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 _____	04/20/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 4/17/17 through 4/20/17. The following common abbreviations are used throughout this document: ADLs- Activities of daily living ADON- Assistant director of nursing CAAs- Care area assessments CNA- Certified nurse aide DON- Director of nursing services LPN- Licensed practical nurse MDS- Minimum Data Set MAR- Medication administration record RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency	F 000		
F 156 SS=B	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:	F 156	F – 156 1. The 8x11 inch framed document hanging in the lobby and depicting the requisite agencies has been updated to include each listed agency's email address as well as a statement to show that the residents may file a complaint with the State Agency. 2. This is the only such posting in the facility	05/14/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] RN/DON — TITLE — (X6) DATE: 5-12-2017

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 _____	04/20/2017

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 156	Continued From page 1 (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.	F 156	3. The facility Director of Social Services will advise the facility's resident council group at the next scheduled meeting that the posting has been updated and remind them of their right to file a complaint with the State Survey Agency. Each month, the facility Executive Director will review the posting for accuracy/currenc 4. The results/findings of the monthly review will be reviewed at each of the facility's next 3 monthly Performance Improvement Committee meetings. Note: The facility's Performance Improvement committee consists of (at least) the facility's Executive Director, Medical Director, Director of Nursing, and Director of Social Services. Other attendees as applicable and appropriate. The committee reviews at a minimum, and continually, internal audits of facility systems, facility policies, compliance issue(s), other Quality Measures, et.al. If the committee recognizes a problematic trend(s) within any of the review(s),	

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 _____	04/20/2017

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 156	Continued From page 2 (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance	F 156	the committee or a subcommittee is assigned to create and implement an action plan designed specifically to mitigate the outlying trend. Subsequent meetings review the results of the action plan(s).	

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 _____	04/20/2017

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 156	Continued From page 3 directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights	F 156		

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 _____	04/20/2017

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 156	Continued From page 4 and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must– (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.	F 156		

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 _____	04/20/2017

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 156	Continued From page 5 (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.	F 156		

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 _____	04/20/2017

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 156	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the posting of all pertinent State regulatory and informational agencies and resident advocacy groups contained all required information. The census was 111. The findings were: Observation of the facility posting during the survey timeframe showed it was on an 8 by 11 inch framed document and was located in the front lobby on a wall near the front entrance door across from the reception desk. The document did not contain the required email addresses or a statement to show residents may file a complaint with the State Survey Agency. Interview with the administrator on 4/20/17 at 10:10 AM confirmed the posting did not contain the necessary information.	F 156		
F 225 SS=E	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his	F 225	F – 225 1. The facility can not go back retrospectively and change the date stamp(s) of the 3 identified late reports. No residents were injured as a result of the late reporting. 2. Any allegation involving abuse and/or an allegation involving serious bodily injury might be at risk of not being reported timely.	05/14/17

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 _____	04/20/2017

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 225	Continued From page 7 or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 225	3. All staff will be re-serviced on, or before, 05/16/17 by the facility's Staff Development Coordinator (or her designee) regarding the new (and shorter) reporting requirement for these two types of allegations, as well as, the facility's updated policy designed to comply with same. The facility's Executive Director will review the time frame of each future report against the time the allegation was received by the facility to ensure compliance with the reporting requirements. 4. The results of the Executive Director review will be discussed at PI each month. If problematic concerns arise, an action plan will be devised to correct the issue(s).	

