

POC accepted
9/17/12
J. Nelson, ONK

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

RECEIVED
WY Dept of Health

PRINTED: 08/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY Dept of Health 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING Healthcare Licensing 503 S 18TH ST LARAMIE, WY 82070	(X3) DATE SURVEY COMPLETED 08/09/2012
NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070		
(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: CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MAR- Medication Administration Record MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency. F 176 SS=D 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to determine if self-administration of medications was a safe practice for 1 of 1 non-sample residents (#23) allowed to self-administer medications. The findings were: Observation on 8/7/12 at 7:50 AM showed LPN #1 handed medications she had prepared to resident #23 who was in his/her room. After handing the medications to the resident (including a narcotic, a muscle relaxant, an antidepressant, and a medication specific for the resident's disease), the LPN left the room and shut the	F 000	F176 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 and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. 1) Correction: Resident #23 was assessed on 8/7/12 prior to the surveyors exiting. Her care plan has been updated to include that she can take her medications alone after they have been prepared by the nursing staff. Resident #23 stated that she was uncomfortable with the "strangers" (state surveyors) watching her take her medications. 2) Identification: Residents that reside at the facility are at potential risk. 3) Systemic Changes: When admitted, alert residents will be informed of their right to self-administer medications. If resident wishes to exercise this right and participate in self-administration, the interdisciplinary team will assess the	9/23/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Rene Nelson

Administrator

8-30-12

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

POC accepted. Carol J. Nelson, ONK on 9/17/12 @ 1:36pm

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F 176	Continued From page 1 door. The LPN stated the resident became angry if nursing stayed and observed him/her actually swallowing the medications. The LPN also stated the resident's condition was declining and that s/he did not always comprehend that the medications should be swallowed. Review of the medical record showed no evidence the resident had been assessed or care planned by the interdisciplinary team as safe for self-administration of medications. After reviewing the record, the LPN confirmed, at 10:10 AM that day, that the resident had not been assessed or care planned for self-administration of medications.	F 176	competence of the resident to participate, by completing a self-administration of medication assessment. A nurse will interview the resident to determine their ability to identify, prepare, and administer medication. Based on the interdisciplinary team's assessment, a decision will be made as to whether or not the resident is a candidate for self-administration. This will be recorded on the self-administration of medication assessment form. The nurse will obtain a physician's order for each resident conducting self-administration of medications. Nurses will assess accuracy and compliance of self-administration of medications by periodic observation and counting doses. Storage of self-administered medications will comply with state and federal requirements of medication storage. On or prior to the allegation of compliance the Nurses will be in serviced on this process including not leaving medications at a resident's bedside unless that resident has been appropriately assessed to self administer.		
F 253 SS#E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of cleaning and maintenance schedules, the facility failed to provide adequate housekeeping services in 1 of 2 dining areas and 1 of 3 day room areas. In addition, the facility failed to provide adequate maintenance in various resident rooms, the women's shower room, and 1 of 5 hallways. The findings were: Housekeeping: 1. Observation in dining room 2 (assisted dining) on 8/6/12 at 11:30 AM revealed two resident family members placed towels on two rolling	F 253	4) Monitoring: Nurse managers will monitor compliance to the self-administration of medication process through periodic general observation rounds, medication pass evaluations on nurses on hire, annually and prn, and through resident/family interviews and resident council. Issues identified will be		

tracked/trended by the DON/Designee
and reviewed in QAPI to ensure the
system has been initiated,
implemented, sustained, and evaluated
for its effectiveness. The
DON/Designee is responsible for
monitoring and oversight.

