PRINTED: 11/28/2005
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	11/10/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	603 S 18TH ST LARAMIE, WY 82070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of policies and procedures, the facility failed to ensure staff provided the necessary care to maintain good personal hygiene for one (#66) of eight sample residents who were incontinent of urine. The findings were: Review of the 4/25/05 admission Minimum Data Set (MDS) assessment for resident #66 revealed he/she was incontinent of urine (all or almost all of the time) and required extensive staff assistance with personal hygiene. Observation on 11/8/05 at 10 AM revealed the resident was incontinent of urine. Observation further revealed certified nurse aide (CNA) #1 provided perineal care for the resident. Observation of the perineal care provided revealed the CNA used the same area of the wash cloth two times, folded the wash cloth to a clean area, and then used the same area of the wash cloth four times to cleanse the perineum. Interview with the CNA on 11/8/05 at 10:10 AM revealed each area of the wash cloth should only be used once. Review the facility's policy on perineal care dated 1/1/01 revealed "Use clean section of washcloth for each stroke."	F 312	F312 Residents who are unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident # 66, and all other residents who are incontinent, will receive proper perineal care as needed C.N.A staff were in-serviced on 12/7/05 proper technique for regarding perineal care. Yearly skill lists will be done. ~~Upon orientation~~ New C.N.A's will complete a skills list within the 1st 90 days of employment, ~~prior to coming off orientation~~. QA committee will receive a report at least quarterly regarding the skills check lists. The SDC will assure that skills check lists are completed yearly and with all new hires upon hires. Overall responsibility is the DON. In-servicing will be re-done as indicated.	1/10/06
F 318	483.25(e)(2) RANGE OF MOTION	F 318		

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

Ronna Nelson — Administrator — 12-8-05

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 received 12/13/05 & corrections/additions per telephone call & Jo Ann Pouit, SDC at 2:40 PM. [illegible]

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER 12/13/05	603 S 16TH ST LARAMIE, WY 82070

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F 318 SS=E	Continued From page 1 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to provide restorative range of motion services as planned for eight of nine sample residents (#3, #5, #8, #34, #52, #61, #66, #68) who had limited range of motion or were at risk for developing contractures. The findings were: 1. During an interview on 11/9/05 at 2:05 PM, the restorative nurse and restorative nurse aides (RNAs) #1 and #2 stated the restorative documentation was accurate. All three stated restorative services did not get done because the restorative aides were frequently pulled from their duties to work on the floor as a certified nurse aide (CNA). All three stated the RNAs were pulled from their duties about five days per week, and they spent about four of their twelve hour work day working the floor as a CNA. RNA #1 and #2 stated they had to prioritize their caseload, and it was "not fair" to the other residents. 2. Review of the 9/19/05 quarterly Minimum Data Set (MDS) assessment showed resident #8 had range of motion limitations to one arm, both legs, and one foot. Review of the care plan (updated 10/3/05) showed the restorative nurse aide was	F 318	F318 The facility will ensure that residents with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Residents # 3, 5, 8, 34,52,61,66,68 will receive restorative range of motion as ordered by the physician. All residents with physician orders for ROM will receive it as prescribed..	1/10/06

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F 318	Continued From page 2 supposed to do stretching and passive range of motion (PROM) to the lower extremities on Saturday, Tuesday, and Thursday. A physician's order dated 10/3/05 showed the resident was to receive restorative services three times per week. However, review of the restorative documentation from October 1, 2006 through November 4, 2005 showed the resident did not receive services at least three times per week during four of the five weeks. 3. Review of the 9/26/05 quarterly MDS assessment showed resident #5 had range of motion limitations to one leg. Review of the 9/27/05 care plan showed the restorative nurse aide was supposed to do PROM/stretching to the lower extremities five times per week. A physician's order dated 8/29/05 showed the resident was to receive restorative services five times per week. However, review of the restorative documentation from October 1, 2005 through November 4, 2005 showed the resident did not receive services at least five times per week during four of the five weeks. 4. Review of the 10/14/05 physical therapy discharge summary dated 10/14/05 showed resident #3 was going to continue with lower extremity strengthening through restorative nursing; five times per week. However, review of the medical record revealed no evidence the resident received restorative services. During an interview on 11/9/05 at 1:25 PM, the physical therapist stated the resident was at risk for contractures because he/she was frequently in the wheelchair. The physical therapist stated he should have done a referral to restorative, but did not. On 11/9/05 at 2:05 PM, the restorative nurse confirmed the resident did not receive restorative	F 318	All Residents will be screened for necessary range of motion. The restorative Nurse will evaluate the caseload and report to the DON. If the restorative C.N.A are pulled to the floor, the C.N.A's will provide the ordered restorative care for that time period. The DON and physical therapist will meet weekly to discuss any referrals being made to restorative to prevent any missed referrals. An audit of residents with orders for ROM will be completed monthly. A report will be given to the QA committee monthly for 3 months and then quarterly to assure compliance. DON is responsible for overall compliance.	