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 _____	04/20/2017

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 225	Continued From page 8 (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility investigation documentation, staff interview, and review of policies and procedures, the facility failed to report allegations of abuse to Healthcare Licensing and Surveys (HLS) within 2 hours for 3 of 4 allegations reviewed. The findings were: 1. Review of facility investigation documentation revealed the following concerns: a. An allegation of physical abuse involving resident #84 occurred on 3/2/17, but was not reported to HLS until 3/3/17. b. An allegation of physical abuse involving resident #15 occurred on 3/5/17, but was not reported to HLS until 3/6/17. c. An allegation of verbal abuse involving resident #42 occurred on 3/13/17, but was not reported to HLS until 3/15/17. 2. Review of the facility's policy "Reporting Alleged Abuse" (Revised 2/7/17) showed "...Facilities must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury..."	F 225		

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 _____	04/20/2017

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 225	Continued From page 9 3. During an interview on 4/18/17 at 4:40 PM, the administrator stated he was aware of the 2 hour reporting timeframe for allegations involving abuse. He further stated the facility did some investigation, which could take longer than 2 hours, to try to determine if the allegations actually involved abuse and would need to be reported.	F 225	F-253 1. A. The bathroom floor was repaired by the facility's Director of Maintenance on 05/11/17. B. The ceiling tiles in the Bistro dining room (6) were replaced or repaired on 05/11/17 by the facility's Director of Maintenance.	
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 5 resident areas (Unit 1, Bistro) were clean and in good repair. The findings were: 1. Concerns identified on Unit 1: a. Observation on 4/19/17 at 5:15 PM showed the bathroom floor in resident room #112 had a gap between the tiles that measured 1 and 1/2 inches wide by 4 feet long and could not be effectively cleaned. 2. Concerns identified in the Bistro: a. Observation on 4/19/17 at 5:40 PM showed 6 ceiling tiles in the Bistro dining room were damaged or dirty with large brown stains. 3. Interview with the maintenance director on 4/20/17 at 9:05 AM verified the identified building concerns were in need of repair but he did not have a timeline in place to address these areas.	F 253	2. A. On 05/09/17, the facility's Director of Maintenance inspected all resident bathroom floors. No other floors had gaps between the tiles. B. On 05/11/17, the facility's Director of Maintenance inspected all the resident areas in the facility for dirty or damaged ceiling tiles. Tiles deemed in need of repair/replacement were addressed that day. 3. The facility's Director of Maintenance will commence weekly audits of a random sample of five resident bathroom floors and five resident areas. Identified concerns will be addressed in real time. The results of the weekly audits will be given to the facility's Executive Director. 4. The findings and fixes (if applicable) of the weekly audits will be reviewed at each months PI meeting for the next 3 months.	05/14/17
F 274	483.20(b)(2)(ii) COMPREHENSIVE ASSESS	F 274		

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 _____	04/20/2017

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 274 SS=D	Continued From page 10 AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of the MDS 3.0 RAI (Resident Assessment Instrument) manual, the facility failed to ensure a significant change assessment was completed for 1 of 5 residents (#96) with a significant change. The findings were: 1. Review of the 2/28/17 significant change MDS assessment showed resident #96 was cognitively intact with a brief interview for mental status (BIMS) score of 13/15. Section I of the MDS showed a diagnosis of depression in Psychiatric/Mood and no diagnoses marked in the Neurological section. The MDS assessment further showed no hallucinations or delusions, no physical or verbal behavioral symptoms directed towards others, and no rejection of care. Since this assessment the following changes with cognition, mood and behavior were identified: a. Review of a progress note dated 3/11/17 showed "resident is oriented to self. [S/he] is	F 274	F-274 1. A significant change of condition assessment was completed for resident #96 with an ARD of 5/3/17. 2. The inter-disciplinary team met on 5/10/17 and reviewed current resident roster to determine if any residents met the requirements for a significant change of condition assessment. Of the residents reviewed, three residents had previously been set for a significant change of condition assessment, a significant change of condition assessment is to be set on two residents, and six residents were placed on a list to be watched for a significant change assessment. 3. On 5/10/17 the inter-disciplinary team was educated by MDS Coordinators on requirements for completion of a significant change of condition assessment following the MDS 3.0 RAI manual. On or before 5/12/17, the facility Interdisciplinary Team (IDT) will be educated by the Director of Nursing (or her designee) on requirements for completion of a change in condition (including but not limited to changes in behavioral frequencies) assessment following the MDS 3.0 RAI manual and how suspected changes are to be reported.	05/14/17