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NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER.			STREET ADDRESS, CITY, STATE, ZIP CODE 603 S 18TH ST LARAMIE, WY 82070		
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F 253	Continued From page 2 stools soiled with food and liquids. The family members covered the seats prior to assisting a resident with lunch. Further observation showed three additional stools with food smeared on top. An additional observation on 8/7/12 at 7:40 AM showed the five stools were still dirty with dried and smeared food. On 8/7/12 at 7:40 AM the housekeeping supervisor confirmed the stools were not clean. She provided a monthly cleaning schedule at that time that included the stools in dining room 2. However, she acknowledged staff should have spot checked the stools for cleanliness. 2. Observation on 8/7/12 at 8 AM showed a couch and chair in the day room across from Station 2 were stained and dirty in various areas. An additional observation on 8/9/12 at 8 AM showed the couch and chair remained stained and dirty. During an interview on 8/9/12 at 9:15 AM, the housekeeping supervisor confirmed the couch and chair were stained and dirty. She further stated that the couch and chair were not on the monthly schedule because they were supposed to be cleaned daily. Maintenance: During observations on 8/7/12 from 8:10 AM through 8:30 AM, and on 8/9/12 from 8 AM through 8:45 AM the following issues were noted: 1. Floor tile damage and resultant dirt accumulation was noted in the following locations: a. In room #117, a 2 inch area of tile was torn off in the bathroom. b. In room #335, a 4 inch by 5 inch area of tile	F 253	F253 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 and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. 1) Corrective Action; Stools in the assisted dining area will be observed on a daily basis and cleaned as needed. Furniture in common areas will be observed daily and cleaned as needed. The broken tile in room #117 will be replaced. The broken/missing tile in room #335 will be replaced. The missing bathroom tile in room #344 will be replaced. The missing tile in room #346 will be replaced. The area in the hallway leading from station 3 at the center of the emergency doorway has been repaired. The front door to the women's shower will be repaired. The inside bathroom door of room #101 will be repaired. The inside bathroom door of room #110 will be repaired. The front door to room #254 will be	9/23/12	

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F 253	Continued From page 3 was missing by bed A. c. In the bathroom of room #344, a 9.5 inch by 10.5 inch area of tile was missing. d. At the front door to room #346, a 9.5 inch by 6 inch area of tile was missing. e. A 12 inches in diameter by 1 inch deep circular area was noted in one floor tile in the hallway leading from Station 3 at the center of the emergency doorway. The area was sunken and contained multiple cracks. 2. Door damage and resultant dirt accumulation was noted in the following locations: a. The front door to the women's shower room across from room #117 had 3 chipped areas on the outside; the largest measured 3 inches by 1 inch. b. The inside bathroom door of room #101 had a scrape 18 inches above the floor that measured 2 feet long by 6 inches across. c. The inside bathroom door of room #110 had a hole near the lower hinge that measured 1 inch by 1.5 inches, and a gash by the door handle that measured 2 inches by 3 inches. d. The front door to room #254 had a chipped area on the inside from the floor to 2 feet, 3 inches. e. The front door to room #256 had a 2 inch by 1.5 inch chipped area at the outer handle. 3. Dirt accumulation as a result of inadequate maintenance was noted in the following locations: a. The bathroom wall by the sink in room #103 had a gash just above the baseboard that measured 2 inches by 2 inches. b. The wall in the bathroom of room #107 had a 5 foot by 2 inch unpainted board nailed above the baseboard across from the toilet.	F 253	repaired. The front door to room #256 will be repaired. The bathroom wall by the sink in room #103 will be repaired. The wall in the bathroom in room #107 will be painted. The wall in the bathroom in room #112 will be painted. The bathroom wall in room #335 will be repaired and painted. The board in the bathroom of room #341 will be painted. The wall by the bed in room #344 will be painted. 2) Identification: Facility staff will conduct visual rounds to assist them to identify other housekeeping/maintenance concerns that need to be addressed. Issues identified will be addressed as indicated. Residents residing at the facility are potentially affected. 3) Systemic Changes: Facility staff will conduct visual rounds to ensure that items are stored properly, and that rooms, common areas and equipment are cleaned and maintained on a regular basis. On or before the allegation of compliance the Administrator/Designee will in-service facility staff on communication of maintenance/housekeeping concerns issues via maintenance log and/or the 24 hour report. An attendance sheet will be utilized and reconciled with the current active staff roster. Housekeeping staff will be in-serviced on the importance of cleanliness of the facility. The Nursing Home Administrator (NHA) will provide		

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F 253	Continued From page 4 c. The wall in the bathroom to the right of the sink in room #112 had paint removed from an area 10 inches above the floor that measured 2 feet across and 1 inch wide. d. The bathroom wall in room #335 had a 3 feet by 2 inch scrape with a tear into the plaster just above the baseboard across from the toilet. e. The wall in the bathroom of room #341 had a 4 inch by 2 feet unpainted board nailed above the baseboard to the left of the toilet. f. The wall by the bed in room #344 had a 5 feet by 2 feet area where paint had been removed. 4. During an interview with the maintenance director on 8/9/12 at 9 AM, he confirmed the issues with doors, floors and walls. He stated he intended to repair these items; however, no specific plan with a timeframe was in place.	F 253	oversight to ensure identified issues have been resolved. 4) Monitoring: The Maintenance Director, Housekeeping Director and the NHA, or designee, will conduct monthly environmental rounds in order to identify outstanding housekeeping and maintenance issues with overall oversight provide by the NHA. Findings to be presented to QAPI monthly as needed.		
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278			

