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 _____	12/21/2017

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 recertification survey was conducted by Healthcare Licensing and Surveys from 12/18/17 to 12/21/17. The following common abbreviations are used throughout the document: ADL: Activities of Daily Living BIMS: Brief Interview for Mental Status CAA: Care Area Assessment CNA: Certified Nursing Assistant DON: Director of Nursing MAR: Medication Administration Record MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		1/26/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/18/2018

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 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, and policy review, the facility failed to ensure resident rights were promoted for 1 of 19 sample residents (#69). The findings were: Observation on 12/18/17 at 3:28 PM showed resident #69 wore a WanderGuard bracelet (device that prevents exit/elopement from the building) on his/her right wrist. Interview with the resident at that time showed s/he was alert and oriented, and that the WanderGuard bracelet was placed on his/her wrist upon admission. Review	F 550	F550 Resident rights 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 purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation,	

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F 550	Continued From page 2 of the 11/29/17 admission MDS assessment showed the resident had a BIMS score of 12 (moderately impaired). The following concerns were identified: a. Interview on 12/18/17 at 3:28 PM revealed the resident was unsure why s/he had a WanderGuard bracelet on, and the resident stated that s/he did not want it. The resident further stated staff told him/her the WanderGuard bracelet was placed on his/her wrist because it was cold outside and staff did not want the resident to go out in the cold. b. Review of the 11/20/17 elopement screening tool showed the resident was not at risk for elopement. c. Review of the 11/29/17 admission MDS assessment showed triggered areas requiring additional assessment included cognitive loss/dementia, behavioral symptoms, and ADL function. Review of these CAAs showed no indication the resident was at risk for elopement. d. Review of the resident's care plan showed no indication the resident was at risk for elopement. e. Review of the entire medical record showed no documentation the resident had attempted to elope. f. Interview with the DON on 12/20/17 at 10:46 AM revealed she was unsure why the resident had a WanderGuard bracelet on. Interview with the DON on 12/20/17 at 11:55 AM confirmed the facility could not find a rationale for the resident's WanderGuard bracelet, and staff were at that time removing the bracelet. g. Observation on 12/21/17 at 10:16 AM showed the resident did not have a WanderGuard bracelet on. Interview at that time revealed the resident was happier without the WanderGuard bracelet.	F 550	this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state Correction: Resident was reassessed on December 29, 2017, at which time it was determined that he was at high risk for wandering/elopement and required a wander guard. The resident's care plan was reviewed and updated to include the risk for elopement and the need for a wander guard on December 29, 2017 2) Identification: Residents residing at Laramie Health care that currently have a wander guard have the potential to be affected by this practice. On or before the allegation of compliance Residents currently utilizing wander guards will be reviewed by the IDT to determine the appropriateness of the wander guard placement. When the wander guards are indicated per the evaluation, the Residents and/ or their legal decision makers will be informed regarding the need for the wander guard. The residents care plan regarding wandering/ elopement risk will be reviewed and updated at that time. 3) Systemic changes: Residents are evaluated for their wandering/ elopement risk on admission, every 6 months, annually and with a significant change in condition .When the wander guards are indicated per the evaluation, the Residents and/ or their	

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F 550	Continued From page 3 h. Review of the 1/6/16 updated policy titled, "Guideline for Completion of Wandering/Elopement Risk Evaluation (Tool)" showed the following: "The Wandering/Elopement Risk Evaluation (Tool) is completed to determine the Resident risk score for wandering and/or elopement and to assess potential risk factors for wandering and elopement... Elopement-attempt-when a Resident, without supervision, is exit seeking or attempting to leave the community/secured area but does not cross the threshold of a secured area. Note: A scenario is not considered an elopement or elopement attempt when the Resident is in the continuous presence or sight of staff...Tool Scoring: 1-3 low risk, 4-7 At risk to wander, 8+ High risk to wander."	F 550	legal decision makers will be informed regarding the need for the wander guard. Beginning January 2, 2018 and continuing up until the allegation of compliance licensed nursing care staff, Restorative Nursing and Social Services will be reeducated by the SDC/Designee on resident's rights, specifically, the right to be informed regarding treatment such as wander guard placement. An attendance sheet will be kept and staff unable to attend will be provided 1:1education provided. 4) Monitoring: Monthly for 3 months, then quarterly thereafter, Residents utilizing wander guards will be reviewed by the DON/Designee to ensure the wander guard is still appropriate and the Resident/ Resident's legal decision maker is aware of the plan of care. Results will be tracked/trended for any issues. Issues identified will be corrected at that time. The results will be reviewed in QA&A monthly to assure the system is maintained and evaluated for its effectiveness. 5) Date of alleged compliance: January 26,2018	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		1/26/18

