

Reviewed & approved
12/3/14 Linda Brown

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

RECEIVED

WY Dept of Health

PRINTED: 11/24/2014
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 _____ Healthcare Licensing and Surveys		(X3) DATE SURVEY COMPLETED 10/09/2014
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: ADLs: Activities of Daily Living CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set CAA: Care Area Assessment BIMS: Brief Interview for Mental Status RN: Registered Nurse MAR: Medication Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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, resident and staff interview, and review of the medical records, the facility failed to promote care in a manner to ensure the dignity and respect for 4 of 13 sample residents (#15, #57, #80, #81), and 9 non-sample residents (#4, #5, #8, #14, #16, #39, #49, #53, #64). A variety of areas were identified including hygiene and grooming, staff interactions, and food/drink preferences. The findings were: Related to Grooming/hygiene/bathing:	F 241	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		11/21/14

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

TITLE

(X6) DATE

Andrea Stannard

NHA

11-23-14

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

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F 241	Continued From page 1 1. Observation on 10/6/14 at 2 PM and 5:35 PM showed resident #80 had thick stubble on her chin and upper lip. Review of the 8/25/14 quarterly MDS assessment showed the resident required extensive assistance for hygiene and bathing. When reviewed the monthly personal care record showed the latest shower or bath was provided for the resident on 10/4/14; however, there was nothing to show if the resident was shaved at that time. Review of the bath and skin reports showed this is where staff documented specifics provided during the bath such as cleaning of ears, trimming nails and shaving. Review of the October 2014 reports showed there was not a sheet completed for the 10/4/14 shower. Interview on 10/6/14 at 4:47 PM with the resident and RN #2 verified the CNAs were responsible for shaving residents when baths/showers were given and as needed. The resident at that time stated she could not recall the last time she was shaved. The resident also stated she feels the stubble when touching her face and finds it "embarrassing and degrading." 2. Observation on 10/6/14 at 4:15 PM showed resident #81 was awake and seated in her wheelchair. The resident was noted at that time to be wearing soiled clothes and to have long chin hairs. Review of the September and October 2014 monthly personal care record showed the resident required extensive assistance for personal hygiene and bathing. These records and the bath and skin reports for this time frame showed the resident was last bathed/showered on 9/30/14 and the last time there was documentation of the resident having been shaved was on 9/6/14.	F 241	requirements of participation, this response and plan of corrections constituted the facility's allegation of compliance in accordance with section 7305 of the state operations manual. 1. Corrective Action: Related to grooming and Hygiene. Resident #80 was shaved by nursing staff prior to surveyors exiting the facility. Resident #81 was changed into cleaned clothes and shaved by nursing staff prior to surveyors exiting the facility. Resident #8 now has clean shoes. Resident #64 now has her call light in reach and he/she receives timely assistance with toileting and positioning. Resident #39 now receives timely assistance with placement of her O2 and her catheter tubing. Resident #57 is now unclothed in the bath/shower house after transport and redressed in the bath/shower house prior to transport back to room. Resident #14 is now unclothed in the bath/shower house after transport and redressed in the bath/shower house prior to transport back to room. Resident #16 now has her call light in reach and he/she receives timely assistance with toileting. Resident #53 is showered in a clean bath/shower house. Related to Food and Beverages: Resident #15 does not received plastic dishes. Resident #80 is now aware that Regular Coffee is available. Resident #4 is now aware that Regular coffee is available. Resident #5 is now aware that Regular coffee is available. Resident #49		

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F 241	Continued From page 2 3. Review of the 7/28/14 quarterly MDS assessment showed non-sample resident #8 required extensive assistance for grooming and dressing. Observation on 10/6/14 at 3:50 PM showed the resident was wearing black shoes with large spots of a dried white liquid splattered on both shoes. During an interview with the DON on 10/8/14 at 12:05 PM she was made aware of the resident's shoes. The DON verified residents' clothing should be clean and if they became soiled staff should help them to change. Observation on 10/8/14 at 5:05 PM showed the residents continued to wear the soiled shoes. 4. Review of the 7/7/14 quarterly MDS assessment showed resident #64 had diagnoses including heart disease and diabetes, and s/he did not have cognitive impairment. This review also showed the resident had functional limitation in range of motion in both legs and required extensive assistance with toileting, transfers, bed mobility, and personal hygiene. The following concerns regarding this resident's dignity were identified: a. Observation on 10/6/14 at 10:40 AM revealed the resident was calling out for assistance. The resident was observed positioned in the wheelchair and the call light was not within reach. During the observation the resident stated s/he could not reach the call light and could "hardly hold it any longer." The resident stated it was "embarrassing" to have to call out loudly for assistance with toileting. b. Observation on 10/6/14 at 3 PM revealed CNA #1 responded to the resident's call light and the resident requested assistance to get up. At that time the CNA told the resident to wait until the CNAs finished passing linen to resident rooms. Observation at 3:38 PM revealed the	F 241	is now aware that Regular coffee is available. On or before the allegation of compliance the DON/designee provided re-education to nursing staff regarding treating residents with respect and dignity, specifically ensuring men and women are properly groomed and shaved, clothes/showers are clean and not soiled, residents are undressed and redressed in the shower/bath house prior to transport, and call lights are in reach and answered timely without telling residents they need to wait. On or before the allegation of compliance the Dietary manager/designee provided re-education to dietary/nursing staff regarding treating resident with respect and dignity, specifically ensuring that plastic ware is not used during meal times and resident can receive regular or decaffeinated coffee as requested and residents are aware that regular coffee is available. 2. Identification: Residents who reside at the facility are at potential risk. 3. Systemic Changes: The facility will provide care for residents in a manner that respects and enhances each resident's dignity, individuality, and right to personal privacy. "Dignity" means that interacting with residents during care, staff carries out activities that assist the resident in maintaining and enhancing self-esteem and self-worth. Care for residents in a manner that maintains dignity and individuality includes ensuring they are in clean clothes/shoes; that they		

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F 241	Continued From page 3 resident activated his/her call light and asked RN #1 for assistance to get out of bed. Further observation revealed the RN told CNAs #1 and #2 that the resident wanted to get up. Interview with the resident at 3:40 PM revealed his/her position in bed was uncomfortable and s/he could not reposition himself/herself without staff assistance. Observation at 3:50 PM revealed the resident activated the call light again (this was the third time). At that time CNAs #1 and #2 wheeled the mechanical lift into the room and began to provide the assistance the resident had requested 50 minutes earlier. 6. Review of the 9/30/14 admission MDS assessment showed resident #39 showed s/he was alert and oriented and required limited assistance with ADLs. According to the 10/3/14 care plan the following interventions were implemented: a bed alarm to prevent falls due to forgetfulness; oxygen due to chronic obstructive lung disease; and a suprapubic catheter due to a history of urinary problems. Observation on 10/9/14 at 8:45 AM revealed CNA #7 responded to the bed alarm that was activated when the resident attempted to transfer from the bed to the wheelchair without staff assistance. During the observation the CNA stood closely by as the resident completed the transfer. After the resident was positioned in the wheelchair the CNA departed without applying the oxygen that was disconnected during the transfer, moving the urinary drainage bag that remained attached to the bed or asking the resident why s/he wanted to get up. During an interview conducted immediately after the CNA departed, the resident stated s/he had gotten out of bed to go to the bathroom, but the CNA departed without providing the needed assistance.	F 241	are assisting with grooming before and after meals, that they are appropriately shaved, they are fully covered when in the bath chair, ensuring we do not tell them "they have to wait" when answering their call light, ensuring they receive Regular coffee, and grooming them appropriately. Starting 10/30/2014, and up to the date of compliance, the SDC/designee will in-service staff on resident dignity 4. Monitoring: Facility managers will monitor to ensure resident's dignity is maintained though the General rounds/observation monitoring program at least 3 times weekly for one month, then weekly for one month and as needed until facility determines substantial compliance has been met. During these rounds, facility managers will be ensuring care is provided for residents in a manner that maintains dignity and individuality includes ensuring they are in clean clothes, that they are assisted with grooming before and after meals, that they are appropriately shaved, they are fully covered when in the bath chair, ensuring staff do not tell them "they have to wait" when answering their call light, ensuring they receive Regular coffee, and grooming them appropriately. Further review/monitoring will be done through the Resident Council, the facility grievance process ombudsman, and family feedback. Results through these reviews will be tracked/trended for any issues. Issues identified will be review in AQ&A for process improvement evaluated for its effectiveness.		

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F 241	Continued From page 4 6. Review of the 7/7/14 quarterly MDS for resident #57 showed s/he had severe cognitive impairment and required extensive and total assistance with bathing, showers, and personal hygiene. Observation on 10/8/14 at 3:10 PM revealed CNA #6 wheeled the resident from the resident's room through the hallway to the shower room. At that time the resident was observed to be unclothed with only a blanket draped around his/her upper torso and knees. Further observation revealed the resident was visible to other residents and visitors as s/he was wheeled to the shower. 7. Review of the 9/22/14 quarterly MDS assessment revealed resident #14 was severely cognitively impaired and needed extensive assistance with bathing. The following concerns were noted: a. Observation on 10/6/14 at 3 PM showed the resident was pushed down the hall in a shower chair wearing a bath blanket which left the resident's legs exposed from the thigh down. The resident was taken from his/her room, past the front door and lobby area where residents were visiting with staff and visitors, and then to the shower room. Further observation the same day at 3:15 PM showed the resident in the shower chair returning to his/her room in the same manner. b. Interview with CNA #3 on 10/7/14 at 4:45 PM revealed the system for showers was to disrobe the resident in their room, transfer the resident to the shower chair in their respective rooms using a mechanical lift. The CNA stated the residents were transferred without a brief or any clothing under the bath blanket because the lifts cannot be taken into the shower room.	F 241	5. 11/24/14		

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F 241	Continued From page 5 c. Interview with the staff development coordinator on 10/9/14 at 1:45 PM revealed staff should be taking the lift into the shower room and transferring and disrobing the resident there. 8. Review of the 7/14/14 significant change MDS assessment revealed resident #16 required extensive assistance with transferring and toilet use, and was cognitively intact (alert and oriented). Observation on 10/6/14 at 4:06 PM showed the resident activated the call light for assistance to the restroom. Interview with the resident at that time revealed the resident needed assistance to use the toilet. The following concerns were noted: a. At 4:22 PM (16 minutes after the call light was turned on) CNA #3 answered the call and told the resident "I have to help another lady who is first. Give me about ten minutes." The CNA left the resident's room without assisting her to the bathroom. At 4:40 PM CNA #3 and NA #1 returned to assist the resident to the bathroom. The resident waited a total of 34 minutes to be assisted to the bathroom. b. Interview with resident #16 on 10/7/14 at 12 noon revealed the staff "don't answer the call light, and they get mad at me when I call for help." 9. Confidential interview with 8 residents on 10/7/14 at 3 PM revealed the facility is consistently short-staffed with regards to CNA's. The resident's commented the CNA's answer the call light and then say "I will be back," but the residents then have to wait another 20 minutes to as much as two-and-a-half hours to get the help they require. Being showered in a dirty shower room:	F 241			

