior to the discharge because all arrangements were made by the representative of an outside advocacy agency. She stated discharge plans included home health nursing services for pressure ulcer care. The resident was discharged with a bedside commode, sliding board and pill locking mechanism for self medication administration. She further stated the resident had taken care of himself/herself independently prior to discharge. c. Interview on 5/3/18 at 3:45 PM with CNA (certified nurse aide) #1, RCS (resident care specialist) #1, licensed practical nurse #1, and director of nursing revealed the resident used a sliding board to transfer independently from the bed to wheelchair and to the bedside commode. CNA #1 and RSC #1 also stated the only time staff assisted the resident was when they emptied the commode after use and at times reminded the resident to use the sliding board because s/he did not consistently use it. Review of the discharge plan and summary form, dated 4/13/18, showed the resident could perform activities of daily living independently and arrangements had been made for therapy and home health after discharge. d. Review of the 3/12/18 significant change MDS (minimum data set) assessment showed the resident had a BIMS (Brief Interview of Mental Status) score of 10/15, and required extensive assistance with bed mobility, transfers, personal hygiene and toilet use. Review of the 3/12/18 care area assessment summary for triggered MDS assessed areas showed the resident required supervision while smoking; chose not to use suggested safe transfers with a sliding board; and had a history of [REDACTED]. e. Review of the care plan, revised 3/19/18, showed identified problems included safety risk due to operating motorized wheelchair unsafely, requiring supervision with smoking and at risk for falls. Further review of the care plan showed the resident needed assistance with bed mobility, personal hygiene, dressing, and transfers. f. Review of the activities of daily living documentation completed by the CNAs revealed the resident required extensive assistance with toileting 7 times, bed mobility 9 times, transfers 11 times, personal hygiene 7 times, and dressing 8 times during the 4/1/18 to 4/13/18 time period. g. Interview on 5/3/18 at 1:56 PM and again on 5/4/18 at 3 PM with the retirement home assistant manager revealed the resident arrived on 4/13/18 and within hours it was obvious the retirement home was not the appropriate setting for this resident because the resident needed a facility that provided nursing care assistance. The assistant manager stated the representative of an outside advocacy agency made all the discharge arrangements and the retirement home staff did not follow its usual process of pre-admission screening. She stated if the process had been done, they would not have accepted the resident. She stated the following events occurred the day after the resident was admitted : The resident asked for assistance with medications and to go to the bathroom. Both were services not provided by the retirement home. The fire department was called and they were unable to assist the resident to the bathroom. Then emergency medical services was called and the resident was transported to the hospital. h. Interview on 5/10/17 at 11:50 AM with resident #2 revealed the brief stay at the retirement home did not make me feel good because when the firemen tried to help him/her to the bathroom, s/he ended up on the floor, and finally they had to call the ambulance. The resident stated the retirement home was not set up for handicapped people like me and the facility staff did not tell him/her about that set up prior to the discharge. The resident also stated it wasn't a good feeling to have to go the hospital in an ambulance in order to go to the bathroom. i. Review of the facility social services follow up discharge note, dated 4/16/18, revealed social worker #1 had a conversation with the home health nurse who reported she found the resident at the retirement home on 4/14/18 on the floor covered with urine. Further review revealed the home health nurse also reported the resident was transported by ambulance to the emergency room .

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

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.