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F 278	Continued From page 5 false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure signatures of individual assessors at Z0400 were obtained in a timely manner for 4 of 16 sample residents (#3, #6, #72, #78). The findings were: 1. During the survey from 8/6/12 through 8/9/12, review of the most recent MDS assessments for residents #3, #6, and #72 revealed each had a sticky note attached to Section Z containing a list of names and dates. The following concerns were identified: a. The completion date for Section Z0500B for resident #3 was 7/2/12. The attached note indicated a staff member still needed to sign Section Z0400 for information obtained on 6/20 and 6/25/12. b. The completion date for resident #6 was entered as 7/30/12 on Section Z0500B. The attached note indicated a staff member had not yet signed Section Z0400 for information obtained on 7/24/12. c. Section Z0500B was signed as completed	F 278	F278 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 and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. 1) Corrective Action: Staff involved in signing MDS section Z0400 after the complete date were re educated and the facility will now ensure that that section is signed on or before the completion date. 2) Identification:	9/23/12	

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F 278	Continued From page 6 for resident #72 on 7/23/12. However, the attached note indicated a staff member still needed to sign Section Z0400 for information obtained on 7/20/12. 2. Review of Section Z0500B for resident #78 showed it was dated 5/13/12. However, one signature at Section Z0400 was dated 5/14/12, one day after the MDS coordinator signed the assessment as complete. 3. On 8/7/12 at 10 AM the MDS coordinator confirmed she had difficulty getting signatures for the assessments in a timely manner, so she left notes for the individual assessors. She stated the signatures at Section Z0400 were not always obtained before she signed each assessment as complete.	F 278	Residents that reside at the facility are at potential risk. On or before the allegation of compliance the MDS Coordinator will review Residents' MDSs to ensure that Section Z0400 is signed on or before complete date. Issues identified will be trended because staff cannot go back and re-sign a different date. 3) Systemic Changes On or before the allegation of compliance the MDS Coordinator will in-service the MDS Staff and Interdisciplinary Team on the importance of accurately and timely assessing the resident's status to include signing section Z0400 on or before the completion date. An attendance sheet will be utilized and reconciled to the list of IDT Members and staff who sign MDS's and the staff who were unable to attend will be given 1:1 education. The MDS Coordinator will bring each Resident's MDS to the morning leadership meeting and prior to filing MDS in the Resident's record the MDS Coordinator		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280			



will review Sec Z0400 for a
timely signature.

4) Monitoring:

The MDS Coordinator will
bring the resident's MDS to the
morning leadership meeting and
care plan meetings prior to filing
MDS in the resident's record the
MDS Coordinator will review
sec Z0400 for a signature on
or before the completion date.,
The MDS Coordinator will
report trends in QAPI to ensure
the plan is implemented,
sustained, and evaluated for it's
effectiveness. The MDS
coordinator will be responsible
for oversight

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F 280	Continued From page 7 each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure staff reviewed and revised care plans to accurately reflect the current status of 3 of 13 sample residents (#21, #66, #72). The findings were: 1. According to the 7/31/12 care plan, resident #21 had a good appetite and ate independently in dining room #1, received Zolof and Remeron for depression and Xanax for agitation, and ambulated to the bathroom with a walker and one assistant. Review of the 7/30/12 quarterly MDS assessment showed the resident did not ambulate in his/her room. Review of physician orders dated 7/16/12 showed Zolof was discontinued and the resident no longer received Xanax. Observations on 8/8/12 at 12 PM, 8/7/12 at 7:59 AM, and 8/8/12 at 12:04 PM showed the resident ate in dining room #2 (for residents needing cueing or assistance) and had a poor appetite. At the meal on 8/8/12, the resident was observed to eat one bite and then push the plate away and refuse other food; the resident was observed to eat under 25 percent of each of the other two meals. On 8/9/12 at 8:15 AM the assistant DON reviewed the care plan and confirmed it needed to be revised to reflect the resident's current condition. 2. Review of the medical record and care plan for	F 280	F280 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 and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. 1) Corrective Action: On or before the allegation of compliance the DON/Designee corrected the care plan for resident #21 to ensure that her/his nutritional needs, her/his dental needs and her/his psychotropic medications were addressed on her/his plan of care. On or before the allegation of compliance the DON/Designee corrected the care plan for resident #66 to ensure that her/his COR status and respiratory medications were accurately addressed on her/his plan of care. On or before the allegation of compliance the DON/Designee corrected the care plan for resident #72 to ensure that her/his depression and	9/23/12	