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F 241	Continued From page 6 Observation on 10/9/14 at 10 AM showed resident #53 was transported to the women's shower room near the 200 nursing station via shower chair by bath aide #1. The observation revealed the shower room floor was dirty with various stains, the room had a strong odor of feces, and the toilet was not flushed. In the same shower room, a rubber duck hanging from the wall was dusty. Interview with the bath aide immediately after she showered the resident verified the shower room had not been cleaned between resident showers. Related to Food/beverages: 1. Observation on 10/8/14 at 11:12 AM showed peaches for the noon meal were portioned into plastic disposable cups. In addition, there were disposable cups on 13 room trays. Interview with the dietary manager on 10/8/14 at 11:20 AM verified disposable dinnerware including utensils were being used daily due to a lacking supply of dishes and silverware. The following concerns were identified: a. Observation on 10/6/14 at 6:55 PM showed resident #15 was served a dinner tray with plastic utensils and plastic dishes with applesauce and fruit. Interview with the alert and oriented resident on 10/7/14 at 12 noon revealed the resident did not like being served meals with plastic utensils and plastic dishes. b. Confidential interview with 8 residents on 10/7/14 at 3 PM revealed the facility uses plastic utensils and plastic dishes frequently. The resident's comments included: "It is a problem to use the plastic knife to cut up meat..." "I don't like eating soup with plastic utensils..." "Using plastic utensils and plastic dishes bothers some of the	F 241			

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F 241	Continued From page 7 residents." 2. Interview on 10/8/14 at 3:25 PM with dietary staff #1 verified both coffee dispensers in the main dining room contained decaffeinated coffee. Interview with the dietary manager on 10/8/14 at 4:50 PM verified the coffee available for the residents in the dining room was decaffeinated and she was uncertain why they were not provided a choice. The following concerns were identified: a. Interview with resident #80 on 10/8/14 at 4:58 PM verified s/he drank coffee and his/her preference was for regular coffee. The resident stated s/he was not aware the coffee served in the dining room was decaffeinated. b. Interview with resident #4 on 10/8/14 at 5 PM revealed s/he liked regular coffee in the morning to help wake up. c. Interview with resident #5 on 10/8/14 at 5:06 PM verified s/he enjoyed coffee and drank it throughout the day. The resident stated a preference for regular coffee, not decaffeinated. d. Interview with resident #49 on 10/9/14 at 9:30 AM revealed s/he was unaware the coffee served in the dining room was decaffeinated. S/he further stated "people should have a right to choose what kind [of coffee] they get."	F 241			
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248			11/21/14

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F 248	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on medical record review, activity calendar review, and resident and staff interview, the facility failed to ensure 1 of 13 sample residents (#40) received an ongoing program of activities. In addition, the facility failed to provide activities that met residents' needs on Sundays. The facility census was 80. The findings were: 1. Confidential interview with 8 residents on 10/7/14 at 3 PM revealed a lack of activities in the facility. Comments made by the residents included the following: a. A lack of Sunday activities, b. The residents have requested more late activities, more word games, card games and board games. The Activity Director's response to the residents' request for these activities was reported as "that's as good as they can get them." 2. Review of the facility's October activity calendar revealed the only scheduled activity on Sunday was a church service, except on the first and third Sunday there was a Gospel Hour scheduled. 3. Interview with the activity director on 10/8/14 at 4:35 PM confirmed the resident had requested additional Sunday activities, and they were not provided due to a shortage of staff. In regards to lack of individualized activities: Review of the 9/27/14 admission MDS assessment showed resident #40 was totally dependent on staff for all ADLs except eating and did not have cognitive impairment. This review also showed the resident was admitted to the	F 248	Preparation and execution of this response and plan of correction does not constitute an admission agreement by the provider of the truth of the facts alleged or conclusion 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 7306 of the state operations manual. The facility will provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. Corrective Action: The facility will ensure there are activity choices on Sunday. The facility now has The facility now has Sunday night football games in the TV lounge, Puzzles and games available in Activity room, two Sundays a month Abby's violin concert for residents to participate in. on Sunday's for residents to participate in. Resident # (40) has been interviewed regarding activity interests and the resident's care plan has been updated to match activity interests. She/he now enjoys Pet visits as part of the activity plan and if weather and health permits she/he can sit outside in the sun		

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F 248	Continued From page 9 facility with a stage IV pressure ulcer on his/her ischium and a urinary catheter. According to the 9/24/14 to 10/7/14 daily nursing notes interventions for care of the pressure ulcer included limiting the number of consecutive hours the resident sat in the wheelchair. During an interview on 10/9/14 at 3:30 PM the resident stated s/he did not mind staying in bed most of the time due to the pressure ulcer, but occasionally looking at the four walls in room was depressing. The resident stated s/he did not mind attending bingo and crafts and watching television, but would prefer sitting outside in the sun on warmer days or visits with pets. The resident further stated s/he was not pleased with the activities because his/her preferences had not been included in the activities provided. Review of the 10/3/14 care plan showed interventions for recreation included remind the resident when pets were in the building, watching television, and invite to socials, crafts, jewelry making, church service and bingo. Review of the September and October 2014 activity participation documentation for this resident showed pet visits and sitting outside were not offered or provided.	F 248	for a short period of time. Identification: Residents that currently reside at the facility are at risk. On or prior to the allegation of compliance, the Activity Director/Designee will review each resident's interests/needs and then insure the Residents care plan is updated/ revised to include the residents interests. Systemic Changes: All recreation programs are based on interests and needs of the residents. For those residents unable to express their needs, reasonable attempts will be made to discern past interest from family and friends. Residents/loved one will be interviewed regarding activity interest on admission. Recreation programs will be designed to cover the full scope of residents' life activities and should include opportunities for social, physical, intellectual, emotional, and spiritual needs. Programming will be offered in the morning and afternoons seven days a week including Sundays and holidays and evening programs will be offered a minimum of two times per week. Residents will be encourages to reevaluate the programs offered on an ongoing basis. Residents will be invited each month to participate in development of the Activity calendar. On or before the allegation of compliance, the NHA/Designee in-serviced the Activity staff on the Recreation Program per policy CL-REC-9014(SNF).		

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F 248	Continued From page 10	F 248	Monitoring: The activity director will interview 3 random residents a week for 3 months, then monthly for one month, regarding the Recreation Program. Further monitoring will continue through Resident council and ombudsman feedback. Issue identified will be presented in QA&A to ensure plan has been implemented, sustained, and evaluated for its effectiveness. Date of Compliance: 11/21/14		
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 and staff interview, the facility failed to ensure a variety of items in 3 of 3 resident areas, which included the 100 unit, central (200) unit, and 300 unit, were clean and well maintained. The findings were: 1. Observation on 10/6/14 at 2:15 PM in resident room #256 revealed the top drawer of the chest of drawers by the bathroom entrance had the front with the handle torn off, which showed the inside contents of the drawer to be resident underclothing. The the torn off area was placed on top of the chest of drawers. Immediately after the observation, one of three burgundy chairs was observed in the television room across from the 200 nursing station to be dirty with numerous	F 253	Corrective Action: 1. Maintenance repaired top drawer of the chest of drawers in room #256 immediately after notification from surveyor. 2. (A) the burgundy chairs in the television room will be steam cleaned by Housekeeping. (B) The fire sprinkler head in room #71 bathrooms has been cleaned by Housekeeping. (C) The shower room in the hallway leading from the front of the building has been deep cleaned and the rubber duck in shower room has been removed by Housekeeping. Wall, ceiling, and baseboard: (A) The corner wall to the right of bathroom door in room #336 bathroom door walls and baseboard	11/21/14	

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F 253	Continued From page 11 whitish stains. 2. Observation on 10/9/14 from 8:15 AM through 10 AM revealed the following issues with cleanliness and building maintenance: General cleanliness: a. One of three burgundy chairs in the television room across from the 200 nursing station continued to be dirty with multiple whitish stains. b. The fire sprinkler on the ceiling of the bathroom in room #71 had a spider web covering the sprinkler head. c. The women's shower room in the hallway leading from the front of the building to the back of the building had a strong odor of feces, and the toilet was not flushed. In the same shower room, a rubber duck hanging from the wall was dusty. Wall, ceiling, and baseboard issues: a. The corner wall to the right of the bathroom door in room #336 had wall and baseboard damage from the floor to 20 inches in height that exposed the metal underneath. b. The left bathroom wall in room #338 was scraped at 1 foot in height and 1 foot across. c. The baseboard was missing in the 300 tub room at the back of the shower area 50 inches across and 2 inches in height on one area, and 49 inches across and 2 inches in height on another area. d. The ceiling over the entire shower area was damaged which created an uncleanable surface. The left wall corner (intersection of two walls) by the bathroom door of room #346 was damaged from the floor to 33 inches in height that exposed the metal underneath. e. The baseboard by the closet in room #261	F 253	damage has been repaired by maintenance. (B) Room #338 baseboard has been repaired by Maintenance. (C) the #300 Tub room baseboard installed and correctly by Maintenance. (D) The shower room on 300 hall ceiling was scraped, primed and repainted by Maintenance. The left wall corner by bathroom door of room #346 was repaired by Maintenance. (E) Room #261 baseboard was secured to wall by Maintenance. (F) The Light cover in the hallway to activities has been replaced by Maintenance. (G) The carpet by room #170 on the wall has been secured by Maintenance. (H) Room #9 scrape was repaired, primed and painted by Maintenance. Floor: (A) Cracked tile in room #335 was repaired by Maintenance. (B) The 4 tiles with chips were replaced in bathroom #336 by Maintenance. (C) Tile with a crack and small chip was replaced by Maintenance. (D) Chipped area that covered 4 tiles was replaced and two tiles that did not mesh were replaced with little gap by Maintenance. (E) The five cracked hallway tile outside of room #36 were replaced by Maintenance. (F) Four cracked tiles in hallway between room #47 and #29 were placed by Maintenance. (G) Replacement carpet for flooring between Rm. #252 was ordered prior to survey. Flooring company was awaiting down payment to purchase materials. New flooring was scheduled for November 2, 2014. Outside flooring contractor will replace carpet. (H) The baseboard in the		

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F 253	Continued From page 12 was pulled loose from the wall 4 inches by 5 inches. f. The first light fixture on the hallway which lead to the activity area was held together on one side by several strips of duct tape. g. A carpeted wall covering outside of room #70 was pulled loose at the wooden frame at the top 44 inches by 15 inches. h. The inner right wall in the bathroom of room #9 was scraped at the corner from the floor to 20 inches in height with metal showing. Floor issues: a. The floor to the left of the front door of room #336 had one cracked tile 6 inches across that was darkened which created an uncleanable surface. b. The bathroom floor of room #336 had four tiles to the left of the toilet with small chips out which created a darkened dirty and uncleanable surface. c. One tile in front of the front door of room #338 was cracked 6 inches across and had a small chip which created a darkened and uncleanable surface. d. The floor to the left of the front door of room #40 had a chipped area that covered the corner of four tiles which created a darkened and uncleanable surface. An additional tile was cracked 6 inches across which created a darkened and uncleanable surface, and two of the tiles did not mesh together evenly which created a darkened area. e. In the hallway outside of room #36 there were multiple cracks through 5 (1 foot by 1 foot) tiles that left darkened and uncleanable surfaces. f. In the hallway between rooms #47 and #29 there were four cracked tiles with a darkened and uncleanable surface.	F 253	hall outside Rm. #73 was secured to wall by Maintenance. (I) The baseboard on right wall of the #100 nurses station has been secured to wall by Maintenance. (J) The women's shower room in the hallway leading from the front of the building 17 tiles was replaced by Maintenance. The rust stains on the tile the back corner by sink will be scrubbed by Housekeeping. The tiles in the Southwest corner were replaced. (K) The two damaged tiles in the hallway between the nursing station 200 and 300 nursing station have been replaced by Maintenance. (L) The two tiles chipped in the bathroom of Rm by #10 were replaced by Maintenance. (M) The bathroom baseboard on the left in rm. #9 has been secured by Maintenance. (N) The loose baseboard in Rm. #7 by bathroom door was secured by Maintenance. Doors (A) bathroom door chips in Rm #331 will be replaced with wood putty, sanded and stained by Maintenance. (B) The kick plate on the door of Rm #335 under the door knob will be replaced by maintenance. (C) The closet door in room #261 has been repaired by Maintenance. (D) The front door of room #70 has been repaired by Maintenance. (E) The kick plate on the bathroom door of room #73 was been tightened, the chips on the hinge have been repaired by Maintenance. (F) The bathroom door in Room #2 with 4 inch wide scrape has been repaired by Maintenance. (H) The inner bathroom door of room #9 chips have been repaired by Maintenance.		

