DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| 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 _____ | 04/07/2016 |

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

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| F 000 | INITIAL COMMENTS<br><br>The following common abbreviations are used throughout this document:<br><br>CNA- Certified Nurse Aide<br>DON- Director of Nursing<br>RN- Registered Nurse<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F 000 | Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with the federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in an accordance with the state operations manual. | |
| F 167 SS=E | 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE<br><br>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.<br><br>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure survey results were posted in a location readily accessible to all residents. The census was 106. The findings were:<br><br>Observation on 4/6/16 at 3 PM showed the survey results were in a binder located behind the reception desk. Further observation showed the binder was in a holder mounted on the wall 64 inches from the floor, with a rolling cart and a miniature refrigerator along the wall underneath | F 167 | F167<br><br>A. Survey results were made accessible by moving the location into the lobby and lowering the holder.<br>B. The Executive Director inspected the results accessibility on 4/20/16 | 4/20/16 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Exec Dir | (X6) DATE: 4/27/16

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
WY Dept of Health
APR 28 2016
Healthcare Licensing and Surveys



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4/19/16

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| F 167 | Continued From page 1<br>the binder.<br><br>Interview with the administrator on 4/7/16 at 9:15 AM confirmed the survey results were not accessible to all residents, including residents in wheelchairs. | F 167 | C.<br>The Executive Director educated the receptionists on the need to have the results accessible. E.D. or designee will inspect lobby weekly for the next two weeks and then monthly for the next two months to ensure accessibility.<br>D.<br>All audits will be summarized, reported and reviewed by the P.I. Committee for the next three months.<br><br>The P. I. committee is the quality assurance group within the facility that is composed of the Executive Director, Director of Nursing, Medical Director and other department managers. The group meets monthly to review clinical audits, customer service issues and other regulatory compliance issues. If a problematic trend(s) is identified the committee develops, or causes the development, of an action plan designed to mitigate the chance of recurrence. The results of the action plan are reviewed in subsequent months for effectiveness and modified as necessary. | |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>The facility must not employ individuals who have 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.<br><br>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).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated | F 225 | F225<br><br>A.<br>The executive director sent the | |



5/9/16 The POC for their 4/7/16 Recert Survey was accepted with agreed to changes between Matthew Everthman, Administrator and Tony Madden, Health Services 5/9/16

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| F 225 | Continued From page 2<br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on policy review, staff interview, and review of facility abuse investigation documentation, the facility failed to ensure the State survey and certification agency was notified of the results for 2 of 2 allegations of staff to resident abuse reviewed. The findings were:<br><br>1. Review of the facility's abuse investigation documentation showed the following allegations of staff to resident abuse:<br>a. An allegation of abuse dated 2/14/15 involving resident #112 and an activities staff person.<br>b. An allegation of abuse dated 9/11/15 involving resident #113 and a CNA.<br>Further review showed the State survey and certification agency was notified of the allegations, but there lacked evidence the State survey and certification agency was notified of the results of the investigations.<br><br>2. During an interview on 4/7/16 at 9:35 AM the administrator stated the facility's practice was to fax the results of the investigation to the State survey and certification agency. However, he stated he was unable to provide any documentation to show the results of the two allegations of abuse reviewed were faxed to the State survey and certification agency. | F 225 | investigation results in question to the department on 4/26/16.<br>B.<br>An Audit of Investigations from the past 6 months was performed by the E.D. on 4/25 and any results that were not documented to be sent were resent.<br>C.<br>The facilities E.D. was educated on 4/24/16 by the Regional Vice president on the need and process of reporting investigation results.<br>D.<br>Abuse allegations and investigations will be summarized, reported and reviewed by the P.I. Committee for the next three months. | |



