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 06/10/2021

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 from 6/7/21 to 6/10/21. Also reviewed in the course of the survey were complaint intakes WY00003188 and WY00003212. The following common abbreviations are used throughout this document: CMS- Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set SDC- Staff Development Coordinator 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 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 substantial compliance with the federal requirements of participation, this response and plan of correction constitutes the facilitie's allegation of compliance in an accordance with the state operations manual.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the CMS Resident Assessment Instrument (RAI) manual version 3.0, the facility failed to ensure quarterly MDS assessments were completed once every 3 months for 1 of 23 sample residents (#1). The findings were: 1. Review of a progress note dated 9/16/19 and	F 638	F 638 1.) The MDS Assessment for resident #1 was corrected to accurately reflect the appropriate assessment date. 2.) The DON or designee will conduct a monthly audit to ensure that the OBRA assessment is completed timely and dated correctly. The initial audit was completed 7/1/21 and no other residents were identified as being affected by this deficiency. 3.) The DON or designee will provide a written education to staff responsible	7/3/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
T-B	Executive Director	7/2/21

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

PRINTED: 06/23/2021
FORM APPROVED
OMB NO. 0938-0391

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F 638	Continued From page 1 timed 2:09 PM showed resident #1 discharged to the community with family. The resident was not expected to return to the facility. The following concerns were identified; a. Review of the resident's MDS assessments showed the resident had a completed admission MDS assessment dated 6/15/19 and a discharge return not anticipated assessment completed 9/16/19. Further review showed a quarterly MDS assessment dated 12/22/20, 15 months and 6 days after the resident discharged from the facility. b. Interview with the MDS coordinator on 6/10/21 at 10:46 AM revealed she was unsure why the 12/22/20 quarterly assessment was completed and believed the assessment must have been done following a corporate request due to a possible error received. Further interview revealed the MDS coordinator would not have completed the assessment if she did not receive guidance to do so from corporate. c. Interview with the administrator on 6/10/21 at 11 AM revealed the resident should have had a quarterly MDS assessment completed on 9/15/21 and it was not done. The quarterly assessment completed in December of 2020 was an attempt to correct the missing assessment. d. Review of the "CMS RAI version 3.0 manual, October 2018," showed "...05. Quarterly Assessment (A0310A = 02) The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD	F 638	for completing MDS quarterly assessments to include: a. CMS RAI Manual 3.0 regarding (A0310A) Quarterly Assessment to be completed at least every 92 days following the previous OBRA assessment. b. MDS Coordinator to complete monthly audit to ensure compliance with MDS quarterly assessment requirements. c. MDS coordinator will reflect the accurate date when completing MDS quarterly assessments. 4.) The DON or designee will conduct a monthly audit monthly for at least 90 days or until substantial compliance is met. The audit will be reported in the facilities monthly PI meeting. 5.) Compliance met on or before July 3, 2021.	

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F 638	Continued From page 2 (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type..."	F 638		
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 medical record review and staff interview, the facility failed to ensure residents received the necessary services to maintain personal hygiene for 2 of 6 sample residents (#122, #123) reviewed for activities of daily living (ADL) assistance. The findings were: 1. Review of the 10/21/20 significant change MDS assessment showed resident #123 required total assistance for bathing. Review of the 12/28/20 quarterly MDS assessment showed bathing did not occur during the observation period. Review of the care plan for bathing, initiated 4/22/20, showed bathing was scheduled for Tuesdays and Fridays. Review of nursing notes showed the resident tested positive for COVID-19 on 12/22/20. Review of the December 2020 and January 2021 bathing documentation and nursing notes showed the resident refused a bath on 12/22/20, and the next documented bath was on 1/6/21 (14 days). A handwritten note on the December 2020 bathing documentation read "COVID/isolation" for 12/22/20-12/31/20. 2. Review of the 10/21/20 quarterly and 12/31/20	F 677	F677 1.) The residents found to have been affected by the deficient practice have discharged from the facility. 2.) The DON or designee will conduct a weekly audit of the POC related to completion and documentation of resident bathing including bed baths. An initial audit of resident bathing was conducted. Findings determined that there were other residents in the facility that had missed a shower in the review period. Social service director or designee to interview all residents or family to determine shower preference. Interview findings will be added to the residents care plan. Facility will continue to monitor though audit. 3.) The DON or designee will provide education to direct nursing staff related to the CFR(s): 483..24(a)(2) ADL Care Provided for Dependent Residents: a.) A resident who is unable to carry out activities of daily living	7/13/21