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F 253	Continued From page 13 g. The carpet under the love seat across from room #262 was ripped at the right corner 5 inches by 2 inches. h. The baseboard in the hallway outside of room #73 was loose from the wall 7 inches across. i. Across from the 100 nursing station the right wall baseboard was loose from the wall 6 inches by 4 inches at the corner of two walls. j. The floor in the women's shower room in the hallway leading from the front of the building to the back had 17 tiles (3 inches each) that were damaged and darkened and had an uncleanable surface. The floor in the back corner by the sink had a 3 inch long area that had collected rust. The southwest corner of the shower had chipped tiles from the floor to 5 inches in height. k. The hallway between the 200 nursing station and 300 nursing station had two tiles that were darkened and damaged with an uncleanable surface. l. The bathroom floor of room #10 had two chipped tiles between the sink and toilet that created a darkened and uncleanable surface. m. The bathroom baseboard in room #9 was loose from the wall 4 inches by 3 inches on the left. n. The baseboard in room #7 by the bathroom door was loose from the wall from the floor to 4 inches up. Door issues: a. The bathroom door of room #331 was chipped on both sides from the floor to 26 inches in height. In addition, the front of that door had a 1 inch chip out of the door at 26 inches in height and 12 inches from the door edge. b. The front door kick plate under the doorknob of room #335 was ripped loose from	F 253	Heat vent: (A) The heat vent in the hallway outside of room #36 has been tightened by Maintenance. B) The heat vent cover to the right of the front door to the building has been tightened by Maintenance. 3. (A) The carpet on the wall outside of room #112 will be steam cleaned by housekeeping. (B) The sit-to stand #10 has been cleaned by Housekeeping. Systemic Changes: Housekeeping and Maintenance Director and facility management team will conduct visual rounds to ensure that rooms, common areas and equipment are cleaned and maintained on a regular basis. Starting 10/24/14, and up to date of compliance the Administrator/designee will in-service facility staff on communication of maintenance and housekeeping concerns via log books located throughout the facility and on/or change of condition report. On 10/29/14 the NHA/designee in-serviced housekeeping staff on the importance of cleanliness of the facility. The NHA will provide oversight to ensure identified issues have been resolved. Monitoring: The Maintenance Director, Housekeeping Director, and NHA/designee will conduct monthly environmental rounds in order to identify outstanding housekeeping and maintenance issues with overall oversight provided by the NHA/designee. Finding will be resented to QA&A monthly as needed until substantial compliance has	

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F 253	Continued From page 14 the door to 23 inches in height and 1 inch across. c. The closet door in room #261 was sticking and difficult to open and close. d. The front door of room #70 had a 2 inch by 1 inch chipped area underneath the doorknob. The inside of that door by the hinges had multiple chips from the floor to 21 inches in height. e. The kick plate on the bathroom door of room #73 was loose from the door 10 inches by 6.5 inches at 2 feet in height. Also, the front door had chips underneath the doorknob from the floor to 15 inches in height, and chips on the hinge side from the floor to 21 inches in height. f. The bathroom door of room #2 had chips out on each side from the floor to 15 inches in height. g. The front of the bathroom door had a 4 inch wide scrape that was 36 inches across. h. The inner bathroom door of room #9 had chips out from the floor to 18 inches in height. Heat vent issues: a. The heat vent in the hallway outside of room #36 was loose 11 inches across and 5.5 inches wide. b. The heat vent cover to the right of the front door to the building was loose 60 inches across. 3. Observations on 10/6/14 from 3:40 PM through 6:20 PM revealed the following cleanliness concerns: a. 2. Observation on 10/6/14 at 3:40 PM revealed the carpet on the wall outside of room #112 was visibly soiled. b. Observation on 10/6/14 at 6:20 PM revealed the sit-to-stand lift labeled #10 stored in the 100 hallway had a footrest that was visibly soiled. Observation on 10/9/14 at 10:25 AM showed the footrest of the lift was still visibly	F 253	been met.	

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F 253	Continued From page 15 soiled. Interview on 10/9/14 at 1 PM with the housekeeping supervisor revealed the expectation that housekeeping staff were to deep clean the shower rooms and bathrooms at least once a day and as needed, and that the department had been short staffed lately. He further revealed the facility had several new housekeeping staff, and they needed additional oversight. Interview with the maintenance director on 10/9/14 at 11:20 AM confirmed he was aware of the building issues. He further confirmed the facility failed to have a plan with a timeframe to address those issues.	F 253			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279			11/21/14

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F 279	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a care plan for 1 of 5 sample residents (#24) related to behaviors. The findings were: Review of the 9/8/14 quarterly MDS assessment showed resident #24 had verbal behaviors directed at others 4 to 6 days per week. The MDS assessment also showed the resident required extensive assistance for bathing and did not have behaviors related to rejection of care. The following concerns were identified: a. Review of the bathing documentation for September 2014 to 10/8/14 showed the resident refused bathing. According to the records for this time frame, the resident received a shower/bath on 9/1, 9/8, 9/11, 9/18, and 10/7. The resident had documented refusals of bathing on 9/15/14, and 9/27/14. b. Review of the care plan related to bathing and ADLs showed it was last reviewed on 9/1/14 and a bath or shower were planned twice per week on Mondays and Thursdays. This care plan failed to address any problems or approaches related to the resident's refusals of bathing. In addition, review of the care plan for mood and behaviors was last dated 9/10/14, and there was no mention of the resident's refusals of care. c. Interview with the DON on 10/9/14 at 8:25 AM verified although the records failed to show refusals or that baths were given between the 8 day gap from 9/18/14 to 9/27/14, and the 9 day gap from 9/27/14 to 10/7/14, the resident was offered bathing and refused. The DON further acknowledged the care plan for this resident did	F 279	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 of the provisions of federal and state law required 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 # 24 care plan was reviewed on 10/30/2014, by the DON/Designee to ensure refusals of baths is appropriately addressed on the ADL care plan as well as her care plan for mood and behaviors. 2) Identification For identifications purposes, on 11/10/2014 a review of current residents' care plans will be completed by DON/Designee to pinpoint residents at the facility potentially at risk for care plans lacking inclusion of services provided to address care related to behaviors such as refusal of baths. 3)Systemic Changes		

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F 279	Continued From page 17 not address the resident's behavior of refusing the care.	F 279	Residents will be reviewed upon admission, quarterly, annually, and with significant change of condition utilizing the admission/MSD/RAI/ Care planning process. Care plans will be developed to include services provided to attain or maintain their highest practicable physical, mental, and psychosocial well-being, including ensuring a care plan is in place to address the residents' behaviors such as refusals of baths. Beginning on 10/24/2014 and continuing up until the allegation of compliance the DON/Designee will in-service the IDT and Nursing staff on care plan preparation. 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 Individual care plans to be reviewed and revised, to include services provided based on individual need, upon admission and quarterly, annually and with change of condition. Care plan documentation review will be completed quarterly. Issues identified through this review will be discussed at QA&A for the purpose of process improvement and to ensure plan has been implemented, sustained and evaluated for it's effectiveness. 11/21/2014		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		11/21/14	

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F 281	Continued From page 18 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of infection control information, and resident and staff interview, the facility failed to ensure physician orders were followed related to the administration of the Zostavax (Shingles) vaccine for 29 of 29 residents (#1, #4, #8, #9, #10, #11, #18, #24, #25, #26, #30, #32, #34, #41, #45, #47, #49, #55, #66, #67, #69, #70, #71, #72, #73, #74, #75, #76, #77). The findings were: Interview with resident #47 on 10/6/14 at 11 AM revealed s/he was given a vaccine for the shingles. The resident expressed concerns related to having received the vaccine and was worried about possible side effects. The following concerns were identified: a. Interview with the infection preventionist (IP) on 10/7/14 at 4:40 PM verified the resident was provided the vaccine the day before. The IP further stated the facility did not have a policy and procedure related to informed consents for vaccines other than influenza and pneumococcal, and she had not obtained any written consent from the resident or responsible party. She stated she had explained to the resident what was being given and that it was ordered by the physician. She then revealed there were other residents with orders for the vaccine, and the vaccines were in the facility available to be administered. Additionally, she stated the orders on the medical record for these residents were not completed in a timely manner based on changes in the pharmacy process at the facility and delays in receiving the vaccines.	F 281	The facility will provide or arrange services to meet professional standards. Corrective Action: For Resident #'s 1,4,8,9,10,11,18,24,25,26,30,32,34,41,45,47,49,55,66,67,69,70,71,72,73,74,75,76,77 his/her orders were clarified. He/she received the shingles vaccine prior to the allegation of compliance. Identification of residents potentially affected: Residents who currently reside at Laramie Care Center are at risk. Systemic changes: Licensed nurses have been in services on provision/arrangement of the following services to meet professional standards, including ensuring timely administration of physician orders, specifically administration of Shingles Vaccine per the physician's orders. Physician's orders received via a fax or progress not will be transcribed unto the telephone order sheet to ensure proper transcription occurs over the MAR (medication administration records). The DON/Designee will conduct a review of the medication administration records 3 times weekly and pm to ensure shingles vaccines are completed per MD orders. The DON will provide follow up with the		

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PRINTED: 11/24/2014
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 10/09/2014
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 281	Continued From page 19 b. Medical record review showed a physician order for the Zostavax (Shingles) vaccine for resident #47 was dated 7/17/13 (more than 1 year old). In addition, the medical record showed the resident had a durable power of attorney, and there was no evidence this responsible party was notified prior to the vaccine administration. c. Review of the list provided by the IP on 10/8/14 at 4:45 PM showed 5 additional residents (#32, #30, #45, #34, #41) were administered the vaccine on 10/6/14, and 23 additional residents (#1, #4, #8, #9, #10, #11, #18, #24, #25, #26, #49, #55, #66, #67, #69, #70, #71, #72, #73, #74, #75, #76, #77) were identified with orders to have the vaccine, however, the vaccine was not yet administered. Review of the physician orders for these 28 residents showed they were all dated from July 2013. d. Interview with the Administrator and DON on 10/8/14 at 12:05 PM revealed the physician orders that were in the residents' records were being questioned due to the origin of the orders. There had been discussion in a recent quality meeting related to these orders and the fact they had not been fulfilled. There was at that time nothing conclusively decided. e. Review of the orders showed they were signed and dated by the physicians, and included the resident name, facility name, name of the vaccine, and a statement with the physicians decision to "Please administer 1 dose subcutaneous when available." f. Review of infection information from July 2013 to 10/9/14 verified one of these residents (#1) with the orders not completed, had been isolated and treated for the Shingles in February 2014. According to the Wyoming Nursing Practice Act	F 281	appropriate caregivers on identified problems, as deemed necessary. Monitoring: The DON/Designee will conduct a review of the treatment administration records 3 times weekly and pm to ensure vaccines are completed per MD orders. The DON will provide follow up with the appropriate caregivers on identified problems, as deemed necessary. identified issues will be tracked and trended and results will be included in the DON's/designee's monthly AQ and A report in order to ensure that plan has been implemented, sustained and evaluated for it's effectiveness. 11/21/2014		