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F 641	Continued From page 4 by: Based on medical record review and staff interview, the facility failed to ensure MDS assessments were accurately completed for 1 of 19 sample residents (#40). The findings were: Review of the December 2017 MAR showed resident #40 had been prescribed Xarelto (an anticoagulant) 20 mg daily for atrial fibrillation on 5/17/17. Review of the October 2017 and November 2017 MARs showed the resident received the scheduled medication as ordered every day of the 7-day look-back period. However, review of the quarterly MDS assessment dated 11/4/17 revealed the anticoagulant was not included in the medication section of the MDS. Interview with MDS coordinator #1 and #2 on 12/20/17 at 4:29 PM confirmed the use of the anticoagulant was not accurately coded.	F 641	F641 ASSESSMENT ACCURACY 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 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: On 12/21/2017 the MDS for Resident #40 was modified to accurately reflect the use of an anticoagulant medication on or before date of compliance. Corrective action will be completed on or before date of compliance January 26, 2018 Identification of other residents potentially affected: Residents currently residing at Laramie and utilizing anticoagulant medications are found to be potentially affected by the deficient practice. On December 20, 2017 the MDS nurse/designee reviewed assessments for residents currently	

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F 641	Continued From page 5	F 641	utilizing an anticoagulant to ensure the assessment was accurate. There were no other issues identified System Changes: The Interdisciplinary Team will review the status of the resident□s assessment for those residents taking anticoagulant medications each quarter to ensure accuracy. If the team identifies an inaccuracy a modification/significant correction will be completed at that time. On or prior to the allegation of compliance the DON/Designee will in service the MDS staff and The Interdisciplinary Team with regards to this process. The DON/Designee will oversee this process. Monitoring: The MDS Nurse//Designee will review 3 records of residents on anticoagulant medications each month for three months and then prn to determine if the MDS assessment is accurate. Issues identified will be corrected at that time. The MDS-Nurse/Designee will report her findings to the Interdisciplinary Team at the Leadership Meeting. The RN-MDS coordinator will report Negative trends to the QAPI team monthly and issues will be action planned and prioritized for process improvement.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		1/26/18

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F 689	Continued From page 6 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, medical record review, and policy review, the facility failed to ensure a safety/supervision plan was implemented for 1 of 1 sample residents (#3) who left the facility at routine intervals. The findings were: Review of the 9/6/17 quarterly MDS assessment for resident #3 showed the resident had diagnoses which included epilepsy, depression, and schizophrenia. Further review showed the resident had a BIMS score of 15 (cognitively intact), was independent for ADLs, and had hallucinations and delusions 1 to 3 days of the 7-day look-back period. Review of the care plan under the category of "Behavioral Symptoms" revealed the resident had hallucinations and delusions related to the diagnoses of paranoia, alcohol abuse, schizophrenia, and depressive disorder. Review of a facility incident report dated 9/27/17 showed at around 8 AM the resident "was found confused and combative at the sidewalk. [S/he] was riding [his/her] bike this AM. Per ER [emergency room] nurse; obviously the resident has a feeling [s/he] will having [sic] a seizure and trying to park [his/her] bike at the sidewalk. Taken by police car to ER." Review of the post-fall investigation report dated 9/29/17 showed interventions included continue wearing a medical identification bracelet and have the bike helmet inspected. The following concerns were identified:	F 689	F689 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; Resident #3 has been evaluated by provider 12/20/2017 and deemed capable of leaving the facility on his/her own. The resident understands he/she is required to sign in and out. The resident has been educated on safety when he/her leave independently. 2) Identification: Residents who leave facility independently are at risk. Currently there is only 1 other	