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 _____	04/20/2017

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 274	Continued From page 11 impulsive and exhibits cognitive impairment, poor judgment and safety awareness." b. Review of a progress note dated 3/12/17 and timed 2:09 PM showed "resident is alert to person, sometimes alert to place, sometimes [s/he] is confused about where [s/he] is at." c. Review of a progress note dated 3/12/17 and timed 5:05 PM showed "resident at 1500 [3 PM] became confused, and agitated, refusing [his/her] shower, and saying things such as we are all in it together, we are in a bank and have a bomb and are going to blow this place up...[s/he] grabbed a walker out of a Resident room and threw it down in the middle of the hallway while another Resident was wheeling [him/herself] by." Further review of this note showed the resident exhibited paranoid behaviors, was verbally abusive to other residents and was unable to be redirected. d. Review of a progress note dated 3/13/17 and timed 9:54 PM showed new medication orders for PRN Ativan (antianxiety medication) both topically and IM (intramuscular). In addition, "Resident continues to be aggressive and uncooperative with cares." e. Review of a progress note dated 3/17/17 and timed 11:48 AM showed "Resident continues to work with therapies related to cognition...Resident continues with confusion. Resident spit out all AM oral medication." f. Review of a progress note dated 3/18/17 and timed 1:24 PM showed a change of medication to include PRN Lorazepam (antianxiety medication) either topically or orally for behavior "that can not be redirected with a maximum of two doses of all forms of Ativan." In addition, a note timed 5:16 PM showed a change of medication to include a decrease in Wellbutrin (antidepressant) and to start Remeron	F 274	The Director of Nursing or her designee will conduct audits to monitor for significant changes of condition via ground rounds and 24-hour report books. The audits are designed to identify and/or aggregate a patient's issue or issues that might require a new assessment. The audits will be completed five times a week for one week, then one time for three weeks, and then monthly for two months. 4. The Director of Nursing or her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved.	

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 _____	04/20/2017

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 274	Continued From page 12 (antidepressant) and Aricept (medication for dementia). g. Review of a progress note dated 3/19/17 and timed 11:48 AM showed "Resident continues with confusion...Resident apprehensive with treatments, medications and cares. Resident suspicious of staff and roommate as well as family visiting...Medications require multiple attempts to administer." An addendum at 1:30 PM showed "Resident continues with physical and verbal aggression toward staff, visitors and other residents." The resident was placed on "one on one" with staff until 3 PM. h. Review of progress notes dated 3/21/17, 3/22/17, 3/23/17, 3/24/17, 3/28/17, 3/30/17, 4/6/17, 4/13/17, 4/15/17, and 4/17/17 showed a continued pattern of refusal of care, verbal and physical aggression, confusion and agitation. 2. Observation on 4/17/17 at 4:26 PM showed the resident was agitated and yelled at people walking by in the hallway. The resident stated "All of you guys need to eat a sandwich then get out of here. I'm shutting this place down and calling the police." 3. Interview on 4/20/17 at 10:32 AM with the DON and ADON verified the resident had an abrupt change in cognition and behavior at the end of February 2017. 4. Interview on 4/20/17 at 11:35 AM with MDS coordinators #1 and #2 verified the resident had undergone a change of condition and a significant change MDS assessment was needed. 5. Review of the "MDS 3.0 RAI Manual, October 2016," showed "...04. Significant change in status assessment (SCSA) (A0310A=04)...other	F 274		