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F 677	Continued From page 3 discharge MDS assessments showed resident #122 required total assistance for bathing. Review of the care plan for bathing, initiated 3/9/20, showed the resident was scheduled for a bath on Sundays and Thursdays. Review of nursing notes showed the resident tested positive for COVID-19 on 12/27/20 and was transferred to the hospital on 12/31/20. However, review of the bathing documentation for December 2020 showed no baths were documented on 12/25/20 through 12/31/20 (7 days). A handwritten note on the copy of the bathing record read "COVID/isolation" for those dates. Review of nursing notes for those dates showed no documentation of bathing, including bed baths. 3. During an interview on 6/10/21 at 9:55 AM the SDC stated if a resident had an infection which required transmission-based precautions they were supposed to be scheduled at the end of the day for a shower. She stated at the time of the COVID-19 outbreak, the residents in the isolation unit received bed baths to prevent residents from coming out of the unit to use the shower room. 4. During an interview on 6/10/21 at 10:41 AM the DON confirmed there was no documentation to show bathing, including a bed bath, occurred for resident #122 from 12/25/20 to 12/31/20, or for resident #123 from 12/22/20 to 1/5/21.	F 677	receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. b.) Adherence to appropriate documentation of resident bathing. 4.) The DON or designee will complete a weekly audit and will report monthly in the facility PI meeting for at least 90 days or until substantial compliance is met. 5.) Compliance met on or before July 3, 2021.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		

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F 684	Continued From page 4 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policies and procedures, the facility failed to ensure neurological assessments were completed as required for 1 of 8 residents (#123) reviewed for falls. The findings were: 1. Review of the discharge MDS assessment dated 1/6/21 showed resident #123 had one fall with no injury since the last assessment. Review of nursing notes showed on 1/6/21 at 6:50 AM the nurse heard the resident yelling from his/her room. The resident was found lying on his/her left side next to the bed on the floor. The resident stated s/he hit his/her head. The nurse observed blood on the resident's forehead. Review of the incident report dated 1/6/21 showed the resident "...bumped head possibly on oxygen concentrator." The report showed neurological assessments were started and the resident discharged home at noon. The resident stated s/he hit his/her head. The nurse observed blood on the resident's forehead. The following concerns were identified: a. Review of the "Neurological Check List" in the medical record showed the initial neurological assessments were performed on 1/6/21 at "00:00." There lacked evidence of the remaining being completed. The form indicated neurological assessments should have occurred, prior to the resident's discharge, every 15 minutes for the first hour, every 30 minutes for the next two hours, and then every two hours.	F 684	F684 1.) The resident associated with this event has discharged from the facility. The nurse associated with this deficiency was provided education related to completion of the facility Neurological Check List and Life Care Center of Casper's policy regarding neurological checks following a resident fall on 6/30/21. 2.) The DON or designee will complete a monthly audit to determine completion of the facilities Neurological Check List following resident falls. The initial audit competed on 7/1/21 resulted in no identification of additional residents affected by the deficiency. 3.) The DON or designee will provide education to direct nursing staff related to Life Care Center of Casper's policy	7/31/21

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F 684	Continued From page 5 b. During an interview on 6/10/21 at 10:28 AM the DON stated she was unable to find any other documentation to show neurological assessments were completed. She stated the neurological assessment policy should have been followed from the time of the fall until the resident discharged that day. c. Review of the facility's policy "Neurological Assessment" (undated) showed "The Neurological Check List User Defined Assessment (UDA) in Point Click Care (PCC) [electronic medical record] shall be initiated by a written physician's order for neurological checks or when indicated by resident assessment (e.g., head injury, post fall, neurological decompensation)...The assessing nurse initiates the Neurological Check List UDA in PCC and completes as indicated. d. On 6/10/21 at 11:20 AM the staff development coordinator (SDC) stated the neurological assessment policy would be to follow the timeframes in the neurological assessment in PCC.	F 684	regarding neurological checks following a resident fall. 4.) The DON or designee will complete the audit monthly and will report findings at the facilities monthly PI meeting for at least 90 days or until substantial compliance is met. 5.) Compliance met on or before July 3, 2021.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical	F 693		

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F 693	Continued From page 6 condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of Wyoming Board of Nursing advisory opinions and certifications, the facility failed to ensure treatment and services were provided by a qualified individual during 1 of 2 observations of care for residents with a feeding tube, which affected resident #15. The findings were: 1. Review of the quarterly MDS assessment dated 3/26/21 showed resident #15 had diagnoses which included aphasia following cerebral infarction, dysphagia, cognitive communication deficit, and dysarthia following cerebral infarction. Further review showed the resident required a feeding tube for 51% or more of total daily calories received and 501 cubic centimeters (cc) per day or more of fluid intake. Review of the care plan titled "PEG Tube Placement" last revised 3/29/21 showed interventions to be provided by a LPN or RN included "...TF [Tube feeding] orders- Jevity 1.2 full strength at 65cc /hr [hour] continuous- 210cc free water q4hrs, 15cc flush before/after RX [prescription] administration..." The following concerns were identified:	F 693	F693 1.) The staff member associated with this deficiency has been provided a written corrective action related to scope of practice. 2.) The DON or designee will conduct a weekly observational audit of ADL care performed on residents that require Tube Feeding Management to ensure compliance with the facilities policy regarding Tube Feed Management and CNA scope of practice. There is currently one other resident in the facility that has the potential to be affected by this deficiency. The audit will address all residents that require tube feed management at the time of the audit. 3.) The DON or designee will provide education to direct nursing staff related to the facilities policy on Tube Feed Management and CNA scope of practice related to Tube Feed Management. 4.) The DON or designee will conduct the audit weekly and report monthly in the facilities PI meeting for at least 90	7/13/21

