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 10/11/2016

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 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 10/10/16 through 10/11/16. The survey was prompted by complaint intakes WY00002294, WY00002260 and WY00002236.	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 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of grievances, and policy and procedure review, the facility failed to ensure 3 of 3 grievances reviewed (#1, #2, #3) were investigated or resolved. The findings were: Review of grievance #1 showed it was dated 8/2/16, grievance #2 was dated 8/28/16, and grievance #3 was dated 9/26/16. These 3 grievances were related to resident care issues, and each form showed the issue was unable to be resolved at the time it was filed. The form used included an area to assign a designee to further investigate the issue, an area to describe the investigation findings, and an area to show the concerned party was notified of the interventions/resolution. The grievance forms for each of these showed these areas were not completed. Interview with the administrator on 10/11/16 at 12 PM verified the forms were not completed, and there was no additional information found related to investigation, or how	F 166	1. On or before 10/17/16 the family or representative for the concern and comment card(s) identified during the survey will be contacted to review the outcome and actions of said card. 10/17/16 2. Any resident and/or family expressing a concern (via the concern and comment card) may be at risk for the same incomplete follow up on the concern/comment card. 3. The facility will follow the policy provided for addressing and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — E.D. 11/3/16 — (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.

Over

11/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 166	Continued From page 1 the concern was attempted to be resolved, or if the concerned party was provided any follow-up on any actions that may have been taken. Review of the facility policy and procedure "Concerns & Comment Program" updated on 7/9/2011 showed "If possible, the concern will be resolved by the person accepting the information. When unable to resolve the concern, share with the individual that someone who will be assigned to investigate the concern will get back with them as soon as possible...The Concern & Comment form is then routed to the Executive Director of designee and to the appropriate department manager who will investigate and resolve the concern...The facility's response as well as the concerned individual's reaction to the remedy will be recorded on the Concern & Comment Form."	F 166	following up on concerns and comments. The following summarizes the flow of the policy: Newly written concern and comment cards will be delivered to the facility's Executive Director (ED) on or before the next business day. The ED will log (date, time and nature of concern) the concern and comment card and distribute the card to the appropriate department head charged with investigating/responding to the concern. The ED will receive and review the results of the department head's response, and interpret the response for thoroughness/completeness. The ED will "score" the response and contact the family for confirmation of satisfactory resolution if that has not been indicated to have been completed. Education will be completed with individuals tasked with addressing concern and comment cards on or before 10/17/16 4. Concern and comment cards will be reviewed daily by the executive director and reviewed for trends on a monthly basis by the Performance improvement committee.	10/17/16

11/7/16 - This POC accepted between Matt Guerthman, Administrator and Tony Madden, Health Surveyor.

11/7/16

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.

11/28/16