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 _____	04/26/2018

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 recertification survey was conducted by Healthcare Licensing and Surveys on 4/23/18 through 4/26/18. Also reviewed during the course of the survey were complaint intakes WY000002516, WY000002558, and WY000002592. The following common abbreviations are used through this document: CNA; Certified Nurse Aide CNO: Chief Nursing Officer PRN : Pro re nata; as needed RD: Registered Dietitian Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		5/20/18

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

Electronically Signed | 05/18/2018

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.

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 _____	04/26/2018

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 578	Continued From page 1 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure the medical record accurately reflected resident advance directive preferences for 1 of 21 sample residents (#1) . The findings were: 1. Review of the medical record form (Code Status) dated 4/3/18 for resident #1 showed the resident's code status as do not resuscitate (DNR). Review of the April medication administration record (MAR) showed the resident's code status as full code. a. Interview with unit manager on 04/24/18 at 4:47 PM confirmed the MAR was inaccurate. b. Review of the advance directives policy and procedures showed "...DNR order is flagged	F 578	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 because it is required by the provisions of the state and federal law. For the purpose 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.	

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 _____	04/26/2018

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 578	Continued From page 2 appropriately on the resident's chart to alert staff as to status..." "... Social Services or Nursing Administration's documentation of the DNR must be present in the medical record regarding the DNR status ..."	F 578	F578 1. Resident #1 medication administration record (MAR) has been corrected to reflect the resident□s accurate advance directive preference. 2. The DON or designee will conduct a 100% audit to ensure that all residents□ medical records accurately reflects the residents□ advance directive preferences. 3. The DON or designee will conduct an in-service on or before 5/20/2018 with licensed nursing staff and medical records on the requirement to ensure the medical records reflect the accurate advance directive preference. 4. At least monthly for the next 90 days, a Performance Improvement tool will be utilized to randomly audit the preferred code status and medical record of facility residents. The results/findings of the audits will be reviewed at each of the facility□s Performance Improvement Committee meetings. Note: The facility□s QAPI meetings consist of (at least) the facility□s Executive Director, Medical Director, Director of Nursing, and Director of Social Services. Other attendees as applicable and appropriate. The committee reviews at a minimum, and continually, internal audits of facility systems, facility policies, compliance issue(s), other Quality Measures, et. al. If the committee recognizes a problematic trend(s) within any of the review(s), the committee or a subcommittee is assigned to create and implement an action plan designed specifically to mitigate the	

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 _____	04/26/2018

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 578	Continued From page 3	F 578	outlying trend. Subsequent meetings review the results of the action plan(s). 5. Compliance met on or before May 20, 2018.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		5/20/18

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 _____	04/26/2018

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 623	Continued From page 4 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the	F 623		

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 _____	04/26/2018

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 623	Continued From page 5 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a transfer notice was issued to 9 of 9 sample residents (#1, #34, #45, #79, #84, #91, #105, #253, #256) with hospital transfers. The findings were: 1. Review of the medical record showed resident #1 was transferred to the hospital on 3/26/18 and returned to the facility on 3/29/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 2. Review of the medical record showed resident #34 was transferred to the hospital on 4/23/18.	F 623	F623 1. The facility cannot go back retrospectively and issue this notice at the time of the hospital transfer for residents #1, #34, #45, #79, #84, #91, #105, #253, and #256. 2. Any resident transferred to the hospital, prior to the completion of our in-service, would not have received a written notice of transfer. 3. The ED or designee will conduct an in-service on or before 5/20/2018 with all licensed nursing staff on the requirement to provide the notice of transfer/discharge	

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 _____	04/26/2018

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 623	Continued From page 6 The review showed the resident remained at the hospital during the survey. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 3. Review of the medical record showed resident #45 was transferred to the hospital on 1/16/18 and returned to the facility on 1/20/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 4. Review of the medical record showed resident #79 was transferred to the hospital on 2/7/18 and returned to the facility on 2/10/18. In addition, the resident was transferred to the hospital on 2/20/18 for planned surgery and returned to the facility on 2/25/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or resident's representative for either transfer. 5. Review of the medical record showed resident #84 was transferred to the hospital on 2/11/18 and returned to the facility on 2/19/18. In addition, the resident was transferred to the hospital on 3/15/18 and returned to the facility on 3/17/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or resident's representative for either transfer. 6. Review of the medical record showed resident #91 was transferred to the hospital on 4/11/18 and returned to the facility on 4/12/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or resident's representative.	F 623	to the resident or resident representative. 4. At least monthly for the next 90 days, a Performance Improvement tool will be utilized to randomly audit the issuing of any notices of transfer/discharge. The results/findings of the audits will be reviewed at each of the facility□s Performance Improvement Committee meetings. 5. Compliance met on or before May 20, 2018.	

