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 _____	02/03/2005

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 PRECEEDED 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 174 SS=B	483.10(k) TELEPHONE The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to provide private phone access for resident use. The census at the time of the survey was 112. The findings were: 1. Confidential interview with 12 residents revealed the residents were unaware they should be able to have private phone conversations. Each resident assumed that private phone access was only available if using a personal phone (which residents said was cost prohibitive for most). Residents were also aware of phone access at either the nurses' station or across from the ice cream parlor, but neither location provided privacy. 2. Observation on 2/3/05 at 10:23 AM showed a telephone for resident use located on the wall in an alcove across from the ice cream parlor. A chair, situated directly below the telephone, provided seating during conversations. The following concerns with this arrangement were identified: a. The top of the telephone measured 54 inches from the floor, and the phone numbers on the box could not be seen by residents in wheelchairs. b. The chair blocked residents in wheelchairs from using the phone. During the observation, resident #82 asked an unidentified staff member to dial a phone number. A few minutes later, the resident stated s/he was unable to read the	F 174	This Plan of Correction is submitted as required under Federal and State regulations and statues applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, or that the scope or severity of deficiencies cited is correctly applied. The facility will ensure that residents have reasonable access to use of telephone. 1: Residents rights to phone privacy will be reviewed at Resident Council monthly for 3 months and then quarterly. AD to monitor.	3/21/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dan Miller ED — TITLE — (X6) DATE: 3/9/05

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.

POC accepted & all changes & corrections on 3/25/05 @ 085

per phone Dan Miller, Adm. Reviewed & Revised per phone & Betty Nelson 3/14/05 State Survey

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F 174	Continued From page 1 numbers or reach the phone independently. 3. On 2/3/05 at 9:15 AM an unidentified resident asked a staff member if he/she could make a phone call. The staff member took the resident to the nurses' station and placed the call. The resident then conducted the conversation in the presence of staff who were at the nurses' station. At no time was the resident able to have a private conversation. On 2/3/05 at 1:02 PM a licensed practical nurse (LPN, employee #58) stated the facility did not have a cordless phone. The LPN further stated the phone usually used by residents was at the nurses' station, and it was difficult to get residents there for calls from relatives or friends.	F 174	2&3: The facility is in the process of obtaining a new phone system which will include a privacy phone in the lounge as well as two cordless phones which can be taken to resident rooms. The capitalization paperwork and bid has been accepted and the system will be implemented by 6/1/05. In the interim, the residents will be assisted to an office for privacy and the phone in the phone nook will be lowered to accommodate residents. ED to monitor. Resident Council minutes will be reviewed by QA Committee for resident satisfaction. 3/21/05 3/21/05	
F 272 SS=B	483.20(b) RESIDENT ASSESSMENT A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272	F272 The facility will ensure that each resident will have a comprehensive assessment completed. 3/21/05	

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F 272	Continued From page 2 Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure comprehensive assessments were completed for 3 (#3, #16, #40) of 23 sample residents who required the assessments in a variety of areas. In addition, three (#76, #78, #99) sample residents had incomplete assessments. The findings were: 1. Review of the 12/16/04 admission Minimum Data Set (MDS) assessment showed resident #16 was admitted with diagnoses which included urinary tract infection, status post (S/P) bowel resection, S/P pneumonia, peripheral vasoular disease, diabetes, depression, and S/P open	F 272	Resident #16 will have additional assessments in the areas of communication, psychosocial wellbeing and dehydration/fluid maintenance and will identify causes and contributing factors for the above areas.	3/31/05

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F 272	Continued From page 3 reduction/internal fixation of a hip fracture. Interview with the resident on 2/1/04 revealed his/her speech was slightly slurred and difficult to understand. Observation during the interview revealed the resident wore a boot on the right foot and had difficulty moving the right leg. Review of the MDS assessment showed the resident required additional assessments in the areas of communication, psychosocial well-being, and dehydration/fluid maintenance. That assessment information was identified in Section V as located in each Resident Assessment Protocol (RAP) module. However, review of the RAP modules revealed the facility failed to identify the causes and contributing factors which impacted the individual areas of communication, psychosocial well-being, and dehydration. The facility simply repeated facts such as the resident's diagnosis, medications, consumption of insufficient fluids, and difficulty making self understood. The effect of the recent surgeries, infections, decreased mobility, depression, and diabetes on the resident were not addressed. 2. Review of the 5/21/04 annual MDS assessment showed resident #3 triggered for use of antianxiety, antidepressant, and hypnotic (all psychotropic) medications. According to Section V of that MDS, the assessment information was in the Resident Assessment Protocol (RAP) summary. Review of the RAP information revealed the names of the medications the resident was taking and the statement that s/he was "very anxious." A comprehensive assessment which identified why the psychotropic medications were used was not completed. On 2/3/05 at 9:15 AM a registered nurse, employee #56, confirmed further information was not available.	F 272	Resident #3 no longer in the facility.	

