

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  535032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2026
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Cheyenne		STREET ADDRESS, CITY, STATE, ZIP CODE  1330 Prairie Ave Cheyenne, WY 82009	
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 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on resident representative and staff interview, medical record review, and policy and procedure review, the facility failed to ensure a notification of change of condition was given for 1 of 3 sample residents (#6) reviewed for a change in condition. The findings were:1.Review of the 1/12/26 annual MDS assessment showed resident #6 had a BIMS score of 11 out of 15 (which indicated mild cognitive impairment); showed no signs or symptoms of delirium, behaviors, or hallucinations; was continent of both bladder and bowel, and was independent with personal hygiene, oral hygiene, and toileting hygiene. The resident had diagnoses which included non-Alzheimer's dementia and depression. The findings were:a. Telephone interview with the resident's representative on 3/26/26 at 11:51 AM revealed the resident had a urinary tract infection (UTI) in February. Further, the resident's representative stated the resident had told her s/he was taking medication for an infection. At that time the resident's representative contacted the facility to obtain information related to the resident's change of condition. b. Review of a Health Status Note, dated 2/2/26 and timed 8:02 AM, showed [The resident] reported c/o [complained of] dysuria, urinary urgency and frequency. UA [urinalysis] collected and pending.c. Review of a Health Status Note, dated 2/2/26 and timed 10:38 PM, showed Resident is being monitored for keflex (antibiotic) for UTI day 1/7 [1 out of 7] with no adverse reaction.d. Review of a Health Status Note, dated 2/3/26 and timed 11:45 AM, showed Resident is on Keflex day 2/7 [2 out of 7] for UTI. [S/he] is up out of bed. Alert to staff and all cares. No complaints of nausea, vomiting or diarrhea. No adverse skin reactions or complaints of discomfort.e. Review of an Infection Note, dated 2/3/26 and timed 1:30 PM, showed the resident had been diagnosed with a UTI related to dysuria, increased urgency/frequency and a positive urine culture. The resident was prescribed cephalexin (antibiotic) for 7 days per the culture and sensitivity report. Good hygiene to be encouraged and fluids offered per current medical condition. Will continue to monitor.f. Review of the communication with family notes showed the resident's representative was notified on 2/12/26 at 9:53 AM to inform her the facility was collecting a urine sample to ensure the infection was cleared. There was no evidence the resident's representative had been notified of the change of condition at the onset of the UTI.2. Interview with the DON on 3/26/26 at 1:56 PM confirmed there was no documentation the resident's representative had been notified of the change of condition. 3. Review of the Changes in Resident's Condition or Status policy, last reviewed 8/29/25, showed This facility will notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status .A facility must immediately inform the resident' consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is .(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) .</p>		

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.

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