

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

PRINTED: 04/10/2008
FORM APPROVED
OMB NO. 0938-0391

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 03/27/2008
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 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure privacy concerning personal information for 1 (#37) of 13 sample residents. The findings were: Observation on 3/24/08 at 3:10 PM revealed	F 164	The facility will ensure that all residents' information will be kept confidential and their personal privacy will be maintained. All resident rooms were reviewed to assure that any signage that could potentially violate privacy will be removed. Staff will be in-serviced by April 14th regarding privacy including but not limited to signage in resident rooms. Nurses on each shift will complete a monitoring tool daily that will include observation of privacy issues including inappropriate signage. Deficient practices will be corrected immediately. Nursing staff with deficient habits will be counseled. Monitoring tools will be reviewed by the DON or designee at least 5 times per week. For the next three months or until 100% compliance is met, a report will be prepared for the QA Committee monthly to allow them to determine the effectiveness of the systemic changes related to resident privacy and confidentiality. It will include the number of times deficient practices were noted and the action taken to correct the deficient practice. Overall Compliance is the responsibility of the interdisciplinary team (IDT) and overseen by the Director of Nursing. 04/30/08	4/30/08

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

TITLE

(X6) DATE

Ron N... *ADMINISTRATOR* *4-21-08*

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 noted 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.

Accepted w/changes by Joann Foster APR 23 2008
date of compliance = 4/30/08
4/28/08

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F 164	Continued From page 1 three signs posted on the wall toward the head of the bed that showed personal care instructions for resident #37. These signs were addressed to "nurse aides", and could be seen by anyone who stood in the doorway to the room. Interview on 3/27/08 at 8:55 AM with certified nurse aide #1 confirmed the displayed signs around the resident's bed could be considered a violation of privacy.	F 164			
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff treated 2 (#37, #68) of 13 sample residents with dignity and respect. The findings were: 1. Observation on 3/25/08 at 8:20 AM revealed resident #68 was incontinent of bowel. Observation revealed while certified nurse aide (CNA) #4 provided perineal care she stated "... [the resident] is a constant pooper." Interview with the director of nursing on 3/27/08 at 8:30 AM revealed the comment made by the CNA was inappropriate and not respectful. 2. Observation in the assisted dining room on 3/24/08 from 5:30 PM to 5:35 PM revealed resident #37 was eating and had pureed food dripping down his/her chin. The resident was feeding him/her self with the assistance of CNA #2. During the observation the resident wiped	F 241	The facility promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Resident #68 is not being subjected to insensitive comments by the staff. Resident #37 is being assisted in the removal of food from her face as needed during meal times. Facility staff will be in-service by April 14 th regarding dignity issues including but not limited to insensitive remarks and assuring that residents' mouths are wiped when needed. Nurses on each shift will complete a monitoring tool daily that will include observation of dignity and respect issues. Deficient practices will be corrected immediately. Nursing staff with deficient habits will be counseled.		4/30/08

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F 241	Continued From page 2 his/her mouth twice with a napkin missing the large amount of food on the chin. The aide did not help the resident wipe the food during these attempts. Finally at 5:35 PM when the resident was finished eating, the aide took the clothing protector off the resident and used it to wipe the food off the resident's chin.	F 241	Monitoring tools will be reviewed by the DON or Designee at least 5 times per week. For the next three months or until 100% compliance is met, a report will be prepared for the QA committee monthly to allow them to determine the effectiveness of the systemic changes related to resident dignity and respect issues. It will include the number of times deficient practices were noted and the action taken to correct the deficient practice.		
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure social service needs regarding depression were provided for one (#68) of six sample residents with a diagnosis of depression. The findings were: Review of the March/April 2008 physician's order recapitulation for resident #68 revealed s/he had diagnoses including depressive disorder. Review of the 2003 admission history and physical revealed this resident had a long history of severe depression with symptoms including not drinking, not eating, weight loss, and withdrawal. Review of the November 2007 through March 2008 monthly nursing summaries revealed the resident was sad and withdrawn, not eating, not drinking, and losing weight. Review of the 2/20/08 social services notes revealed the resident continued to stay in bed, refused to eat and drink, had lost weight, and continued with self isolation. Interview with certified nurse aide (CNA) #4 on 3/25/08 at	F 250	Overall compliance is the responsibility of the IDT and overseen by the Director of Nursing and the NHA. The facility provides medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Resident #68 will be reevaluated to determine the level of social services that she/he needs. A comprehensive <u>not will</u> <i>note</i> be included in the Social Service section of his chart indicating interventions as they are tried and the results of those interventions. The physician will be contacted for reevaluation. The Registered Dietician (RD) and the food service director (FSD) are working on a comprehensive nutritional reevaluation to include likes and dislikes. Social and recreational services are providing therapeutic visits to attempt a reversal of self isolation. A meeting will be held by the IDT to discuss these findings and any changes to the plan of care.		4/30/08