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F 689	Continued From page 7 a. Interview with resident #3 on 12/18/17 at 3:06 PM revealed s/he left the facility whenever s/he chose to and would take the bus to various locations in the community. In addition, the resident stated s/he would take medications with him/her and tell the nurse s/he was leaving, but would not sign in or out. b. Interview with the DON on 12/19/17 at 5:27 PM revealed no safety assessment had been completed regarding the resident's outings. She also confirmed the resident left the building whenever s/he chose and did not sign in or out. c. Review of the policy entitled "Resident Safety Program..." last revised 10/31/07 showed under section "4.0 Fundamental information 1. All residents who leave the building must sign out or be signed out by the appropriate individuals..."	F 689	resident that leaves the facility independently. That resident has been evaluated by Provider and deemed capable of leaving the facility independently. The resident has been educated on safety when leaving the facility including signing in and out. 3) Systemic Changes; The facility must ensure that the resident□s environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistive devices to prevent accidents. The facility will, to the extent possible, reduce the risks of possible accident hazards to include educating Residents on safety precautions when they come and go from the facility independently. Residents who wish to come and go independently will be evaluated by the IDT to determine whether or not they are safe. They will be educated to sign themselves out when they leave and sign themselves in when they return. The IDT will educate the resident on safety measures when leaving the facility and the resident□s care plan will be updated at that time. On or before the date of alleged compliance, the DON/Designee will in service the IDT staff and nursing staff on this process 4) Monitoring: The DON/Designee will monitor incidents/accidents for Residents who come and go from the facility	

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F 689	Continued From page 8	F 689	independently weekly for 1 month, then monthly for three month, then quarterly and then as needed. Any identified trends will be presented by the DON/Designee to the QAPI committee for the purpose of process improvement and to ensure the plan has been implemented, sustained, and evaluated for its effectiveness. 5) Date of alleged compliance: January 26, 2018	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and 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 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) 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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under	F 725		1/26/18

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F 725	Continued From page 9 paragraph (e) 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 review of the December 2017 and November 2017 "Declaration of Direct Care Staffing," review of posted staffing numbers/hours, review of the Facility Assessment Tool, the "Nursing Staffing Ladder," and family, resident, and staff interview, the facility failed to ensure adequate nurse aid staffing on 43 of 50 days reviewed. The findings were: Review of the 10/9/17 "Facility Assessment Tool" showed the facility's estimation of nurse aide staffing need was 2.2 PPD (patient per day hours). The following concerns were identified: a. Interview on 12/18/17 at 3:56 PM with resident #11 revealed s/he had to wait up to an hour at times for assistance, especially in the morning. b. Interview on 12/20/17 at 10:15 AM with a family member of resident #43 revealed concerns about staffing being short on the weekends. c. Interview on 12/20/17 at 10:30 AM with resident #22 revealed s/he felt there was not enough staff to assist him/her with ambulation as often as s/he would like. d. Interview on 12/20/17 at 10:30 AM with resident #35 revealed s/he agreed with resident #22 that the facility was short of staff. e. Interview with CNA #1 on 12/20/17 at 2:22 PM revealed they were "short staffed frequently" and there will only be 1 CNA on a shift for unit 1 or 2 and unit 1 was especially hard because there were many residents who required lifts. The aide stated there were times when CNAs were sent home because the census was low. The CNA	F 725	F725 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 No specific Residents were named. The facility will ensure sufficient staff is available to care for the residents needs as identified in the Facility Assessment Tool IDENTIFICATION: Residents residing in the facility are a potential for risk. SYSTEMIC CHANGES The facility will ensure that measures and/or systemic changes are put into place that will include but not be limited to providing staffing on a daily basis that is appropriate to meet the needs of the residents as identified in the Facility Assessment tool. On or prior to the	

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F 725	Continued From page 10 stated the facility currently had 3 aides per unit because surveyors were in the building, but this was not the usual staffing pattern. f. Review of the December 2017 "Declaration of Direct Care Staffing" and daily staff posting showed the facility failed to meet the estimated CNA staffing need on 18 of 20 days (December 1 -20). g. Review of the November 2017 "Declaration of Direct Care Staffing" and daily staff posting showed the facility failed to meet the estimated CNA staffing need on 25 of 30 days. h. Interview with the DON on 12/21/17 at 8:27 AM revealed an average daily census matrix was utilized to determine staffing needs (Nursing Staffing Ladder). The DON further stated she would have to research this further, and would provide a copy of that matrix. She was uncertain if acuity was factored in when filling staffing needs. Interview on 12/21/17 at 10:57 AM with the DON, administrator, and the BOM (business office manager) revealed the facility had 5 full-time CNA positions open. In addition, the administrator confirmed the facility had 1 full-time and 3 PRN (as needed) nursing positions open. The administrator confirmed, based on the information provided in the facility assessment tool, the facility required 2.2 PPD (patient per day hours) to meet basic resident needs. They each confirmed that sometime in November 2017 was the last time agency staff had been utilized to meet staffing requirements. .	F 725	allegation of compliance the NHA/Designee will in-service the Nursing Leadership on ensuring adequate staff are provided to meet resident's needs per the Facility Assessment Tool. The Community will review and update the assessment tool as needed with appropriate staffing parameters. MONITORING The Director of Nursing or designee will monitor the staffing patterns weekly for one month then monthly for three months identifying any patterns and or staff that does not meet the needs of the Residents as identified in the Facility Assessment tool and if necessary, a report will be developed and submitted to the QAPI Committee. Issues identified with staffing will be corrected at that time and trends will be presented by the DON/Designee in QAPI to ensure the plan has been implemented, sustained, and evaluated for its effectiveness. DATE OF COMPLIANCE: January 26, 2018	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident	F 756		1/26/18