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F 272	Continued From page 4 3. Review of the 10/6/03 admission MDS assessment showed resident #40 was admitted with diagnoses which included hypertension, renal insufficiency, cardiovascular accident and depression. At the time of admission, the resident was completely continent of bowel. Review of the annual MDS dated 10/6/04 revealed the resident was occasionally incontinent of bowel (once a week). A bowel function evaluation completed on 9/29/04 did not address the causative or contributing factors for the decline in the resident's bowel continence. 4. Review of the significant change MDS assessment for resident #76 with a reference assessment date of 5/20/04 revealed there was no date or signature documented in section R2 a and b. Interview with the MDS coordinator on 2/3/05 at 10:10 AM revealed this section should have been signed and dated. According to the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) manual, version 2/0 revised 8/03, pages 3-211 and 212 instruct that the MDS assessment must be signed and dated in sections R2 a and b. 5. Review of the 12/23/04 initial MDS assessment for resident #78 revealed section R2b documented all assessments were completed by 12/23/04, and R2a was signed by the MDS coordinator. Review further revealed section AA 9 had the following areas signed and dated as being completed on 12/24/04 (1 day after the MDS coordinator documented all assessments were completed): Section A: Identification and Background information,	F 272	F272 Resident #40 is no longer in the facility. Resident #76's section R2a&b will be dated and signed. Resident #78 MDS Coordinator and Interdisciplinary team will be re-inserviced on proper coding and timely signing of MDS. 3/21/05	

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F 272	Continued From page 5 Section B: Cognitive Patterns, Section E: Mood and Behavior Patterns, Section F: Psychosocial Well-Being, Section Q: Discharge Potential and Overall Status, and Section R: Assessment Information. According to the CMS RAI manual, version 2.0 revised 8/03, page 3-212, the RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. 6. Review of the 1/13/05 initial RAP summary for resident #99 revealed documentation for the location and date of RAP assessments was blank, the care planning decision documentation was missing, and there were no signatures on the form. According to the CMS RAI manual, version 2.0 revised 8/03, page 3-238 staff must indicate where information related to the RAP assessment can be found under the location of RAP Assessment Documentation column. It further instructs that for each triggered RAP, whether or not a new care plan is necessary must be documented under the care planning decision column. Finally, the RAI manual instructs the RAP Summary must be signed at VB1 and VB2.	F 272	Review with MDS Coordinator and inservice on RAI Manual, Version 2/0, pgs 3-211 and 212, dating of assessments. Resident #99. The RAP summary and care plan decision documentation will be completed and signed. This will include where the information related to the RAP assessment can be found under location of RAP assessment column and if a new care plan is necessary, under the care planning decision columns. All residents will have their assessments reviewed & updated. They will be reviewed in Q standards of care mtg monthly. Any trends will be reviewed by DN & changes made as needed. The DON & MDS Coord. will monitor by random audits. 3/21/05 3/21/05	
F 278 SS=B	483.20(g) - (h) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		

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F 278	Continued From page 6 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly-- Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure each resident's assessment was accurate and complete for 9 (#3, #7, #23, #30, #36, #67, #99, #104, #112) of 23 sample residents. The findings were: 1. Review of the 3/5/04 admission Minimum Data Set (MDS) assessment revealed resident #7 was coded as having no limitations in ROM. On the 6/4/04 MDS assessment the resident was coded as having limitations on one side with partial loss of voluntary movement in the hand. On the 11/29/04 assessment, the resident was coded as having limited ROM on both sides with full loss of voluntary movement in the neck, arms, hand, and other; additionally, the resident was coded as	F 278	All residents will have their assessments and care plans reviewed and updated. They will be reviewed in standards of care meeting monthly. Any trends will be reviewed by QA and changed made as needed. 3/21/05 Residents #7, 23, 30, 36, 67, 99, 104, and 112, assessments that were incorrectly coded will be modified to show the correct information. 3/21/05 Resident #7: Section G will be modified to reflect correct coding for ROM.	3/21/05 3/21/05

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F 278	Continued From page 7 having full loss of voluntary movement with limited ROM on both sides of the leg and foot. During an interview with the director of nursing (DON), the administrator, the corporate nurse consultant, and the current MDS coordinator on 2/2/05 at 4:45 PM, each stated these were coding errors. The DON stated she incorrectly coded the resident as having no limitations in ROM on the 3/5/04 assessment. Each of the four employees stated the resident exhibited no change in ROM status since admission. Interview with the resident on 2/3/05 at 8:30 AM confirmed no change in ROM. During an interview on 2/3/05 at 12:55 PM, the physical therapist stated he re-evaluated the resident on 2/3/05 and found no declines in ROM since admission. 2. On 2/1/05 at 7:40 AM observation showed certified nurse aide (CNA) #24 loosely fastened a seat belt around resident #23, who was seated on a pommel cushion in a wheelchair. When asked to unfasten the seat belt at 1:15 PM that day, the resident attempted to open it, then shook his/her head "no". Review of the 6/22/04 significant change and 1/19/05 quarterly MDS assessments revealed the resident was not coded as having restraints nor as using a seat belt for a positioning device. During an interview on 2/2/05 at 4:20, the DON stated the resident wore the seat belt for a positioning device. Interview with the MDS coordinator on 2/2/05 at 5:00 PM revealed she had not coded the resident for either a restraint or a positioning device. She confirmed the mis-coding on 2/3/05 at 12:45 PM. 3. According to the 11/1/04 quarterly MDS assessment, resident #3 received antianxiety, antidepressant, and antipsychotic medications daily during the seven days preceding the	F 278	Resident #23, Section P4E. Staff has been inserviced on the proper application of a positioning device to assist resident in positioning. Resident is unable to position self and is extensive assist of 2 to transfer. Resident does not ambulate. therapy evaluated the resident for alternate positioning device & documented their findings & updated the care plan. Resident #3 no longer is in facility.	3/21/05