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F 280	Continued From page 8 resident #66 showed the following concerns: a. Review of the 2/1/12 "Preferred Intensity of Medical Care and Treatment" document showed "Do Not Resuscitate." Review of the resident's care plan for advance directives last dated on 5/10/12 showed s/he was a "Full Code" indicating s/he want to be resuscitated. b. Review of the 5/1/12 physician orders showed the resident was to receive Spiriva (bronchodilator) through a hand held inhaler daily. Further review of the medical record showed the order remained in effect. Review of the respiratory care plan last revised on 5/14/12 showed the resident was not receiving respiratory medications or interventions. c. During an interview with the MDS coordinator and the social services director on 8/9/12 at 8:25 AM, they acknowledged the care plans should have been revised to show the resident's current status. 3. Review of the psychosocial care plan last reviewed on 7/17/12 for resident #72 showed s/he was on mirtazapine for depression. Review of the 7/1/12 MAR did not show the resident was on the medication. An interview with the social services director on 8/9/12 at 8:25 AM confirmed the resident was no longer on the medication and the care plan should have been updated.	F 280	any antidepressant use was accurately reflected on the plan of care. 2) Identification: Residents that reside at the facility are at potential risk. On or before the allegation of compliance the Interdisciplinary Team will review resident's care plans to ensure that the care plans are up to date and accurately reflect the residents status, interventions are clear, individualized, and do not contradict themselves. Issues identified will be corrected at that time. 3) Systemic Changes Resident's Care plans will be reviewed quarterly, annually, and with significant changes in status, Revisions if indicated will be completed at that time. RN's and LPN' will place resident status changes on the 24 hour Report, and the Interdisciplinary Team will review the 24 hour report and the telephone orders from the prior day each business day and identified status changes will be care planned at that time. On or before the allegation of compliance the MDS Coordinator/Designee will in-service the Interdisciplinary Team members and the licensed Nursing Staff on care plan revisions. An attendance sheet will be utilized and reconciled with the Interdisciplinary Team and the Licensed Nursing Staff and those staff unable to attend will be provided 1:1 education. 4) Monitoring:		
F 282 SS=D	483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282			

h

The resident care plans will be reviewed on admission, each quarter, and/or with significant change in status at time of care plan meeting to ensure any appropriate care plan revisions have been made. Issues identified will be corrected at that time and the MDS Coordinator/Designee will report issues in QAPI to ensure plan is implemented, sustained, and evaluated for its effectiveness.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/09/2012
NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070		
(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 282	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, and review of the diet cards, the facility failed to ensure the care plan was followed for 1 of 1 non-sample resident (#55) concerning food allergies. The findings were: Review of the admission face sheet for resident #55 showed s/he was admitted to the facility on 8/22/11 with allergies to fish and mushrooms. Review of the resident's care plan, last updated on 7/14/12 revealed the following, "I am allergic to fish and mushrooms. The kitchen has been advised of this, but if I do receive the wrong meal I am to tell someone immediately and get a new meal." The following concerns were noted: a. During interviews on 8/7/12 at 2:30 PM and 8/8/12 at 4:30 PM, the resident stated the facility served him/her food that s/he was allergic to "on at least two occasions", though the resident had informed staff of the allergy prior to being served those foods. The resident stated s/he was upset that staff served food s/he was allergic to and was concerned this might happen again. The resident was also concerned the facility might serve a confused resident food to which they were allergic. b. Review of the resident's diet card showed the resident's allergies were not listed. c. Observation of the lunch meal service on 8/8/12 from 11:40 AM through 12:15 PM showed dietary staff relied on the diet cards when serving. At that time cook #1 confirmed she followed the diet cards when serving. d. During an interview with the dietary manager on 8/8/12 at 4:35 PM, he confirmed the resident's food allergies were not listed on the resident's	F 282	F282 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 and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. 1) Corrective Action: Resident #55's meal tracker now identifies the resident's stated allergies and she/he is receiving food that she/he prefers and is not allergic to. 2) Identification: Beginning August 20, 2012 up until the allegation of compliance the Dietary Manager/designee reviewed the records of residents residing at facility and reconciled any resident allergies with the information in meal tracker so that the meal tickets printed reflect the residents dietary needs including allergies 3) Systemic Changes: Allergy information will be obtained on admission/re-admission and includes sensitivities to drugs, food items and the type of reaction	9/23/12	

