STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	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 A complaint survey was conducted by Healthcare Licensing and Surveys from 8/26/15 to 8/27/15. The survey was prompted by complaint intakes WY00002020, WY00002071 and WY00002094. The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide DON: Director of Nursing RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	F203 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. CORRECTIVE ACTION: Resident #30 has been retracted, Resident #69 letter has been revised.	October 2, 20
F 203 S6=E	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered	F 203	IDENTIFICATION: Residents that currently reside at Laramie Care Center are considered to be at risk SYSTEMIC CHANGES The facility will ensure that all required information is included when providing a resident a notice of discharge, specifically the Discharge location and the Right to appeal to the State. The facility will also ensure that the 30 day notice is appropriately dated to allow 30 days for the discharge. The template utilized to formulate the 30 day notice letter has been amended so that it includes discharge location and informs the resident/residents legal authority of his/her right to appeal to the State. On or prior to the allegation of compliance the NHA/Designee reeducated the Business Office Staff and Social Service Staff on accurate and thorough completion of the 30 day notice of discharge and ensuring the notice of discharge is dated appropriately to give the entire 30 day. A sign in sheet will be utilized and Social Service or Business office staff unable to attend will be provided with 1:1 education.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrea Stannard	Administrator	9/18/2015

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.

RECEIVED
WY Dept of Health
SEP 18 2015
Healthcare Licensing and Surveys

over

9/21/15

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F 203	Continued From page 1 under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on incident report review and staff interview, the facility failed to include all required information in a notice of discharge for 2 of 2 sample residents (#30, #69) who received discharge notices. In addition, the facility failed to allow at least 30 days from the initiation of a discharge notice to the date of discharge for 1 of 2 residents (#69) who received discharge notices.	F 203	MONITORING The NHA/Designee will review all 30 day discharge notices to ensure all required information is include and the appropriate 30 days is given. Any issues identified will be corrected at that time and then tracked to be presented by the NHA/Designee in QA&A monthly for 3 months then quarterly and prn to ensure plan was implemented, is sustained, and evaluated for its effectiveness	October 2, 2015

9/21/15 This POC accepted between Andrea Stannard, Administrator and Tony Madden, Surveyor with a DOC of 10/2/15 for all tags.

9/21/15

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F 203	Continued From page 2 The findings were: 1. Review of a notice of discharge dated 8/17/15 and sent from the facility to the power of attorney for resident #30 and the State survey agency showed the notice failed to include the discharge location. In addition, the notice did not include the right to appeal to the State. The letter incorrectly stated the appeal was to the ombudsman. 2. Review of a notice of discharge dated 8/14/15 and sent from the facility to resident #69 and the State survey agency showed the notice failed to include the discharge location. In addition, the notice failed to give at least a 30 day notice of discharge. The discharge date was 9/8/15 (24 days). In addition, the notice did not include the right to appeal to the State. The letter incorrectly stated the appeal was to the ombudsman. 3. Interview with the administrator on 8/27/15 at 9:30 AM confirmed the discharge notices for residents #30 and #69 failed to contain the discharge location. In addition, she confirmed the timeframe for discharge regarding resident #69 was not the required 30 days. Further interview with the administrator on 9/10/15 at 3:25 PM verified the contact information for the State survey agency was listed on both letters, but not that the resident had the right to appeal to the State.	F 203	F225 Corrective Action: The staff members responsible for not reporting the resident to resident abuse altercations related to resident #67 have been reeducated on ensuring that Resident to Resident altercations are reported and investigated and the results of all investigations are reported to officials in accordance with State Law including to the State survey and certification agency. The staff members responsible for not reporting the resident to resident abuse altercations related to resident #71 have been reeducated on ensuring that Resident to Resident altercations are reported and investigated and the results of all investigations are reported to officials in accordance with State Law including to the State survey and certification agency. The staff members responsible for not reporting the resident to resident abuse altercations related to resident #65 have been reeducated on ensuring that Resident to Resident altercations are reported and investigated and the results of all investigations are reported to officials in accordance with State Law including to the State survey and certification agency. Resident to resident altercation involving resident #67 will be officially reported to state agency and investigation will be documented.	October 2, 2015
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have	F 225		

4/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 3 had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of incident information and staff interview, the facility failed to ensure 3 of 3 resident to resident abuse allegations were investigated and reported to the State survey	F 225	Resident to resident altercation involving resident #65 will be officially reported to state agency and investigation will be documented. Resident to resident altercation involving resident #71 will be officially reported to state agency and investigation will be documented. Identification: Residents who reside at facility are at potential risk. On or prior to the allegation of compliance the DON/Designee reviewed the last 30 days of incidents/accidents to identify if there were other Resident to Resident Altercations that may not have been investigated and/ or reported.There have been no further allegations of abuse that were not reported. Systemic changes: Beginning September 1st 2015 and continuing up until the allegation of compliance the Staff employed at Laramie Health Care have been in serviced regarding the timely and accurate reporting of all abuse allegations to the IDT including Resident to Resident Altercations. Residents, families and staff will be able to report concerns, incidents and grievances without fear of retribution. Facility supervisors will immediately correct and intervene in reported or	October 2, 2015

