STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING _____ B. WING _____	C 03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	4041 SOUTH POPLAR STREET CASPER, WY 82601

(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 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to ensure a care plan was developed for 2 (#1, #2) of 2 residents whose reluctance to comply with care resulted in the development of avoidable pressure sores. 1. Refer to F314 for specific information regarding staff failure to include care plan interventions and information for resident #1 regarding the resident's reluctance to allow staff to reposition him/her at frequent intervals. 2. Refer to F314 for information regarding staff's	F 279	F279 The facility will ensure the result of the assessment is used to develop and review and revise the resident's comprehensive plan of care. This will be accomplished by: A) The care plan for resident #1 will be revised to include interventions to be made in regards to the resident's reluctance to allow staff to reposition her at frequent intervals. Staff will document education given to the resident regarding the importance of changing positions throughout the day. The care plan for resident #2 will be updated to address the resident's non-compliance with repositioning. Staff will document education given to the resident regarding the importance of changing positions throughout the day. B) The staff nurse will identify all residents with a pressure ulcer and the wound nurse will assess their compliance in changing positions and assure the care plan has been updated to include interventions and resident's compliance to our treatment regime.	and at risk for a pressure ulcer.

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

Paul RN/DON for Dana Delahoyde, ED — 04/10/2009

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.

RECEIVED
Wyoming Dept of Health
APR 13 2009
Office of Healthcare Licensing and Surveys

This POC accepted & agreed to changes on 4/13/09 between Sara Delahoyde and Tony Madden - POC date 5/31/09. ASP

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F 279	Continued From page 1 failure to update the care plan for resident #2 to address the resident's noncompliance with repositioning.	F 279	F-279 - Continued C) Education will be provided to all nursing staff regarding the importance of keeping the care plan updated on residents with pressure ulcers, interventions and the residents' compliance in changing positions and documentation of resident education. D) On-going performance improvement tool will be utilized to ensure the care plan is updated for residents with pressure ulcers and their compliance in positioning changes and other interventions as well as documentation of resident education. The monitor will be conducted monthly for three months and quarterly thereafter. The director of nursing or designee will report to the facility's Performance Improvement Committee quarterly. Please see next page for F-314	05/03/2009
F 314 SS=G	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of policy and procedures, and staff and family interviews, the facility failed to implement measures for noncompliant behavior for 2 (#1,#2) of 3 residents who were at risk for developing pressure sores. As a result of this failure, the residents experienced long periods of unrelieved pressure and developed avoidable harmful pressure sores. The findings were: 1. Review of the 2/27/09 significant change Minimum Data Set (MDS) assessment and corresponding resident assessment protocol (RAP) summary revealed resident #1 was at risk for developing pressure sores due to the following risk factors: frequent episodes of urinary incontinence; inability to reposition independently; diabetes and a history of recurrent pressure sores and stasis ulcers. Further review revealed the resident was reluctant to lie down between meals to provide pressure relief. Review of the January	F 314		

This POC accepted & agreed to changes on 4/23/09 between Sara Delahoyde and Tony Madden — POC date 5/3/09.

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F 314	Continued From page 2 to March 2009 care plan revealed no information or interventions regarding the resident's reluctance to lie down between meals. Review of the 1/9/09 nurse's notes revealed staff offered a new pressure relief cushion for the resident's wheelchair, but s/he refused. Further review of the medical record revealed no indications that other alternatives were offered or additional efforts were made to determine why the resident did not want the cushion. Interview on 3/19/09 at 7:10 AM with the resident revealed s/he enjoyed doing crafts. During the interview the resident stated that prior to developing the pressure sore, staff did not talk with him/her about various pressure relief alternatives or individualized scheduled repositioning that would allow him/her to do crafts activities comfortably for long periods of time. Observation of a dressing change performed by the facility's wound care nurse on 3/19/09 at 7:25 AM revealed the resident had an eschar covered unstageable pressure sore on his/her right gluteal area . Review of the pressure ulcer status record revealed the resident developed a 1.5 x 2 centimeter unstageable pressure in February 2009. Interview on 3/19/09 at 1:25 PM with the unit one manager; at 1:58 PM with registered nurse (RN) #1; at 2:05 PM with certified nurse aide (CNA) #1; at 2:08 PM with aide CNA #2; and at 2:09 PM with CNA #3 revealed the resident developed pressure sores because s/he sat in his/her wheelchair or remained in the same position in bed for long periods of time during the day. The interviews also revealed staff did not develop or implement a plan of care to address the resident's reluctance to reposition at frequent intervals. 2. Observation of a dressing change performed by the facility's wound care nurse on 3/19/09 at 8 AM for resident #2 revealed a	F 314	F314 The facility will ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This will be accomplished by: A) Resident #1 will receive education from nursing staff regarding the importance of changing positions at frequent intervals throughout the day in order to decrease the potential for pressure sores. Nurses will document this education in the resident's chart. The resident's care plan will reflect interventions to be used in an attempt to encourage the resident to change her position throughout the day. Nursing staff will document the resident's compliance with the interventions. Continued on next page -	