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F 281	Continued From page 20 of July 2005 and the Administrative Rules and Regulations of November 2003, pages 3-6, nursing must function under the direction of a physician. According to the Centers for Disease Control website: <a href="http://www.cdc.gov/vaccines/hcp/vis/about/facts-v
is.html">http://www.cdc.gov/vaccines/hcp/vis/about/facts-v is.html accessed on 10/16/14, "A VIS or Vaccine Information Statement is a document, produced by CDC, that informs vaccine recipients - or their parents or legal representatives - about the benefits and risks of a vaccine they are receiving...CDC encourages healthcare providers to use these whenever they give one of these vaccines, but they must be used when the vaccine is purchased under CDC contract. These vaccines are:...Shingles..."	F 281			
F 282 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the plans of care were followed as written for 8 of 13 sample residents (#15, #24, #46, #48, #52, #57, #61, #80). The findings were: 1. Review of the 8/18/14 care plan for falls and safety showed resident #80 was at risk for falls and the resident was known to "climb" out of bed	F 282	1) Corrective Action: Resident #15: The resident now has skid strips in front of her bed, the skin assessments are done weekly per policy, and staff is documenting effectiveness of pain medication, and checking on her frequently. Resident #'s 24, 46, 48, 52, and 61. The residents are now receiving baths per his/her plan of care. Resident #80:		11/21/14

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F 282	Continued From page 21 without calling for assistance. The interventions included a floor mat placed at the side of the resident's bed. Observation on 10/6/14 at 2:20 PM showed the resident was lying in bed sleeping. At that time the fall mat was noted to be folded and stored at the end of the resident's bed not in use by the bedside as planned. At 4:40 PM RN #1 verified the fall mat should have been placed at the bedside when the resident was laid down. 2. Review of the care plan for resident #24 related to bathing and ADLs showed it was last reviewed on 9/1/14 and a bath or shower were planned twice per week on Mondays and Thursdays. Review of the bathing documentation for September 2014 to 10/8/14 showed the resident refused bathing at times. According to the records for this time frame, the resident received a shower/bath on 9/1, 9/8, 9/11, 9/18, and 10/7. The resident had documented refusals of bathing on 9/15/14, and 9/27/14. Interview with the DON on 10/9/14 at 8:25 AM verified although the records failed to show refusals or that baths were given between the 8 day gap from 9/18/14 to 9/27/14, and the 9 day gap from 9/27/14 to 10/7/14, the resident was offered bathing and refused. The DON further acknowledged the care plan for this resident did not address the residents behavior of refusing the care. 3. Review of the 8/26/14 admission MDS assessment revealed resident #15 had diagnoses that included diabetes mellitus (DM) II with neurological effects and osteoarthritis and was cognitively intact (alert and oriented). Review of the care plan related to "impaired skin integrity" dated 10/6/14 revealed interventions that included "staff will check on resident frequently." Review of	F 282	Now has a fall mat at her bedside when she is in bed. 2) Identification of other Residents who may be at Risk Residents who reside at facility are at risk. On or before the allegation of compliance the DON/Designee will reeducate the Licensed Nursing Staff and the C.N.A's on the importance of following the Resident's plan of care to include checking on the resident, documenting effectiveness of pain medications, skin assessments, bathing per the resident individual care plan and ensuring interventions to reduce fall risk and/or injury risk are in place per the plan of care. 3) Systemic Changes The Resident's individual bathing preferences and fall risk prevention interventions, if indicated will be included on the C.N.A's ADL sheets/plan of care. The C.N.A's ADL sheets/plan of care are updated by the DON/designee when indicated. The skin assessments will be on the treatment administration records for the nurses to document and effectiveness of pain medication will be on the medication administration records. On or before the allegation of compliance the DON/Designee will reeducate the Licensed Nursing Staff and the C.N.A's on the C.N.A's care plan and the importance of following the Resident's plan of care to include ensuring fall prevention interventions are in place and bathing per the resident individual care plan as well as documenting the skin assessments and		

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F 282	Continued From page 22 the care plan related to "potential for alteration in skin integrity" dated 9/1/14 revealed interventions that included "LN [licensed nurse] to assess my skin with skin check Q [every] week." Review of the care plan related to alteration in "skin integrity ulcers r/t [related to]...diabetic: at risk" dated 8/28/14 revealed interventions that included "Braden scale X4 for first 4 weeks." Review of the care plan related to functional status dated 8/26/14 revealed interventions that included "nonskid strips next to bed." Review of the care plan related to pain dated 8/26/14 revealed interventions that included "a LN/Med aide will Assess and document response to each prn [as needed] dosage of analgesic." The following concerns were noted: a. Observation on 10/6/14 at 2:05 PM showed a lack of nonskid strips next to bed. b. Observation on 10/6/14 from 2:20 PM to 4:22 PM showed no staff checked on the resident. c. Interview with CNA #3 on 10/7/14 at 4:45 PM revealed she did not check on the resident frequently on 10/6/14 as the care plan stated. d. Interview with the DON on 10/9/14 at 3:15 PM revealed the expectation was to check on the resident every hour. e. Review of the medical record for September 2014 revealed no weekly skin assessment was performed for the week of 9/1/14 to 9/7/14 and the week of 9/22/14 to 9/28/14. Further review of the same record revealed no Braden scale was performed from 9/1/14 through 9/12/14 (missing two weeks). f. Review of the medication administration record (MAR) for September 2014 revealed-PRN pain medication oxycodone/acetaminophen was administered on the following days without a corresponding assessment and documentation of	F 282	the effectiveness of pain medication. An attendance sheet will be utilized and reconciled with the C.N.A's and the licensed Nursing Staff and those staff unable to attend will be provided 1:1 education. 4) Monitoring to ensure on going Compliance The DON/Designee will do facility rounds 3 times weekly and pm observing care to ensure staff are following the resident's bathing plan of care and fall interventions are in place per individual resident care plans. The DON/Designee will review the C.N.A documentation weekly to ensure that baths and/or refusals are documented accordingly. The DON/Designee will review the MARS/TARS 3 times weekly and prn to ensure the Skin assessments and effectiveness of pain medication is documented. Issues identified will be corrected at at time and the DON/designee will review trends in AQ&A to ensure plan is implemented, sustained, and evaluated for its effectiveness. 5) Allegation of Compliance 11/21/2014		

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F 282	Continued From page 23 pain medication effectiveness: 9/8, 9/9, 9/14, 9/17, 9/18, 9/19, 9/21, 9/22, 9/28, and 9/29 (10 times out of 21 opportunities). 4. Review of the 5/12/14 significant change MDS assessment for resident #46 showed s/he required total assistance with baths. Review of the care plan for resident #46, updated 5/6/14, showed the resident required 1 staff assist for a bath or shower twice a week. Review of the September and October 2014 Resident Monthly Personal Care Records showed the resident did not receive a bath from 9/16/14 until 9/23/14 (7 days), and no baths from 10/1/14 thorough 10/8/14 (8 days). 5. Review of the care plan for resident #48, updated 9/25/14, showed the resident required 1 staff assist for a bath or shower twice a week. Review of the September and October 2014 Resident Monthly Personal Care Records showed the resident did not receive a bath from 9/7/14 until 9/13/14 (7 days), from 9/18/14 until 9/25/14 (8 days), and from 10/1/14 until 10/8/14 (7 days). 6. Review of the 8/24/14 care plan for resident #52 showed the resident required 1 staff assist for bed baths, with no specific timeframes noted. Review of the September and October 2014 Resident Monthly Personal Care Records showed the resident did not receive a bath from 9/7/14 until 9/13/14 (7 days), from 9/14/14 until 9/24/14 (11 days), and from 9/25/14 until 10/4/14 (10 days). 7. Review of the 7/7/14 care plan for resident #57 showed s/he required assistance with all ADLs including transfers, showers and baths. This review also showed staff were directed to provide	F 282			

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F 282	Continued From page 24 showers/baths 2 times each week. Review of the 9/2/14 to 10/7/14 bath and skin reports and resident monthly personal care records showed the resident received 6 showers during that time (5 weeks). 8. Review of the 8/5/14 care plan for resident #81 showed s/he required assistance with all ADLs including transfers, showers and baths. This review also showed staff were directed to provide showers/baths 2 times each week. Review of the 9/2/14 to 10/7/14 bath and skin reports and resident monthly personal care records showed the resident received 7 showers during that time (5 weeks). 9. Interview with CNA #3 on 10/7/14 at 4:45 PM revealed the bath aide "get[s] pulled to the floor because we are short on aides...3 to 4 times a week...and the bath/shower schedule is confusing [which shower is to be done each day]." Interview with RN #4 on 10/7/14 at 5:05 PM confirmed the bath aide gets pulled 3 times a week. Interview with CNA #3 on 10/7/14 at 5:10 PM confirmed the bath aide gets pulled a couple of times a week.	F 282			
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309		11/21/14	

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F 309	Continued From page 25 by: Based on medical record review, review of infection control information, and resident and staff interview, the facility failed to ensure physician orders were followed related to the administration of the Zostavax (Shingles) vaccine for 29 of 29 residents (#1, #4, #8, #9, #10, #11, #18, #24, #25, #26, #30, #32, #34, #41, #45, #47, #49, #55, #66, #67, #69, #70, #71, #72, #73, #74, #75, #76, #77). In addition, the facility failed to monitor pain intervention effectiveness for 2 of 13 open sample residents (#15, #47). The findings were: 1. Interview with resident #47 on 10/6/14 at 11 AM revealed s/he was given a vaccine for the shingles. The resident expressed concerns related to having received the vaccine and was worried about possible side effects. The following concerns were identified: a. Interview with the infection preventionist (IP) on 10/7/14 at 4:40 PM verified the resident was provided the vaccine the day before. The IP further stated the facility did not have a policy and procedure related to informed consents for vaccines other than influenza and pneumococcal, and she had not obtained any written consent from the resident or responsible party. She stated she had explained to the resident what was being given and that it was ordered by the physician. She then revealed there were other residents with orders for the vaccine, and the vaccines were in the facility available to be administered. Additionally, she stated the orders on the medical record for these residents were not completed in a timely manner based on changes in the pharmacy process at the facility and delays in receiving the vaccines. b. Medical record review showed a physician	F 309	Preparation and execution of the 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 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: A) for Resident #'s 1,4,8,9,10,11,18,24,25,26,30,32,34,41,45, 47,49,55,66,67,69,70,71,72,73,74,75,76,7 7, his/her orders were clarified. He/she received the shingles vaccine prior to the allegation of compliance. B) On or before the allegation of compliance the DON/Designee reeducated the nurses identified as failing to document the effectiveness of the pm pain medication that they gave the resident #15. On or before the allegation of compliance the DON/Designee will reeducate the C.N.A identified the 2667 as not having informed the nurse regarding a resident #15's pain. 2) Identification: A) Resident who currently reside at Laramie Care Center are at risk.		