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 _____	04/20/2017

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 274	Continued From page 13 conditions may not be permanent but would have such an impact on the resident's overall status for more than two weeks that they would require a comprehensive assessment and care plan revision. "Further, the RAI stated a significant change assessment is appropriate when "...There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments..."	F 274		
F 356 SS=B	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census.	F 356	F – 356 1. A new Nurse Staffing Board, replete with the requisite breakdown(s) of Registered Nurses, Licensed Practical nurses and Certified Nursing Assistance (and the hours for same) was ordered, received and installed on 04/28/17. 2. This is the only Nurse Staffing Board in the facility. 3. The staff scheduler will update the Nurse Staffing Board daily and receptionist will maintain a daily log of Nurse Staffing Board completion. 4.The results of the daily logs will reviewed at each of the next 3 months PI meetings.	05/14/17

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 _____	04/20/2017

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 356	Continued From page 14 (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on review of daily staff postings, and staff interview, the facility failed to accurately post the number of nursing staff and their actual hours worked for 4 of 4 days of survey (4/17/17 - 4/20/17). The findings were: Review of the daily staff postings for 4/17/17 through 4/20/17 showed each day the facility identified licensed nursing staff and unlicensed nursing staff. The facility failed to break down the categories of staff as required (RNs, LPNs, CNAs). Further, the postings failed to show the actual hours worked for each category of licensed and unlicensed nursing staff directly responsible	F 356		

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 _____	04/20/2017

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 356	Continued From page 15 for resident care per shift. Interview on 4/20/17 at 11:09 AM with the staff scheduler and the receptionist verified that the daily posting did not include all of the required information.	F 356		
F 371 SS=E	483.60(l)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (l)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (l)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (l)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, review of sanitation logs, and staff interview, the facility failed to ensure food and equipment was maintained in a clean and sanitary manner in 1 of 1 food preparation areas (the main kitchen). The findings were:	F 371	F – 371 1. A. The appropriate strips to test a bleach solution were received into the kitchen on 4/19/17, the day of the survey, and are now available to staff to use. B. The three boxes of food containing ice build up (and the shelf holding them) were removed from under the walk-in freezer condenser unit on 04/21/17. C. The six areas cited: - a. The kitchen floor around edges near the hand washing sink - b. The back preparation table - c. The equipment on the service line - d. The drain on the floor near the steamer - e. The water filtration unit behind the steamer and - f. The 15 ceiling tiles in the Bistro	05/14/17

(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 371	Continued From page 16 1. Observation in the kitchen on 4/19/17 at 10:50 AM showed the back food preparation table was being used to prepare food. Dietary aide #1 used a wet wiping cloth to wipe down the food preparation surface after completing her task. The wet cloth was put back into the bucket with a solution, Interview with the dietary manager and the kitchen supervisor at 11 AM revealed they used chlorine bleach or quaternary ammonia as a sanitizing solution in the buckets, and the bucket used to clean the back table had a chlorine bleach solution at that time. These staff members were unaware the test strips to test the concentration of the solutions were different for each chemical. There were no test strips available to test the chlorine bleach solution. Review of the April 1-18, 2017 sanitizer bucket logs showed there were 3 buckets used daily and the parts per million (ppm) were to be recorded every 2 hours. Review of the logs showed the chemical used for each bucket varied. When the quaternary ammonia was used, the ppm were recorded based on the test strip results. When the chlorine bleach was used, the word "bleach" was recorded. 2. Observation on 4/17/17 at 1:11 PM and 4/19/17 at 10:50 AM showed the walk-in freezer had food boxes stored on shelves under the condenser unit. The sides of the condenser, the ceiling around the unit, and 3 of the boxes of food had a build-up with ice. Interview with the dietary manager on 4/19/17 at 11:33 AM revealed the ice should not be allowed to accumulate on the food boxes. She stated the ice had been an ongoing issue, but a work order had not yet been submitted.	F 371	"a-e" above were "deep cleaned" on (or before) 05/10/17 and all the discolored ceiling tiles were replaced on 05/11/17. 2. A. Sanitizing buckets containing Bleach or Quaternary Ammonia are used though out the main (and only) kitchen. The appropriate tests strips are available to staff regardless of the location of the bucket. B. There is only one walk-in freezer in the facility. C. There is only one food preparation area (the main kitchen area) in the facility. 3. A. All dietary staff were retrained by the Dietary Manager on 05/09/17 as to the availability and proper use of sanitizing solution test strips and the facility's policy on same. Newly hired staff as well as staff not available for the training on 05/09/17 will be required to sign acknowledgment of having received the training prior to the start of their next shift. B. All dietary staff were trained by the Dietary Manager on 05/12/17 regarding the prohibition of storing food/food boxes under the condenser in the walk in freezer.	