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F 278	Continued From page 8 assessment. Interview with a registered nurse (RN, employee # 56) on 2/3/05 at 9:15 AM revealed she was unaware of any recent antipsychotic and antianxiety medications; she thought they were discontinued during the summer. Interview with the MDS coordinator on 2/3/05 at 12:45 PM revealed she reviewed the old medical record and confirmed the antipsychotic and antianxiety medications were discontinued. She further stated the coding was an error. 4. Review of the 2/27/04 annual MDS assessment showed resident #30 had limited ROM on one side with full loss of voluntary movement in the arm and hand. In addition, the resident was coded as having limited ROM on one side with partial loss of voluntary movement in the leg and foot. According to the 11/17/04 quarterly MDS assessment, the resident had declined and had limited ROM on one side with partial loss of voluntary movement in "other" (spine). Interview with the MDS coordinator on 2/3/05 at 12:45 PM revealed "other" was coded incorrectly on the 11/17/04 assessment. 5. Review of the 9/27/04 significant change MDS assessment showed resident #36 was coded as having limited ROM and partial loss of voluntary movement in the neck. Comparison of that assessment with the previous 8/7/04 significant change and current 1/7/05 quarterly assessments revealed the resident was coded with limited ROM on both sides and partial loss of voluntary movement in the arm. Interview with the MDS coordinator on 2/3/05 at 12:45 revealed the limited ROM in the neck was coded incorrectly. 6. Review of the quarterly MDS assessment dated 1/9/05 revealed resident #67 received an	F 278	Resident #30 – MDS modified to reflect current level of ROM and will be reflected in careplans. 3/21/05 Resident #36 – MDS modified to reflect current level of ROM and will be reflected in careplans. 3/21/05 Resident #67 Section O &U of MDS will be modified and will be reflected in care plan. 3/21/05	

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F 278	Continued From page 9 antipsychotic, an antidepressant and a diuretic during the 7 day look back period. Review of the physician's order sheet dated 10/27/04 revealed "Discontinue all meds [medications]. Comfort measures only". The order sheet was signed 10/28/04 and confirmed via fax from the physician's office. The only medication the resident received from that time was Morphine Sulfate (pain medication). RN #60 was interviewed on 2/1/05 at 2:00 PM. When shown the 1/9/05 MDS, the employee stated, "That's a mistake." 7. Review of the medical record for resident # 99 revealed he/she was admitted with diagnoses including Alzheimer's Disease and dementia. Review of the interdisciplinary treatment (IDT) notes dated 1/11/05 at 3:30 PM revealed the resident was aggressive. IDT notes dated 1/3/05 at 9:45 PM revealed the resident was wandering and had angry outbursts. Review of the 1/13/05 initial MDS assessment revealed the resident had no behaviors. Interview with the MDS coordinator on 2/3/05 at 10:10 AM confirmed behaviors should have been coded on the MDS assessment. 8. Review of the medical record for resident #104 revealed he/she was admitted with diagnoses including convulsions and Alzheimer's Dementia. Observation on 2/2/05 from 3:30 PM to 6 PM and on 2/3/05 from 8 AM to 11 AM revealed the resident had a lap buddy restraint (a cushion attached to the wheelchair to prevent the resident from rising) in place. Review of the physician's orders dated 9/12/04 revealed an order for a lap buddy. Review of the significant change MDS assessments dated 9/27/04 and 10/19/04 revealed the resident had no restraints. Interview	F 278	Resident #99, section E4-5 will be modified to reflect both behaviors and reflected in the care plan. 3/21/05 Resident #104 – Section P.4E will be modified to reflect proper coding for restraint.	3/21/05 3/21/05

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F 278	Continued From page 10 with the MDS coordinator on 2/3/05 at 10:10 AM confirmed restraints should have been coded on the MDS assessment. 9. Review of the medical record for resident #112 revealed he/she was admitted with diagnoses including Alzheimer's Disease, dementia with behaviors, and personality disorder. Observation on 2/2/05 from 3:30 PM to 6 PM and on 2/3/05 from 8 AM to 11 AM revealed the resident had a lap buddy restraint in place. Review of the physician's orders revealed a lap buddy was ordered on 4/30/04. Review of the significant change MDS assessment dated 8/9/04, and two quarterly MDS assessments dated 11/9/04 and 1/24/05 revealed the resident had no restraints. Interview with the MDS coordinator on 2/3/05 at 10:10 AM confirmed restraints should have been coded on the MDS assessment.	F 278	Resident #112 – MDS will be modified in Section P.4E to reflect use of restraint. 3/21/05 Completeness and accuracy will be monitored through standards of care meeting. Trends will be reviewed by QA Committee and changes made as needed. 3/21/05	
F 281 SS=D	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to assure medication storage met professional standards of practice. One of three medication carts in the main dining room was left unlocked with medications available to residents. In addition, one treatment cart was left unlocked. The findings were: 1. Observation of a medication pass on 1/31/05 at 5:12 PM showed a registered nurse (RN,	F 281	F281 1,2,3: This facility will ensure that the facility meets professional standards. All nurses will be inserviced on the importance of locking the med cart and ensuring medication is secure and out of reach of residents. DON, ADON to monitor. 3/21/05	

