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 07/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	603 S 16TH 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 on 7/7/16. The survey was prompted by complaint intakes WY00002250 and WY00002256. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide LPN- Licensed Practical Nurse MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000	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.	
F 225 SS=D	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 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	F 225	F225 August 21, 2016 Correction: Three staff members were interviewed regarding incident with Resident #50. Follow up from investigation was sent to State Agency 7/22/2016. Staff's completing investigation forms were interviewed and correct dates were identified and put on investigation forms with staff initials. Identification: Residents at facility have the potential to be affected by practices. Systemic changes: Beginning 7/22/16 and continuing up until the allegation of compliance the NHA/Designee in serviced facility managers on the abuse reporting policy. Specifically a report of an investigation must be provided to State Agency within (5) working days of incident along with interviews from staff members and correct documentation of dates. Monitoring: NHA/Designee will review reportable incidents weekly for ongoing compliance. Issues identified will be corrected at the time. Issues will be tracked	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrea Stannard — TITLE: NHA — (X6) DATE: 7-22-2016

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
JUL 31 2016
Healthcare Licensing and Surveys

8/11/16 - 10:08AM Spoke to Andrea Stannard NHA. Plan of Correction accepted & agreed changes.

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F 225	Continued From page 1 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 investigation review, staff interview, and review of abuse program procedures, the facility failed to ensure 1 of 1 abuse investigations (involving resident #50) reviewed was thorough, and reported in the required time frame. The findings were: Review of the abuse investigation related to a staff incident with resident #50 revealed the allegation was related to verbal abuse. The nurse aide was suspended the date of the incident. However, the investigation was incomplete and the investigation showed inaccurate dates. The date of the allegation was 6/24/16. However, the date the resident was interviewed about the incident was shown as 6/22/16. The investigation was lacking as no staff members were interviewed other than the nurse aide involved. Further, the dates when other residents were interviewed as part of the investigation was	F 225	and trended. The NHA/Designee will report the results to the QA/A monthly for the next three months and then PRN to assure plan is implemented, sustained and evaluated for compliance. August 21, 2016	

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F 225	Continued From page 2 shown as 6/30/16. Interview with the administrator on 7/7/16 at 4:45 PM revealed the date of 6/22/16 must have been in error. The date when the other residents were interviewed was accurate according to the administrator, and the reasoning for the several day delay was so the social worker could conduct the interviews. The administrator also verified the investigation did not include interviews with other staff, and there was no evidence the allegation or the investigation findings were reported to the state survey agency. Review of the Abuse Prohibition and Prevention Program dated 10/1/12 showed "...report all allegations of abuse neglect, injuries of unknown source, and all substantiated incidents to the appropriate state authorities, including the State Certification Agency and all other agencies as required, immediately, but no later than 24 hours after the allegation...A complete investigation will be conducted for any allegation of abuse, neglect, or injury of unknown source...A report of the investigation will be provided to the appropriate state agency within five (5) working days of the incident..."	F 225	August 21, 2016 F253 Correction action: 1, a: Room 250. Floor will be cleaned of sticky surface; caulking around base of toilet will be replaced before date of compliance. B: Room 256. Bathroom floor will be cleaned from strong odor and stains before date of compliance. Black tray from toilet base was removed. C: Room 252. Toilet base in bathroom will be clean before date of compliance. D: Room 338. The following will be complete before the day of compliance. Anti-fall strips in bathroom will be replaced. The bathroom floor will be cleaned. The black	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview,	F 253	mat in bathroom will be removed. The cracked tile in front of toilet will be replaced. E: Room 332, bathroom floor will be cleaned before date of compliance. F: The floor on all sides of the partition in the main dining area will be cleaned before date of compliance. G: The table legs in the assisted dining will be cleaned before date of compliance. H: The television room across from nursing station II	