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 _____	04/20/2017

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 371	Continued From page 17 3. Observation on 4/17/17 at 1:11 PM and 4/18/17 at 10:50 AM showed the kitchen floor had a build-up of dark-colored debris around the edges near the hand-washing sink, the back preparation table, the equipment on the service line, and the drain on the floor near the steamer. In addition, the water filtration unit located on the wall behind the steamer was noted to be soiled with a black substance. There were also more than 15 ceiling tiles that were noted to be discolored with a yellow color and several had stains of splattered debris. Interview with the maintenance director and the dietary manager on 4/20/17 at 9:58 AM revealed there was not an effective cleaning schedule related to these areas. 4. According to Food code 2013, Public Health Service: 4-702.11 Before Use After Cleaning. "UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT shall be sanitized before use after cleaning." 5. According to Food code 2013, 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 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." 6. According to Food code 2013, Public Health Service: 3-307.11 Miscellaneous Sources of Contamination. "FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 -3-306."	F 371	Newly hired staff as well as staff unable to attend the training on 05/12/17 will be required to sign acknowledgment of having received the training prior to the start of their next shift. C. The facility's Dietary Manager implemented a new, more aggressive and detailed cleaning schedule on 05/09/17. The schedule is designed to highlight the thoroughness of cleaning "a-e" above (cross reference POC F-465 #3) as well as the frequency of said cleaning. 4. The aforementioned audit(s) will be reviewed each month for the next three months at the facility's regularly scheduled Performance Improvement meeting.	

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 _____	04/20/2017

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 431	Continued From page 18	F 431	F – 431	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who– (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals.	F 431	1. On 4/18/17, RN #2 and the Assistant Director of Nursing reconciled the liquid lorazepam bottle in question to accurately reflect the actual number of milliliters of medication. The unopened bottle of lorazepam found on the fourth nursing cart was replaced on 4/18/17. 2. On 4/18/17 all controlled liquid medications were checked to ensure in-dates were in place. They all were. 3. On or before 5/12/17, nurses will be re-educated by the Director of Nursing or her designee regarding the policy and procedure to ensure accurate accounts of all controlled medications, how to maintain and periodically reconcile discrepancies, and the policy and procedure to ensure in-dates for temperature-sensitive medications. The Director of Nursing or her designee will conduct audits (randomly two times each day) of controlled liquid medications five times for one week, then one time a week for three weeks, and the monthly for two months to ensure controlled liquid medications are reconciled	05/14/17

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 _____	04/20/2017

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 431	Continued From page 19 (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policy and procedure, the facility failed to ensure accurate accounts of all controlled medications were maintained and periodically reconciled in 1 of 3 medication rooms. In addition the facility failed to ensure in-dates for temperature-sensitive medications stored in 1 of 6 medication carts. The findings were: 1. Review of the the policy and procedures titled Controlled Medication Storage, effective date 7/1/13, showed at each shift change, a physical inventory of all controlled medications was to be conducted by two licensed nurses and documented on the controlled medication accountability record. Further review revealed any discrepancy in the counts should be reported to the director of nursing immediately. Observation with RN #2 and the ADON on 4/18/17 at 2:55 PM revealed one 30 ml bottle that contained 21 milliliters (ml) of liquid lorazepam (a controlled anti-anxiety medication) was stored in the locked	F 431	and dated properly. The audits are designed to ensure accurate accounts of controlled liquid medications, discrepancies are reconciled per facility policy, and controlled liquid medications are dated per facility policy. 4. The Director of Nursing or her designee will report the results of the audits at the Monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved.	