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F 281	Continued From page 11 employee #60) left the medication cart unlocked and administered medications to resident #80, who was seated in the main dining room. While the RN administered the medications, her back was to the medication cart for one minute. In addition to leaving the cart unlocked, the RN left bottles of Mapap 500 milligrams (mg) and Calcium with Vitamin D 500/200 mg on top. Furthermore, the RN administered medications to other residents at 5:14 PM, 5:15 PM, 5:18 PM, 5:24 PM, and 5:25 PM; each time the cart was out of sight of the nurse and left unlocked with medications on top. The cart remained continuously unlocked with medications within reach of residents in the dining room from 5:12 PM to 5:30 PM. 2. On 2/1/05 at 10:05 AM observation showed the treatment cart on Unit 2 was left unlocked while at the nurses' station. Licensed staff were not always at the desk and the cart contained multiple creams and ointments (medications) and hand sanitizers which were labeled "For external use only." Interview with RN #57 on 2/1/05 at 1:50 PM revealed the treatment cart was usually unlocked when stored at the nurses' station. 3. Review of the facility's undated policy and procedure, Medication Storage & Security in the Facility, showed "Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access." Interview with the director of nursing on 2/2/05 at 5:40 PM revealed her expectation was that the carts be kept locked. On 2/3/05 at 8:00 AM the corporate nurse consultant confirmed that locking the carts was a standard of practice. According to the 2004 3rd edition of "Nursing Interventions & Clinical Skills" by Elkin, Perry, and Potter, the medication	F 281	Inservice 1:1 all licensed nurses regard med cart security and proper storage of medication ~~med care needs~~ to be in direct line of vision if unlocked. 3/21/05 Nurses will be in serviced on the need to lock treatment carts when not in use. DON and ADON will check treatment and med carts daily on rounds. Nurses will be in serviced or disciplined if an unlocked treatment and/or med cart is found. Trends will be reviewed by the QA Committee and addressed as needed. 3/21/05	3/21/05

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	535049	A. BUILDING _____ B. WING _____	02/03/2005

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F 281	Continued From page 12 cart should be kept locked when not in use.	F 281		
F 318 SS=E	483.25(e)(2) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of policies and procedures, the facility failed to assure staff provided restorative services as ordered for five of five sample residents (#7, #36, #74, #76, #77) and one non-sample resident (#91) who were on restorative programs. In addition, restorative services for three sample residents (#25, #30, #40) were discontinued without an order. The findings were: 1. Review of the annual 9/22/04 and quarterly 12/3/04 Minimum Data Set (MDS) assessments revealed resident #74 had functional limitation in range of motion on both sides with partial loss of voluntary movement in the arm, shoulder and elbow, in the leg, hip and knee, and in the foot, ankle and toes. Review further revealed the resident had limitation in one hand including the wrist and fingers with partial loss of voluntary movement. Review of the 9/22/04 Rehabilitation/Restorative Transfer Form revealed the resident had restorative therapy ordered five times per week. The restorative program included heat packs to both shoulders	F 318	F318 The facility will ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease on range of motion. The Restorative Program has been evaluated and the following changes implemented: 1) A new Restorative Nurse has been hired and will be oriented in-house and in the Cheyenne Life Care facility. 2) Restorative Aides will be evaluated and trained in-house and in the Cheyenne Life Care facility. 3) A new Rehab Therapist has been appointed as the referral therapist and attends meetings to assess residents and recommend changes. 4) If RNA's are needed to work on the floor in an emergency, the Restorative Nurse will make alternate arrangements to meet the resident's restorative needs.	

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F 318	Continued From page 13 for 15 minutes prior to treatment, upper extremity exercises, and passive range of motion to both upper extremities in all pivots. Review of the restorative flow sheets and notes revealed the resident did not receive restorative therapy as ordered during the months of September, October, November, and December 2004 and January 2005. The following concerns were identified: a. On 9/29/04 the reason documented for not providing restorative therapy was due to a heavy case load. b. In October, 2004, the resident did not receive restorative as ordered on 10/8/04, 10/21/04, and 10/22/04 because the restorative nurse aide (RNA) was "pulled to the floor" to work. On 10/26/04 the restorative notes documented therapy was not done due to a heavy case load. c. In November, 2004, restorative therapy was not provided on 11/1, 11/11, 11/17, and 11/30 because the restorative nurse aide (RNA) was either reassigned to other non-restorative duties or the case load was too heavy. d. In December, 2004, the resident did not receive restorative therapy on 12/2, 12/8, 12/13, 12/15, 12/30, and 12/31 because the RNA was reassigned to non-restorative duties or because of a heavy case load. e. In January, 2005, restorative therapy was not provided on 1/17, 1/24, and 1/31 because of a heavy case load or because the RNA was reassigned to non-restorative duties. 2. Observation on 2/1/05 at 8:10 AM showed resident #7 required extensive assistance of staff to be repositioned in bed. During the observation the resident was able to move his/her head, the first two fingers and thumb of the left hand, and	F 318	5) Residents who need upper and lower extremity exercises will be done as a group to allow staff to better utilize time and to increase the benefits of the program by providing a social setting. 6) New forms have been implemented to better track the restorative program and to provide accurate information for MDS coding. 7) Caseload was evaluated and adjustments made according to resident needs. 8) Staff CNA's will be inserviced on maintenance therapy after referral from Restorative Nursing. 9) All residents will be evaluated to ensure they are appropriate for either a 1:1 program or group program. ~~Based on their ability to participate in the group.~~ 3/21/05 3/21/05 all res. with a ↓ in ROM will be evaluated and an appropriate program implemented.	

