STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING _____ B. WING _____	C 05/10/2018

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 complaint survey was conducted by Heathcare Licensing and Surveys on 5/10/18. The survey was prompted by complaint intake #WY00002602.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and policy and procedure review the facility failed to complete a post-fall assessment for 1 of 5 sample residents (#3) with a fall. The failure to conduct a post-fall assessment resulted in a delay in treatment and a lack of adequate pain relief. The findings were: Review of the quarterly MDS (minimum data set) assessment with an assessment reference date of 4/24/18 showed resident #3 had diagnoses that included Alzheimer's and non-Alzheimer's dementia, and history of left hip joint replacement. Further, the resident required the extensive assistance of 2 or more staff members for transfers. Review of the care plan showed the resident was dependent with all cares and required a mechanical lift for transfers. The following concerns were identified:	F 684	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared because it is required by the provisions of the state and federal law. For the purpose of any allegation that the facility is not in substantial compliance with the federal requirements of participation, this response and plan of correction constitutes the facility□s allegation of compliance in an accordance with the state operations manual. F684	6/3/18

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

Electronically Signed | 05/30/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 684	Continued From page 1 a. Review of the nursing progress note dated 4/30/18 at 6:31 AM showed the CNA assisted the resident to sit on the edge of the bed, when the resident slid to the floor, and "landed softly onto left leg/hip." The resident complained of hip/leg pain and hydrocodone (opiod pain medication) was administered. The physician, the director of nursing (DON) and the daughter/power of attorney (POA) were notified. b. Review of the nursing progress note dated 4/30/18 at 9:08 showed " ...Resident was sent to Wyoming Medical Center (WMC) this morning at 9:00 AM related to the fall that s/he had this morning. Resident has been complaining of left leg pain his/her POA wanted him/her to go and get his/her leg further checked out." c. Review of the incident follow-up and recommendation form dated 4/30/18 showed the resident sat on the edge of the bed and slid to the floor landing on the left hip. Further review showed the resident was "... 1) assessed for injury 2) pain med given 3) changed to hoyer lift 4) boat mattress in place." Further review showed "the resident continued to have anxiety and was given an anxiety pill and a half hour later was given pain medication." Further review showed " ...the resident was less anxious but continued to complain about leg pain ..." d. Review of the witness interview form dated 5/3/18 detailed events of the incident that occurred on 4/30/18 at 5:00 AM. The form showed the resident was positioned onto his/her back where the nurse "..checked for injury, legs appeared to be the same length, no sign of knee injury although resident kept complaining of leg pain there was no sign of bruising or injury ..." e. Interview with the DON on 5/10/18 at 5:23 PM revealed the expectation after a fall was for the nurse to do a head-to-toe assessment for injury,	F 684	1. Resident #3 no longer resides in the facility. 2. Any resident that has a fall would require a post-fall assessment. The DON or designee will conduct an audit of completed post-fall assessments in the last 30 days. 3. The DON or designee will conduct an in-service on or before 6/3/2018 with licensed nursing staff on completing a post-fall assessment to avoid any delay in treatment or lack of adequate pain relief. A Performance Improvement tool will be utilized to audit the completion of post-fall assessments no less than 5 days a week for the first thirty days, weekly for the following thirty days, then monthly thereafter or until substantial compliance. 4. The results/findings of the audits will be reviewed at each of the facility□s Performance Improvement Committee meetings. Note: The facility□s QAPI meetings consist 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), 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). 5. Compliance met on or before June 3,	

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F 684	Continued From page 2 check vital signs and notify the DON, the physician and the resident representative. The DON revealed the nurse completed an assessment which was documented in the witness interview form. The DON further stated the resident was usually anxious at that time of day and they did not suspect an injury until the morning wore on and his/her pain level increased. The DON felt the impact of the fall was not enough to sustain an injury. She further stated they transferred the resident to the hospital via wheelchair in their facility van, instead of calling an ambulance. f. Review of the fall management policy dated 11/2016 showed, " ...With the event of a patient fall a complete nursing assessment will be performed by the nurse ..." Review of the nursing progress notes failed to show a complete nursing assessment was done. g. Review of the WMC emergency triage notes dated 4/30/18 at 9:34 AM showed the resident arrived to the department in a wheelchair via the facility van. Further review showed "the resident complained of pain, was agitated and moaning, and left leg swelling was present." h. Review of the WMC emergency room physician history and physical dated 4/30/18 showed the resident was "found to have a distal femur fracture (periprosthetic) on the left side."	F 684	2018.	