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 _____	04/20/2017

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 431	Continued From page 20 medication room refrigerator in the secure unit. Review of the pharmacy label on the bottle showed 0.25 ml was equal to 0.5 milligrams. The following concerns were identified: a. Review of the controlled drug administration records showed the nurses withdrew 0.25 ml from the bottle 15 times between 1/16/17 and 4/5/17 (totaling 4.25 ml), and at the time of the observation on 4/18/17, the remaining amount was recorded as 26.25 ml. An explanation for the discrepancy between the observed remaining amount (21 ml) and the documented remaining amount (26.25 ml) was lacking. b. Review of the controlled drug administration records showed on the 1/24/17 documentation the remaining amount decreased from 29 ml to 28.5 ml after 0.25 ml was administered (a .25 ml discrepancy). c. Review of the controlled drug administration records revealed the remaining amount did not change after 0.25 ml was withdrawn from the bottle on 3/30/17. d. Interview with RN #2 on 4/18/17 at 2:55 PM revealed she counted the controlled medications with another nurse when the shift changed earlier that day. She stated she signed the form verifying the accuracy of the count without observing the actual amount in the bottle of liquid lorazepam. e. Interview with the ADON on 4/18/17 at 2:55 PM revealed the nurses did not follow the facility procedures for reconciling the liquid lorazepam during shift change. She stated if the procedure had been followed they would have identified the discrepancy and reported it so it could have been resolved. f. Interview with the pharmacist on 4/20/17 at 4:10 PM revealed the controlled	F 431		

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 _____	04/20/2017

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 431	Continued From page 21 medications should be reconciled each shift and this required both nurses to visually verify an accurate count. 2. Observation of the fourth medication cart with LPN #1 on 4/18/17 at 5:45 PM revealed two 30 ml bottles of lorazepam were stored in the locked section of the cart and available for use. Further observation revealed 1 bottle was partially full, and the second bottle was unopened. Review of the labels on each bottle showed the medications were to remain refrigerated until opened. This review also showed neither bottle was dated. Interview with the LPN at the time of the observation revealed both bottles should have been dated. Interview with RN #3 on 4/18/17 at 5:50 PM revealed the liquid lorazepam should remain in the refrigerator until opened, then it could remain out of the refrigerator for 28 days. Interview with the pharmacist on 4/20/17 at 4:10 PM verified the medications remained stable out of the refrigerator after opening for 28 days, but should remain refrigerated until opened. She further stated the undated bottles made it difficult to know how long the medications had been out of the refrigerator.	F 431		
F 441 88=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff,	F 441	F – 441 1.On or before 5/12/17, RN #1 and LPN #1 will be given written education by the Director of Nursing or her designee regarding the proper policy and procedure for cleaning of glucometers. On or before 5/12/17, the laundry Director will be given written education by the Director of	05/14/17

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 _____	04/20/2017

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 441	Continued From page 22 volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 441	of Nursing or her designee regarding the proper use of Personal Protective Equipment PPE when handling contaminated linen items. Appropriate PPE, including impermeable gowns/aprons were provided to the laundry staff on 05/10/17. 2. The facility has 12 glucometers and one laundry room. All 12 glucometers have been properly cleaned. 3. On or before 5/12/17, nurses will be re-educated by the Director of Nursing or designee regarding the proper policy and procedure for cleaning glucometers. On or before 5/12/17, laundry staff will be re-educated by the Director of Nursing or her designee regarding the proper use of Personal Protective Equipment PPE when handling contaminated linen items. The Director of Nursing or her designee will conduct audits (randomly two times per day) of glucometer cleaning for five times for one week, then one time a week for three weeks, and then monthly for two months.	