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F 318	Continued From page 14 the left arm. Review of the 3/1/04 Rehabilitation/Restorative Transfer Forms showed restorative staff were to perform lower extremity exercises five to six times per week and upper extremity exercises six times a week. However, review of the documentation in the restorative slow sheet from July 2004 through January 2005 showed staff never performed the exercises five to six times per week as ordered. The number of times per week staff performed the exercises varied from one to a maximum of four, with an average of three. Further review of the documentation revealed multiple instances where the program was not done due to a heavy case load or the RNA was reassigned to non-restorative duties. Interview with the restorative nurse on 2/3/05 at 8:28 AM revealed the restorative documentation was accurate. The nurse also confirmed no other information was available. 3. Review of the 11/2/04 restorative progress notes showed the upper extremity exercise program for resident #38 was to be done three times per week. Further review of the notes showed ambulation and "NuStep" were added four times a week on 11/29/04. Review of the December, 2004, and January, 2005, restorative documentation showed the resident was not offered ambulation and "NuStep" four times a week. In addition, the documentation showed staff did not offer upper extremity exercises to the resident three times a week during during December, 2004, and January, 2005, as the RNA was pulled to the floor four times during each month. Interview with the restorative nurse on 2/3/05 at 8:28 AM revealed the restorative documentation was accurate.	F 318	F318 Residents #7, 36, 74, 76, 77, and 91 will be evaluated as to restorative needs and program implemented and monitored by the Restorative Nurse for compliance. 3/21/05 Resident #7 was evaluated by therapy and restorative and is in a program. Her upper and lower extremity function has remained the same since admission. Care plan reflects the updated restorative plan. Residents #30 and #25 order obtained from therapy and physician to discontinue restorative services. 3/21/05	

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F 318	Continued From page 15 4. Review of the medical record for resident #76 revealed he/she was admitted with diagnoses including cerebral vascular accident (stroke) with hemiplegia (paralysis), abnormal gait, muscle weakness, and history of hip fracture in 2/04. Review of the significant change MDS assessment (undated) completed sometime in 5/04 and the quarterly MDS assessments dated 11/17/04 and 1/27/05 revealed he/she had limitation in range of motion in the right arm, hand, and leg with partial loss of voluntary movement. Review of the 10/18/04 Rehabilitation/Restorative Transfer Form revealed the resident had restorative therapy ordered three times per week. The restorative program included ambulation with a front wheeled walker, knee extensions, and sit to stand exercises. Review of the restorative flow sheets and notes revealed the resident did not receive restorative therapy as ordered during the months of October, November, and December, 2004, and January, 2005, because the case load was too heavy or the RNA was reassigned to non-restorative duties. 5. Review of the 10/7/04 annual MDS assessment and the quarterly 12/29/04 MDS assessment for resident #77 revealed he/she had limited ROM in one arm with partial loss of voluntary movement. Review of the 10/27/04 Rehabilitation/Restorative Transfer Form revealed the resident had restorative therapy ordered three times per week. The restorative program included balance (standing) exercises, heat packs to the left elbow and upper extremity exercises. Review of the restorative transfer form dated 11/15/04 revealed restorative therapy was increased to four times per week and included ambulation with a front wheeled walker and	F 318		

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F 318	Continued From page 16 "NuStep" exercises to both lower extremities. Review of the restorative flow sheets and notes revealed the resident did not receive restorative therapy as ordered during the months of October, November, and December, 2004, and January, 2005, because the RNA was pulled to the floor or the case load was too heavy. 6. Review of the 7/21/04 restorative progress notes showed staff were to provide non-sample resident #91 with upper extremity exercises six times a week. Further review showed NuStep, level 3, for 15 minutes and ambulation with a front wheeled walker was added six times per week on 7/29/04. Review of the restorative documentation showed staff did not offer the program six times per week during September, October, November, and December, 2004, and January, 2005. Many of the documented reasons for not providing the program were "heavy case load," "working the floor," and "due to a meeting." Interview with the restorative nurse on 2/3/05 at 8:28 AM revealed the restorative documentation was accurate. 7. Review of the restorative notes and orders showed the restorative programs for the following residents were discontinued without orders: a. Review of the 6/4/04 restorative notes showed resident #30 was to receive NuStep, balance, and upper extremity exercises two times a week. Further review showed a note dated 10/5/04 which documented the resident only participated twice during the month and would be evaluated for discontinuing the program. No further information was available. Interview with the restorative nurse on 2/2/04 at 5:20 PM revealed restorative must go through therapy before discontinuing a resident from the program. The nurse further stated resident #30 was not	F 318 7-A&B:	New Restorative Nurse has been inserviced on the appropriate discontinuing procedure and will monitor the process for accuracy.	3/31/05

