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

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FORM APPROVED
OMB NO. 0938-0391

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 _____	12/16/2010

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 The following common abbreviations are used throughout this document: LPN: Licensed practical nurse DON: Director of Nursing RN: Registered Nurse CDM: Certified Dietary Manager Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	F 226 This facility will follow our abuse/neglect policy that ensures we will protect the Resident when an allegation of abuse is identified, notify the Office of Healthcare Licensing and Surveys (OHLS), investigate the allegations of Resident abuse, and formally report to OHLS and adult protective services. This will be accomplished by:	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policy and procedures, the facility failed to implement procedures related to reporting and investigation for 1 of 4 incidents reviewed. The findings were: Review of an addendum to the facility's abuse/neglect policy dated 11/9/2009 showed, the administrator, director of nursing or designated representative would notify designated offices including the state survey agency and adult protection agency within 24 hours of an allegation of abuse, neglect or misappropriation of resident funds. The	F 226	A) Resident #25 was discharged 12/21/2010. Adult protective services was called and notified of concerns for Resident discharged to home. B) Any Resident identified for allegation of abuse of spouse, family, etc. will be reported according to Life Care Center of Casper's policy. C) The Executive Director will provide an in-service to the department managers and staff regarding appropriate reporting of allegations of Resident abuse and review the policy. D) A quality improvement monitoring tool will be developed to track the appropriate reporting of allegation of abuse of outside persons to OHLS. The results of the tracking will be reported monthly for ninety days to the facilities performance improvement committee by the Executive Director.	01/20/2011

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

EXECUTIVE DIRECTOR 1/12/11

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 appropriate plan of correction is requisite to continued program participation.

RECEIVED
Wyoming Dept of Health
JAN 13 2011
Office of Healthcare Licensing and Surveys

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F 226	Continued From page 1 procedures further showed, an investigation of the incident including a written summary of the findings would be provided to the above agencies no later than five working days after the reported occurrence along with any corrective actions necessary in accordance to state and federal laws. The following concerns were identified with adherance to this policy and procedure: a. Review of nursing notes dated 12/7/10 at 7:45 PM showed resident #25 was possibly being verbally abused by his/her family member. The note showed, the family member was "...swearing and trying to force pen in [the resident's] hand to sign medicare check. He was utilizing verbal explicatives..." b. Interview on 12/15/10 at 12:46 PM with the facility's social service director revealed she was not aware of the incident. After reviewing the nurse's note, the social service director went on to say if she had been aware of the incident she would have contacted adult protective services. c. Interview on 12/15/10 at 1:45 PM with the marketing director who was functioning as the administrator at the time of the incident, revealed the nurse had reported the incident to him when it happened and he interviewed the resident. At that time, he decided there was no threat and did not follow the policy to notify any agencies or complete any investigation or written report.	F 226		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363		

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F 363	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 2 residents (non-sample resident #36, and sample resident #71) who were observed to receive pureed textured diets were provided the planned menu portions. The findings were: During observation of the mid-day meal service on 12/14/10 at 11:35 AM, dietary aide #1 began to dish up the food for residents. At that time, the aide verified the scoop sizes in the pureed spaghetti, meat sauce and the vegetables were #10 scoops (equivalent to 2/5 cup). Review of the planned menu for that meal showed the scoop size for each of these items should be a #8, equivalent to 1/2 cup. Continued observation revealed two residents, #71, #36 had orders for pureed diets and were served their meals using the unplanned serving size. Interview with the CDM on 12/14/10 at 11:48 AM verified the wrong portion size was served. She corrected the scoop size to be appropriate for the remainder of the residents who were served pureed diets.	F 363	F 363 This facility will ensure that Residents receiving pureed textured diets will be provided the planned menu portions. This will be accomplished by: A) Residents #36 and #71 are receiving the appropriate menu portions for pureed textured diets. B) All Residents menu portions with pureed textured diets will be audited to assure they have the appropriate portions served. C) The CDM or designee will provide education at the next dietary meeting of the importance of portion size of puree textured diets and how to select the correct scoop size. D) A quality improvement monitoring tool will be developed to audit the correct scoop size for the puree textured diet menus. The tracking will be performed by the CDM or designee. The results of the monitor will be reported monthly for ninety days to the facility's performance improvement committee by the CDM.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		01/20/2011