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F 318	Continued From page 3 services. 5. Review of the November 2005 physician's orders for resident #61 revealed he/she had diagnoses including difficulty walking. Further review revealed an order dated 8/29/05 for restorative passive range of motion to both lower extremities and stretching three times per week with a goal to maintain strength and flexibility. However, review of the restorative documentation from September 1, 2005 through November 4, 2005 showed the resident did not receive restorative services three times per week during four of the nine weeks. 6. Review of the 4/25/05 admission, 7/25/05 quarterly, and 10/24/05 quarterly MDS assessments for resident #66 revealed he/she had partial loss of the arm and hand on one side. Observation on 11/8/05 at 9:45 AM revealed contractures in both hands. Review of physician's orders revealed an order dated 8/29/05 for restorative passive range of motion to the upper and lower extremities and stretching to the lower extremities three times per week. However, review of the restorative documentation from September 1, 2005 through November 4, 2005 showed the resident did not receive restorative services three times per week during five of the nine weeks. 7. Review of the 6/13/05 annual and the 9/12/05 quarterly MDS assessments for resident #68 revealed he/she had partial loss of function of the arm, hand and foot on both sides and full loss of function in both legs. Review of the physician's order dated 8/25/05 revealed an order for restorative passive range of motion to the upper and lower extremities seven times per week.	F 318		

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F 318	Continued From page 4 However, review of the restorative documentation from September 1, 2005 through November 4, 2005 showed the resident did not receive restorative services seven times per week during two of the nine weeks. 8. Review of resident #52's medical record revealed a physicians order dated 8/29/05 for a restorative program three times per week for lower extremity stretching. Review of the October 2005 nursing rehab/restorative documentation revealed services were only provided twice per week during two of the four weeks. There was no documented reasons why the stretching was not done as ordered for these weeks. 9. Review of resident #34's medical record revealed a physicians order dated 8/29/05 for a contracture prevention program including passive range of motion to lower extremities and stretching four times per week. Review of the October and November 2005 nursing rehab/restorative documentation revealed services were not provided four times per week during any week in October, or the first week in November. There was no documented reasons why the stretching was not done as ordered for these weeks.	F 318		
F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	F 353		

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F 353	Continued From page 5 The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, confidential interviews with residents and families, and staff interview, the facility failed to provide sufficient staff to provide timely care and services for eight (#3, #5, #8, #34, #52, #61, #66, #68) of nine residents who required restorative services. The findings were: 1. Review of the 9/19/05 quarterly Minimum Data Set (MDS) assessment showed resident #8 had range of motion limitations to one arm, both legs, and one foot. Review of the care plan (updated 10/3/05) showed the restorative nurse aide was supposed to do stretching and passive range of motion (PROM) to the lower extremities on Saturday, Tuesday, and Thursday. A physician's order dated 10/3/05 showed the resident was to receive restorative services three times per week. However, review of the restorative documentation from October 1, 2005 through November 4, 2005 showed the resident did not receive services at	F 353	F 353 The facility will have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Refer to response for F318. In the event that there is a need fore additional staff on the floor, the facility will utilize other available C.N.A's to assure all residents receive restorative services required. In the event that restorative does have to be pulled to the floor, all C.N.A's will provide the restorative responsibilities for that day.	1/10/06

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LARAMIE CARE CENTER JH 12/13/05	503 S 18TH ST LARAMIE, WY 82070