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F 318	Continued From page 17 discussed or evaluated by therapy prior to discontinuing the program. Interview with the director of nursing (DON) on 2/3/05 at 8:25 AM confirmed the lack of a physician's order to discontinue the program. b. Review of the restorative notes dated 6/4/05 showed resident #25 was to receive passive range of motion exercises four to five times per week. There was no further documentation until "DC [discontinue] restorative program" was written on 10/19/04. However, according to the January, 2005, physicians's orders, the resident was to receive restorative exercises as previously described. On 2/3/05 at 8:25 AM the DON confirmed the program was discontinued without an order, and no further information was available. c. Review of the restorative nursing notes dated 6/4/04 for resident #40 indicated staff were to offer restorative services three times per week. Review of a progress note dated 10/20/04 revealed the resident was discontinued from the restorative program on 10/20/04 after meeting with occupational therapy (OT). Interview with the restorative nurse on 2/3/05 at 9:45 AM revealed no meeting minutes existed between the two programs (OT and Restorative) and no physician order existed documenting the decision to discontinue restorative services. The restorative nurse stated the decision to discontinue restorative services was based upon the resident's refusal to cooperate with the restorative program. 8. According to the facility's undated policy and procedure, Life Care Centers of America Restorative Services, "Restorative nursing services are provided seven (7) days per week." Further review of the policy showed the	F 318 C 8	All residents who have reached their restorative goals or have plateaued will be reviewed at the monthly Restorative/Rehab meeting prior to discharge and an order will be obtained as appropriate. 3/21/05 Restorative programs will monitor through Standards of Care Committee. Any trends will be reviewed by QA Committee and changes made as needed. 3/21/05 Resident #40 is no longer in the facility. Ongoing advertising, hiring and retention of staff is in effect to ensure RNA's will not be pulled to work the floor. DON to monitor. QA Committee will review trends and changes made as appropriate. 5/2/05	

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F 318	Continued From page 18 restorative aide "is a dedicated member of the services" who "will not perform routine CNA [certified nurse aide] activities due to shortage of CNAs within the facility without the approval of the Director of Nursing." Interview with an RNA (employee #24) on 2/3/05 at 1:05 PM revealed the restorative program was frequently not provided when they were short staffed. The RNA further stated there were times when she was instructed by the DON to leave the restorative program and work as a CNA.	F 318		
F 329 SS=D	483.25(l)(1) QUALITY OF CARE Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, medical record review, and review of policies and procedures, the facility failed to assure one of one sample residents (#36) who received a hypnotic (psychotropic medication used for sleep) did not receive it unnecessarily. The findings were: Interview on 2/2/05 at 2:45 PM revealed resident #36 received a "sleeping pill" so s/he could get "a good night's sleep." Review of the physician's orders revealed 5 milligrams (mg) of Ambien (a hypnotic) was ordered nightly on 9/13/04.	F 329	F329 The facility will ensure that the Pharmacist will review and report any inequities. Resident #36: The Ambien was dc'd and Trazadone was initiated as recommended by Consultant Pharmacist. The Consultant Pharmacist will be inserviced on importance of completing a thorough drug review and reporting irregularities to DON and physician. 5/01/05 DON will monitor for discrepancies. Trends will be identified by QA Committee and changes made as needed.	

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F 329	Continued From page 19 According to the medication administration records (MAR), it was given from that date through 2/1/05. Review of the entire medical record failed to show physician documentation explaining why the hypnotic medication was prescribed for more than short term use and why alternative methods of sleep induction, a decreased dose, or different medications were not attempted. In addition, the facility failed to provide evidence that other possible reasons for insomnia (e.g., depression, pain, noise, light, caffeine,) were eliminated. Interview with the director of nursing (DON), the assistant DON, and the corporate nurse consultant on 2/3/05 at 10:55 AM revealed the psychotropic medication was missed in the standards of care conferences. They each confirmed the lack of physician documentation which supported continued use of the medication or documented that the benefits of daily consecutive use for over four months outweighed the risks. According to the facility's undated Psychotropic Drug Use Policy, hypnotics "will be used only if other causes for insomnia (depression, pain, noise, light, caffeine, incontinence) have been ruled out..." and daily use "will not exceed 10 days..."	F 329	The pharmacist will fax the discrepancies to the physician and DON will follow up to ensure physician documentation for appropriateness is in place. 3/21/05 All residents on psych meds will be evaluated through standards of care. Trends will be reported by QA Committee to evaluate. Changes will be completed as needed. 3/21/05	
F 368 SS=E	483.35(f)(1)-(3) DIETARY SERVICES Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily.	F 368	This facility will ensure that residents receive meals at regular times that will follow the 14-hour rule.	3/21/05

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F 368	Continued From page 20 When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on review of the posted meal times and staff interviews, the facility failed to assure staff offered residents nourishing snacks at bedtime when meal times were scheduled in excess of 14 hours. At the time of the survey the census was 112. The findings were: Review of the posted meal times showed the evening meal was scheduled to begin at 4:30 PM and breakfast was scheduled at 7:00 AM the next morning, a time lapse of 14.5 hours. On 2/2/04 at 5:45 PM the administrator and director of nursing confirmed meals were served as scheduled. In addition, the administrator stated the kitchen provided nourishing snacks to each unit, but she was not sure if the nursing staff offered the snacks to the residents. Interview with the dietary supervisor on 2/3/05 at 1:12 PM revealed the kitchen sent nourishing snacks to each unit every evening and nursing passed the snacks to the residents. This was confirmed by the dietary manager on 2/3/05 at 4:20 PM. However, interviews with three evening certified nurse aides (employees #17, #19, #28) on 2/3/05 at 3:07 PM, 3:10 PM and 3:12 PM revealed they did not offer snacks to all residents. Each CNA stated she only gave snacks to those residents who requested them.	F 368	The meal times will be changed to 6:45 and 4:45 to ensure that the 14-hour time lapse is meet. 3/1/05 Designated diabetics, weight loss, or special snacks will be delivered as needed. Extra snacks will be available on the floor for residents. DM and ADM will monitor meal times to ensure the 14 hour rule is met. Trends will be reviewed by 3/21/05 Q A Committee	