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F 309	Continued From page 26 order for the Zostavax (Shingles) vaccine for resident #47 was dated 7/17/13 (more than 1 year old). In addition, the medical record showed the resident had a durable power of attorney, and there was no evidence this responsible party was notified prior to the vaccine administration. c. Review of the list provided by the IP on 10/8/14 at 4:45 PM showed 5 additional residents (#32, #30, #45, #34, #41) were administered the vaccine on 10/6/14, and 23 additional residents (#1, #4, #8, #9, #10, #11, #18, #24, #25, #26, #49, #55, #66, #67, #69, #70, #71, #72, #73, #74, #75, #76, #77) were identified with orders to have the vaccine, however, the vaccine was not yet administered. Review of the physician orders for these 28 residents showed they were all dated from July 2013. d. Interview with the Administrator and DON on 10/8/14 at 12:05 PM revealed the physician orders that were in the residents' records were being questioned due to the origin of the orders. There had been discussion in a recent quality meeting related to these orders and the fact they had not been fulfilled. There was at that time nothing conclusively decided. e. Review of the orders showed they were signed and dated by the physicians, and included the resident name, facility name, name of the vaccine, and a statement with the physicians decision to "Please administer 1 dose subcutaneous when available." f. Review of infection information from July 2013 to 10/9/14 verified one of these residents (#1) with the orders not completed, had been isolated and treated for the Shingles in February 2014. 2. Review of the 8/26/14 admission MDS assessment revealed resident #15 had diagnoses	F 309	B. Residents that currently reside at Laramie are at Potential risk. 3) Systemic Changes: A) Licensed nurses have been in services on provision/arrangement of the following services to meet professional standards, including ensuring timely administration of physician orders, specifically administration of Shingles Vaccine per the physician's orders. Physicians' orders received via a fax or progress note will be transcribed onto the telephone order sheet to ensure proper transcription occurs over to the MAR (medication administration records). The DON/Designee will conduct a review of the medication administration records 3 times weekly and pm to ensure shingles vaccines are completed per MD orders. The DON will provide follow up with the appropriate caregivers on identified problems, as deemed necessary. B) on or prior to the allegation of compliance the DON/Designee will reeducate staff on ensuring that when a residents report that he/she is in pain that it is communicated to the nurse assigned to that resident. On or prior to the allegation of compliance the DON/Designee will reeducate RN's/LPN's on ensuring they document the effectiveness of the pm medication on the back of the Medication administration record. A sign in sheet will be kept and reconciled with active RN's/LPN's and those staff unable to attend will be		

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F 309	Continued From page 27 that included diabetes mellitus (DM) II with neurological effects and osteoarthritis and was cognitively intact (alert and oriented). Review of the care plan related to pain dated 8/26/14 revealed interventions that included a "LN/Med aide will Assess and document response to each pm [as needed] dosage of analgesic." The following concerns were noted: a. Observation on 10/6/14 at 4:55 PM showed the resident reported having pain in his/her legs to CNA #3 who stated she would tell the nurse. b. Interview on 10/6/14 at 5:10 PM with RN #1 revealed she had not received report of a resident in pain. c. Interview on 10/7/14 at 4:45 PM with CNA #3 revealed she had forgotten to tell the nurse the resident was in pain. d. Interview on 10/6/14 at 7 PM with RN #1 confirmed the expectation is the CNA is to report the resident's complaint of pain to the nurse. e. Interview on 10/6/14 at 5:45 PM with the resident and the administrator revealed the resident was still complaining of pain (50 minutes later). f. Review of the medication administration record (MAR) for 10/6/14 revealed the resident received PRN pain medication oxycodone/acetaminophen at 5:50 PM after the administrator was made aware of the resident being in pain. g. Review of the medication administration record (MAR) for September 2014 revealed PRN pain medication oxycodone/acetaminophen was administered on the following days without a corresponding assessment and documentation of pain medication effectiveness: 9/8, 9/9, 9/14, 9/17, 9/18, 9/19, 9/21, 9/22, 9/28, and 9/29 (10 times out of 21 opportunities).	F 309	provided 1:1 education. 4) Monitoring performance to Ensure Compliance is sustained: A) The DON/Designee will conduct a review of the treatment administration records 3 times weekly and pm to ensure vaccines are completed per MD orders. The DON will provide follow up with the appropriate care givers on identified problems as deemed necessary. Identified issues will be tracked and trended and results will be included in the DON's/designee's monthly QA and A report in order to ensure that correction is implemented, achieved, sustained and evaluated for its effectiveness. The DON will be responsible for follow up on identified problems/trends. B) The DON/Designee will review the medication Administration records 3 times weekly for 1 month, the weekly for 1 month thereafter to ensure nursing staff is documenting effectiveness of pm pain medication. Any issues identified will be addressed at that time and the issues identified will be reported to the QAA committee by the DON/Designee to ensure the plan has been implemented, achieved, sustained and evaluated for its effectiveness. 11/21/2014		

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F 312 SS-E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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, medical record review, and resident and staff interview, the facility failed to ensure staff provided toileting assistance for 1 of 7 sample residents (#39) and 1 non-sample resident (#16), grooming assistance for 2 non-sample residents (#80, #81), and shower/bath assistance for 5 of 13 sample residents (#46, #48, #52, #57, #61) who required assistance with ADLs. The findings were: Regarding toileting assistance: 1. Review of the 9/30/14 admission MDS assessment showed resident #39 was alert and oriented and required limited assistance with ADLs. According to the 10/3/14 care plan the following interventions were implemented: a bed alarm to prevent falls due to forgetfulness; oxygen due to chronic obstructive lung disease; and a suprapubic catheter due to a history of urinary problems. Observation on 10/9/14 at 8:45 AM revealed CNA #7 responded to the bed alarm that was activated when the resident attempted to transfer from the bed to the wheelchair without staff assistance. During the observation the CNA stood closely by as the resident completed the transfer. After the resident was positioned in the wheelchair the CNA departed without applying the	F 312	F312 Corrective Action: Resident #39 and #16 now receive timely assistance with toileting per the plan of care. Resident #80 and #81 receive grooming assistance according to the plan of care. They were shaved prior to the surveyors leaving the facility and will receive assistance with shaving per the plan of care. Residents #46, 48, 52, 57, and 61 now receive bathing assistance per the plan of care. Identification: Residents who currently reside at Laramie Care Center are at potential risk. System: Beginning 10/29/2014, and continuing up until the allegation of compliance the DON/Designee will in-service C.N.A's and licensed Nursing staff on the importance of ensuring that residents are receiving assistance with ADL's per the plan of care and residents preference, to include toileting, grooming, and bathing	11/21/14	

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F 312	Continued From page 29 oxygen that was disconnected during the transfer, moving the urinary drainage bag that remained attached to the bed, or asking the resident why s/he wanted to get up. During an interview conducted immediately after the CNA departed, the resident stated s/he had gotten out of bed to go to the bathroom, but the CNA departed without providing the assistance s/he needed. 2. Review of the 7/14/14 significant change MDS assessment revealed resident #16 required extensive assistance with transferring, hygiene and toilet use, and was cognitively intact (alert and oriented). The following concerns were noted: a. Observation on 10/6/14 at 4:06 PM showed the resident activated the call light for assistance to the restroom. b. Interview with the resident at that time revealed the resident needed assistance to go to the bathroom. c. Observation that same day showed CNA #1 answered the call light at 4:22 PM (16 minutes later) and told the resident "I have to help another lady who is first. Give me about ten minutes." The CNA left the resident's room without assisting him/her to the bathroom. CNA #1 and NA #1 returned at 4:40 to assist the resident to the bathroom (18 minutes later). The resident waited a total of 34 minutes to be assisted to the bathroom. Regarding shower/bath assistance: 1. Review of the 7/7/14 care plan showed resident #57 required assistance with all ADLs including transfers, showers and baths. This review also showed staff were directed to provide showers/baths 2 times each week. Review of the	F 312	assistance. Monitoring: Don or designee with monitor and licensed staff and CNA's by reviewing C.N.AADL documentation and completing care rounds three times weekly for 1 month, then weekly for 1 month, then monthly and PM to identify issues with ADL assistance to assess continued compliance. Further monitoring will occur through the grievance process, resident and family interviews, resident council and ombudsman feedback. Identified issues will corrected and then the DON/Designee will report trends to QA&A to ensure plan has been implemented, sustained, and evaluated for it's effectiveness. 11/21/2014		

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F 312	Continued From page 30 9/2/14 to 10/7/14 bath and skin reports and resident monthly personal care records showed the resident received 6 showers during that time (5 weeks) and there was no documented refusals. 2. Review of the 8/5/14 care plan for resident #61 showed s/he required assistance with all ADLs including transfers, showers and baths. This review also showed staff were directed to provide showers/baths 2 times each week. Review of the 9/2/14 to 10/7/14 bath and skin reports and resident monthly personal care records showed the resident received 7 showers during that time (5 weeks) and there were no documented refusals. 3. Review of the 5/12/14 significant change MDS assessment for resident #46 showed s/he required total assistance with baths. Review of the resident's care plan, updated 5/6/14, showed the resident required 1 staff assist for a bath or shower twice a week. Review of the September and October 2014 Resident Monthly Personal Care Records showed the resident did not receive a bath from 9/16/14 until 9/23/14 (7 days), and no baths from 10/1/14 thorough 10/8/14 (8 days). 4. Review of the 9/1/14 annual MDS assessment for resident #48 showed s/he required total assistance with baths. Review of the resident's care plan, updated 9/25/14, showed the resident required 1 staff assist for a bath or shower twice a week. Review of the September and October 2014 Resident Monthly Personal Care Records showed the resident did not receive a bath from 9/7/14 until 9/13/14 (7 days), from 9/18/14 until 9/25/14 (8 days), and from 10/1/14 until 10/8/14	F 312			

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F 312	Continued From page 31 (7 days). Interview with the resident on 10/8/14 at 3 PM confirmed s/he was required to receive 2 baths or showers per week. The resident stated that some weeks s/he receives 2 baths/showers a week and sometimes not. S/he stated staff were too busy when the facility failed to perform the required baths/showers. 5. Review of the 9/1/14 significant change MDS assessment for resident #52 showed s/he was confined to the bed and required total assistance with bed baths. Review of the resident's 8/24/14 care plan showed the resident required 1 staff assist for bed baths, with no specific timeframes noted. Review of the September and October 2014 Resident Monthly Personal Care Records showed the resident did not receive a bath from 9/7/14 until 9/13/14 (7 days), from 9/14/14 until 9/24/14 (11 days), and from 9/25/14 until 10/4/14 (10 days). 6. Interview with CNA #3 on 10/7/14 at 4:45 PM revealed the bath aide "get[s] pulled to the floor because we are short on aides...3 to 4 times a week...and the bath/shower schedule is confusing [which shower is to be done each day]." Interview with RN #4 on 10/7/14 at 5:05 PM confirmed the bath aide gets pulled 3 times a week. Interview with CNA #3 on 10/7/14 at 5:10 PM confirmed the bath aide gets pulled a couple of times a week. Regarding nail and facial hair assistance: 1. Observation on 10/6/14 at 2 PM and 5:35 PM showed resident #80 had thick stubble on her chin and upper lip. Review of the 8/25/14 quarterly MDS assessment showed the resident required extensive assistance for hygiene and	F 312			

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F 312	Continued From page 32 bathing. When reviewed the monthly personal care record showed the latest shower or bath was provided for the resident on 10/4/14 however, there was nothing to show if the resident was shaved at that time. Review of the bath and skin reports showed this was where staff documented specifics provided during the bath such as cleaning of ears, trimming nails and shaving. Review of the October 2014 reports showed there was not a sheet completed for the 10/4/14 shower. Interview on 10/6/14 at 4:47 PM with the resident and RN #2 verified the CNAs were responsible for shaving residents when baths/showers were given and as needed. The resident at that time stated she could not recall the last time she was shaved, she also stated s/he feels the stubble when she touches her face and finds it "embarrassing and degrading." 2. Observation on 10/6/14 at 4:15 PM showed resident #81 was awake and seated in his/her wheelchair. The resident was noted at that time to be wearing soiled clothes and to have long chin whiskers. Review of the October 2014 monthly personal care record showed the resident required extensive assistance for personal hygiene and bathing. Review of the September and October 2014 records showed the resident was last bathed/showered on 9/30/14 and the last time there was documentation of the resident having been shaved was on 9/6/14.	F 312			
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	F 315		11/21/14	