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F 250	Continued From page 3 8:20 AM revealed the resident refused to get up or leave his/her room except for a shower twice weekly. She stated sometimes s/he even refused the shower. The CNA further stated the resident ate and drank almost nothing. The following concerns were identified:			F 250	A review of residents starting with those who have the potential for self isolation will be completed to identify any other residents in need of additional social service interventions. Any resident identified as needing additional social service interventions will be assisted with arrangements for them. Social service interventions will be included in their care plans.		
F 272 SS=D	a. Review of the medical record revealed there was no evidence the resident's depression was evaluated since admission in 2003. There was no evidence psychiatric interventions, other than medications, were attempted. Review of the physician's progress notes since 2/13/07 revealed the resident's depression was not evaluated, only his/her medical condition. b. Interview with licensed practical nurse #1 on 3/26/08 at 3:37 PM revealed the resident's care was "status quo." She stated other than medications, no treatment that addressed the resident's depression was provided and she felt staff just treated "the shell of[his/her] body." 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;			F 272	Residents will continue to be assessed following the RAI guidelines and standards of care. For the next three months or until 100% compliance is met, a report will be prepared for the RAI Committee monthly to allow them to determine the effectiveness of the systemic changes related to resident social service interventions. It will include which residents were determined to need social service interventions and the interventions that were implemented. Overall compliance is the responsibility of the IDT and Director of Social Services.		

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F 272	Continued From page 4 Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.			F 272	F 272 The facility conducts initial and periodic assessments that are comprehensive, accurate, standardized and reproducible on the resident's functional capacity.		4/30/08
	This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a comprehensive assessment was completed for one (#3) of six sample residents who used psychotropic medications. The findings were: Review of the 2/25/08 annual Minimum Data Set (MDS) assessment for resident #3 revealed s/he triggered for psychotropic drug use related to the use of an antipsychotic medication and an antidepressant. Review of the resident assessment protocol (RAP) for psychotropic drug use showed it was not comprehensive. The RAP showed the resident used the medications daily, and they were not new, there were no side effects, and they would be continued as ordered. Interview with the social worker on 3/26/08 at 2:25 PM revealed the antipsychotic medication was used to treat hallucinations. She then stated the resident was no longer having hallucinations, and confirmed a comprehensive assessment related to the hallucinations and the antipsychotic being				Resident #3's resident assessment protocol (RAP) for psychotropic drug use will be corrected by April 25 to include symptoms and medications used to manage those symptoms. Resident #3's physician will be involved with any changes that may be needed. An audit on RAPs will be completed by the IDT to identify other residents that may need further assessments related to symptom management. Residents identified with needs will have further assessments completed and interventions put into place. For the next three months or until 100% compliance is met, a report will be prepared for the QA Committee monthly to allow them to determine the effectiveness of the systemic changes related to residents with symptom management needs. It will include which residents were determined to have symptom management needs and the interventions that were implemented. Overall compliance is the responsibility of the IDT and Director of Nursing.		