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F 371	Continued From page 21	F 371		
F 371 SS=F	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on staff interview and observation, the facility failed to provide sanitary conditions for the storage of food and eating utensils. The findings were: 1. On 1/31/05 at 2 PM during the initial tour of the facility kitchen, the bin containing clean eating utensils for residents had an accumulation of dirt and crumbs at the bottom. Further observation of the bin on 2/3/05 at 8:55 AM revealed the same amount of dirt and crumbs still present. On 2/3/05 at 8:56 AM the assistant supervisor of the kitchen stated that the bins contained clean silverware for use in the dining room. 2. On 1/31/05 at 2:15 PM during the initial tour of the walk in refrigerator, the following was observed: a. An opened box of vanilla Health Shakes containing individual servings of shakes did not have a documented thaw date. Clearly printed on the box was "keep frozen at 0 degrees or below." Each individual container stated it was to be used within 14 days of thawing. In addition, observation of the refrigerator on 2/3/05 at 9 AM revealed one box of 75x4 fl oz of chocolate Health Shakes, one box of 75x4 fl oz of vanilla Health Shakes and one box of 50x6 fl oz of vanilla Health Shakes. None of the three boxes had a thaw date. b. An opened box containing individual 8 fluid ounce containers of Glucerna stated on each container "use by the date on end of container".	F 371	F371 The facility will ensure that food is stored, separated and distributed under sanitary conditions. The bins containing clean utensils were cleaned and will be put on a routine cleaning schedule. DM and ADM will review weekly and trends will be reported to QA Committee. 3/21/05 All outdated food was destroyed the day of the survey. Staff will be inserviced on the policy and procedure for monitoring outdated food. DM and ADM will monitor the walk-in 2 times/week to ensure all food dates meet the standard. Staff will be inserviced on importance of dating health shakes as they are taken out of the freezer to monitor freshness. Trends will be reviewed by QA committee. 3/21/05 3/21/05	

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	535049	A. BUILDING _____ B. WING _____	02/03/2005

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 371	Continued From page 22 The date was 1Feb2004. c. One unopened quart carton of buttermilk listed "sell by 12/20." In addition, the carton had ballooned outward. d. Two 80 oz. cartons of ricotta cheese listed an expiration date of "13Jan05." e. A five pound jug of sour cream listed "Jan24" as the expiration date. f. The expiration date on all 3 four-quart containers of concentrated orange juice was "Dec13." In addition, one of the containers was leaking and orange juice concentrate covered the bottom of the container and the shelf grate beneath it. g. An opened box of bologna slices had hand written on it "12/13/04 pulled for 12/17/05 dinner." h. A covered container of olives in juice had written on the container "1/11/05." Interview with the kitchen supervisor on 2/3/05 at 8:50 AM revealed that the date on the top of the containers represented the date the item was opened. In addition, the supervisor stated the shelf life of all opened food items was three days. 3. Observation of the dish machine temperature log for the month of January, 2005, revealed the wash and rinse temperatures for the dinner dishes were not listed. Interview with the employee who was washing dishes revealed that he was responsible for posting the breakfast and lunch temperatures, but he did not know who was responsible for the dinner posting. Interview with the consultant registered dietitian on 2/3/05 at 2 PM revealed that failure to post dinner temperatures was "clearly unacceptable according to facility policy."	F 371	3 All dietary staff was inserviced on the importance of monitoring dish machine temperatures and documenting. DM and ADM will monitor weekly and document. Staff will be inserviced or disciplined as needed. QA Committee will review trends. 3/21/05	
F 387 SS=E	483.40(c)(1)&(2) PHYSICIAN SERVICES	F 387	3/21/05	

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

FORM APPROVED
OMB NO. 0938-0391

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F 387	Continued From page 23 The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure physician visits occurred at least every 60 days. Five (#30, #65, #74, #75, #76) of twenty sample residents did not receive visits from their physicians at 60 day intervals. The facility census was 112. The findings were: 1. Review of the physician's entries in the progress notes showed a physician visited resident #30 on 8/4/04 and 12/2/04. Review of the nursing notes revealed an entry related to a physician visit on 4/1/04. These physician visits were over 4 months apart. The director of nursing (DON) reviewed the record on 2/2/05 at 5:15 PM and confirmed there was no further information related to physician visits. Interview with the medical records director on 2/3/05 at 10:00 AM revealed she had contacted the physician's office, but they had no additional information. On 2/3/05 at 11:09 AM the DON and corporate nurse consultant confirmed there were only three documented physician visits from 3/26/04 to 2/3/05. 2. Review of the physician's progress notes revealed the last time a physician visited resident #67 was 7/27/04 (over 6 months elapsed time).	F 387	All residents, including Residents #30, 65, 74, 75, and 76, will be reviewed and physician appointments scheduled to ensure they meet the requirements of 60 day visit. DON, scheduler, and MRS will monitor. 3/21/05 Medical Records will audit the charts for last physician visits, both outside and inside facility. Each physician will be notified by letter when the visit is due. If a trend is identified of noncompliance, the QA Committee will notify our Medical Director who will contact the individual physicians regarding the noncompliance. Van Scheduler will be inserviced on importance of scheduling appointments and rescheduling those appointments cancelled. DON, ADON ED to monitor.	3/21/05