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F 353	Continued From page 6 least three times per week during four of the five weeks. 2. Review of the 9/26/05 quarterly MDS assessment showed resident #5 had range of motion limitations to one leg. Review of the 9/27/05 care plan showed the restorative nurse aide was supposed to do PROM/stretching to the lower extremities five times per week. A physician's order dated 8/29/05 showed the resident was to receive restorative services five times per week. However, review of the restorative documentation from October 1, 2005 through November 4, 2005 showed the resident did not receive services at least five times per week during four of the five weeks. 3. Review of the 10/14/05 physical therapy discharge summary dated 10/14/05 showed resident #3 was going to continue with lower extremity strengthening through restorative nursing, five times per week. However, review of the medical record revealed no evidence the resident received restorative services. During an interview on 11/9/05 at 1:25 PM, the physical therapist stated the resident was at risk for contractures because he/she was frequently in the wheelchair. The physical therapist stated he should have done a referral to restorative, but did not. On 11/9/05 at 2:05 PM, the restorative nurse confirmed the resident did not receive restorative services. 4. Review of the November 2005 physician's orders for resident #61 revealed he/she had diagnoses including difficulty walking. Further review revealed an order dated 8/29/05 for restorative passive range of motion to both lower extremities and stretching three times per week	F 353	Staffing patterns will be reviewed weekly to anticipate the possibility of additional staffing needs. An audit of residents with orders for ROM will be completed monthly. A report will be given to the QA committee monthly for 3 months and then quarterly to assure compliance. DON is responsible for overall compliance.	

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F 353	Continued From page 7	F 353		

with a goal to maintain strength and flexibility. However, review of the restorative documentation from September 1, 2005 through November 4, 2005 showed the resident did not receive restorative services three times per week during four of the nine weeks.

5. Review of the 4/25/05 admission, 7/25/05 quarterly, and 10/24/05 quarterly MDS assessments for resident #66 revealed he/she had partial loss of the arm and hand on one side. Observation on 11/8/05 at 9:45 AM revealed contractures in both hands. Review of physician's orders revealed an order dated 8/29/05 for restorative passive range of motion to the upper and lower extremities and stretching to the lower extremities three times per week. However, review of the restorative documentation from September 1, 2005 through November 4, 2005 showed the resident did not receive restorative services three times per week during five of the nine weeks.

6. Review of the 6/13/05 annual and the 9/12/05 quarterly MDS assessments for resident #68 revealed he/she had partial loss of function of the arm, hand and foot on both sides and full loss of function in both legs. Review of the physician's order dated 8/25/05 revealed an order for restorative passive range of motion to the upper and lower extremities seven times per week. However, review of the restorative documentation from September 1, 2005 through November 4, 2005 showed the resident did not receive restorative services seven times per week during two of the nine weeks.

7. Review of resident #52's medical record revealed a physicians order dated 8/29/05 for a

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F 353	Continued From page 8	F 353		

restorative program three times per week for lower extremity stretching. Review of the October 2005 nursing rehab/restorative documentation revealed services were only provided twice per week during two of the four weeks. There was no documented reasons why the stretching was not done as ordered for these weeks.

8. Review of resident #34's medical record revealed a physician's order dated 8/29/05 for a contracture prevention program including passive range of motion to lower extremities and stretching four times per week. Review of the October and November 2005 nursing rehab/restorative documentation revealed services were not provided four times per week during any week in October, or the first week in November. There was no documented reasons why the stretching was not done as ordered for these weeks.

9. During an interview on 11/9/05 at 2:05 PM, the restorative nurse and restorative nurse aides (RNAs) #1 and #2 stated the restorative documentation was accurate. All three stated restorative services did not get done because the restorative aides were frequently pulled from their duties to work on the floor as a certified nurse aide (CNA). All three stated the RNAs were pulled from their duties about five days per week, and they spent about four of their twelve hour work day working the floor as a CNA. RNA #1 and #2 stated they had to prioritize their caseload, and it was "not fair" to the other residents.