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F 272	Continued From page 5		F 272	F 274		4/30/08	
F 274 SS=D	used to treat them was not done. 483.20(b)(2)(ii) RESIDENT ASSESSMENT- WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a significant change Minimum Data Set (MDS) assessment was completed when indicated for one (#3) of two sample residents who required a significant change MDS assessment. The findings were: Medical record review showed resident #3 had an initial MDS assessment completed on 2/27/07. This assessment showed the resident did not have any pressure ulcers at that time. Review of the quarterly MDS assessment that was dated 5/28/07 showed the resident had two stage two pressure ulcers. The next MDS assessment that was completed in the record was another quarterly dated 8/27/07. Interview with the MDS assessment coordinator on 3/27/08 at 11:53 AM		F 274	The facility conducts a comprehensive assessment of residents' within 14 days of determining that a resident has had a significant change of condition. Resident #3 did receive a comprehensive annual assessment on 2/18/08 that included the pressure ulcers in the assessment. The IDT will complete a resident review to identify any other residents who may need a significant change MDS. Any residents that are identified will receive a significant change MDS within the guidelines of the RAI process. For the next three months or until 100% compliance is met, a report will be prepared for the QA Committee monthly to allow them to determine the effectiveness of the systemic changes related to any residents identified with the need for a change of condition MDS. It will include which residents were determined to need a change of condition MDS and the interventions that were implemented. Overall compliance is the responsibility of the IDT and Director of Nursing.			

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F 274	Continued From page 6 confirmed a significant change was required based on the development of pressure ulcers, and it was missed. According to the "Revised Long Term Care Facility Resident Assessment Instrument User's Manual" version 2.0, revised March 2007, page 2-9 showed a significant change was indicated due to "...Emergence of a pressure ulcer at Stage II or higher, when no pressure ulcers were previously present at Stage II or higher..."	F 274			
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure the physician's orders were followed in regard to monitoring blood pressures (B/P) for 4 (#56, #62, #68, #71) of 13 sample residents who had significant B/P problems. The findings were: 1. Review of the March/April 2008 physician's order recapitulation for resident #62 revealed s/he had diagnoses including end stage renal disease. Review of the physician's order dated 2/21/08 revealed an order for B/P readings daily due to severe hypertension and the use of an antihypertensive (Norvasc and lisinopril). Review of the February and March 2008 MAR revealed the resident's blood pressure was not taken on 2/27/08, 3/11/08 and 3/17/08. 2. Review of the March/April 2008 physician's order recapitulation for resident #68 revealed s/he had diagnoses including hypertension. Review of	F 281	F 281 The facility provides or arranges services that meet professional standards of quality. Resident #62, #68, #71, and resident #56 are having their blood pressure checked and documented according to physician orders. A review of physician orders is being completed by nursing leadership to identify any other residents that may have orders for blood pressure checks that are not being evaluated according to physician orders. Any residents identified will have monitoring put into place. Licensed nurses will be educated on the professional standards with emphasis on importance of monitoring hypertension and following physicians' orders. The Director of Nursing or designee will monitor the MARs at least weekly to assure that blood pressure checks are being completed as ordered. Deficient practices will be corrected immediately. Nursing staff with deficient habits will be counseled.		4/30/08

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F 281	Continued From page 7 the 8/30/06 physician's orders revealed an order dated 8/30/06 for weekly B/P monitoring. Review of the March 2008 MAR revealed the resident's blood pressure was not taken during the week of 3/9/08 through 3/15/08 and the week of 3/16/08 through 3/22/08.	F 281	For the next three months or until 100% compliance is met, a report will be prepared for the QA Committee monthly to allow them to determine the effectiveness of the systemic changes related to blood pressure monitoring. It will include the number of times deficient practices were noted and the action taken to correct the deficient practice. Overall Compliance is the responsibility of Nurse Managers and overseen by the Director of Nursing.		
	3. Review of the March/April 2008 physician's order recapitulation for resident #71 revealed the resident had diagnoses including hypertension. Review of physician's order revealed the resident received lisinopril and Toprol XL, both antihypertensive medications. Review of the 1/24/08 physician's order revealed an order for weekly B/P monitoring. Review of the February and March 2008 MARs revealed the resident's B/P was not taken during the weeks of 2/17/08 through 2/23/08 and 3/2/08 through 3/8/08. 4. Review of the March/April 2008 physician's orders for resident #56 revealed an order dated 1/16/08 for weekly blood pressure monitoring due to low B/P. Review of the physician's orders revealed the resident received ProAmatine which was specifically ordered to raise the resident's B/P. Review of the March 2008 medication administration record (MAR) revealed blood pressure monitoring was not performed during the week of 3/16/08 through 3/22/08. 5. According to "Fundamentals of Nursing" by Taylor, Lillis, LeMone and Lynn, sixth edition, 2008, page 574, elevated blood pressure is the leading cause of cardiovascular disease and is often called "the silent killer" because there are few symptoms beyond the increased blood pressure. In addition, on page 581, the blood pressure reading is used "to determine how well medications are working to control high blood				