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F 387	Continued From page 24 The resident was seen as an outpatient at the local hospital on 10/18/04 for an x-ray examination. It was uncertain if the resident was seen by a physician at that time. 3. Review of the medical record for resident #74 revealed he/she was admitted with diagnoses including senile dementia and hypertension. Medical record review failed to reveal physician visits occurred every 60 days. Physician's orders and progress notes revealed the physician visited on 5/3/04 and on 1/29/05 (242 days later). Interview with registered nurse (RN) #60 on 2/3/05 at 10:30 AM revealed there was no other evidence of physician visits. 4. Review of the medical record for resident #75 revealed he/she was admitted with diagnoses including peptic ulcer disease, coronary artery disease, and end stage renal disease. Medical record review failed to reveal physician visits occurred every 60 days. Physician's orders and progress notes revealed the physician visited on 3/17/04 and on 9/16/04 (182 days later). Interview with RN #60 on 2/3/05 at 10:30 AM revealed no other evidence of physician visits. 5. Review of the medical record for resident #76 revealed he/she was admitted with diagnoses including cerebral vascular accident (stroke) with paralysis, muscle weakness, diabetes, and hypertension. Medical record review failed to reveal physician visits occurred every 60 days. Physician's orders and progress notes revealed the physician visited on 3/15/04 and on 9/3/04 (171 days later). Interview with RN #60 on 2/3/05 at 10:30 AM revealed no other evidence of physician visits.	F 387		

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F 429	Continued From page 25	F 429		
F 429 SS=D	483.60(c)(2) PHARMACY SERVICES The pharmacist must report any irregularities to the attending physician and the director of nursing. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews, and review of reported irregularities, the facility failed to assure the pharmacist reported an irregularity for one of one sample residents (#36) who received hypnotic (sleeping) medications. The findings were: Interview on 2/2/05 at 2:45 PM revealed resident #36 received a "sleeping pill" so s/he could get "a good night's sleep." Review of the physician's orders revealed 5 milligrams (mg) of Ambien (a hypnotic) was ordered nightly on 9/13/04. Review of the medication administration records (MAR) showed it was given from that date through 2/1/05. Review of the pharmacy drug regimen review notes dated 10/10/04 showed "Recommend to committee to try DC [discontinue] of Ambien..." Further review showed a note dated 11/7/04, "Apparently committee refused suggestion to DC Ambien..." , and on 12/21/04 the pharmacist wrote,"Continues on Ambien daily - not appropriate. Recommend DC of Ambien..." However, on 2/3/05 at 10:55 AM, interview with the director of nursing (DON), the assistant DON, and the corporate nurse consultant revealed they had no recommendation from the pharmacist on the October, 2004, irregularities report to discontinue the medication. In addition, the assistant DON stated there were no irregularities reported for November, 2004, and the December, 2004, report did not address	F 429	F429 The facility will ensure that the pharmacist will review all files, records, and report any irregularities to the attending physician and the DON. 3/21/05 Resident #36: The Ambien was dc'd and Trazadone was initiated as recommended by Consultant Pharmacist. The Consultant Pharmacist will be inserviced on importance of completing a thorough drug review and reporting irregularities to DON and physician. DON will monitor for discrepancies. Trends will be identified by QA Committee and changes made as needed. 3/21/05	

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F 429	Continued From page 26 the hypnotic. Review of the reported irregularities for October and December 2004 confirmed no recommendation to discontinue Ambien.	F 429		
F 465 SS=D	483.70(h) PHYSICAL ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and staff and resident interviews, the facility failed to assure a safe environment in several locations for residents, staff and visitors. The findings were: 1. Observation on 2/3/05 at 2:05 PM revealed the water softener tank contained liquid. The tank did not contain any salt pellets. On the floor next to the tank was one sack of salt pellets. Interview with the facility maintenance supervisor on 2/3/05 at 1:30 PM revealed he had been in his position a few months and was still learning the job requirements. 2. Observation on 1/31/05 at 5:30 PM and again on 2/1/05 at 7:50 AM revealed the exterior grate was missing from one of two heaters in the special care unit dining room (on the north wall). In addition, both heaters contained an accumulation of dirt, leaves, and debris beneath their interior grates. 3. Observation of the kitchen on 2/3/05 at 8:50 AM revealed a large box fan sitting on the hand washing sink. The fan was plugged into an electric outlet and operating at the time of the	F 465	The facility will ensure a safe, functional, sanitary and comfortable environment for residents, staff and the public. The salt pellets were installed in the tank the day of the survey. Maintenance Supervisor has been inserviced on need to monitor and maintain the tank. QA will review trends and make changes as needed. 3/21/05 3/21/05 2. Grates have been repaired and heater cleaned. Maintenance to place on daily maintenance list and monitor during daily rounds. QA will review trends & make changes as needed. 3/21/05 3. DM, ADM and staff were inserviced on the danger of placing the fan in an unsafe place. DM/ADM to minitor and inservice and/or discipline asa needed. 3/21/05 QA will review trends & make changes as needed.	

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F 465	Continued From page 27 observation.	F 465		