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| F 225 | Continued From page 3<br><br>3. Review of the facility's policy "Chapter 2: Protection of Residents: Reducing the Threat of Abuse & Neglect" (7/2011) revealed on page 2-22 "...Facilities must satisfy the federal requirement to report the results of an investigation within 5 working days from the date of the incident (or knowledge of the incident)." | F 225 | F253<br><br>A.<br>1. The bathroom door in room #116 was patched and the baseboard in the bathroom was re-attached on 4/20/16<br>2. The bathroom floor in room #130 is scheduled to be replaced on 5/20/16<br>3. The wall in resident room #206 was patched and painted on 4/25/16<br>4. The bathroom sink in room #208 was tightened and sealed on 4/20/16.<br>5. The bathroom door in room #209 was patched and the sink was tightened and sealed on 4/20/16.<br>6. The sink in room #212 was tightened and seal and the cracked tile was replaced on 4/20/16<br>B. A 100% audit of all rooms was completed with the survey team on 4/5/16<br>C. The E.D. educated the maintenance director on the need to ensure rooms are well maintained on 4/11/16. The maintenance director of designee will inspect five rooms per week for the next | 5/20/16 ~~5/1/16~~ |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure a safe and sanitary environment for 3 of 3 resident areas (unit 1, unit 2, secure unit). The findings were:<br><br>1. Observation on 4/6/16 at 4:30 PM showed the following concerns:<br>a. In resident room #116, the outside of the bathroom door had a hole that measured 1 inch by 1 1/2 inch. Further, an 8 inch long segment of the bathroom baseboard to the left of the door was coming loose from the wall.<br>b. In resident room #130, the bathroom floor had a slight raised area with a crack in the linoleum that measured 2 inches in length, and created uncleanable surface.<br>c. In resident room #206, the wall above the bed farthest from the door had multiple areas of peeling paint and gouges in the drywall, which created an uncleanable surface. | F 253 | | |



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| F 253 | Continued From page 4<br>d. In resident room #208, the bathroom sink was loose, with the seal along the wall cracked, which created an uncleanable surface.<br>e. In resident room #209, the outside of the bathroom door had a hole that measured 1/2 inch by 1/2 inch. Further, the bathroom sink was loose, with peeling grout and paint along the seal, which created an uncleanable surface.<br>f. In resident room #212, the bathroom sink was loose, with peeling grout and paint along the seal, which created an uncleanable surface. Further, the floor to the left of the entry door had a crack 4 inches in length and 1/2 inch wide, with dirt and debris accumulation.<br><br>2. Interview on 4/7/16 at 8:30 AM with the maintenance director and the administrator confirmed the identified areas needed repair. | F 253 | two weeks and then five rooms per month for the next three months, any deficiencies will be fixed upon discover.<br>D. All audits will be summarized, reported and reviewed by the P.I. Committee for the next three months.<br><br>F281<br><br>Cross-reference with F-431<br>A.<br>On or before 4/28/16, RN#1 will be given written discipline and re-educated by the director of nursing or her designee following the policy and procedure titled "Preparation and General Guidelines HA2: Medication Administration-General Guidelines" which confirms … "Medications are administered at the time they are prepared. Medications are not pre-poured," and according to Elkin, Perry, and Potter in "Nursing Interventions and Clinical Skill, 4th Edition…Keep tablets and capsules in their wrappers and open them at the resident's bedside."<br>B. The survey team completed an audit of a sampling of medication passes and found no other nurses to be pre-pouring medications. | 4/28/16 |
| F 281 SS=E | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and policy and procedure review, the facility failed to ensure acceptable standards of practice were performed regarding medication preparation in 1 of 3 resident areas (secure unit). The secure unit census was 20. The findings were:<br><br>Observation in the secure unit on 4/5/16 at 4:45 PM showed RN #1 was preparing to administer medications to residents. The following concerns were identified: | F 281 | | |



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| F 281 | Continued From page 5<br>a. The observation with RN #1 revealed the medications in the secure unit medication cart had already been removed from pharmacy packaging and placed into individual medication cups.<br>b. Interview with RN #1 at that time confirmed dispensing medication in advance was her usual practice, and confirmed she had dispensed all medications at 3 PM into cups without pharmacy labels.<br>c. Interview with the DON on 4/5/16 at 4:55 PM confirmed her expectation was for nurses to dispense medications at the time the medications were to be given, and she confirmed that dispensing medications in advance of a prescribed administration time was unacceptable.<br>d. Review of the policy and procedure titled, "Preparation and General Guidelines HA2: Medication Administration-General Guidelines" with an effective date of 7/1/13 confirmed the following..."B. Administration...3.) Medications are administered at the time they are prepared. Medications are not pre-poured."<br><br>According to Elkin, Perry and Potter in "Nursing Interventions and Clinical Skill, 4th edition, 2007, page 375: "...8. Keep tablets and capsules in their wrappers and open them at the resident's bedside." | F 281 | C. On or before 4/28/16, nurses will be re-educated by the Director of Nursing or her designee following the policy and procedure titled, titled "Preparation and General Guidelines HA2: Medication Administration-General Guidelines" which confirms ... "Medications are administered at the time they are prepared. Medications are not pre-poured," and according to Elkin, Perry, and Potter in "Nursing Interventions and Clinical Skill, 4th Edition...Keep tablets and capsules in their wrappers and open them at the resident's bedside." The Director of Nursing or her designee will conduct audits of medication preparation on each of three units (one nurse/unit), five times a week for one week, then once a week for three weeks, then monthly for two months.<br>D.<br>The Director of nursing or her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved. | |
| F 311 SS=D | 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS<br><br>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.<br><br>This REQUIREMENT is not met as evidenced | F 311 | | |