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F 371	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff practiced acceptable hand hygiene, and food equipment was kept clean and sanitary. The findings were: Observation during the initial kitchen tour on 12/13/10 at 1:17 PM revealed the stand mixer located in the preparation area of the kitchen was not clean, there was dried food splattered on the underside of the mixer arm. In addition, the table-mounted can opener had food build-up on the blade. Finally, the ice machine located in the kitchen was not sanitary. On the inside of the ice machine there was a white plastic piece where the ice, once made, fell down into the holding container. This white piece was soiled with a yellowish, slimy substance the entire width of the plastic piece. Observation on 12/14/10 at 10:45 AM revealed these pieces of equipment remained in the same un-cleaned condition. Interview with the CDM on 12/14/10 at 11:35 AM revealed the maintenance staff "sanitized" the ice machine twice a year. She was not sure what the yellowish substance was, nor was she aware of the last time the machine was cleaned. According to Food Code 2009, U.S. Public Health Service: 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces	F 371	F 371 This facility will ensure that staff practice acceptable hand hygiene, and food equipment is kept clean and sanitary. This will be accomplished by: A) The stand mixer, can opener, and ice machine were cleaned 12/14/2010. Cook #1 and dietary aide #1 will be re-educated regarding proper hand washing technique. B) Dietary staff will clean the stand mixer and can opener to sight and touch after each use. The inside of ice machine will be de-limed monthly by Dietary staff and Maintenance will de-lime all parts of machine quarterly. C) The CDM, Staff Development Coordinator, and/or designee will re-educate all dietary staff to proper hand washing technique according to the Food Code 2009, monthly and as needed. The CDM will educate all dietary staff the importance and technique of cleanliness of non-food-contact and equipment food-contact surfaces. D) A quality improvement monitoring tool will be developed to audit the cleanliness of the stand mixer, can opener and ice machine. The CDM will monitor the cleanliness of dietary equipment and report to Executive Director (ED) weekly and report to the performance improvement committee monthly for ninety days.	01/20/2011

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F 371	Continued From page 4 of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371		
	Handwashing:			
	During the observation of the midday meal service on 12/14/10 from 10:45 AM to 11:48 AM, cook #1 and dietary aide #1 failed to use appropriate hand washing techniques on multiple occasions. Both staff members were observed to wash their hands at the handwashing sink and turn off the manually operated faucet handles with their clean hands. The staff members failed to use a paper towel or similar clean barrier to avoid re-contaminating their hands when turning off the faucets. Interview with the CDM on 12/14/10 at 2:15 PM revealed the staff had all been educated on handwashing techniques. The CDM stated education was done at least quarterly and as needed. She further stated turning off the faucets with a paper towel was the expectation. According to Food Code 2009, U.S. Public Health Service, 2-301.12 "(C) To avoid recontaminating their hands or surrogate prosthetic devices, FOOD EMPLOYEES may use disposable paper towels or similar clean barriers when touching surfaces such as manually operated faucet handles on a HANDWASHING SINK or the handle of a restroom door.			
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness	F 406		

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F 406	Continued From page 5 and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure specialized therapy services related to a swallowing evaluation was obtained for 1 of 1 sample residents (#73) with orders for these services. The findings were: Review of a physician communication dated 11/19/10 showed the resident was having difficulty with choking during meals. The note also showed the resident received a modified diet texture, and had been evaluated by speech therapy in July 2010 and was noncompliant with the strategies and exercises recommended. In response to this, on 11/22/10 the physician ordered another speech therapy bedside swallowing evaluation. Review of the medical record revealed there were no results of this swallowing evaluation documented. Interview with the DON on 12/15/10 at 3:50 PM verified the evaluation had not been completed. She stated she was unsure why the evaluation had not been done.	F 406	F 406 This facility will ensure specialized therapy services related to a swallowing evaluation will be obtained as ordered.. This will be accomplished by: A) Resident #73 had a swallowing evaluation completed 12/17/2010. B) The Unit Manager or designee will ascertain physician's orders for swallowing evaluations will be referred to the Therapy Department upon receiving the order. C) The Director of Nurses will educate all nursing staff on the importance of communicating orders to the appropriate ancillary departments. D) A quality improvement monitoring tool will be developed to monitor the efficacy and expediency of nursing compliance with communicating physician orders with ancillary departments. The results of the monitor will be reported monthly for ninety days to the facility performance improvement committee by the Director of Nursing.	01/20/2011
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		