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F 315	Continued From page 33 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 observation, staff interview, and medical record review, the facility failed to provide appropriate interventions to prevent urinary incontinence for 1 of 11 sample residents (#15) with urinary incontinence. The findings were: Review of the 8/26/14 admission MDS assessment revealed resident #15 was independent with personal hygiene and toilet use and was always continent of urine. Review of the care plan related to impaired skin integrity dated 10/6/14 revealed "staff will check on resident frequently." The following concerns were noted: a. Observation on 10/6/14 from 2:20 PM until 4:22 PM showed the resident lying in bed, and no staff checked on him/her. b. Observation the same day at 4:55 PM showed although the resident was not coded as incontinent of urine, the resident was assisted to the bathroom by CNA #3 and NA #1, and was saturated with urine. Urine was visible on the resident's robe, underwear, incontinence pad, as well as the sheet of his/her bed. The staff assisted him/her with a change of incontinence pad and underwear, and removed the sheet, but did not offer to change the resident's robe. c. Observation on 10/7/14 at 12 noon showed the resident wearing the same red, floral robe. d. Interview on 10/7/14 at 4:45 PM with CNA	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. 1) Corrective action: For resident # (15) his/her care plan now includes individualized approaches to address the resident's toileting needs. He/She is being toileted timely per her plan of care. 2) Identification: Residents with incontinence are at risk. Residents who are incontinent will be		

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F 315	Continued From page 34 #3 revealed she was unaware the resident's robe was wet. e. Interview on 10/9/14 at 3:15 PM with the DON revealed the expectation that staff was to check on the resident every hour. f. Interview on 10/9/14 at 3 PM with the MDS coordinator revealed the resident was being watched closely for a significant change.			F 315	evaluated to ensure toileting and/or incontinence care needs are addressed. Care plans will be reviewed/revised at that time. 3) Systemic Changes: Upon admission residents are assessed for incontinence utilizing the data collection tool. Residents will be assessed continually through the RAI process. When a resident is identified as incontinent he/she will be evaluated by a licensed nurse and the nurse will develop a care plan that will include individualized approaches to address the resident's toileting needs. The IDT will update the plan of care and communicate to the nursing staff the suggested toileting plan/incontinent care plan. On or before the date of alleged compliance, the SDC/Designee will inservice the nursing staff on ensuring residents are toileted timely. 4) Monitoring: The DON/Designee will do Quality of Care rounds 3 times weekly and pm to ensure residents who are incontinent of bladder receive appropriate treatment and services as indicated. Further monitoring will include review resident council concerns and resident grievances regarding timely toileting. Issues identified will be reviewed in QA&A to ensure plan has been implemented, sustained and evaluated for its effectiveness. 5) Date of alleged compliance: 11/21/2014		

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F 318 F 318 SS=D	Continued From page 35 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION 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 ensure restorative services were consistently provided for 2 of 7 sample residents (#61, #72) who needed this service to increase their range of motion. The findings were: 1. Review of the 8/6/14 admission MDS assessment showed resident #61 had diagnoses that included peripheral vascular disease, a urinary catheter, severe cognitive impairment, limited mobility in all extremities, and required extensive and total assistance with all ADLs. Review of the 8/14 to 9/2/14 physical therapy (PT) and occupational therapy (OT) notes showed the therapy goals for the resident included increase range of motion due to contractures. Review of the PT note dated 9/2/14 showed, "restorative program established. Trained restorative aide on ROM [range of motion] program to maintain ROM". Review of the PT restorative program recommendations, dated 9/2/14, showed range of motion and stretching was to be provided 3 to 5 times a week. Interview with the restorative aide #1 on 10/9/14 at 9:50	F 318 F 318	F318 Range of Motion 1) Corrective Action: Resident (61) is receiving restorative services per his plan. Resident (72) is receiving restorative services per her plan. 2) Identification of other Residents who may be at Risk. Residents who reside at facility and require Restorative services are at risk. 3) Systemic Changes Residents who enter the facility with limitations of motion or residents who have primary risk factors for decreased range of motion will be identified via the data collection tool and the MDS/RAI process. Risk factors include: Immobilization's (bedfast, casts, weakness) Deformities and Increased muscle tone. Nursing will perform baseline assessment on admission, quarterly and for change in condition of		11/21/14

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F 318	Continued From page 38 AM, and review of the restorative nursing documentation, revealed range of motion had not been provided three days a week consistently in September and October 2014. 2. Review of the 9/28/14 annual MDS assessment revealed resident #72 had diagnoses that included COPD and depression, was cognitively intact (alert and oriented), needed assistance to walk, and had shortness of breath on exertion. Review of the September 2014 restorative documentation revealed the resident was to receive restorative nursing services at least three times a week. The following concerns were noted: a. Review of the nursing restorative care flow record for September 2014 revealed a lack of documentation for the week of 9/28/14 through 10/3/14 as ordered. b. Interview on 10/9/14 at 4:45 PM with the resident verified staff were not available to walk with him/her three times that week.	F 318	range of motion. Nursing to assess for change in condition or change in risk factors on an ongoing basis. Nursing will then follow through with contracture prevention or management program developed by Therapy or Restorative Nurse incorporating range of motion activities. The R.N.A will follow the Resident Restorative plan which includes positioning residents appropriately in bed and wheelchair to inhibit, maintain, or prevent abnormal positioning, performing ROM exercises actively, assisted actively, or passively as indicated, maximizing functional level in bed mobility, transfers, WC mobility, and ambulation and Encouraging independence in ADL's. Range of Motion Program will be documented according to the Residents plan of care. 4) Monitoring: The DON/Designee will review Restorative documentation Three times weekly and pm to ensure no gaps in the restorative documentation occur. Issues identified will be corrected at the time and the DON/Designee will reports issues in QA&A to ensure plan is implemented, sustained and evaluated for its effectiveness. 5) Allegation of Compliance 11/21/2014		
F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		11/21/14	

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F 323	Continued From page 37 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, resident and staff interview, and medical record review, the facility failed to ensure effective supervision and interventions were in place to prevent falls for 1 of 5 sample residents (#15) with a history of falls. In addition, the facility failed to ensure a safe environment in two resident rooms (room #5, room #8). The findings were: 1. Review of the 8/26/14 admission MDS assessment revealed resident #15 was alert and oriented, with a BIMS (brief interview for mental status) score of 13, and was able to make him/herself understood. Review of the nursing notes showed the resident had falls on the following dates: 9/26/14, 9/27/14, 9/29/14, 10/1/14, 10/3/14, and 10/5/14. Review of the 9/29/14 interdisciplinary team (IDT) fall review note showed it only addressed the 9/26/14 fall, and at that time the plan was to "encourage the resident to wear night gowns that were not too long." Review of the 9/30/14 IDT fall review showed the resident had an unwitnessed fall in the bathroom on 9/29/14 with no injuries. The note showed the resident was evaluated by physical therapy (PT), and the resident would be re-educated to call for assistance when getting up, and non-skid strips would be added in front of resident's bed and in the bathroom. Review of the IDT fall review note dated 10/2/14 revealed the	F 323	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. F323 Corrective Action: Resident # (15) has been moved closer to the nurses' station. The IDT met on 10/30/2014 to review her falls and the following measure have been put in place. The sharp edges on the heater vents noted in rooms (#5, #8) were repaired no longer pose a safety risk.		

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F 323	Continued From page 38 resident had a witnessed fall on 10/1/14. Prior to the 10/1/14 fall, the following measures were in place: fall mat, alarms to bed, shorter nightgowns, and a PT evaluation tht determined the resident was a candidate for restorative therapy (the resident refused PT). At that time the plan was for an enabler bar to be added to the outside of the resident's bed, non-skid socks and shoes be available, the resident to be encouraged to ask for assistance with needs, and for "alarms to be removed due to agitation of resident and resident attempting to turn off and dismantle [alarms]." Review of the 10/6/14 IDT fall review showed the team discussed falls that occurred on 10/3/14 and 10/5/14, at that time the plan was to have PT evaluate, labs evaluated, and a urine analysis was ordered. Review of the care plan related to falls showed it was initiated on 8/28/14 and updated on 9/30/14 and on 10/6/14. The undated approaches included non-skid footwear, reminding the resident to use the call light, non-skid strips to the floor in the bathroom, keeping necessary items in reach, and keeping the walker in area or position for next time. The 10/6/14 dated approaches were for a PT evaluation, the addition of an enabler bar to the bed, working with restorative for strengthening, and urine analysis with culture and sensitivity. In addition, the resident's 10/6/14 care plan related to impaired skin integrity showed "staff will check on resident frequently." The following concerns were noted: a. Observation on 10/6/14 at 2:05 PM showed the resident was lying awkwardly in bed, with his/her feet and legs hanging off the end of the bed, and head unsupported by pillows. The resident was not assisted with help to elevate his/her feet until CNA #2 heard the resident yelling for help at 2:20 PM. A bed alarm was in	F 323	Identification: Residents who are at risk for falls are at risk. Beginning 10/24/2014 and continuing up until the allegation of compliance the interdisciplinary team will review residents who have had a fall in the last 30 days to ensure the fall was thoroughly investigated and interventions are in place to address the identified risks and decrease residents for falls with injury. Care plans will be reviewed and revised at that time if indicated. The maintenance director/NHA did rounds in all resident room to identify any other heater vents that may need to be replaced/repared. Issues identified were corrected at that time. Systemic Changes All residents are considered to be at risk for falls on admission until all review processes are completed and reviewed by the IDT. Residents will be screened on admission, quarterly, annually, and with significant change in status for risk for falls via the data collection tool and the RAI process. A fall care plan will be developed on admission, readmission, or change in status addressing potential risk factors. When the level of risk, specifically the details of the risk factors have been determined the information will be utilized to further refine the resident's plan of care. The resident's data collection tool will be reviewed for potential fall risks. A resident's care plan will be developed by a		

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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 10/09/2014
NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070		
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F 323	Continued From page 39 place under the resident, but was not alarming, and there were no non-skid strips in front of the bed. b. Observation on 10/6/14 from 2:20 PM until 4:22 PM showed the resident was lying in bed, and no staff checked on him/her during the 2 hours and 2 minutes. c. Observation on 10/6/14 at 5:26 PM showed the resident transferred him/herself from the bed to the wheelchair without assistance. During the observation, the resident made no attempt to use the call light, and the resident was noted to be unsteady. The bed alarm sounded, and the resident turned it off after sitting in the wheelchair. d. Interview with the resident on 10/7/14 at 12 noon revealed the staff "don't answer the call light, and they get mad at me when I call for help." e. Interview with CNA #3 on 10/7/14 at 4:45 PM revealed the facility expectation was to check on the resident frequently, and she was unsure why that was not done during the observation period from 2:20 PM to 4:22 PM on 10/6/14. f. Review of the care plan for falls showed alarms were not included as an approach. However, they were in use and had been determined by the IDT on 10/1/14 to be non-effective and "agitate the resident." g. Interview with the DON on 10/9/14 at 3:15 PM revealed the expectation was for staff to check on the resident every hour. 2. Observation on 10/9/14 at 10 AM showed floor heat vents against the back walls of rooms #5 and #8. Both vents were secured with metal fastener strips. The observation revealed each had a metal edge jutting outward that created a risk of injury.	F 323	licensed nurse and will include all identified risks with appropriate interventions. A resident's care plan will be reviewed and updated with each additional fall which might occur. Facility staff, residents, and family members will be made aware of the different interventions to be used with resident through the care planning process. A licensed nurse will thoroughly assess and evaluate the resident immediately when the fall has occurred including reviewing the resident for pain and providing pain medication if indicated. The IDT will meet to complete a careful review and analysis of the possible contributing factors to the fall with or without injuries. In addition, resident falls will be documented, reported, assessed and care planned by the interdisciplinary team to prevent repeat falls or falls resulting in significant injury. The Interdisciplinary team will review resident falls within 24 to 72 hours to evaluate circumstances and probable cause for the fall utilizing the post fall review. The interdisciplinary team will then modify or implement a care plan and treatment approach, including addressing any identified need for interventions and/adequate supervision to prevent falls resulting in injury or prevent repeat falls. Beginning October 30, 2014 and continuing until the allegation of compliance Staff will be in-serviced by the SDC/designee on the above information and Fall Management and Investigation Program (SNF) CL-INTER-0102, to include the importance of providing adequate supervision and implementation		