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F 282	Continued From page 10 diet card (computer generated from "Meal Tracker"). He stated he was unaware of the resident's allergies. He also stated the dietary staff relied on these cards during serving for food orders, preferences, and allergies.	F 282	experienced by the resident. Documentation from the referring facility/agency should be thoroughly reviewed for allergy information. Resident allergies will be recorded on the resident's care plan, medication/treatment records, physician's orders and any other appropriate forms such as the dietary communication form and meal tracker. The resident's chart will be flagged accordingly. The physician and pharmacy are notified of stated allergies. Dietary is notified of any food allergies. Should a resident develop an allergic reaction/drug sensitivity post admission, the facility will notify the physician and follow orders. On or before the allegation of compliance the DON/Designee will in- service the nursing and dietary staff regarding ensure we accommodate the residents needs, specifically allergies. An attendance sheet will be kept and reconciled to the active nursing and dietary department roster and those staff unable to attend will be provided with 1-1 education.		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, staff interview and review of the facility policies and procedures, the facility failed to ensure proper placement of the drainage tubing to prevent infection for 1 of 2 sample residents (#66) with a suprapubic catheter. The findings were: Review of the medical record for resident #66 showed s/he had diagnoses to include multiple sclerosis (MS) and muscular atrophy (muscular weakness). Review of the 2/12/12 admission MDS care area assessment showed the resident had a catheter due to MS and bladder urgency with the inability to "control voiding" (urination). The following concerns were identified: a. Observation on 8/7/12 at 9:35 AM showed	F 315	4) Monitoring: Residents will be reviewed for allergies on admission, quarterly, annually, and if a significant change in condition occurs and at that time the Dietary Manager will reconcile the resident's record with the resident's meal tracker/meal ticket. Issues identified will be corrected when identified and the Dietary Manager		

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will trend concerns to be reviewed in
QAPI to ensure plan has been
implemented, sustained, and evaluated
for its effectiveness.

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F 315	Continued From page 11 CNA #1 and CNA #2 transferred the resident into bed. The CNAs left the room leaving the urine drainage bag on the bed with the resident. Further, the tubing was not positioned to promote drainage of urine from the bladder. b. Observation with RN #1 on 8/7/12 at 10 AM showed the tubing was not positioned to allow drainage of the resident's bladder. At that time the RN confirmed the tubing needed to be repositioned. c. Review of the facility policies and procedures for suprapubic catheter care last revised on 3/19/12, showed the catheter tubing should not be kinked or blocked.	F 315	F315 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 and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual.	9/23/12	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the facility was free from accident hazards in the activity area and various resident areas in 3 of 3 Stations (Stations 1, 2, 3). The findings were: 1. Observation on 8/9/12 at 8:45 AM showed a stove in the activities room with two knobs that controlled two of four stove top burners. No staff or residents were observed in the area, and the	F 323	constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. 1) Corrective action; Resident #66's catheter was placed off of the bed and into a pink basin next to the bed to facilitate draining of urine. 2) Identification; Prior to the surveyors exiting the facility the DON/Designee visually reviewed each resident residing at the facility with indwelling Foley catheters/supra pubic catheters to ensure their tubing was not above the level of the bladder. There were no other issues identified at that time. 3) Systemic changes: Beginning August 8, 2012 prior to surveyor exiting the facility and continuing up until the date of alleged compliance, the DON/ designee will in-service the nursing staff on the urinary management practice		

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guidelines and the prevention of infection as it relates to indwelling catheters; specifically placement of the Foley tubing to ensure it is not placed above the level of the bladder. An attendance sheet will be utilized and reconciled with the active nurse staff roster and those nurses unable to attend will be provided 1:1 education.

4) Monitoring:

The DON/Designee will do visual rounds 3 times weekly and PRN to ensure residents who have indwelling Foley catheters / supra pubic catheters receive appropriate treatment and services as indicated in their plan of care to prevent urinary tract infections; specifically that their Foley tubing is not placed above the level of the bladder. Issues identified will be reviewed in QAPI to ensure plan has been implemented, sustained and evaluated for its effectiveness.