10. Observation on 11/8/05 from 8:30 AM through 11:30 AM revealed CNA #1 was providing care to residents on the floor. Interview with the CNA on 11/8/05 at 10:20 AM revealed she was a

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F 353	Continued From page 9 restorative aide who was pulled to work the floor. 11. During a confidential interview on 11/8/05 at 1:30 PM, five residents stated the facility did not have enough staff. In addition, confidential family interview on 11/9/05 at 6:40 PM revealed the concern that if the family had not hired private aides, their loved one would not get the care he/she needed. The family member visits daily and stated, "it seems like they don't have enough people to do it all". 12. Interview with the assistant director of nursing on 11/10/05 at 9:05 AM confirmed staffing was challenged and restorative CNAs were sometimes pulled to work the floor instead of performing their restorative duties.	F 353	F387 The resident will be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. Resident #40 has expired. Resident # 66 was seen at IMH on November 22. All residents who need to see their primary MD at the clinic will have MD visits arranged by transportation upon admission. For those residents whose their primary MD at the facility, the transportation C.N.A will notify the MD at the beginning of the month that their visit is due.	1/10/06
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure that 2 (#40, #66) of 17 sample residents were seen by a physician as required. The findings were:	F 387		

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F 387	Continued From page 10 1. Review of the medical record revealed resident #40 was admitted to the facility on 3/10/05, and was last seen by a physician on 7/27/05. There was no evidence of any physician visits documented since this date. Interview with the assistant director of nursing (ADON) on 11/9/05 at 2:26 PM confirmed the resident was not seen by a physician since 7/27/05. 2. According to the code of federal regulations (CFR) 483.40(c) a resident must be seen by a physician at least once every 30 days for the first 90 days after admission. Review of the admission face sheet for resident #66 revealed he/she was admitted to the facility on 4/14/05. Review of the entire medical record revealed there was no physician visit during the month of May 2005. Interview with the ADON on 11/9/05 at 3:30 PM confirmed there was no physician visit during May, the second month of the resident's admission to the facility.	F 387	Monthly An Audit will be completed to assure that all residents are seen by their primary physician according to regulation. The report will be shared with the QA committee monthly for 3 months and then quarterly. DON will be responsible to assure compliance is met.	
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, and medical record review, the facility failed to ensure laboratory tests were completed as ordered for two (#23, #66) of 17 sample residents. The findings were: 1. Review of the 12/16/04, 4/21/05, and 7/20/05	F 502	F502 The facility will provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. The residents will have timely laboratory test as ordered by MD. Upon notification that res # 66 did not have a magnesium level drawn timely, a current magnesium level was drawn and results are in the chart.	1/10/06

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	11/10/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER 12/12/05	503 S 18TH ST LARAMIE, WY 82070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 502	Continued From page 11 laboratory reports for resident #66 revealed he/she had an elevated magnesium level. Review of the November 2005 physician's orders revealed an order for a magnesium level every three months in (January, April, July, and October). Review of the all the laboratory reports revealed no magnesium level was drawn in October 2005 as ordered. Interview with the assistant director of nursing (ADON) on 11/9/05 at 3:30 PM confirmed the magnesium test was not done. 2. Review of nursing notes dated 10/20/05 revealed resident #23 had an abnormal CBC (complete blood count). Review of physician orders showed on 10/24/05 the physician ordered a "CBC in two weeks" (two weeks would be 11/7/05). Review of the medical record on 11/9/05 revealed no CBC since 10/20/05. During interviews on 11/9/05 at 10:25 AM and 1:50 PM, the ADON stated the CBC was not done. The ADON stated the CBC was probably missed because the order was not carried over from the October medication administration record (MAR) to the November MAR.	F 502	Upon notification that resident # 23 did not have a CBC drawn timely, a current CBC was drawn and results are in the chart. Error occurred when carrying orders from past month to current month. Nurse managers will be responsible to double check MARs by the 10th of each month to assure that all lab orders are carried over to the new MARS The facility has implemented a lab tracking form. The lab tracking form will be audited weekly by Medical records to assure all labs have been drawn and results back to the facility in a timely manner. Medical records will also audit charts throughout the month and report to the DON any problems identified. A report to the QA meeting will be done for 3 months and then monthly. All charts have been audited to assure that all labs that were ordered have been completed and results are in the chart.	