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F 323	Continued From page 40	F 323	of interventions to reduce residents risks of falling. An attendance sheet will be kept and reconciled with the active RN, LPN, CNA roster and those unable to attend will be provided with 1:1 reeducation. The NHA/Designee in-serviced the maintenance staff on preventative maintenance program and ensure rooms are checked for safety hazards such as sharp edges on heater vents. Monitoring: Charge nurses will monitor for residents receiving supervision and application of interventions to prevent falls via care rounds during their shift. Members of the IDT will assist in monitoring by conducting administrative rounds 3 times weekly times one month then weekly for a month and then monthly and if no concerns are identified as needed thereafter. In addition the DON/designee will oversee the 24-hour reporting system via the morning Leadership Meeting as well as the IDT review of incidents/falls. DON/Designee will analyze results for trends and patterns in resident falls to use as a basis for implementation of process improvement and trends will be reviewed monthly in QA&A for purposes of process improvement and to ensure plan is implemented, sustained and evaluated for its effectiveness. The maintenance director will conduct room rounds weekly and pm to ensure there are no safety hazards such as sharp		

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F 323	Continued From page 41	F 323	edges on heater vents. issues will be corrected at that time and trends will be used as a basis for implementation of process improvement and trends will be presented by maintenance director monthly in QA&A for purposes of process improvement and to ensure plan is implemented, sustained and evaluated for effectiveness. 11/21/2014		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure continuous oxygen therapy was provided for 1 of 6 sample residents (#63) who required oxygen therapy. The findings were: Review of the admission nursing data collection tool showed resident #63 was admitted to the facility on 9/26/14 with memory problems and	F 328	F328 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	11/21/14	

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F 328	Continued From page 42 some confusion. Review of the care plan, dated 10/3/14, showed s/he required assistance with continuous oxygen therapy and transfers. Further review of the care plan interventions showed staff were directed to monitor the resident's oxygen saturation level to keep the rate up (specific parameters were not documented). Review of the 9/27/14 physicians orders showed orders for continuous oxygen at 2.5 liters by nasal cannula. Periodic observations on 10/6/14 from 2 PM until 4:10 PM revealed the resident was asleep in bed with the oxygen cannula appropriately positioned in his/her nose; however, the tube was not connected to the oxygen. During the observed period of time, staff did not connect the resident's oxygen when they responded to the roommate's call light at 3 PM, 3:30 PM, 3:38 PM and 3:50 PM. At 4:10 PM the surveyor asked RN #3 to check the resident's oxygen saturation rate and it was 82%. At that time the RN stated the rate was too low and she connected the disconnected tube to the oxygen.	F 328	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. Corrective action: Resident #63 receives oxygen per physicians order as she will allow. Identification: Residents requiring O2 are at risk. Systemic: On or before the date of compliance the nursing staff will be inserviced on Oxygen Delivery, specifically ensuring that residents who use oxygen have oxygen in place per the physicians order. Monitoring: The nurse management staff will do quality of care rounds 3 times weekly and pm to ensure those residents who wear oxygen have it in place per the physicians order and issues identified will be corrected immediately and trended to be reviewed in QA&A to ensure plan is implemented, sustained and evaluated for it's effectiveness.		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353	11/21/2014	11/21/14	

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F 353	Continued From page 43 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. 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, staff and resident interviews, and review of shower records and staff schedules, the facility failed to consistently ensure 3 of 3 nursing units were sufficiently staffed to meet the needs of the residents. The census was 80. The findings were: Regarding staff interviews: 1. Interview on 10/6/14 at 4:40 PM with RN #3 revealed the CNAs were "doing the best they can." She then stated "staffing is a problem, they [the staff] are all burned out."	F 353	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 substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of		

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F 353	Continued From page 44 2. Interview with CNA #3 on 10/7/14 at 4:45 PM revealed the bath aide "get[s] pulled to the floor because we are short on aides...3 to 4 times a week...and the bath/shower schedule is confusing [which shower is to be done each day]." 3. Interview with RN #4 on 10/7/14 at 5:05 PM confirmed the bath aide gets pulled 3 times a week. 4. Interview with CNA #3 on 10/7/14 at 5:10 PM confirmed the bath aide gets pulled a couple of times a week. Regarding resident interviews: 1. Confidential interview with 8 residents on 10/7/14 at 3 PM revealed the facility is consistently short-staffed with regards to CNA's. The resident's comments included: a. When the facility is short-staffed the shower CNA is pulled to the floor and the showers do not get done. b. The CNA's answer the call light and then say "I will be back," but the residents have to wait another 20 minutes to as much as 2.5 hours to get the help they require. c. Residents have to wait a long time to eat because there is "not enough help." 2. Interview on 10/9/14 at 8:50 AM with resident #10 revealed the facility was short of help and she and others "have to be patient" when waiting to be helped. Interview on 10/6/14 at 2:30 PM with resident #10 revealed the facility needs more CNAs during the day. 3. Review of the 8/7/14 annual MDS assessment	F 353	compliance in accordance with section 7305 of the state operations manual. Corrective Action: The facility will have sufficient staff to provide nursing and related services to attain, maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and individual plans of care. Identification: The residents at the facility are at risk. Systemic changes: The facility will be staffed sufficiently to provide nursing and related services to attain, maintain the highest practicable physical, mental and psychosocial well-being of each resident as determined by resident assessments and individual plans of care. Residents will receive assistance with bath/showers per the individual plan of care and the schedules will were as documentation of the facility staffing. In the event that a nursing staff member calls off work that staff member will be replaced accordingly. Prior to the allegation of compliance the NHA/Designee will educate the Nursing leadership team on ensuring staffing		

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F 353	Continued From page 45 revealed resident #6 was alert and oriented. Interview on 10/6/14 at 2:10 PM revealed it "takes them [staff] a while [to answer the call light]...they [the facility] need more CNAs here." 4. Review of the 8/26/14 admission MDS assessment revealed resident #15 was cognitively intact (alert and oriented). Interview with resident #15 on 10/7/14 at 12 noon revealed the staff "don't answer the call light, and they get mad at me when I call for help." 5. Review of the 9/29/14 annual MDS assessment revealed resident #72 was cognitively intact (alert and oriented). Interview with the resident on 10/8/14 at 10:45 AM revealed "staff take a while to answer [my] call light and [the facility lacks] enough help." Regarding resident assistance with baths/showers and activities of daily living: 1. Review of the 7/14/14 significant change MDS assessment revealed resident #16 required extensive assistance with transferring, hygiene and toilet use, and was cognitively intact (alert and oriented). The following concerns were noted: a. Observation on 10/6/14 at 4:06 PM showed the resident activated the call light for assistance to the restroom. b. Interview with the resident at that time revealed the resident needed assistance to go to the bathroom. c. Observation that same day showed CNA #1 answered the call light at 4:22 PM (16 minutes later) and told the resident "I have to help another lady who is first. Give me about ten minutes." The CNA left the resident's room without assisting her	F 353	needs are met based off the current census. Monitoring The NHA/DON will review staffing each weekday and on Fridays will review the weekend staffing. They will also review schedules weekly to ensure sufficient staffing. The DON/Designee will interview 3 residents weekly regarding receiving assistance with bathing, and timeliness of call lights. Issues identified will be tracked to be presented in QAA by the DON/Designee to ensure the plan is implemented sustained, and evaluated for its effectiveness. Date: 11/21/2014		

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F 353	Continued From page 46 to the bathroom. CNA #1 and NA #1 returned at 4:40 to assist the resident to the bathroom (18 minutes later). The resident waited a total of 34 minutes to be assisted to the bathroom. 2. Review of the 5/12/14 significant change MDS assessment showed resident #46 required total assistance with baths. Review of the resident's care plan, updated 5/8/14, showed the resident required 1 staff assist for a bath or shower twice a week. Review of the September and October 2014 Resident Monthly Personal Care Records showed the resident did not receive a bath from 9/16/14 until 9/23/14 (7 days), and no baths from 10/1/14 through 10/8/14 (8 days). 3. Review of the 9/1/14 annual MDS assessment showed resident #48 required total assistance with baths. Review of the resident's care plan, updated 9/25/14, showed the resident required 1 staff assist for a bath or shower twice a week. Review of the September and October 2014 Resident Monthly Personal Care Records showed the resident did not receive a bath from 9/7/14 until 9/13/14 (7 days), from 9/18/14 until 9/25/14 (8 days), and from 10/1/14 until 10/8/14 (7 days). Interview with the resident on 10/8/14 at 3 PM confirmed s/he was required to receive 2 baths or showers per week. The resident stated that some weeks s/he receives 2 baths/showers a week and sometimes not. S/he stated staff were too busy when the facility failed to perform the required baths/showers. 4. Review of the 9/1/14 significant change MDS assessment showed resident #52 was confined to the bed and required total assistance with bed baths. Review of the resident's 8/24/14 care plan showed the resident required 1 staff assist for	F 353			

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F 353	Continued From page 47 bed baths, with no specific timeframes noted. Review of the September and October 2014 Resident Monthly Personal Care Records showed the resident did not receive a bath from 9/7/14 until 9/13/14 (7 days), from 9/14/14 until 9/24/14 (11 days), and from 9/25/14 until 10/4/14 (10 days). 5. Review of the 7/7/14 care plan showed resident #57 required assistance with all ADLs including transfers, showers and baths. This review also showed staff were directed to provide showers/baths 2 times each week. Review of the 9/2/14 to 10/7/14 bath and skin reports and resident monthly personal care records showed the resident received 6 showers during that time (5 weeks) and there was no documented refusals. 6. Review of the 8/5/14 care plan showed resident #61 required assistance with all ADLs including transfers, showers and baths. This review also showed staff were directed to provide showers/baths 2 times each week. Review of the 9/2/14 to 10/7/14 bath and skin reports and resident monthly personal care records showed the resident received 7 showers during that time (5 weeks) and there were no documented refusals.	F 353			
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363			11/21/14

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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		
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F 363	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the planned menu, the facility failed to ensure portion sizes were followed for 17 residents (#3, #13, #14, #22, #29, #35, #36, #41, #42, #53, #57, #61, #69, #75, #77, #80, #81) who had orders for puree or mechanical ground diets. The findings were: Review of the menu for the noon meal on 10/8/14 showed the main meal was tuna croquet, mashed potatoes, and vegetables. The planned portions for the main item the tuna croquet was a number 8 scoop (equivalent to 4 ounces) for the puree and mechanical ground diets. Observation of the noon meal service on 10/8/14 at 11:30 AM showed cook #1 used a number 16 scoop (equivalent to 2-2 1/4 ounces) as the serving size for this main food item. Review of the diet cards of those served this meal showed there were 17 residents (#3, #13, #14, #22, #29, #35, #36, #41, #42, #53, #57, #61, #69, #75, #77, #80, #81) with mechanical and/or pureed diets (excluding those with small portions) who were provided one half of the planned portion for this food item. Interview with the cook and the dietary manager on 10/8/14 at 12 PM verified the appropriate portion size was not used. The interview revealed additional training related to the menus and scoop sizes were needed.	F 363	F363 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 purpose 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 allegation of compliance in accordance with 42 C.F.R & 488.18 section 7317a of the state operations manual. 1) Correction: A) For Resident #'s 3,13,14,22,29,35,36,41,42,53,57,61,69,75 ,77,80,81. He/she who are pureed diets are receiving the appropriate portion sizes unless otherwise requested by the resident. 2) Identification: Resident's residing in the facility have the potential to be affected by the practice. 3) Systemic Changes: On or prior to the allegation of compliance the FSD and Dietician reeducated the dietary staff on following all appropriate		

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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 10/09/2014
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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

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F 363 Continued From page 49

F 363

Scoop sizes are utilized per the menus and ensuring residents who receive pureed diets gets the appropriate portion size.