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F 323	Continued From page 12 stove was operable without any safety features. During an interview with the activity director on 8/9/12 at 8:50 AM, she confirmed residents could enter the activity area at any time, and staff were not always present. She further confirmed the stove did not have any safety features to protect residents. 2. Observation on 8/9/12 at 8:30 AM showed a heat vent on the bathroom floor of room #108 across from the toilet that measured 5 feet across by 1 foot high. The heat vent had the cover off, exposing multiple jagged edges with the potential to injure residents. 3. Observations on 8/9/12 from 8 to 8:45 AM revealed baseboard and kickplate damage in the following rooms on Stations 1, 2, and 3 that had the potential to cause injury: a. In the bathroom of room #102, the baseboard behind the sink was pulled from the wall for a 2 inch by 6 inch space. b. The baseboard between the sink and door in the bathroom of room #104 was pulled from the wall in an area that measured 3 inches by 1.5 inches. c. In room #112 the bathroom wall to the right of the sink had a 4 inch by 2 inch area where the baseboard was pulled from the wall. d. In room #117 the bathroom had a 3 inch by 1 inch area of baseboard pulled from the wall. e. In room #253, a 16 inch area of baseboard was pulled from the wall. f. The front door to room #335 had a kick plate that was jagged on the outer edge to 2 inches up. 4. During an interview with the maintenance	F 323	F323 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 and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. 1) Corrective Action; The stove in the activity room was unplugged; the breaker was shut down and tagged as lock-out- tag-out. This has been corrected by an electrician who installed a shut off switch in a lock box. The heater vent cover in room #108 will be replaced. The loose base boards identified in the facility by the survey team were replaced. This includes the bathrooms in rooms #102, 104, 112, 117, and room #253. The kick plate on the front door of room #335 will be repaired. The vent cover in room 108 was re applied and is no longer a safety risk. 2) Identification; Beginning 8/9/12, 2012 the Maintenance Director and NHA	9/23/12

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conducted Visual rounds to identify any other safety concerns such as loose base board covers, loose or missing vent covers, or access to stoves/ovens that can potentially burn residents. There were no other safety issues identified.

3) Systemic Changes:

Maintenance Director/ Designee will conduct visual rounds weekly to ensure safety issues such as loose or missing vent covers, loose base boards and/ or access to stoves. On or before the allegation of compliance the Maintenance Director and/ or designee will in-service Facility staff on communication of maintenance issues that may pose a safety risk via maintenance log and/or the 24 hour report. The NHA will provide oversight to ensure identified issues have been resolved.

4) Monitoring;

The Maintenance Director, Housekeeping Director and the NHA, or designee, will conduct monthly environmental rounds in order to identify outstanding housekeeping and maintenance issues that may pose a safety risk oversight provide by the NHA. Findings to be presented to QA&A monthly as needed.

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F 323	Continued From page 13 director on 8/9/12 at 9 AM, he confirmed the stove in the activities area was operable and had no safety features to protect residents. He further confirmed the heat vent should be covered and the baseboards and kickplate should be repaired for safety.	F 323	F356 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 and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. 1) Corrective Action: The staffing was correctly posted during the three days the survey. 2) Identification: Residents that reside at the facility are at potential risk. 3) Systemic change: The DON/Designee must post the nurse staffing data on a daily basis to include the following; the facility name, the current date, the total number and the hours scheduled for the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift; registered nurses, licensed practical nurses, certified nurse aides, resident census. The data must be posted in a clear and readable format, in a prominent place readily accessible to		9/23/12
F 368 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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. 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.	F 368			

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residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public to review at a cost not to exceed the standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months. On or prior to the allegation of compliance the NHA/Designee will re educate the DON/ADON/Designee on the Nurse staffing posting requirements.

4) Monitoring:

The NHA/Designee will review the posted staffing forms weekly for accuracy and completeness, issues identified will be reviewed with the DON/Designee at that time. Trends will be reviewed in QAPI for purposes of process improvement. The NHA will be ultimately responsible.

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NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 803 S 18TH ST LARAMIE, WY 82070		
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F 356	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the daily staffing reports, the facility failed to ensure the daily staffing reports were completed each shift. The findings were: Review of three randomly selected nurse staffing reports for July 2012 showed the reports were incomplete and did not indicate the number of nursing staff assigned for every shift. Review of two staffing reports for June 2012 did not show staff assigned to any shift. During an interview with the DON on 8/9/12 at 10:10 AM, she verified the daily posted staffing reports were not always completed or updated by the supervisors each shift.	F 356	F431 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 and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. 1) Corrective Action: The nurse's lunch that was left inside the medication refrigerator was removed during survey immediately when surveyor brought it to the facility's attention. On 8/9/12 the DON/Designee re-educated the nurses involved in leaving the lunch in the medication refrigerator. The Medication cart left unattended and unlocked during survey was locked immediately when surveyor brought it to the facility's attention. On 8/9/12 the DON/Designee re educated the nurses involved in leaving the medication carts unlocked and unattended.		9/23/12
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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.	F 431	2) Identification: Residents that reside at the facility are at potential risk.		