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F 281	Continued From page 8 pressure. The blood pressure is usually checked once a week. A record of blood pressure readings over time is more important than one reading." 6. According to the State of Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, pages 3-6, nursing must function under the direction of a licensed physician. 7. Interview with the director of nursing on 3/27/08 at 8:30 AM revealed not monitoring B/P readings as ordered by the physicians was an area of concern that she had identified. She further stated for these residents monitoring the B/P was an important part of managing their particular blood pressure medical problems.	F 281			
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to follow the written plan of care for 3 (#3, #68, #56) of 13 sample residents. The findings were: 1. Review of the 3/7/08 care plan revealed resident #68 had a pressure sore on his/her coccyx. Review of the care plan revealed approaches for treating the pressure sore included turning the resident every two hours to keep him/her off the coccyx area. In addition, the	F 282	F 282 The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. Resident #68 is receiving repositioning as scheduled by the plan of care. Resident #3's meal intakes are being documented according to her plan of care. Resident #56 is receiving incontinence management according to the plan of care. Facility nursing staff will be in-serviced by May 1, 2008 regarding their responsibilities related to the resident's care plans.		4/30/08

already done

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F 282	Continued From page 9 resident's heels should be floated to keep them off the bed. Observation on 3/24/08 from 3:10 PM until 6 PM (2 hours and 50 minutes) revealed the resident was on his/her coccyx and his/her heels were on the bed without support or protection. Interview with the director of nursing on 3/27/08 at 8:30 AM revealed the resident should be turned and repositioned every two hours and the heels should be elevated off the bed. 2. Review of the dehydration care plan for resident #3 dated 2/21/08 revealed staff were to document the resident's fluid intake with meals. Review of the meal intake record for February 2008 showed the intake was not recorded for 39 meals, and refusals were not indicated for these meals. Review of the March 2008 intake record showed the intake was not recorded for 29 meals, and there were no refusals indicated for these meals. Interview with the director of nursing on 3/27/08 at 2:30 PM confirmed the care plan should be followed. 3. Review of the 4/23/07 annual and the 1/15/08 quarterly Minimum Data Set assessments for resident #56 revealed s/he was incontinent (all or almost all of the time) of urine and feces. Observation on 3/24/08 from 2:10 PM until 6:20 PM (4 and 1/2 hours) revealed the resident was not checked for incontinence. Review of the 2/7/08 care plan revealed the resident should be checked and changed every two hours and PRN (as needed). During an interview with certified nurse aide #5 on 3/24/08 at 6:20 PM, she stated the resident was a check and change every two hours. She also stated the last time the resident was checked and changed was while she, the nurse, and the surveyor were in the room which was around 3:30 PM. However, the surveyor was	F 282	Nurses on each shift will complete a monitoring tool daily that will include observation of incontinence management, meal intake documentation, and repositioning management. Deficient practices will be corrected immediately. Nursing staff with deficient habits will be counseled. Monitoring tools will be reviewed by the DON or designee at least 5 times per week. For the next three months or until 100% compliance is met, a report will be prepared for the QA Committee monthly to allow them to determine the effectiveness of the systemic changes related to results identified on the monitoring tools. It will include the number of times deficient practices were noted and the action taken to correct the deficient practice. Overall compliance is the responsibility of the Director of Nursing.		

