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

PRINTED: 10/09/2009
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 _____	09/30/2009

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 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS 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 policy review, staff and resident interviews, and review of facility investigation documentation, the facility failed to develop a policy to ensure the Office of Healthcare Licensing and Surveys (OHLS) was notified immediately of allegations of misappropriation of resident property. The findings were: During an interview on 9/30/09 at 11:05 AM, resident #109 stated she realized she was missing money a couple of weeks ago, and reported it to facility staff. Review of the facility documentation regarding the investigation of the missing money revealed although the police were notified, the facility did not notify OHLS of the allegation. During an interview on 9/30/09 at 1:15 PM, the administrator stated she treated it more like a "concern", since she was not able to substantiate exactly how much money was missing yet. Review of the facility's policy "Misappropriation of Resident Property Investigation" (revised 4/07) did not specify that OHLS would be notified immediately, but rather "...Should the investigation reveal that suspected or actual misappropriation of resident property has occurred...the facility administrator or his/her designee will notify...State licensing & certification agency..."	F 226	The facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. This is being accomplished by: A) Resident # 109 is alert and oriented and has refused to provide evidence of the missing funds by going with a witness to her bank. The local police were also unable to convince the resident to provide evidence of the missing funds. B) An audit conducted by the Executive Director or designee of the facility Concern and Comment Log using the facility Misappropriation of Resident Property/OHLS notification tracking tool has been completed to identify any other potential state reportable misappropriations of resident property. Life Care Center of Casper's Abuse policy was updated to include contacting the Office of Healthcare Licensing and Surveys immediately (not to exceed 24 hours) of misallocation of resident's property. C) The Executive Director conducted an in-service for the department managers to review the Wyoming OHLS occurrence reporting requirements, including misappropriation of resident property. Notification of the OHLS is to occur immediately (not to exceed 24 hours) of the allegation of misappropriation of property as clarified by the state agency.	11/11/2009
F 241 SS=E	483.15(a) DIGNITY	F 241		

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

Sona Dellahoyde — Executive Director — 10-22-2009

ty deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

RM CMS-2567(02-99) Previous Versions Obsolete Event ID: ES1V11 Facility ID: WY0013 If continuation sheet Page 1 of 5

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Wyoming Dept of Health
OCT 26 2009
Office of Healthcare Licensing and Surveys

Accepted w/ Sona Dellahoyde, NHA on 11/2/09 DOC = 11/11/09

D) An audit of the Concern and Comment log utilizing the Misappropriation of Resident Property/OHLS tracking tool will be completed weekly for 30 days and then monthly for an additional 60 days by the Executive Director or designee.

The results of the audits will be presented to the Performance Improvement Committee by the Executive Director or designee monthly for the next 90 days or until the committee determines substantial compliance has been achieved.

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F 241	Continued From page 1 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on staff interview and observation, the facility failed to assure dignity was maintained for 6 of 11 residents (#13, #55, #56, #66, #82, #110) who were observed as ready for bed in the secured unit The findings were: Observation on 9/28/09 at 3 PM at the nurses' station in the secure unit revealed a hand written note which showed, "Evenings - Nights request that you don't put resident's own PJs on them. Gowns only please. Thanks." Observations that evening, 9/28/09, from 7:10 PM to 8:15 PM revealed residents #13, #55, #56, #66, #82 and #110 were observed wearing hospital gowns to bed. In an interview on 9/28/09 at 8 PM with certified nurse aide #1 who was working in the secure unit revealed she was told to put hospital gowns on the residents when they were going to bed because it was easier for the 11 PM - 7 AM shift to change their briefs. In addition, interview with licensed practical nurse #1 on 9/29/09 at 8 AM revealed some residents in the secured unit were put in hospital gowns at night because it was easier for the residents and easier for the staff.	F 241	The facility will ensure that resident care is promoted in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This will be accomplished by: A) Resident's #13, #55, #56, #66, #82, and #110 reside on the facility's Secured Unit, are cognitively impaired and are not able to be interviewed regarding what they would like to wear to bed. The responsible party was interviewed and preferences for night wear were determined and will be being followed. B) All residents able to be interviewed on the Secure Unit have been questioned regarding their preference / choice as to what they wear to bed. The responsible parties of residents not able to be interviewed have been questioned as to preferences for night wear. An observation audit of Secured Unit residents was completed by Nursing Administration to assure night wear preferences are being followed. C) The director of nursing provided education on 10/19 at the monthly all staff meeting discussing the importance of allowing residents to make choices which will enhance their dignity. The Staff Development Coordinator or designee will provide education on Nov. 4 at the monthly facility nursing staff meeting of the importance of promoting dignity and full recognition of each resident's individuality and responsible party preferences / choices as to what residents wear to bed.	11/11/2009
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		

D) An observation audit of the Secured Unit residents will be completed by Nursing Administration to assure night wear preferences are being followed weekly for 30 days and monthly for an additional 60 days.