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F 225	Continued From page 4 agency. The findings were: Review of the incident and accident tracking information showed 3 cases of resident to resident altercations: 1. On 8/15/15 resident #67 went into the room of resident #25 and hit him/her in the face. 2. On 6/20/15 resident #67 hit resident #71 in the shoulder. 3. On 5/13/15 resident #71 went into the room of resident #66 and hit him/her on the head, additionally on this date, resident #71 went into the room of resident #65 and slapped him/her in the face. 4. Interview with the DON on 8/27/15 at 3:33 PM verified she was unable to locate investigations related to these incidents. She also verified the incidents were not reported to the State survey agency.	F 225	identified situations in which abuse, neglect or misappropriation of resident property is at risk for occurring including conducting an investigation of an alleged abuse/neglect, misappropriation of resident property and reporting to appropriate agencies in accordance with state law. The investigation will include interviews of other residents as well as staff members. The facility will investigate all patterns, trends or incidents that suggest the possible presence of abuse, neglect to include Resident to Resident Altercations, identified through analysis conducted by the, Quality Assurance and Assessment Committee, with intervention, reporting or policy/procedure modification conducted as appropriate. In the absence of the DON the administrator will conduct investigations which fall under criteria for resident abuse and will ensure that investigations are reported accurately and timely. In the absence of the DON and administrator the ADON will conduct investigations which fall under criteria for resident abuse and will ensure that investigations are reported accurately and timely.	October 2, 2015
F 463 SS=F	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, call light activity reports, and review of manufacturer's instructions for use, the facility failed to ensure the call light system was operated per	F 463		

8/24/15

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F 225	Continued From page 3 had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of incident information and staff interview, the facility failed to ensure 3 of 3 resident to resident abuse allegations were investigated and reported to the State survey	F 225	Monitoring; The nurse management team will monitor effectiveness of the system through review of the 24 hour report in the morning stand up meeting, abd through investigation of incidents for patterns, or trends that may indicate the presence of possible abuse. The DON/Designee will review incident/accident reports and grievances monthly for three months then quarterly thereafter to ensure any incident/grievance that may indicate abuse has been investigated and appropriately reported if indicated. Issues identified will be presented by the DON/Designee to the quality improvement team to ensure the system has been implemented, sustained and evaluated for it's effectiveness. Date of Compliance: October 2nd 2015	October 2, 2015

9/21/15

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F 225	Continued From page 4 agency. The findings were: Review of the incident and accident tracking information showed 3 cases of resident to resident altercations: 1. On 8/15/15 resident #67 went into the room of resident #25 and hit him/her in the face. 2. On 8/20/15 resident #67 hit resident #71 in the shoulder. 3. On 8/13/15 resident #71 went into the room of resident #66 and hit him/her on the head, additionally on this date, resident #71 went into the room of resident #65 and slapped him/her in the face. 4. Interview with the DON on 8/27/15 at 3:33 PM verified she was unable to locate investigations related to these incidents. She also verified the incidents were not reported to the State survey agency.	F 225	F463 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 and section 7317a of the state operations manual. CORRECTIVE ACTION 1. No specific Residents were identified. On August 27, 2015 staff were given pagers to the call light system in accordance with the user manual to allow staff to hear as well as visualize when call light are on, and the time was adjusted to ensure the system was exhibiting the correct time.	October 2, 2015
F 463 SS=F	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, call light activity reports, and review of manufacturer's instructions for use, the facility failed to ensure the call light system was operated per	F 463		

9/11/15 DS

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F 463	Continued From page 5 manufacturer's instructions and regulatory requirements. The findings were: 1. Observation during the survey timeframe from 8/26/15 at 10 AM through 8/27/15 at 4:30 PM showed the facility call light system did not produce a sound when residents pushed their call button. The system had a visual board that displayed the room number when a resident called. 2. Review of the 8/22/15 to 8/26/15 Device Activity Report showed the following prolonged periods between the call light activation and deactivation times: a. Review of the call light report for Saturday 8/22/15 showed room #254 (bed not indicated) showed the light was not answered/deactivated for 160 minutes from 8:44 AM to 11:24 AM. b. The call light was on for room #250 on 8/22/15 for 43 minutes and 10 seconds from 10:19 AM through 11:50 AM, and 36 minutes and 46 seconds which ended at 11:50 AM. In addition, on 8/25/15 the call light was on for 97 minutes and 38 seconds from 1:06 PM through 2:44 PM, and 43 minutes and 58 seconds from 9:35 AM through 10:19 AM. c. The call light was on for room #335 on 8/23/15 for 29 minutes and 45 seconds from 9 PM to 9:30 PM, on 8/26/15 for 31 minutes and 58 seconds from 6:19 AM through 6:51 AM, and on 8/26/15 for 36 minutes and 9 seconds from 11:09 AM through 11:45 AM. d. On 8/22/15 the call light was activated in room #257 at 10:52 AM and remained on until 11:30 AM (37 minutes and 44 seconds). On 8/23/15 the same call light was activated at 10:17 AM and remained on until 11:17 AM (70 minutes). e. On 8/23/15 the call light was activated in	F 463	2. On September 18th hand held radios were ordered, upon hand held radios arrival the charge nurse at each station will carry a pager and use hand held radios to notify the C.N.A. s when a resident call light is on. IDENTIFICATION: 3. All residents have the potential to be at risk. SYSTEMC CHANGES 4. The facility will ensure that measures and/or systemic changes put into place will include but not be limited to providing a safe, functional and comfortable environment for residents, staff and the public including the administrator or his designee will providing in-service education and training to the facility maintenance staff regarding the importance of ensuring all call lights are properly functioning, specifically that the right time is evident when review the Call	October 2, 2015