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FORM APPROVED
OMB NO. 0938-0391

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F 282	Continued From page 10 in the resident's room continuously from 2:10 PM through 3:30 PM and observation during that time revealed the resident was last checked and changed after his/her shower at 2:10 PM.	F 282		
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.	F 312	F 312 Residents who are unable to carry out activities of daily living are receiving the necessary services to maintain good nutrition, grooming and personal care and oral hygiene.	4/30/08
F 314 SS=D	This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff provided appropriate perineal care for sample resident #37 during one of five observations of incontinence care for dependent residents. The findings were: Review of the 9/26/07 admission Minimum Data Set (MDS) assessment for resident #37 revealed s/he required extensive staff assistance for personal hygiene. Observation on 3/24/08 at 3:10 PM revealed the resident was incontinent of urine and bowel. At that time, certified nurse aide #3 provided perineal care to the resident, but did not cleans the anterior perineal area. Interview with unit two charge nurse on 3/27/08 at 10:20 AM confirmed the aides were taught to use three washcloths to clean the resident anterior to posterior, including all areas that came in contact with urine or feces. 483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314	Resident #37 is receiving personal care related to incontinence according to facility policy. The staff development coordinator (SDC) is reviewing facility policy related to perineal care with the nursing staff. They will then perform return demonstrations to assure that they understand the expectations. Nurses on each shift will complete a monitoring tool daily that will include observation of incontinence management including at least on observation of perineal care daily. Deficient practices will be corrected immediately. Nursing staff with deficient habits will be counseled. Monitoring tools will be reviewed by the DON or designee at least 5 times per week. For the next three months or until 100% compliance is met, a report will be prepared for the QA Committee monthly to allow them to determine the effectiveness of the systemic changes related to results identified on the monitoring tools. It will include the number of times deficient practices were noted and the action taken to correct the deficient practice. Overall compliance is the responsibility of the SDC and overseen by Director of Nursing.	

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F 314	Continued From page 11 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	The facility will ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable. Resident #68 is receiving interventions as care-planned-to-prevent-pressure-ulcers.	4/30/08	
F 315 SS=D	This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and staff interview, the facility failed to ensure one (#68) of three sample residents who had pressure sores received treatment as ordered. The findings were: Review of the 3/7/08 care plan revealed resident #68 had a pressure sore on his/her coccyx. Review of the care plan revealed approaches for treating the pressure sore included turning the resident every two hours to keep him/her off the coccyx area. In addition, the resident's heels should be floated to keep them off the bed. Observation on 3/24/08 from 3:10 PM until 6 PM (2 hours and 50 minutes) revealed the resident was on his/her coccyx and his/her heels were on the bed without support or protection. Interview with the director of nursing on 3/27/08 at 8:30 AM revealed the resident should be turned and repositioned every two hours and the heels should be elevated off the bed. 483.25(d) URINARY INCONTINENCE 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	F 315	Nursing staff will be in-serviced by May 1, 2008 regarding their responsibilities related to the resident's care plans. Nurses on each shift are completing a monitoring tool daily that will include observation of pressure ulcer reduction management. Members of nursing leadership are making random rounds to ensure that care is being given according to the written plans of care. Deficient practices will be corrected immediately. Nursing staff with deficient habits will be reeducated and or counseled. Monitoring tools will be reviewed by the DON or designee at least 5 times per week. For the next three months or until 100% compliance is met, a report will be prepared for the QA Committee monthly to allow them to determine the effectiveness of the systemic changes related to results identified on the monitoring tools. It will include the number of times deficient practices were noted and the action taken to correct the deficient practice. Overall compliance is the responsibility of the SDC and overseen by the Director of Nursing.	<i>already occurred</i>	

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F 315	Continued From page 12 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.	F 315	F 315 The facility will ensure that residents who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	4/30/08	
	~~This REQUIREMENT is not met as evidenced~~ by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff promoted dryness for one (#56) of eight sample residents who were incontinent. The findings were: Review of the 4/23/07 annual and the 1/15/08 quarterly Minimum Data Set assessments for resident #56 revealed s/he was incontinent (all or almost all of the time) of urine and feces. Observation on 3/24/08 from 2:10 PM until 6:20 PM (4 and 1/2 hours) revealed the resident was not checked for incontinence. Review of the 2/7/08 care plan revealed the resident should be checked and changed every two hours and PRN (as needed). During an interview with certified nurse aide #5 on 3/24/08 at 6:20 PM, she stated the resident should be checked and changed every two hours. She also stated the last time the resident was checked and changed was while she, the nurse, and the surveyor were in the room which was around 3:00 PM. However, the surveyor was in the resident's room continuously from 2:10 PM through 3:10 PM and observation during that time revealed the resident was last checked and changed after his/her shower at 2:10 PM.		Resident #56 is receiving incontinence management according to the plan of care. The SDC will in-service nursing staff by May 1, 2008 regarding their responsibilities related to the resident's care plans. Nurses on each shift will complete a monitoring tool daily that will include observation of incontinence management. Deficient practices will be corrected immediately. Nursing staff with deficient habits will be counseled. Monitoring tools will be reviewed by the DON or designee at least 5 times per week. For the next three months or until 100% compliance is met, a report will be prepared for the QA Committee monthly to allow them to determine the effectiveness of the systemic changes related to results identified on the monitoring tools. It will include the number of time deficient practices were noted and the action taken to correct the deficient practice.	<i>already covered</i>	
F 327 SS=D	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration	F 327	Overall compliance is the responsibility of the Director of Nursing.		