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F 441	Continued From page 6 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff followed appropriate infection control practices related to hand hygiene	F 441	F-441 This facility will ensure nursing staff follow appropriate infection control practices related to hand hygiene during medication passes. This will be accomplished by: A&B) Nurses will follow accepted hand hygiene practices at all times during medication pass. C) The Staff Development Coordinator (SDC) will educate all nurses about appropriate hand hygiene during medication pass. D) A quality improvement monitoring tool will be developed to audit the nurses hand washing technique. The SDC will monitor nurses' compliance with appropriate hand washing technique via random visual audits and the results will be reported to the performance improvement committee monthly for ninety days.	01/20/2011

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F 441	Continued From page 7 during 1 of 4 medication passes. The findings were: Observation during a medication pass on 12/13/10 at 4:30 PM showed RN #1 failed to perform hand hygiene after having direct resident contact and prior to preparing medication for another resident. Interview at that time with RN #1 revealed she was aware hand washing should have been done after the resident contact.	F 441		
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory services were obtained in a timely manner for 1 of 24 sample residents (#15). The findings were: Review of physician orders for resident #15 revealed a blood test for Hemoglobin A1C (a test to measure long term glucose control) was ordered on 11/18/10. Further record review showed results of this laboratory test were not available. Interview with LPN #1on 12/14/10 at 8:05 AM verified the results were not part of the record, and she would call the lab to determine if the service had been provided. At 8:30 AM the LPN revealed the test was not done because, when attempted, the resident was combative. Further review of the medical record showed the physician was not notified and the lab was not	F 502	F 502 This facility will ensure laboratory services will be obtained to meet the needs of its Residents. This will be accomplished by: A) Resident #15 laboratory test was drawn 12/16/2010 which resulted within normal limits. B) All Residents who refuse laboratory testing will be re-approached, and the physician ordering the laboratory testing will be notified of the refusal. C) The Staff Development Coordinator (SDC) and/or Unit Manager (UM) will provide education to nurse staff regarding refusal of laboratory testing, re-approach, and reporting to physician of situation. D) A quality improvement monitoring tool will be developed to track physician ordered laboratory testing which will include refusals, re-approaches, and results received. The DON or designee will audit lab tracking and report to the facilities performance improvement committee monthly for ninety days.	01/20/2011

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F 502	Continued From page 8 re-attempted. The LPN further acknowledged the resident's physician should have been notified.	F 502		
F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory test results were available in the medical record for 1 of 24 sample residents (#40). The findings were: Medical record review for sample resident #40 revealed lab tests for a CBC (complete blood count) and PT/PTT (prothrombin time and partial thromboplastin time) were ordered on 12/6/10. Further record review showed the lab results were not found in the medical record. Interview with the DON on 12/16/10 at 8:20 AM showed the labs were drawn on 12/8/10 however, the results were not obtained and placed in the resident's medical record.	F 507	F 507 This facility will ensure laboratory test results will be available in the medical record. This will be accomplished by: A) Resident #40 laboratory test results were obtained and placed in the medical record. B) All Residents who receive laboratory testing will have results placed in their medical record. C) The Staff Development Coordinator (SDC) and/or Unit Manager (UM) will provide education to nurse staff regarding tracking laboratory testing to ascertain availability of testing results in the Resident medical record. D) A quality improvement monitoring tool will be developed to track physician ordered laboratory testing which will include testing results received. The DON or designee will audit lab tracking and report to the facilities performance improvement committee monthly for ninety days.	01/20/2011