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 06/20/2019

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

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 6/17/19 through 6/20/19 Also reviewed in the course of the survey were complaint intakes WY00002617, WY00002680, WY00002761, WY00002845, WY00002855, and WY00002860. The following common abbreviations are used throughout this document. ADL: Activities of Daily Living CNA: Certified Nursing Assistant DON: Director of Nursing ED: Executive Director MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, medical record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure MDS assessment information was an accurate reflection of resident status for 2 of 22 sample residents (#22, #34). The findings were: 1. Review of the 4/22/19 quarterly MDS assessment showed resident #22 received	F 641	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 purposes of any allegation that the facility is not in	7/20/19

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

Electronically Signed | 07/15/2019

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F 641	Continued From page 1 respiratory treatments which included suctioning, a tracheostomy, and a mechanical ventilator while a resident. Further review showed the resident also received intravenous (IV) medications, transfusions, dialysis, hospice, and was on isolation while a resident. The following concerns were identified: a. Observation of the resident on 6/20/19 at 9:04 AM showed s/he had no physical indication of having a tracheostomy or a mechanical ventilator. During an interview at that time the resident denied s/he had used a ventilator or was on dialysis. b. Review of the medical record showed no evidence the resident had received the respiratory treatments, IV medications, transfusions, dialysis, hospice, or had been on isolation. c. Interview with MDS coordinator #1 and #2 on 6/19/19 at 2:19 PM confirmed the MDS assessment had been marked in error. 2. Review of the most current physician orders showed resident #34 had been prescribed Elliquis (an anticoagulant), 2.5 mg daily for atherosclerotic heart disease with a start date of 4/1/19. Review of the April and May 2019 MAR (medication administration record) showed the resident received the scheduled medication, as ordered, every day of the 7-day look-back period. However, review of the quarterly MDS assessment dated 5/6/19 revealed the anticoagulant was not included in the medication section of the MDS. Interview with MDS coordinator #1 on 6/20/19 at 10:16 AM revealed she was unaware anticoagulants, such as Elliquis, needed to be coded in section N of the MDS.	F 641	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-641 1. The MDS assessments for resident #22 and resident #34 have been modified to ensure accurate reflection of resident status. 2. The DON or designee will conduct monthly audits of a sample of MDS assessments to ensure they accurately reflect resident status. 3. The DON or designee will conduct an education on or before 7/20/2019 with both MDS Coordinators on the importance of accurate MDS assessments. 4. At least monthly for the next 90 days, a Performance Improvement tool will be utilized to report the audits of MDS assessments for accuracy. 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 July 20, 2019.	

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F 641	Continued From page 2 According to the MDS 3.0 RAI Manual version 1.15, page 478: Section N0410E, Anticoagulant: "...Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period..."	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and medical record review, the facility failed to ensure assistance with toilet use was provided as needed for 1 of 22 sample residents (#37) who required assistance with activities of daily living. The findings were: Review of the 5/7/19 quarterly MDS assessment showed resident #37 had severely impaired cognition, 1 sacral region pressure ulcer, and a below the knee amputation. Further review showed the resident required extensive assistance with transfers, toilet use, and personal hygiene care. Review of the care plan, last revised on 6/5/19, showed staff were directed to provide assistance with toilet use and use a mechanical lift for transfers. This review also showed the resident had frequent visits to the wound clinic for care of a stage III sacral pressure ulcer. The following concerns were identified: a. Observation on 6/19/19 at 6:55 AM, showed the resident was in bed and CNA #5 was positioning a bedpan under the resident. Continuous observation showed the resident told	F 677	F-677 1. Resident□s, #37, care plan remains a mechanical left of two person assist for toileting. 2. The DON or designee will conduct weekly audits of ADL cares to ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 3. The DON or designee will conduct an in-service on or before 7/20/2019 with licensed nursing staff on following the care plan/kardex to ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 4. At least monthly for the next 90 days, a	7/20/19

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F 677	Continued From page 3 the CNA that the position of the bedpan was touching his/her sore and it was painful. The CNA responded, "I have to do it this way because there is nobody around to help me." The CNA departed from the room leaving the resident positioned on the bedpan. Interview with the resident at that time revealed s/he did not know why the CNA made him/her use the bedpan because it hurt his/her sore, and other staff always used the mechanical lift to transfer him/her to the bathroom. b. Observation on 6/19/19 at 7 AM showed CNA #5 returned to the resident's room with CNA #6 and a mechanical lift. Continuous observation showed the CNAs removed the urine-filled bedpan; and CNA #6 stated staff should transfer the resident with a mechanical lift when the resident needed to go to the bathroom. At that time, spilled urine was visible on the bed linen, resident gown, and the dressing covering the pressure ulcer. The CNAs provided personal hygiene care and removed and replaced the wet gown and linen; then, RN #1 removed and replaced the pressure ulcer dressing. c. On 6/20/19 at 10:15 AM interview with the DON revealed positioning the resident on the bedpan was not the expectation for assisting this resident with toilet use. d. On 6/20/19 at 11:37 AM interview with MDS assessment coordinators #1 and #2 revealed the care plan did not include directions to use a bedpan for the resident; but there were directions for staff to use a mechanical lift for transfers. They further stated the CNAs should get their care instructions from the CNA Tool posted inside the bathroom door. Review of the CNA Tool with the MDS assessment coordinators at that time verified information about toilet use and using a mechanical lift was included.	F 677	Performance Improvement tool will be utilized to report the audits of ADL cares. 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 July 20, 2019.	