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F 327	Continued From page 13 and health. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff offered adequate fluids to maintain hydration for one (#68) of four sample residents at risk for dehydration. The findings were: Review of the 2/21/08 care plan for #68 revealed s/he was at high risk for dehydration. Further review of the care plan revealed approaches included providing fluids at the bedside, encouraging fluid consumption, and encouraging the resident to drink more at meals. Review of the 8/20/07 annual nutritional assessment revealed the resident required 2031 cc (cubic centimeters) of fluids daily. The following concerns were identified: a. Observation on 3/24/08 at 11:30 AM revealed the resident had dry, cracked lips and appeared dehydrated. b. Observation on 3/24/08 from 3:10 PM through 5:20 PM (2 hours 10 minutes) revealed no staff entered the resident's room. Observation revealed at 5:20 PM certified nurse aide #4 checked the resident's incontinence brief but did not offer the resident any fluids. c. Observation on 3/24/08 at 5:42 PM revealed the resident's meal tray was delivered. Observation revealed the CNA who delivered the tray did not offer or encourage the resident to drink. Continued observation until 6 PM revealed no staff entered the room to encourage the resident to drink the beverages provided on his/her meal tray. Observation at 6 PM revealed the resident consumed only one four ounce glass	F 327	F 327 The facility will provide each resident with sufficient fluid intake to maintain proper hydration and health. Resident #68 is being offered fluids and encouraged to drink throughout the day. Daily fluid intake will be monitored by staff daily. All residents that have been assessed as high risk for dehydration will have their fluid intake monitored throughout the day not just at mealtime. All nursing staff will be in-serviced by may 1, 2008 regarding their responsibilities related to dehydration management. Nurses on each shift will complete a monitoring tool daily that will include observation of dehydration management. Deficient practices will be corrected immediately. Nursing staff with deficient habits will be counseled. Monitoring tools will be reviewed by the DON or designee at least 5 times per week. For the next three months or until 100% compliance is met, a report will be prepared for the QA Committee monthly to allow them to determine the effectiveness of the systemic changes related to results identified on the monitoring tools. It will include the number of times deficient practices were noted and the action taken to correct the deficient practice. Overall compliance is the responsibility of the Director of Nursing.		

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F 327	Continued From page 14 of fluids. d. Observation on 3/25/08 at 8:20 AM revealed upon leaving the resident's room, the CNA moved the bedside table, which had the resident's water pitcher on it, out of the resident's reach. Observation revealed the CNA paused approximately three seconds then said s/he cannot reach the water but oh well, "...[s/he] won't drink anything anyway." Observation revealed the CNA did not move the bedside table closer so the resident could reach the water.	F 327			
F 329 SS=D	e. Review of the medical record revealed there was no monitoring of the resident's fluid intake, other than at meal time. Interview with the director of nursing on 3/27/08 at 8:30 AM revealed all residents who were at risk for dehydration should be monitored for fluid intake. During an interview on 3/27/08 at 11 AM, she confirmed there was no evidence the resident had his/her fluid intake monitored. 483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329	F 329 All residents will be free of unnecessary drugs. Resident #3 will receive a comprehensive assessment of symptoms and medication used to manage those symptoms. Resident #3's physician will be involved with any changes that may be needed and documentation to support any changes or continued use of the medication. Resident #68 will receive a comprehensive assessment of symptoms and medication used to manage those symptoms. Resident #68's physician will be involved with any changes that may be needed and documentation to support any changes or continued use of the medication.	4/30/08	

