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

PRINTED: 09/09/2016
FORM APPROVED
OMB NO. 0938-0391

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 _____	R-C 08/25/2016

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 follow-up survey was conducted on 8/25/16 by Healthcare Licensing and Surveys. The following common abbreviations are used throughout the 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}		
{F 323} SS=E	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, staff interview, review of facility incident reports, review of call management system manufacturer information, and review of call light activity reports, the facility failed to ensure a fully functional call light system was in use to provide necessary supervision of residents at risk of falling for 1 of 2 sample residents (#60) with falls. The findings were: 1. Review of the 6/14/16 quarterly MDS assessment for resident #60 showed the resident had diagnoses that included non-Alzheimer's	{F 323}	F323 Corrective Action Corrective Action: Resident number 60 call light will be answered timely per facility call light policy. Facility call light system will be evaluated, upgraded and repaired on September 22, 2016 and will be fully functioning at that time. Direct care staff were provided with pagers. Identification: Residents at Laramie Care Center are at risk.	9/27/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrea Stannard, NHA — TITLE — (X6) DATE: October 7 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
WY Dept of Health
OCT 07 2016
Healthcare Licensing and Surveys

10/7/16 11:10 am PoC accepted, spoke with Andrea Stannard, Administrator.
PSimonton, SLTC Surveyor

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{F 323}	Continued From page 1 dementia. Further review showed the resident was dependent on two staff members for assistance with activities of daily living such as bed mobility, transfers, and toilet use. The following concerns were identified: a. Review of facility incident reports showed resident #60 had a fall on 8/22/16 at 4:30 AM. b. Review of the device activity report for the call light system showed on 8/22/16 the call light in resident #60 ' s room was activated at 4:27 AM. Further review showed the call light was not turned off until 4:49 AM, 21 minutes and 53 seconds after initiation. 2. Interview with the administrator on 8/25/16 at 1:08 PM revealed the facility ' s expectation was for call lights to be answered in less than 7 minutes. 3. Review of the " Solution Overview: Arial Emergency Call and Wander Management " document provided by the facility showed the facility ' s call light system was designed to work in the following manner: When a resident activated a call light, a signal was sent to the server computer over a wireless network. Nursing staff could then be informed of call light activity by receiving messages on devices including pagers and scrolling signs. Further review of the document showed the system did not send any notifications to non-digital devices, such as " walkie-talkies. " 4. Observation on 8/25/16 at 11:10 AM showed LPN #1 placed a call to one of the facility ' s nursing stations and told the person on the other end of the call to " make sure staff is wearing pagers, I mean walkie-talkies. " Interview with LPN #1 at that time revealed facility staff was	{F 323}	Systemic Changes: Facility will provide an environment that promptly helps meet the resident's needs. Facility will respond to resident's call lights in a timely manner. When a resident activated a call light, a signal will be sent to a server computer over a computer network, staff is informed of a call light activity by receiving a message on scrolling marquees, nursing staff that provides direct care will be informed of call light activity by pagers. Facility will answer emergency lights immediately. Facility will turn off the call light in the room so that others will know it's answered. Facility will complete (if able) the task the resident requests. If facility is unable to complete the request the resident will be informed and notify the appropriate discipline. Facility will make sure the call light is placed within the resident's reach when leaving the room per	9/27/2016

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{F 323}	Continued From page 2 utilizing " walkie-talkies " to communicate with each other about call lights because the facility did not have enough pagers. 5. Review of the manufacturer ' s " Arial 8.1 System Quick Reference Guide, " revised 9/2013 showed the system was designed to send messages to scrolling signs. Different types of alarms could be made to appear on the signs in different colors, and the board could be programmed to show alarms that had been going off longer than new alarms in a different scroll mode to bring attention to them. 6. Interview with CNA #3 on 8/25/16 at 12:35 PM revealed two of the facility ' s scrolling signs, which were used by staff to provide visual confirmation that call lights had been activated, were broken. 7. Interview with the maintenance director on 8/25/16 at 1:08 PM revealed he was aware the scrolling signs were not working, and he thought they had been broken " about two weeks. " Further, the facility did not have the parts on hand to fix the signs, and they were waiting for the new parts to arrive. 8. Interview with the administrator on 8/25/16 at 5:50 PM confirmed resident safety risks increased with longer call light times. Further, it was revealed the facility had ordered more pagers for the call light system because there were not enough pagers on hand for staff to use.	{F 323}	facility call light policy. On or prior to date of allegation of compliance staff will be re-educated by SDC/designee to ensure their call lights are answered timely which includes residents who are at risk of falls. Staff will be re-educated on marquee locations and how to read each marquee which includes different colors and different scroll speed. PRN staff members and staff members on leave of absence will be re-educated before their return date. 9/27/2016 Monitoring: NHA/Designee will monitor average call light response time 3 times a week for three months and PRN thereafter on all three shifts. Facility managers will perform random audits and interview three residents call lights weekly until a pattern of compliance has been identified. Residents issues identified will be addressed through re-	
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive	F 463	education and trends will be reported to QA/A to ensure effectiveness.	