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F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of the facility investigation report, staff interview, and review of facility policies, the facility failed to ensure a safe transfer was provided for 1 of 5 sample residents (#7) reviewed for falls during staff assistance. This failure resulted in actual harm to resident #7 who was dropped during a full body transfer. The resident suffered a skull fracture and subdural hematoma. The findings were: 1. Review of a nurse's note dated 6/12/19 and timed 3:12 AM revealed CNA #1 had "dropped" resident #7 "on the floor" at approximately 7:50 PM on 6/11/19. The CNA told the nurse the resident had slipped out of the sling from "above the height of the wheelchair at approx [approximately] 3 feet." The nurse asked the CNA if she had transferred the resident without assistance and was told "she could not find any help." The nurse wrote the CNA "had not personally asked me nor had I seen her talking to other CNAs during her shift." The nurse also noted there was not a full sling in the room at the time. The CNA told the nurse the resident's head hit the floor first and then his/her back. The resident was transferred to the emergency	F 689	F-689 1. The CNA involved was suspended and subsequently terminated. On 6-12-2019, the therapy and nursing department evaluated resident #7's transfer status and determined the proper sling size that is to be used to safely transfer the resident. 2. The DON or designee conducted an in-service on 6/13/2019 & 6/14/2019 with licensed nursing staff on the policy regarding how to complete a proper mechanical lift transfer. All nursing staff received the competency/education before the date of compliance on 7-20-2019. 3. At least monthly for the next 90 days, the SDC or designee will conduct competency checks on random CNAs across all shifts to ensure compliance with the facility's mechanical lift policy. 4. The results of the competency audits will be submitted to the Performance	7/20/19

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F 689	Continued From page 5 department on 6/11/19 at 8:29 PM. 2. Review of the radiology report dated 6/11/19 showed the resident had an "acute subarachnoid and subdural hematoma..." and a "nondisplaced fracture of the posterior calvarium and skull base..." 3. Review of the ADL care plan last revised 4/18/19 for resident #7 showed the resident required a Hoyer (a full-body mechanical lift) for transfers using a blue full sling. Review of the Kardex (located in the resident's room) showed the resident required the assistance of 2 staff members for transfers using a Hoyer lift and a full sling. 4. Review of the facility's investigation showed an interdisciplinary team (IDT) summary which included "Upon review of the resident's medical record, diagnoses, MDS and care plan, eMAR [electronic medication administration record] and eTAR [electronic treatment administration record], as well as staff/resident and family interviews, by the IDT, this investigation reveal (sic) that the CNA involved in incident did knowingly transfer the resident with one person instead of two, used the wrong type of sling and applied the sling used in an improper manner." 5. Interview with the ED and the DON on 6/19/19 at 2:43 PM revealed corrective actions were implemented on 6/12/19 to prevent re-occurrence. The actions taken by the facility included: a. The CNA involved was suspended and subsequently terminated. b. The nursing staff was re-educated in regard to the policy regarding mechanical lift	F 689	Improvement Quality Assurance Committee by the DON/Designee for input and review. 5. Compliance met on or before July 20, 2019.	

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F 689	Continued From page 6	F 689		

transfers, proper sling, and the proper application of the sling. The DON stated the staff development coordinator had educated all of nursing staff, however 14 PRN (as needed) staff remained, and would be educated before they worked their next shift.

c. The therapy department evaluated the resident's transfer status and informed staff of the proper lift and size of the sling required to safely transfer the resident.

d. The staff were educated as to where the information regarding transfer status was located.

e. The facility provided individual slings for all residents, labeled with the resident's name, and stored on a hook in the bathroom.

f. The facility was promoting a "teamwork" approach to keep residents safe.

g. The DON stated audits would be conducted on a weekly basis to ensure the proper slings were available and functional in the resident's rooms.

6. Review of the facility investigation report showed education was provided to nursing staff on 6/13/19 and 6/14/19. However, due to the date of the incident and the survey timeframe, audits and quality assurance monitoring had not yet been completed.

7. Observation on 6/18/19 at 9:13 AM showed CNA #2 and CNA #3 transferred resident #74 with a Hoyer lift from the bed to his/her wheelchair. Observation on 6/18/19 at 9:36 AM showed CNA #2 and CNA #4 transferred resident #7 from his/her wheelchair to the bed. Interview with the CNAs at that time revealed all transfers were to be done with 2 staff members present.

8. Review of the policy "Mechanical Lift Use"

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F 689	Continued From page 7 dated 11/97 showed "General Guidelines...3. Two (2) persons are required to perform this procedure."	F 689		