This POC accepted & agreed to changes on 4/13/09 between Sara Delahoyde and Tony Madden. - POC date 5/13/09

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F 314	Continued From page 3 pressure sore on the resident's right lower buttock that appeared clean and nearly healed. Review of the resident's medical record revealed s/he was admitted to the facility on 5/27/08. Review of the resident's 5/27/08 Braden scale for predicting pressure sore risk showed s/he was scored at an 18 (at risk). Review of the resident's 6/6/08 admission MDS showed s/he did not have any pressure sores. The MDS and RAP summary documented the resident was at risk for developing pressure sores due to the following risk factors: diabetes, edema, and post-operative marked weakness requiring staff to complete the resident's activities of daily living (ADLs). Review of the resident's care plan for pressure sores, dated 6/6/08, revealed preventative measures were to be implemented including "reposition resident frequently and prn (as needed) based on individual needs." Further review of the care plan showed the resident was "reluctant to lie down in bed during the day to lower pressure to the posterior, low back, or reposition off of her back when in bed." Review of the care plans showed the facility failed to update any of the care plans for resident reluctance to comply with repositioning. Review of the nurses' notes showed no documentation of resident repositioning or refusals to allow repositioning. A specific nurse's note dated 7/22/08, revealed a new stage II pressure sore to the right gluteal area, a new stage I pressure sore to the left gluteal area, and a new stage II pressure sore on the coccyx. Interview with the director of nursing (DON) on 3/19/09 at 10:20 AM revealed the resident entered the facility without a pressure sore. The DON said the resident was not always cooperative with repositioning or off-loading from	F 314	F-314 - Continued Resident #2 will receive education from nursing staff regarding the importance of changing positions at frequent intervals throughout the day in order to decrease the potential for pressure sores. The nurses will document this education in the resident's record. The resident's care plan will be updated to reflect interventions to be used in an attempt to encourage the resident to change her position throughout the day. Nursing staff will document the resident's compliance with the interventions. B) A chart review will be conducted on all residents who currently have a pressure ulcer. The chart review will monitor for resident education of potential consequences of not following the wound care program, assessing why the resident refuses to follow the program, care plan interventions to optimize healing and resident's compliance to the wound care program. Continued on next page -	

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F 314	Continued From page 4 his/her wheelchair. Upon request, the DON did not provide the following: a. Documentation showing the resident's refusal to reposition, b. Documentation concerning assessment for the reasons the resident refused, c. Documentation of education for the resident concerning potential consequences of refusal to reposition, or d. Documentation of any alternative plan of care by the facility in order to prevent the resident from obtaining an impairment of skin integrity.	F 314	F-314 - Continued C) Nursing staff will receive education regarding the importance of educating residents on their wound care program and potential consequences of not following the program, assessing resident's reluctance to follow the wound care program, documenting resident's refusal to follow the wound care program and implementing alternative plans to prevent the resident from obtaining impairment to their skin integrity. D) On-going performance improvement tool will be utilized to ensure the care plan is updated for residents with pressure ulcers. This tool/monitor will be conducted monthly for three months and quarterly thereafter. The result of the monitor will be reported to the facility's Performance Improvement Committee by the Director of Nursing or Designee.	05/03/2009

This POC accepted & agreed to changes on 4/14/09 between Sara Delahoyde and Tony Madden. - POC date 5/3/09

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