4) Monitoring:

FSD/designee will monitor meal service at the tray line 3 times a week for 1 month, then weekly for 1 month, then monthly and as needed to ensure menu portion sizes are followed. Issues identified will be corrected at that time. Results will be tracked/trended for any issues. Issues identified will be reviewed in QA&A monthly to ensure the system is maintained and evaluated for its effectiveness.

11/21/14

F 441 483.65 INFECTION CONTROL, PREVENT
SS=E SPREAD, LINENS

F 441

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and 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.

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F 441

Continued From page 50

(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 and staff interview, the facility failed to practice adequate infection control practices in a variety of areas. The findings were:

1. Observation on 10/6/14 at 4:56 PM revealed admissions staff #1 removed an over-bed table from the dirty utility room, wheeled it through the halls to resident #48's room and placed the resident's food on the table. During the observation the table was not cleaned at any time after it was removed from the dirty utility room.
2. CNAs #1 and #2 were observed providing toileting assistance and perineal care for resident #64 on 10/6/14 at 4:50 PM. At that time the CNAs used a mechanical lift to transfer the resident to the commode, performed perineal care and removed their gloves. Next they donned another pair of gloves and used the mechanical lift to transfer the resident from the commode to the bed. Then they applied a clean disposable brief,

F 441

F441

Corrective Action:

The admissions coordinator was reeducated on ensuring good infection control techniques when assisting residents. C.N.A's and NA identified in the survey have been reeducated on ensuring good infection control techniques, specifically hand washing before and after removal of gloves, hand hygiene between dirty and clean linen and transporting linen appropriately. Resident #15's bathroom was deep cleaned prior to Surveyors leaving the facility. Housekeeper #1 no longer works for in housekeeping. Housekeeping surveyors was replaced.

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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**

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F 441 Continued From page 51

dressed the resident, and transferred him/her to the wheelchair. They removed their gloves and donned another pair of gloves prior to cleaning the resident's dentures. They removed that pair of gloves and donned another pair of gloves prior to removing the trash from the room. During the observation the CNAs did not perform hand hygiene between the glove changes.

3. Observation on 10/6/14 at 2:50 PM showed CNAs #1 and 2 were replacing linens in resident rooms. During the observation the CNAs removed the dirty towels from the resident bathrooms and placed them in a plastic bag hanging off of the clean linen cart. At 2:53 PM CNA #2 brought dirty towels out of room #40 and without any hand hygiene she picked up clean towels and took them into the room. The CNA then performed the same action for the room across the hall again not performing hand hygiene between handling the dirty and clean linens.

4. Observation on 10/6/14 at 3:15 PM showed NA #1 pushed unbagged, uncovered, visibly soiled linen on top of the shower chair down the hallway to an unknown location and did not wear gloves.

5. Observation on 10/6/14 at 4:40 PM showed CNA #3 and NA #1 provided care to resident #16. Perineal care was performed; both staff members removed their gloves, did not perform hand hygiene and lowered the resident to the wheelchair.

6. Observation on 10/6/14 at 4:55 PM showed CNA #3 removed visibly soiled sheets from the bed of resident #15 without using gloves, and

F 441

Identification:

Residents that reside at the facility are at risk.

Systemic Changes:

Beginning 10/24/2014 and continuing up until the allegation of compliance the DON/Designee will in service the RN's, LPN's and CNA's on the facility's IC practices as they pertain to hand washing before and after removal of gloves, hand washing before and after resident care, and transporting soiled linen. An attendance sheet will be reconciled with an active staff roster and those nursing staff unable to attend will be provided 1:1 education. The DON/Designee will review the IC report to identify trends with the medical director during the QA process monthly. The housekeeping staff was reeducated by NHA prior to 11/21/2014 on infection control.

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F 441	Continued From page 52 without performing hand hygiene proceeded to immediately touch the resident's ice water jug on the over-the-bed table. Interview on 10/9/14 at 2 PM with the Infection Preventionist (IP) confirmed the expectation that hand hygiene is to be performed after removing gloves, and that linen is to be bagged appropriately before removing it from the rooms. 7. Review of the 8/26/14 admission MDS assessment revealed resident #15 was alert and oriented. The following concerns were noted: a. Interview on 10/7/14 at 12 noon with the resident revealed it bothered him/her that the bathroom walls were covered with bowel movement and were not thoroughly cleaned by staff. b. Observation at that time showed brown spots on the floor by the toilet, and three of the four walls were covered with brown spots that were identified as bowel movement by the resident. c. Interview at that time with housekeeper #1 revealed she had cleaned the bathroom and confirmed she was rushing through the cleaning process and the bathroom needed to be cleaned better. d. Interview on 10/9/14 at 1 PM with the housekeeper supervisor revealed the housekeepers were in a hurry and do not clean all the way, but the expectation is that housekeeping staff clean the walls and deep clean the bathrooms once a day.	F 441	Monitoring: The DON/Designee will complete visual rounds observing care delivery to ensure hand washing and transporting soiled linen is completed appropriately per infection control guidelines 3 times weekly for 1 month, then weekly for 1 month, then monthly and prn thereafter. The NHA will perform rounds with Housekeeping supervisor monthly. Issues identified will be tracked and corrected at the time, trends as well as infection control reports will be presented in QA&A be the DON/Designee to ensure plan has been implemented, sustained, and evaluated for its effectiveness. 11/21/14		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly	F 468		11/21/14	

12/3/14

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F 468	Continued From page 53 secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure handrails were safely secured to prevent injury in 4 of 8 hallways (north birch hallway, south birch hallway, pine hallway, aspen hallway). The findings were: Random observations on 10/9/14 from 8:15 AM through 10 AM revealed the following handrails were loose: a. The handrail in the hallway outside of room #67. b. Between the 100 nursing station and the dirty utility room the handrail was loose 17 inches by 6 inches. c. The handrail in the hallway outside of room #11. d. The handrail in the hallway outside of room #26. e. The handrail outside the copier room on the hallway near the 200 nursing station. Interview with the maintenance director on 10/9/14 at 11:20 AM confirmed the handrails needed securing for safety.	F 468	F468 Preparation and execution of the response and plan of correction 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 based 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. Handrails that were identified as being loose during survey were securely fastened to the wall by the maintenance director at the time of survey. No residents were identified for this deficiency. (A) The loose handrail outside of Rm. #167 has been secured to the wall by the use of new anchors. (B) The 17" railing that was loose between the #10 nurse station and the dirty utility has been secured to the wall by the use of new anchors. (C) Loose handrail in the hallway outside of Rm. #11 was secured to the wall by the use of new anchors. (D) The loose handrail in the hallway outside of		

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F 468	Continued From page 54	F 468	Rm. #226 was secured by the use of new anchors. (E) The handrail outside the copier room in the hallway near the #200 nursing station has been secured by the use of new anchors. Residents who reside at the facility are at potential risk. The facility will ensure the measures and/or systemic changes put into place will include but not limited to providing a safe, functional and comfortable environment for residents. On 10/29, 2014 Administrator/designee will provide in-service education and training to the facility maintenance staff regarding the importance of ensuring all handrails are tightly fastened to the wall. The Maintenance Director/designee will monitor compliance via the facility's preventive maintenance program monthly for the next 3 months and as needed thereafter until substantial compliance has been met. Rounds/observations will be conducted and cover all of the facility. Further review/monitoring will be done through the Resident Council, the facility grievance process, ombudsman, and family feedback. Results through these reviews will be tracked/trended for any issues. Issues identified will be reviewed in QA&A for process improvement to ensure the system is maintained and evaluated for its effectiveness. 11/21/2014		

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12/31/14

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F 514 F 514 SS=E	Continued From page 55 483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure the clinical records were complete and accurate for 1 of 13 sample residents (#15). The findings were: Review of the 8/26/14 admission MDS assessment revealed resident #15 had diagnoses that included diabetes mellitus (DM) II with neurological effects and osteoarthritis and was cognitively intact (alert and oriented). The following concerns were identified: a. Medical record review of the September MAR revealed a lack of documentation in regards to the administration of scheduled Lantus insulin 10 units subcutaneously at bedtime on 9/13/14, 9/26/14, and 9/30/14. b. Further review revealed a lack of documentation in regards to obtaining a blood sugar level before the dinner meal on 9/11/14 and	F 514 F 514	F514 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 of 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. The facility will maintain clinical recorders		11/21/14

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F 514	Continued From page 56 9/12/14 and before bedtime on 9/16/14. c. Additional review revealed a lack of documentation in regards to the administration of Novolog 8 units subcutaneously before dinner on 9/20/14. d. Further review revealed a lack of documentation in regards to an ordered pulse oximeter check twice a day, on the 6A-6P shift on 9/5/14, 9/23/14, 9/29/14 and 9/30/14; on the 6P-6A shift on 9/10/14. e. Additional review revealed a lack of documentation in regards to an ordered twice a day pain check, on the 6A-6P shift on 9/23/14, 9/29/14 and 9/30/14; on the 6P-6A shift on 9/2/14, 9/3/14, 9/10/14, and 9/24/14. f. Further review revealed a lack of documentation in regards to the administration of scheduled levothyroxine 100 mcg by mouth ever day on the following days: 9/15/14, 9/24/14 and 9/28/14. g. Review of the medical record for September 2014 revealed no weekly skin assessment was performed for the week of 9/1/14 to 9/7/14 and the week of 9/22/14 to 9/28/14. h. Further review of the same record revealed no Braden scale was performed from 9/1/14 through 9/12/14 (missing two weeks). i. Review of the medication administration record (MAR) for September revealed PRN pain medication oxycodone/acetaminophen was administered on the following days without a corresponding assessment and documentation of pain medication effectiveness: 9/8/14, 9/9/14, 9/14/14, 9/17/14, 9/18/14, 9/19/14, 9/21/14, 9/22/14, 9/28/14, and 9/29/14 (10 times out of 21 opportunities). Interview with the DON on 10/9/14 at 3:15 PM	F 514	on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized. Corrective Action: Resident #15 has her medication and treatments appropriately documented in her Medication administration Record and her Treatment administration record. Identification of residents potentially affected: Residents that reside at Laramie Care Center are at Risk. Systemic Changes: a) On or before the allegation of compliance the DON/Designee will inservice Licensed nurses on maintaining clinical records on each resident in accordance with accepted professional standard and practices that are complete, accurately documented, readily accessible and systematically organized including accurate documentation of medications specifically ensuring that the nurses initial the medication administration record after medications are given, skin assessments are completed, pulse oximeter checks are done and pain is evaluated. The DON will prove follow up with appropriate caregivers on identified problems, as deemed necessary. Monitoring: a) DON/Designee will monitor through review of medication and treatment		

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F 514	Continued From page 57 confirmed the lack of documentation for the above findings.	F 514	administration records 3 times weekly and pm. These identified issues will be tracked and trended and results will be included in the DON's/designee's monthly QA and A report to assure the correction is implemented, achieved, sustained and evaluated for its effectiveness. The DON will be responsible for the follow up on identified problems/trends. 11/21/2014		

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10/2/14