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F 329	Continued From page 15 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the drug regimens were free of unnecessary drugs for 2 (#3, #68) of 13 sample residents. The findings were: 1. Review of a 6/19/07 social service note revealed resident #3 was started on the antipsychotic medication Risperdal to treat active hallucinations. The resident did not have any psychiatric diagnoses. On 9/26/07 the dose of Risperdal was increased, from 0.25 every night to 0.50 mg every night. The following concerns were identified: a. Review of the 9/26/07 physician's progress notes revealed there was no mention of the resident having hallucinations, and the reason for the dose increase was "Increased confusion/dementia." b. Review of the September 2007 behavior monitoring related to hallucinations showed there were 2 instances of hallucinations (on 9/1/07) during the month prior to the medication increase. c. Review of the social service progress note dated 8/22/07 revealed the resident was showing improvement with pain control, and hallucinations had decreased. d. According to the social service note dated	F 329	An audit will be completed to determine if there are other residents that have not received dosage reductions as requested by the committee. Any resident identified will receive a comprehensive assessment of symptoms and medication used to manage those symptoms. Each resident's physician will be involved with any changes that may be needed and documentation to support any changes or continued use of the medication. For the next three months or until 100% compliance is met, a report will be prepared for changes related to resident that may have unnecessary drugs. It will include which residents were identified and the interventions that were put in place to reduce or eliminate the medication. Overall compliance is the responsibility of the Director of Nursing.		

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F 329	Continued From page 16 2/22/08, a request for a dose reduction of the Risperdal was made on 2/13/08. However, the physician refused saying the resident was stable, with no further rationale provided. e. Interview with the social service director on 3/26/08 at 2:25 PM revealed a dose reduction had not been tried since the resident was started on the medication in June 2007. She stated the physician did not provide any clinical rationale as to why the dose should not be reduced. She then stated the resident was not having any hallucinations now, and the pain which may have been related to the hallucinations was under good control. 2. Review of the March/April 2008 physician's orders for resident #68 revealed orders for Zyprexa (antipsychotic) for depression, Remeron (antidepressant) for insomnia, Nortriptyline (antidepressant) and Ambien CR (hypnotic) for insomnia on a daily basis. The following concerns were identified: a. Review of the physician's orders revealed the resident had received Zyprexa 10 milligrams since 8/10/06 with no attempt at a dose reduction. Review of the 10/10/07 "Request for Psychotropic Medication Change" revealed the physician had declined the facility request for a dose reduction but did not provide any medical rationale for the declination. During an interview with the social worker on 3/26/08 at 2:25 PM, she confirmed there had been no dose reduction since 8/10/06 (one year and seven months). She further stated the physician did not provide the medical rationale for not trying a dose reduction. b. Review of the March 2008 physician's orders revealed the resident was started on Ambien CR on 2/6/08 for his/her complaint of insomnia. Review of the entire medical record	F 329			

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F 329	Continued From page 17 revealed there was no evidence a sleep assessment was completed to determine the cause of the resident's insomnia. In addition, there was no evidence non-pharmacological interventions were attempted. c. Interview with licensed practical nurse #1 on 3/26/08 at 3:37 PM revealed she was unsure why the resident received duplicate drug therapy for his/her insomnia and depression. She stated she thought the physician just wanted to keep the "status quo" for drug therapy because she had only been the resident's physician for six months and did not know the resident very well.	F 329	F 371 The facility will store, prepare, distribute, and serve food under sanitary conditions. The range top, including the metal back board has been cleaned as of 04-05-08. All accumulated burned on food and grease has been removed from the range. The interior and exterior of the convection oven and two conventional ovens have been cleaned as of 04-01-08 and all food debris has been cleaned off.		4/30/08
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure various pieces of food preparation and storage equipment was cleaned to prevent soil accumulation. The findings were: Observation on 3/25/08 at 2:30 PM revealed the range top, including the metal back board had accumulated burned on food and grease. In addition, the interior and exterior of the convection oven and two conventional ovens were not cleaned to prevent a build-up of grease and food debris. Finally, the exterior side of the walk-in refrigerator door and four reach-in refrigeration/freezer unit doors were soiled with grease and food debris.	F 371	Finally, all walk-in & reach-in refrigerator doors have been cleaned from soiled build up as of 04-01-08. Cleaning schedules for all dietary equipment are in place and dietary staff will be in- served regarding the importance of a clean & sanitary dietary department, and the importance of following the daily cleaning schedule. The dietary Manager will monitor the dietary department's progress on keeping up with daily cleaning procedures. The Dietary Manager will perform random daily & weekly audits to insure that staff performs and understands their reporting responsibilities when initialing the cleaning schedule. For the next three months or until 100% compliance is met, a report will be prepared for the QA Committee monthly to allow them to determine the effectiveness of the systemic changes related to audit results. The Dietary manager is responsible for overall compliance.		