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F 431	Continued From page 15 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. 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 facility policies and procedures, the facility failed to provide appropriate storage of medications in 3 of 5 storage areas. The findings were: 1. On 8/9/12 at 9:50 AM an insulated container was observed in the medication refrigerator at Station 2. It was sitting on a shelf with resident medications but was unlabeled. During the observation RN #1 stated the container held her lunch. She further stated she was unaware staff food could not be stored with resident medications. 2. Observation on 8/9/12 at 10:20 AM showed the Station 3 medication cart was left in the resident hallway outside room #331. The medication cart	F 431	3) Systemic Changes On or before the allegation of compliance the licensed nurses will be re-educated by the SDC/ designee regarding proper storage of medications including not leaving food in the medication refrigerator and/or placing medication in refrigerator's designated for food. On or before the allegation of compliance the licensed nurses will be re educated by the SDC/ designee regarding proper storage of medications including not leaving medications un-attended in unlocked medication carts. An attendance sheet will be utilized and reconciled with the current active staff roster. Nursing staff unable to attend will be provided with one on one in-servicing. 4) Monitoring: Nurse Managers will examine the medication refrigerator in the units, medication rooms on nursing units three times weekly and prn for improper storage of medications, specifically staff storing food in the medication refrigerator or medications being left in refrigerators designated for food. Nurse Managers will examine medication carts, medication rooms, and nursing units three times weekly and prn for improper storage of medications Issues identified will be corrected at that time. Trends will be reviewed by the DON/ Designee in QAPI to ensure plan has		

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F 431	Continued From page 16 was unlocked and several staff were in the hallway, but the licensed nurse was not in sight. At 10:22 AM, LPN #2 came out of a resident's room. She confirmed she should have locked the cart before leaving it in the resident hallway. 3. Observation of a refrigerator containing resident food on Station 1 at 10 AM on 8/9/12 showed a large Ziploc bag containing multiple vials of Piperacillin and Tazobactam, as well as the intravenous solutions for administration, were stored in a bottom drawer. In addition, the refrigerator contained other resident medications. During the observation, RN #3 confirmed the medications should not be stored with the residents' food items. 4. On 8/9/12 at 11:15 AM the facility's Regional Director of Health Services stated medication carts should be locked and medications were not to be stored with food items. She provided the facility's pharmacy policy #5200, "Storage of Medications" dated August 2001, which stated medication carts "...are locked or attended by persons with authorized access." Those with authorized access were identified as licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medications. The policy further stated other foods not used in administering medications "...such as employee lunches..." were not stored in medication refrigerators.	F 431	been implemented, sustained, and evaluated for its effectiveness.		
F 441 SS=E	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 17 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, staff interview and review of the facility policies and procedures, the facility	F 441	F441 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 and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. 1) Correction action; Resident #11 shows no signs of infection. Resident #17 shows no signs of infection. Resident # 66 shows no signs of infection. Resident #72 shows no signs of infection. 2) Identification: Residents that reside at the facility are at potential risk. 3) Systemic Changes: Employees are expected to practice standard precautions including hand washing, proper technique when donning and/or changing gloves when providing per care and proper technique when transporting a resident from his low bed back unto his bed.	9/23/12	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: #36043	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/09/2012
NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070		
(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 18 failed to ensure staff followed accepted standards of practice regarding hand hygiene and infection control practices. These failures were captured during five random observations which affected 3 sample residents (#17, #66, #72) and one non-sample resident (#11). The findings were: 1. CNAs #3 and #4 were observed on 8/6/12 at 9:45 AM while toileting non-sample resident #11. After providing appropriate perineal care, and while wearing the same gloves, CNA #3 adjusted the resident's clothing. Then she removed the oxygen tubing from the resident's face, and handled the sling and lift prior to removing the gloves and transferring the resident to a reclining chair. 2. At 3:20 PM on 8/6/12 CNA #5 and NA #1 were observed while providing incontinence care for resident #17. After providing care, CNA #5 changed her gloves but did not perform hand hygiene prior to completing care for the resident. 3. Observation on 8/7/12 at 9:35 AM showed resident #66 lying on the floor of his/her room with a fall mat under him/her. The resident was covered with a sheet and pillows were placed under his/her head. CNA #1 and CNA #2 assisted the resident from the floor to the bed using a total lift. They took the same sheet and pillows the resident used while s/he was on the floor and placed them on the bed for the resident. During an interview with CNA #2 on 8/8/12 at 10:55 AM she acknowledged she should have taken the linens that had been on the floor to the laundry and replaced them with clean linen. 4. Observation on 8/7/12 at 9:15 AM showed RN	F 441	Licensed nurses will be in-serviced to avoid transfer of microorganisms to other residents or environments through proper infection control techniques especially while practicing clean technique for dressing changes. Nursing staff employed at Laramie will be in-serviced on effective hand washing techniques. Hand sanitizers may be used for routine decontamination of hands when hand washing with soap and water is not indicated. Employees will receive skills validation/return demonstration on proper use of infection control techniques especially during peri care of residents, clean dressing changes, and proper infection control techniques when caring for a resident on a low bed/floor mat. An attendance sheet will be utilized and reconcile with active staff roster and staff unable to attend will be provided 1:1 education. Nursing staff will be in-serviced on Standard precautions also on hire, annually, and prn. 4) Monitoring: Managers will perform periodic general observation rounds to ensure staff is practicing standard precautions and good infection control techniques especially during resident peri care. Issues identified will be corrected at that time. Nurse Managers will perform weekly infection control observation/monitoring of random nurses completing a clean dressing change. Nurse Managers will		