The results of the audits will be presented to the Performance Improvement Committee by the Director of Nursing or designee monthly for the next 90 days or until the committee determines substantial compliance has been achieved.

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F 250	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to obtain services in a timely manner for one of one residents (#17) who had a physician's order for a psychiatric evaluation. The findings were: Review of the medical record for resident #17 revealed a faxed order from the physician for a psychiatric evaluation to be done in the facility. The order was signed and dated 9/4/09. Further record review showed no evidence the evaluation had been completed. In an interview on 9/28/09 at 3:45 PM, licensed practical nurse (LPN) #2 revealed she was unsure if the evaluation was done. Interview with LPN #1 on 9/29/09 at 1:50 PM revealed she called that day, 9/29/09, and made the appointment. She further stated the appointment was scheduled for 10/20/09 (six weeks after the order was written) which was after the resident was planned to be discharged from the facility.	F 250	The facility will ensure to provide medically-related social services to attain or maintain the highest practicable physical, mental , and psychological well-being of each resident. This will be accomplished by: A) Resident # 17 was discharged on 10/10 to her daughter's home and no longer resides in the facility. A psychiatric evaluation was scheduled 10/20/09 for Resident #17. 10/20/09 was the first psychiatric evaluation appointment available. The resident and daughter were made aware of the scheduled psychiatric evaluation appointment at the time of discharge. B) An audit of records of residents identified with psychiatric issues was completed by Nursing Administration to assure psychiatric evaluations have been scheduled when ordered by the attending physician. The Unit Manager and/or Director of Nursing will be notified if scheduling of a psychiatric evaluation appointment on the first attempt is unsuccessful. C) The Executive Director and/or the Director of Nursing educated facility staff who are responsible for arranging outside appointments for the residents on the importance of scheduling psychiatric evaluations and the importance of communicating to the DON or Unit Manager for follow-up if the scheduling of a psychiatric evaluation appointment on the first attempt has been unsuccessful.	11/11/2009
F 329 SS=D	483.25(l) UNNECESSARY DRUGS 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. Based on a comprehensive assessment of a	F 329		

D) An audit of records of residents identified with psychiatric issues will be completed monthly for the next 90 days by licensed staff to assure that psychiatric evaluations have been scheduled timely when ordered by their attending physician..

The results of the audits will be presented to the Performance Improvement Committee by the Director of Nursing or designee monthly for the next 90 days or until the committee determines substantial compliance has been achieved.

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F 329	Continued From page 3 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the drug regimen was free of unnecessary drugs for 2 of 23 sample residents (#41, #77). The findings were: 1. Review of physician orders showed on 6/2/09, zolpidem (a sedative-hypnotic) 5 milligrams (mg) at bedtime was ordered for resident #41 for insomnia. Further review of the medical record showed no comprehensive sleep assessment was completed to identify the resident's sleep pattern/disturbance, and possible reasons for insomnia, such as noise, pain, caffeine, or medication side effects. In addition, there lacked an evaluation to determine the effectiveness of the medication. Review of nursing notes dated 6/3/09, 6/6/09, and 9/30/09 showed the resident still had insomnia, even after taking zolpidem. During an interview on 9/30/09 at 1 PM, the director of nursing (DON) stated there was no comprehensive assessment to determine causes	F 329	This facility will ensure that each resident's drug regimen is free from unnecessary drugs. This will be accomplished by: 11/11/2009 A) The Ambien for Resident #41 has been discontinued. A comprehensive sleep assessment has been developed and completed for #77 including the cause / need for Ambien and the effectiveness of the medication. B) An audit of all residents currently receiving hypnotic medications was completed by Nursing Administration utilizing a comprehensive sleep assessment to determine causes / need for the medication as well as the effectiveness of the medication. C) The Director of Nursing will educate licensed staff on 11/4 at the monthly nurses meeting regarding assessing residents using the comprehensive sleep assessment, observation of the resident using hypnotic medications and documentation of the effectiveness of the medication.	

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F 329	Continued From page 4 of the insomnia. Furthermore, she stated the resident still had insomnia, and "only slept about 45 minutes last night." 2. Review of physician orders for resident #77 showed a PRN (as needed) order dated 6/18/09 for zolpidem (a sedative-hypnotic) 5 mg at bedtime. Review of the July 2009 medication administration record (MAR) showed the resident received the zolpidem on 28 nights. According to the August 2009 and September 2009 MARs the resident received zolpidem on 27 nights each month. Review of the medical record showed no comprehensive sleep assessment to determine possible causes for the insomnia. On 9/30/09 at 2:40 PM, the DON revealed a comprehensive sleep assessment was not completed prior to the use of the hypnotic.	F 329	D) An audit of comprehensive sleep assessment completion for current residents with new hypnotic medication orders and newly admitted residents using hypnotic medications will be completed weekly for 30 days and monthly for the following 60 days by Nursing Administration. The results of the audits will be presented to the Performance Improvement Committee by the Director of Nursing or designee monthly for the next 90 days or until the committee determines substantial compliance has been achieved.	