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F 253	Continued From page 3 and review of facility cleaning schedules, the facility failed to ensure services to maintain a sanitary environment in a variety of resident areas. These areas were identified in 3 of 3 units (unit 1, unit 2, unit 3). The findings were: 1. Observations on 7/7/16 from 9:20 AM through 9:50 AM revealed the following environmental concerns: a. When walked on, the floor in room #250 had a dirty and sticky surface with various darkened stains. The bathroom toilet had a rust colored stain around the caulked base. b. The bathroom floor of room #256 was dirty with urine and darkened stains over the entire floor, and the bathroom had a strong urine and stool odor. In addition, the toilet base had a tray with a black floor mat that appeared to collect urine around the mat on the floor. c. The toilet base in the bathroom of room #252 had a rust colored ring. d. The bathroom floor of room #338 had 3 anti-fall strips that were damaged, and collected dust and debris. The rest of the bathroom floor had discolored stains, was sticky to walk on, and had the odor of urine. In addition, the toilet base had a tray with a black mat that appeared to collect urine around the mat on the floor. The front floor around the toilet also had a cracked tile which was blackened and created an uncleanable surface. e. The bathroom floor of room #332 was discolored with stains over the entire floor, was sticky to walk on, and had the odor of urine. f. The floor on all sides of the partition in the main dining area had built up grime. g. The assisted dining area had 9 of 10 tables with dried accumulated food debris on the legs of the tables.	F 253	will be cleaned before the date of compliance. I: Room 156 bathroom floor will be cleaned along with the commode over the toilet before the date of compliance. 2. A: Eight cracked tile outside dining room and in front of the ice machine will be replaced before the date of compliance. B: Ten cracked tiles in front of nursing station III will be replaced before the date of compliance. 3. Room 250 will be deep cleaned before the date of compliance. Room 338 will be deep cleaned before date of compliance. A deep clean schedule will be made and followed by contracted housekeeping services before the date of compliance. 4. Room 330 will be cleaned and bathroom toilet cleaned and flooring before date of compliance. 5. The black marks will be removed from bathroom before date of compliance. Cracked tile in front of ice machine and station III will be replaced before date of compliance. August 21, 2016	

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F 253	Continued From page 4 h. The television room across from Nursing Station II had ice cream splattered on the back wall that was dried. The ice cream cup was on the floor near the area. The food on the wall and the cup on the floor remained the same when observed at 3 PM. I. The bathroom floor of room #156 was dirty and sticky with thick brown substance, there was an overpowering smell of urine and stool. The commode over the toilet was unclean with splattered stool. 2. Observations on 7/7/16 at 3:25 PM revealed the following environmental concerns: a. Outside of the dining area and in front of the ice machine there were 8 tiles (12 inches by 12 inches) that were cracked through which created an uncleanable surface, and were darkened with collected dirt. b. In front of Nursing Station III there were 10 floor tiles (12 inches by 12 inches) that were cracked through which created an uncleanable surface, and were darkened with collected dirt. 3. Review of facility provided "deep cleaning checkoff" lists showed 2 rooms from the 7/7/16 observation were deep cleaned. Room #250 was deep cleaned on 6/8/16 (29 days before observation) and room #338 was deep cleaned on 6/1/16 (36 days before observation). There was no documentation to show when the other observed resident rooms or dining rooms had been deep cleaned. 4. Interview with a daily visiting family member on 7/7/16 at 11:17 AM revealed the family member had not seen housekeeping clean the bathroom in room #330 for the past three days. Observation of the bathroom at the time of the interview	F 253	August 21, 2016 Systemic Changes: Beginning 7/22/2016 and continuing up until the allegation of compliance the NHA/Designee will in-service maintenance and contracted housekeeping staff on proper cleaning standards and preventive maintenance. Specifically in the area of preventative maintenance, identification of cracked tiles and cleanliness of bathroom floors and toilets. Monitoring: NHA/Designee will perform cleanliness, tile condition and preventative maintenance rounds twice weekly for three month or compliance has been achieved. Then NHA/Designee will perform cleanliness, tile condition and preventative maintenance rounds weekly. Noncompliance will be tracked with trends and presented in monthly QA/A.	