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NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 603 S 18TH ST LARAMIE, WY 82070			
(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 19 #2 performed a dressing change on resident #66 while the resident was resting on the floor. The RN brought the supplies, that included wound cleanser and ointment, and placed them directly on the floor next to the resident. After completing the dressing change, the RN picked up the supplies and placed them into the medication cart without cleaning the containers. During an interview with the RN on 8/8/12 at 10:45 AM, she revealed a barrier should have been placed between the floor and the supplies. In addition, she confirmed she should have cleansed the containers that were placed on the floor before returning them to the medication cart. 5. Observation on 8/8/12 at 12:52 PM showed CNA #6 exited a resident's room located in the Oak hallway carrying a bag of dirty linen. After she disposed of the linen in the dirty utility room, she retrieved the lunch tray for resident #72 from the portable food cart and took it to his/her room. The CNA did not cleanse her hands after disposing of the linen or before passing the lunch tray. During an interview with the Infection control nurse on 8/9/12 at 9 AM, she confirmed the CNA should have cleansed her hands before she started passing food trays. 6. According to the facility's 10/1/09 policy and procedure, "Hand Washing," using gloves "does not eliminate the need to wash hands." Hands should be washed "If moving from a contaminated-body site to a clean-body site..." Hand washing should be performed "After contact with...body fluids" and "Before applying and after removal of...gloves."	F 441	track/trend issues identified and prevalence of infections. Information will be reported to the QAPI committee for the purpose of process improvement to ensure that the system is implemented, maintained and evaluated for its effectiveness.				
F 467 SS=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC	F 467	F467 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 and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. 1) Corrective action: The facility has provided a safe, functional, and comfortable environment for residents, staff and the public. Specifically, the facility has failed to ensure the ventilation was properly functioning in the back hallway. 2) Identification:	9/23/12			

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NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070		
(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 467	Continued From page 20 The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide adequate ventilation in resident bathrooms for 1 of 5 hallways (rooms #252, #253, #254, #255, #256, #257, #258, #259). The findings were: Periodic observations during the survey from 8/6/12 at 9:15 AM through 8/9/12 at 2:05 PM revealed the hallway of rooms #252 through #259 had a noticeable odor of stale urine. During an observation on 8/6/12 at 3 PM, the bathroom ceiling vents in rooms #252 through #259 were tested by the surveyor and the vents were not exchanging air. The process was repeated on 8/8/12 at 8 AM and 8/9/12 at 8 AM with the same results. During an interview with the maintenance director on 8/9/12 at 9 AM, he confirmed the vents were not working. He produced a weekly schedule for maintenance which included spot checking ventilation for the entire facility. However, he was not certain when the bathroom vents in rooms #252 through #259 were last checked.	F 467	Residents that reside at the facility are at potential risk. 3) Systemic changes: The facility will provide a safe, functional, sanitary, and comfortable environment for residents including, adequate ventilation to rooms #252, 253, 254, 255, 256, 257, 258, 259. Specifically, the facility will make sure outside ventilation is present and functioning appropriately. On or before the allegation of compliance the NHA/Designee will in-service the facility maintenance staff on the outside ventilation requirements and the preventative maintenance program. 4) Monitoring: The facility maintenance man/designee will monitor compliance via the facilities preventative maintenance program. Issues identified will be corrected at that time and reviewed in QAPI for purposes of process improvement.		