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 _____	04/26/2018

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 623	Continued From page 7 7. Review of the medical record showed resident #105 was transferred to the hospital on 2/19/18 and returned to the facility on 2/21/18. In addition, the resident was transferred to the hospital on 2/24/18. The resident did not return to the facility. Further review showed no evidence the facility issued a written notice of transfer to the resident or resident's representative for either transfer. 8. Review of the medical record showed resident #253 was transferred to the hospital on 2/24/18 and returned to the facility on 2/27/18. In addition, the resident was transferred to the hospital on 4/7/18 and returned to the facility on 4/8/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or resident's representative for either transfer. 9. Review of the medical record showed resident #256 was transferred to the hospital on 11/6/17 and returned to the facility on 11/14/18. In addition, the resident was transferred out of the facility on 11/16/17. The resident was then sent from the hospital to hospice. Further review showed no evidence the facility issued a written notice of transfer to the resident or resident's representative for either transfer. 10. Interview with the CNO on 4/25/18 at 12:52 PM confirmed the facility had identified failure to issue written notices of transfer, and had started the education of staff regarding this issue.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a	F 625		5/20/18

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 _____	04/26/2018

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 625	Continued From page 8 nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a notice of bed-hold policy was issued to 9 of 9 sample residents (#1, #34, #45, #79, #84, #91, #105, #253, #256) who transferred to the hospital. The findings were: 1. Review of the medical record showed resident #1 was transferred to the hospital on 3/26/18 and returned to the facility on 3/29/18. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or	F 625	F625 1. The facility cannot go back retrospectively and issue the bed hold policy at the time of the hospital transfer for residents #1, #34, #45, #79, #84, #91, #105, #253, and #256. No residents were denied readmission based on the omission of the bed hold policy. 2. Any resident transferred to the hospital, prior to the completion of our in-service, would not have received a written notice	

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 _____	04/26/2018

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 625	Continued From page 9 resident's representative. 2. Review of the medical record showed resident #34 was transferred to the hospital on 4/23/18. The review showed the resident remained at the hospital during the survey. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or resident's representative. 3. Review of the medical record showed resident #45 was transferred to the hospital on 1/16/18 and returned to the facility on 1/20/18. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or resident's representative. 4. Review of the medical record showed resident #79 was transferred to the hospital on 2/7/18 and returned to the facility on 2/10/18. In addition, the resident was transferred to the hospital on 2/20/18 for planned surgery and returned to the facility on 2/25/18. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or resident's representative for either transfer. 5. Review of the medical record showed resident #84 was transferred to the hospital on 2/11/18 and returned to the facility on 2/19/18. In addition, the resident was transferred to the hospital on 3/15/18 and returned to the facility on 3/17/18. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or resident's representative for either transfer. 6. Review of the medical record showed resident #91 was transferred to the hospital on 4/11/18	F 625	of our bed-hold policy. 3. The ED or designee will conduct an in-service on or before 5/20/2018 with all licensed nursing staff on the requirement to provide the bed hold policy upon transfer to the resident or resident representative. 4. At least monthly for the next 90 days, a Performance Improvement tool will be utilized to randomly audit the issuing of any notices of the bed-hold policy. The results/findings of the audits will be reviewed at each of the facility□s Performance Improvement Committee meetings. 5. Compliance met on or before May 20, 2018.	