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 _____	04/20/2017

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 441	Continued From page 23 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of manufacturer's instructions, the facility failed to ensure effective disinfection of point-of-care glucometers during 2 random observations. In addition, the facility failed to ensure effective personal protective equipment (PPE) was used during the processing of soiled linens in 1 of 1 laundry rooms. The findings were: 1. Interview with infection control practitioner #2 on 4/18/17 at 2:05 PM revealed all staff had been trained to clean and disinfect the glucometer between resident use, and to follow instructions for use when using the disinfection cloths. The following concerns were identified: a. Observation on 4/18/17 at 4:22 PM revealed RN #1 disinfected the glucometer after performing glucose testing by wiping the glucometer for 16 seconds with a PDI Sani-cloth wipe. At that time she stated she performed the disinfection process as she had done in the past. She was unsure of the manufacturer required	F 441	4. The Director of Nursing or her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved.	

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 _____	04/20/2017

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 441	Continued From page 24 contact time for effective disinfection. b. Observation on 4/18/17 at 5:05 PM revealed LPN #1 disinfected the glucometer after performing glucose testing by wiping the glucometer for 10 seconds with a PDI Sani-cloth wipe. At that time she stated this was her usual practice for disinfecting the glucometer after use. She also stated she did not know the manufacturer's required contact time for effective disinfection, but had been taught to make sure the glucometer was dry in 4 minutes. c. Review of the PDI Sani-cloth Bleach Germicidal Disposable Wipe label provided by the DON on 4/19/17 at 1:30 PM revealed for effective bactericidal, fungicidal, tuberculocidal and virucidal disinfection the wet contact time must be 4 minutes. 2. The following concerns were identified related to the laundry processing: a. Interview with the laundry director on 4/20/17 at 9:32 AM revealed she used a cloth-type gown for handling contaminated linen items. Observation of the gowns at that time showed they were not fluid resistant, however fluid resistant aprons were observed in the laundry area. b. Interview with infection preventionist #2 on 4/20/17 at 12:50 PM confirmed the appropriate gowns were available and more education was needed in regard to their use. c. Interview with infection preventionist #1 on 4/20/17 at 1:30 PM revealed there were two residents in the facility on contact precautions during the survey timeframe.	F 441		
F 465 SS=D	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465	F – 465 1. The walls and floor under the counter of the dirty side of the dish room, as well as the wall under the 3-compartment sink were scrubbed and cleaned on 05/11/17 and are now free of any dark colored debris or splattered debris. What's more, all the ceiling panels in the dish room were removed, cleaned and replaced on 05/11/17.	05/14/17

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 _____	04/20/2017

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 465	Continued From page 25 (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a sanitary environment in 1 of 1 dish rooms. The findings were: Observation in the dish room on 4/17/17 at 1:11 PM and 4/19/17 at 10:50 AM showed the walls and floor under the counter of the dirty side of the dish room were soiled with dark-colored debris. In addition, the wall under the 3-compartment sink was soiled with splattered debris. Further, the ceiling tiles of the dish room were observed to be discolored and some were soiled with splattered debris. Interview with the maintenance director and the dietary manager on 4/20/17 at 9:58 AM revealed there was not an effective cleaning schedule related to these areas.	F 465	2. This is the only dish room in the facility 3. The facility's Dietary Manager implemented a new, more aggressive and detailed cleaning schedule on 05/09/17. The schedule is designed to highlight the thoroughness of cleaning the dish room walls, ceiling and floors (cross reference POC F-371 #3.C.) as well as the frequency of said cleaning. The facility Dietary Manager will audit the staff's compliance with the newly created cleaning schedule each week for the four weeks and then monthly for the following 2 months. The audit will be turning into the facility's Executive Director each week. 4. The aforementioned audit(s) will be reviewed each month for the next three months at the facility's regularly scheduled Performance Improvement meeting.	