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F 253	Continued From page 5 revealed the interior of the toilet bowl had a brown ring and the bathroom floor was sticky and the bathroom had a urine odor. 5. Interview with the housekeeping supervisor on 7/7/16 at 3 PM revealed the housekeeping service was contracted. He revealed there were issues with allotted hours dedicated to housekeeping to keep the facility clean, and there were issues with staff turnover. The supervisor further revealed the black mats near the toilets were designed to absorb/contain urine when the resident missed the toilet and they were to be disposed of at least once per month. Interview with the maintenance director on 7/7/16 at 3:35 PM revealed he was aware of the cracks in the floor tiles in front of the ice machine and Nursing Station III.	F 253		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to provide a safe mechanical lift transfer for 1 of 1 sample residents (#42) observed during a mechanical lift transfer. The findings were:	F 323	August 21, 2016 F323 Corrective Action a) Resident #42 was provided with appropriate sized sling on 7/7/2016. b) Education to be completed with all nursing staff on appropriate toileting technique, which included using appropriate sized sling for transfer and appropriate positioning. Started 7/7/2016 Complete on 7/30/2016. c) Interview completed with resident on 7/8/2016. Resident stated that she prefers to be left on toilet alone while toileting. Education provided to resident that due to safety staff must stay in room outside of bathroom door with bathroom door cracked during toileting. Resident educated further at this time that it is not safe to leave resident in Hoyer lift while toileting. d) Education started with nursing staff on 7/7/2016 regarding toileting safety with Hoyer lift, complete on 7/30/2016. e) Resident #42 was provided with appropriate sized sling on 7/7/2016.	

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F 323	Continued From page 6 Medical record review showed resident #42 had diagnoses which included lumbar spinal stenosis, dementia, rectal prolapse, and neurogenic bladder. Review of the 6/22/16 quarterly MDS assessment showed the resident was totally dependent on 2 staff members for transfers. Review of the resident's care plans showed the following problem last reviewed 6/8/16, "Potential for bleeding due to prolapsed rectum. Resident wants to spend prolonged time on toilet." The approach was as follows, "Patient to toilet for 5-10 minutes due to rectal prolapse. Patient teaching regarding serious status of rectal prolapse and multiple and extended time on toilet. Patient verbalized understanding. Patient said [s/he] would try to use the bedpan." The following concerns were identified: a. Observation on 7/7/16 at 11:15 AM showed CNAs #1 and #2 used a Hoyer lift (mechanical lift) to transfer the resident to the toilet. Interview with CNA #1 at the time of the observation revealed the usual sized lift sling was not available and the CNAs used a "larger" sling than they usually used. At 11:40 AM the CNAs left the resident's room leaving the resident alone on the toilet and still attached via the lift sling to the hoyer lift. b. Observation from the hallway on 7/7/16 from 11:42 AM until 11:50 AM revealed the resident was shouting "help me." At 11:50 AM the surveyor observed the resident in the bathroom and the resident remained attached to the mechanical lift with the oversized lift sling. At that time the surveyor alerted CNAs #1 and #2 to the situation with the resident. The CNAs then used the mechanical lift and transferred the resident into bed. c. Interview on 7/7/16 at 2 PM with the resident revealed s/he did not like to be left alone	F 323	Identification a) All residents who reside at Laramie care center are at risk. Systemic Changes a) All residents who currently use Joerns Hoyer mechanical lift will be evaluated to ensure correct sling is in place. b) All nursing staff to be educated on not leaving any resident attached to Hoyer during toileting and not leaving residents unattended. c) Education provided to resident on importance of using mechanical lift correctly and that staff will stand outside bathroom door. All residents who use mechanical lift for toileting will be observed x1 by nurse manager to ensure safety. d) All residents using mechanical lift will have education provided in regards to safety and privacy. e) All residents using a mechanical lift will be evaluated for appropriate sling size. August 21, 2016	

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F 323	Continued From page 7 on the toilet while attached to the hoyer lift. d. Interview on 7/7/16 at 3:40 PM with the director of nursing revealed the resident preferred to be left alone on the toilet and the facility had care planned it. Review of the care plan showed the resident liked to be placed on the toilet for extended periods. However, the plan did not address whether or not the resident preferred or was safe to be left alone while on the toilet. e. According to the manufacturer's manual titled, "Joerns Hoyer" pertaining to sling use, "Always check the sling is suitable for the particular patient and is of the correct size and capacity."	F 323	Monitoring a) Resident #42 will be observed during toileting by management 3x/week x 4 weeks. Then weekly. b) Audit will be completed 3x weekly on 10 residents who use Joerns Hoyer lift for appropriate technique. Then weekly c) Audit will be completed 3x weekly x4 weeks to ensure staff is providing privacy but remaining where they can hear and visualize resident during toileting. d) Interview 3 residents weekly who use Joerns Hoyer mechanical lift x 4 weeks for privacy and safety. The monthly. e) Residents slings will be audited 3x weekly x1 month for appropriate size. More slings have been ordered to provide 2 slings to each resident August 21, 2016	