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| F 311 | Continued From page 6<br>by:<br>Based on medical record review and staff and resident interviews, the facility failed to provide the necessary services to maintain the ability to ambulate for 1 of 7 residents (#80) who required services. The findings were:<br><br>During an interview on 4/6/16 at 3:35 PM resident #80 stated s/he wanted more restorative services for ambulation. The resident stated s/he thought his/her physician had ordered more restorative. Review of the medical record showed a physician order dated 3/23/16 to "walk daily with walker." However, review of the CNA and restorative documentation since 3/23/16 showed the resident did not walk every day as ordered. Documentation showed the resident walked on 3/25/16, 3/29/16, 3/30/16, 3/31/16 and 4/2/16; there were no refusals documented. During an interview on 4/7/16 at 9:20 AM the DON confirmed the documentation did not show the resident walked everyday. She stated nursing staff should have put the order on the medication/treatment administration record to monitor it. | F 311 | F311<br><br>A.<br>On or before 4/28/16 resident #80 will be evaluated by physical therapy for ability to ambulate.<br>B.<br>On or before 4/28/16, the DON or her designee will complete a 100% audit of physician orders for resident orders to ambulate. On or before 4/28/16, 100% of resident's with physician's order to ambulate were observed ambulating.<br>C.<br>On or before 4/28/16, the DON or designee will educate nurses that residents with orders to ambulate need to be completed as ordered and the monitoring of completion will be on the resident's treatment record.<br>D.<br>The DON or her designee will conduct audits to ensure residents are ambulated per physician order five times per week for one week and then once per week for the next three weeks and then | 4/28/16 |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be | F 431 | | |



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| F 431 | Continued From page 7<br>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and policy and procedure review, the facility failed to ensure proper labeling of medications in 1 of 3 resident areas (secure unit). The secure unit census was 20. The findings were:<br><br>Observation in the secure unit on 4/5/16 at 4:45 PM showed RN #1 was preparing to administer medications to residents. The following concerns were identified:<br>a. The observation with RN #1 revealed the medications in the secure unit medication cart had already been removed from pharmacy | F 431 | monthly for the following two months. The Director of nursing or her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved.<br><br>F431<br><br>Cross-reference with F-281<br><br>A.<br><br>On or before 4/28/16, RN#1 will be given written discipline and re-educated by the director of nursing or her designee following the policy and procedure titled "Preparation and General Guidelines HA2: Medication Administration-General Guidelines" which confirms … "Medications are administered at the time they are prepared. Medications are not pre-poured," and according to Elkin, Perry, and Potter in "Nursing Interventions and Clinical Skill, 4th Edition…Keep tablets and capsules in their wrappers and open them at the resident's bedside." | 4/28/2016 |



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| F 431 | Continued From page 8<br>packaging and placed into individual medication cups. Each cup had a resident's name. However, the medications in the cups were not identified.<br>b. Interview with RN #1 at that time confirmed dispensing medication in advance was her usual practice, and confirmed that she had dispensed all medications at 3 PM into cups without pharmacy labels.<br>c. Interview with the DON on 4/5/16 at 4:50 PM confirmed her expectation was for nurses to dispense medications at the time the medications were to be given, and stated that dispensing medications in advance of a prescribed administration time was unacceptable.<br>d. Review of the policy and procedure titled, "Preparation and General Guidelines HA2: Medication Administration-General Guidelines" with an effective date of 7/1/13 confirmed the following..."B. Administration...3.) Medications are administered at the time they are prepared. Medications are not pre-poured." | F 431 | B.<br>The survey team completed an audit of a sampling of medication passes and found no other nurses to be pre-pouring medications.<br>C.<br>On or before 4/28/16, nurses will be re-educated by the Director of Nursing or her designee following the policy and procedure titled, titled "Preparation and General Guidelines HA2: Medication Administration-General Guidelines" which confirms ... "Medications are administered at the time they are prepared. Medications are not pre-poured," and according to Elkin, Perry, and Potter in "Nursing Interventions and Clinical Skill, 4th Edition...Keep tablets and capsules in their wrappers and open them at the resident's bedside." The Director of Nursing or her designee will conduct audits of medication preparation on each of three units (one nurse/unit), five times a week for one week, then once a week for three weeks, then monthly for two months.<br><br>D.<br>The Director of nursing or her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved. | |



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