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F 463	Continued From page 3 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, resident and staff interview, review of call management system manufacturer information, and review of call light activity reports, the facility failed to ensure the facility had a fully functional call system. The findings were: 1. Review of the " Solution Overview: Arial Emergency Call and Wander Management " document provided by the facility showed the facility ' s call light system was designed to work in the following manner: When a resident activated a call light, a signal was sent to the server computer over a wireless network. Nursing staff could then be informed of call light activity by receiving messages on devices including pagers and scrolling signs. Further review of the document showed the system did not send any notifications to non-digital devices, such as " walkie-talkies. " 2. Observation on 8/25/16 at 11:10 AM showed LPN #1 placed a call to one of the facility ' s nursing stations and told the person on the other end of the call to " make sure staff is wearing pagers, I mean walkie-talkies. " Interview with LPN #1 at that time revealed facility staff members were utilizing " walkie-talkies " to communicate with each other about call lights because the facility did not have enough pagers. 3. Interview with CNA #1 on 8/25/16 at 11:51 AM	F 463	F463 Corrective Action Corrective Action: Facility call light system will be evaluated upgraded and repaired on September 22, 2016 and will be fully functioning at that time. Direct care staff were provided with pager. Identification: Residents at Laramie Care Center are at risk. 9/27/2016 Systemic Changes: Facility will provide an environment that promptly helps meet the resident's needs. Facility will respond to resident's call lights in a timely manner. When a resident activated a call light, a signal will be sent to a server computer over a computer network, staff is informed of a call light activity by receiving a message on scrolling marquees, nursing staff that provides direct care will be informed of call light activity by pagers. Facility will answer emergency lights immediately. Facility will turn off the call light in the room so that others will know it's answered. Facility will complete (if able) the task the resident requests. If facility is unable to complete the request the resident will be informed and notify the appropriate discipline. Facility will make sure the call light is placed within the resident's reach when leaving the room per facility call light policy. On or prior to date of allegation of compliance staff will be re-educated to ensure their call lights are answered timely which includes residents who are at risk of falls. Staff will be re-educated by SDC/ Designee on marquee locations and how to read each marquee which includes different colors and different scroll speed. PRN staff members and staff members on leave of	

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F 463	Continued From page 4 revealed staff members were to carry the " walkie-talkies " to communicate with each other about call lights. The CNA further revealed the pagers that were meant to be used with the call light system were not available. 4. Review of the manufacturer ' s " Arial 8.1 System Quick Reference Guide, " revised 9/2013 showed the system was designed to send messages to scrolling signs. Different types of alarms could be made to appear on the signs in different colors, and the board could be programmed to show alarms that had been going off longer than new alarms in a different scroll mode to bring attention to them. 5. Interview with CNA #3 on 8/25/16 at 12:35 PM revealed two of the facility ' s scrolling signs, located on the 200 and 300 units, which were used by staff to provide visual confirmation that call lights had been activated, were broken. Further, the CNA revealed staff used the " walkie-talkies " to communicate the call lights that were seen on the scrolling signs; however, the " walkie-talkies " did not receive information directly from the call light system. 5. Interview with the maintenance director on 8/25/16 at 1:08 PM revealed he was aware the scrolling signs were not working, and he thought they had been broken " about two weeks. " Further, the facility did not have the parts on hand to fix the signs, and they were waiting for the new parts to arrive. 6. Interview with the administrator on 8/25/16 at 1:08 PM revealed the facility ' s expectation was for call lights to be answered in less than 7 minutes.	F 463	absence will be re-educated before their return date. Monitoring: NHA/Designee will monitor marquee scrolling signs 3 times a week for three months and PRN thereafter on all three shifts. Facility managers will randomly activate a call light and monitor the notification relayed on the marquee signs on call three shifts. Issues will be reported immediately to maintenance and NHA/designee. Trends will be reported to QA/A to ensure effectiveness.	9/27/2016

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F 463	Continued From page 5 7. Interview with resident #76 on 8/25/16 at 3:30 PM revealed facility call lights were not answered in a timely manner, and this had resulted in the resident being incontinent. Review of the device activity log for the resident ' s room between the dates of 8/21/16 and 8/25/16 showed the call light had been activated 29 times in that period, and 5 of those times, the length of time the call was active exceeded 10 minutes. The longest wait time occurred on 8/23/16 between 11:04 PM and 11:17 PM (13 minutes and 13 seconds). 8. Interview with resident #72 on 8/25/16 at 3:34 PM revealed the resident felt it took a long time for staff to respond to call lights. Review of the device activity log for the resident ' s room between the dates of 8/21/16 and 8/25/16 showed the call light had been activated 50 times in that period, and 15 of those times, the length of time the call was active exceeded 10 minutes. Further, on 4 occasions, the length of time the call was active exceeded 20 minutes. The longest wait time occurred on 8/21/16 between 9:29 AM and 10:14 AM (44 minutes and 32 seconds). 9. Review of the device activity log for resident #13 ' s room between the dates of 8/21/16 and 8/25/16 showed the call light had been activated 24 times in that period, and 6 of those times, the length of time the call was active exceeded 10 minutes. Further, on 8/22/16 the call light was active between 7:20 PM and 8:12 PM (52 minutes and 11 seconds), and on 8/23/16 the call light was active between 7:10 AM and 8:07 AM (56 minutes and 16 seconds). 10. Review of the device activity log for resident #28 and #29 ' s room between the dates of	F 463		

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F 463	Continued From page 6 8/21/16 and 8/25/16 showed the call light had been activated 136 times in that period and 21 of those times, the length of time the call was active exceeded 10 minutes. Further, on 10 of those occasions, the length of time the call was active exceeded 20 minutes. The longest wait time occurred on 8/20/16 between 7:32 PM and 8:47 PM (74 minutes and 59 seconds).	F 463		