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F 371	Continued From page 18 According to Food Code 2005, U.S. Public Health Service, 4-601.11: "(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch...(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." Interview with the dietary manager on 3/25/08 at 3:20 PM revealed the above mentioned items were part of the daily cleaning schedules. He then stated some kitchen staff were having to work double shifts, and the cleaning may not be getting done as often as it needed to be.	F 371	F 444 The facility does require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. All nursing staff will be in-service by May 1, 2008. They will review facility policy related to hand washing. Then they will perform return demonstrations to assure that they understand the expectations.		4/30/08
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy and procedure, the facility failed to ensure staff followed acceptable methods of hand washing during one of five observations of perineal care. The findings were: Observation on 3/25/08 at 8:20 AM revealed certified nurse aide #4 provided perineal care for resident #68 who was incontinent of bowel. Observation revealed after the perineal care was completed, the CNA took the soiled linen and trash to the soiled utility room. Observation revealed the CNA did not wash her hands after	F 444	Nurses on each shift will complete a monitoring tool daily that will include observation of hand washing including at least one observation of appropriate hand washing daily. Deficient practices will be corrected immediately. Nursing staff with deficient habits will be counseled. Monitoring tools will be reviewed by the DON or designee at least 5 times per week. For the next three months or until 100% compliance is met, a report will be prepared for the QA Committee monthly to allow them to determine the effectiveness of they systemic changes related to results identified on the monitoring tools. It will include the number of times deficient practices were noted and the action taken to correct the deficient practice. Overall compliance is the responsibility of the Director of Nursing.		

already scheduled

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

PRINTED: 04/10/2008
FORM APPROVED
OMB NO. 0938-0391

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 03/27/2008
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 444	Continued From page 19 depositing the soiled linen and trash in the soiled utility room. Continued observation revealed, without washing her hands, the CNA went to the clean linen closet and took out clean linen for a resident. Interview with the infection control nurse on 3/27/08 at 8:30 AM revealed the CNA should have washed her hands after handling the soiled linen and trash. Review of the facility policy on hand washing, #CL-DI-6107, dated 1/01, revealed the following instructions: "Hand washing is to be done:.....After contact with soiled or contaminated articles, such as, waste removal and articles that are contaminated with body fluids....Before and after resident contact....."	F 444			
F 466 SS=B	483.70(h)(1) OTHER ENVIRONMENTAL CONDITIONS - WATER The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility disaster plan, and staff interview, the facility failed to maintain an adequate emergency water supply. The findings were: Observation on 3/27/08 at 9:10 AM revealed the facility had four-one gallon plastic containers of water stored in the basement for emergencies. Interview with a maintenance employee on 3/27/08 at 9:10 AM confirmed these four gallons were the emergency water supply they had on hand. The employee then stated this was not an adequate supply. Review of the facility disaster	F 466	F 466 The facility will establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. The facility will maintain a minimum of 120 gallons of fresh water for emergency use. The Director of maintenance will do monthly checks to ensure that 120 gallons of fresh water are available at all times. The director of Maintenance will report immediately to the Administrator and the QA committee if there is a problem with the water supply. Overall compliance is the responsibility of the Administrator.	4/30/08	

9.

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 03/27/2008
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F 466	Continued From page 20 plan revealed the policy titled "Water Outage" called for 120 gallons of water to be stored in the facility for emergencies.	F 466			