9/21/15

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F 463	Continued From page 6 room #258 at 9:34 AM and was not deactivated until 40 minutes later at 10:14 AM. The same call light was activated later the same day for 41 minutes and 56 seconds from 2:05 PM to 2:46 PM. On 8/26/15 this call light was again activated and remained on from 11:04 AM to 11:41 AM (41 minutes). f. The call light was on for room #330 on 8/26/15 for 27 minutes and 22 seconds. g. Observation on 8/26/15 at 10:15 AM showed 12 room numbers were scrolling across the display to have a call answered. One of the room numbers at that time was 114 bed A. Review of the call light report for 8/26/15 showed the call was answered 30 minutes after it was initiated. The report showed from 11:04 AM to 11:35 AM. Observation on 8/27/15 with the DON and the administrator verified the clock on the call light system computer showed the time as 1 hour later than the actual time. 3. Interview with the maintenance director on 8/27/15 at 1:45 PM showed the call light system also included pagers, but he acknowledged the pagers did not appear to be in use. He further confirmed the sound on the call light system was turned down and he could not hear it, though some staff with "better hearing" could hear the system if beside the auditory portion. Interview with CNA #1 on 8/27/15 at 2:05 PM confirmed staff do not use pagers or rely on sound, but instead responded to the visual portion of that system that displayed the room number of the activated call light. Interview with the DON on 8/27/15 at 2:20 PM confirmed the facility had pagers for the call light system, but did not routinely utilize them. She further confirmed she was unaware that sound or pagers were required for the call light system.	F 463	light system reports, and that the nurse at each station has a pager and each C.N.A. has a hand held radio. On or before the date of compliance the DON/Designee will reeducated staff that the nurse on each station will carry a pager and the C.N.A. will be notified of call lights via hand held radio and they should respond to audible notification as well as visual notification. On or before the date of compliance, the NHA/designee will in-service maintenance staff regarding the importance of ensuring the call light system is properly functioning and all call lights are properly functioning. MONITORING 5. The DON/Designee will print call light reports each business to report in the am stand up meeting on the average call light response time and any concerns. Issues identified regarding the system and/ or staff ability to audibly hear the lights will be corrected as identified	October 2, 2015

9/21/15

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F 463	Continued From page 7 4. Review of the manufacturer's instructions for use concerning the Arial Wireless Communication System (the system used by the facility as their call light system) showed the following for "How the Arial wireless communication system works": "The residents push the button on a fixed (wall) or portable (pendant) call device to initiate a call. The receiver that is connected to the Arial CMS, or repeater that is located within the coverage area then receives the signal. Once the signal reaches the Arial CMS, it is processed and a visual cue and audible tone are generated. If the paging system is being used, staff members carrying the pagers are automatically notified of the call, without having to return to the Arial CMS." The basic Arial communication system includes: "Central Monitoring Station: The Arial Central Monitoring Station (CMS) receives, processes, displays and announces alarms from fixed and portable devices. Centrally located at the nurses station or business office, the Arial CMS records staff response time, enables customized staff paging, and stores important resident information. Alarms and calls are easily visible on the monitor screen, and are announce audibly to attract staff attention. Each call is repeated until staff responds, with the response time noted."	F 463	and trended to be reported in QA&A monthly by the DON/Designee to ensure plan is implemented, sustained, and evaluated for its effectiveness. The maintenance supervisor or designee will monitor compliance via the facility's preventive maintenance program monthly ensuring call lights are tested to ensure proper functioning identifying any patterns and if necessary, a report will be developed and submitted to the Quality Improvement/Quality Management Committee. The facility Quality Assurance Program under the guidance of the Administrator will review the report, and if necessary, will direct an improvement plan. ALLEGATION OF COMPLIANCE 6. October 2nd 2015:	October 2, 2015

9/21/15