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 _____	04/26/2018

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 625	Continued From page 10 and returned to the facility on 4/12/18. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or resident's representative. 7. Review of the medical record showed resident #105 was transferred to the hospital on 2/19/18 and returned to the facility on 2/21/18. In addition, the resident was transferred to the hospital on 2/24/18. The resident did not return to the facility. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or resident's representative for either transfer. 8. Review of the medical record showed resident #253 was transferred to the hospital on 2/24/18 and returned to the facility on 2/27/18. In addition, the resident was transferred to the hospital on 4/7/18 and returned to the facility on 4/8/18. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or resident's representative for either transfer. 9. Review of the medical record showed resident #256 was transferred to the hospital on 11/6/17 and returned to the facility on 11/14/18. In addition, the resident was transferred out of the facility on 11/16/17 for a significant decline in condition. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or resident's representative for either transfer. 10. Interview with the CNO on 4/25/18 at 2:30 PM confirmed the facility had failed to issue written notices to the resident or resident representative concerning the bed-hold policy for hospital	F 625		

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 _____	04/26/2018

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 625	Continued From page 11 transfers.	F 625		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		5/20/18

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 _____	04/26/2018

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 758	Continued From page 12 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to develop a system for ensuring prescribing practitioners indicate the duration for PRN psychotropic medications and document the rationale for extending use beyond 14 days. This failure affected 1 of 6 sample residents (#49) reviewed for unnecessary medications. The findings were: Review of the physician's orders for resident #49 showed Alprazalom (a potent, short-acting benzodiazepine anxiolytic, commonly used for the treatment of anxiety disorders) 1 mg (milligram), extended release, orally every 6 hours PRN was ordered on 1/31/18. Further review of the order showed a stop date had not been included in the order or a rationale for extending the use beyond 14 days. Review of the monthly pharmacy review, dated 2/27/18, showed the pharmacist identified the need for the physician to document the rationale for use and duration of the PRN order. However, review of the the 3/9/18 physician's documentation showed his only response was	F 758	F758 1. Facility obtained rationale for Resident #49□s PRN psychotropic medication. 2. The DON or designee will conduct a 100% audit to ensure that all resident□s that have PRN orders for psychotropic drug are limited to 14 days, at which point the attending physician or prescribing practitioner will evaluates the resident for the appropriateness of the medication and provides documentation of duration and rationale. 3. The DON or designee will conduct an in-service on or before 5/20/2018 with all licensed nursing staff on the requirement for PRN orders for psychotropic drugs. 4. At least monthly for the next 90 days, a Performance Improvement tool will be utilized to randomly audit any resident with a PRN psychotropic order. The results/findings of the audits will be reviewed at each of the facility□s Performance Improvement Committee meetings.	

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 _____	04/26/2018

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 758	Continued From page 13 "no change." Interview with the ADON on 4/26/18 at 10:10 AM revealed it was responsibility of the interdiscplinary team to make sure the physician responded to pharmacy recommendations. She further verified they did not have a system that required the physician to document the rationale or indicate a stop date in response to the pharmacist review of the PRN Alprazolam use.	F 758	5. Compliance met on or before 5/20/2018.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the Food Code, the facility failed to ensure food was distributed in a sanitary manner during 1 of 2 meal observations. The findings were:	F 812	F812 1. Staff (including C.N.A. #1) will receive an in-service training on acceptable hand	5/20/18

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 _____	04/26/2018

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 812	Continued From page 14 1. Observation on 4/23/18 at 5:33 PM showed CNA #1 was wearing disposable gloves. She put her arm around the dietary staff who had delivered the food cart, contacting his shoulder with her hand. The aide then opened the cart and began passing food to the residents without any change of gloves. At 5:37 PM the CNA continued to wear the same gloves between serving the resident meals. At 5:38 PM the aide removed the gloves, but did not wash her hands prior to donning new gloves. At 5:47 PM the CNA opened the refrigerator door with her gloved hands and then proceeded to serve resident meals without changing gloves. 2. Interview with the district RD, the facility RD and the dietary manager on 4/26/18 at 10:52 AM verified acceptable hand hygiene techniques had not been followed and needed to be corrected. 3. According to Food Code 2017, U.S. Public Health Service 2-301.14 "FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms ...(H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands."	F 812	hygiene techniques. 2. The DON or designee will conduct random hand hygiene audits to ensure that acceptable hand hygiene techniques for food service safety are being followed. 3. The DON or designee will conduct an in-service on or before 5/20/2018 with staff on the requirement for food service safety □ hand hygiene. 4. At least monthly for the next 90 days, a Performance Improvement tool will be utilized to randomly audit hand hygiene techniques for food service. The results/findings of the audits will be reviewed at each of the facility□s Performance Improvement Committee meetings. 5. Compliance met on or before May 20, 2018.	