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F 693	Continued From page 7 a. Observation on 6/9/21 at 9:25 AM showed CNA #2 and CNA #1 entered the resident's room with a mechanical lift and sling. CNA #2 positioned the sling behind the resident and CNA #1 paused the tube feeding pump, and disconnected it from the resident. After disconnecting the tube from the resident, the CNA laid the tubing on the resident's lap, then moved the tubing to the resident's bed. The CNAs secured the lift sling to the mechanical lift, assisted the resident to stand, provided perineal care to the resident, and lowered the resident back into the recliner. Further observation showed CNA #1 removed her gloves, and without performing hand hygiene re-attached the tube feeding, and re-started the tube feeding pump at 9:32 AM. b. Interview with the SDC on 6/09/21 at 4:29 PM revealed nurses were to stop a resident's tube feeding pump and disconnect it from the resident if needed. Further interview revealed CNAs were not allowed to stop a resident's tube feeding or disconnect the tubing as it was outside their scope of practice. c. Review of the Wyoming Board of Nursing certification originally issued on 8/27/19 showed CNA #1 held an active CNA certification and did not hold a CNA II certification. d. Review of the "Wyoming Board of Nursing Advisory Opinion Certified Nursing Assist (CNA) Role" last revised February 2017 showed tube feeding care and treatment was not included in the scope of practice for a CNA.	F 693	days or until substantial compliance is met. 5.) Compliance met on or before July 3, 2021.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		

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F 880	Continued From page 8 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880	F880-(DPOC) 1.) IDT team will conduct a root cause analysis to identify and address the reasons for non-compliance related to failure to ensure appropriate PPE use including donning and doffing of PPE was performed after contact with blood, bodily fluids, or visibly contaminated surfaces. 2.) The DON or designee will provide education to direct nursing staff related to: a.) The currnet CDC and CMS guidelines. on when to don and doff PPE. 3.) The DON or designee will contact the Mountain Pacific Quality Improvement Organization to Inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility.	7/13/21

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F 880	Continued From page 9 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure infection prevention practices were implemented to prevent cross contamination during perineal care for 1 of 3 sample residents (#15). The findings were: 1. Review of the quarterly MDS assessment dated 3/26/21 showed resident #15 had diagnoses which included aphasia following cerebral infarction, dysphagia, cognitive communication deficit, and dysarthia following cerebral infarction. Further review showed the	F 880	4.) The DON or designee will conduct a weekly observational audit for 12 weeks and a monthly audit for 3 months following to ensure compliance related to appropriate donning and doffing of PPE during resident care. The audit will be reported at the facilities monthly PI meeting for at least 6 months or until substantial compliance is met. 5.) Compliance met on or before July 3, 2021.	

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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 880	Continued From page 10 resident required extensive physical assistance of 2 or more people for bed mobility, transfers, and toilet use and required extensive physical assistance of 1 person for dressing and personal hygiene. The following concerns were identified: a. Observation on 6/9/21 at 9:25 AM showed CNA #2 and CNA #1 entered the resident's room with a mechanical lift and sling. The CNAs secured the lift sling to the mechanical lift and assisted the resident to stand. CNA #2 pulled down the resident's pants and removed the incontinence brief. CNA #2 wiped the resident front to back, and clean to dirty, discarding soiled wipes after each stroke. Without removing his gloves, CNA #2 applied a clean incontinence brief and pulled up the resident's pants, contacting the clean surface of each. The CNAs assisted the resident to sit in the recliner and CNA #2 removed his gloves. b. Interview with the SDC on 6/10/21 at 9:59 AM revealed a staff member would need to change gloves after providing perineal care and before applying a clean brief or touching residents' clothing to prevent cross contamination. c. Review of the facility policy titled "Perl Care Competency" provided by the facility on 6/10/21 showed "...9. Use wipes to clean front of resident. 10. Using one stroke, wipe down one side. (Front to Back) 11. Using one stroke wipe the other side. (Front to Back) 12. Dry Area. 13. Turn over to complete buttock area. (Front to Back) 14. Dry Area. 15. Remove Soiled gloves and apply new pair of gloves. 16. Apply Moisture Barrier. 17. Remove Soiled gloves and apply new pair of gloves. 18. Apply incontinent pad or brief..."	F 880		