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F 756	Continued From page 11 must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the physician	F 756	CORRECTION: For Resident #4 the facility clarified the	

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	535043	A. BUILDING _____ B. WING _____	12/21/2017

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F 756	Continued From page 12 documented a rationale related to an identified medication irregularity for 1 of 6 sample residents (#4) reviewed for medication regimen. The findings were: Review of the 9/20/17 quarterly MDS assessment showed resident #4 had diagnoses that included diabetes mellitus and chronic kidney disease. Review of the physician orders recapitulation dated 11/9/17 showed the resident was prescribed medications including NovoLog sliding scale injectable insulin three times daily and glipizide (oral blood glucose-lowering drug) 2.5 mg twice daily with meals. The following concerns were identified: a. Review of a pharmacist consultation report dated 8/18/17 showed the pharmacist recommended discontinuing the glipizide due to the increased risk of hypoglycemia when used with long-acting insulin. There was no evidence the physician acknowledged or addressed this recommendation. b. Review of a pharmacist consultation report dated 9/7/17 showed the recommendation was repeated. The physician's response, dated 10/3/17, was to make no changes to the resident's medications, with the only rationale being, "[The resident] needs both." This report was noted and signed by the DON on 10/11/17. There was no evidence the physician documented a justification for the continued use of both medications against pharmacist recommendations. c. Review of physician notes dated 9/19/17, 10/16/17, and 11/13/17 showed the physician reviewed the resident's medications; however, there was no evidence the pharmacist's recommendations were addressed. d. Interview on 12/20/17 at 11:48 AM with RN	F 756	order for combination diabetic medication and the MD wrote justification for both medications in the Resident□s record. IDENTIFICATION: Residents on combination diabetic medications are at risk. The DON/Designee will review the medications for diabetics currently residing at the facility to ensure that residents who are on combination diabetic medication have provider justification as to why both medications are needed. For resident identified as not having provider justification for combination diabetic medication, the DON/Designee will ensure that provider justification is documented. SYSTEMIC CHANGES: The Medical Director was re-educated by pharmacist and DON on 1/10/2018 on proper documenting of clinical rationales. The pharmacist will review each resident□s medication regimen once a month in order to identify irregularities. Any irregularities noted by the pharmacist during this review will be documented on a separate, written report that will be sent to the provider and the facility□s medical director and director of nursing. The provider will document his or her rationale in the resident□s medical record. The DON/Designee will review the last 30 days of combination medication pharmacy consults for proper documented clinical rationales. When clinical rationales are absent the DON/designee will clarify with the provider for his/her deemed clinical rational. MONITORING:	

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F 756	Continued From page 13 #1 confirmed there was no evidence in the chart to show the physician documented justification for use of glipizide and insulin in response to the pharmacist's recommendations. e. Interview on 12/21/17 at 10:34 AM with the DON confirmed there was no evidence the physician responded to the recommendation dated 8/18/17. She further verified the physician did not provide justification for continued use of both medications following the recommendation dated 9/7/17.	F 756	The DON/Designee will review the pharmacy consultants MRR□s monthly to ensure the provider has provided clinical rational for any combination diabetic therapy. Any issues identified will be addressed with the primary provider at that time. Trends will be presented in QAPI by the DON/Designee to ensure plan has been implemented, sustained, and evaluated for its effectiveness. Date of Completion 1/26/2018	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza	F 883		1/26/18

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F 883	Continued From page 14 immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on medical record review, policy review, and staff interview the facility failed to implement a system for ensuring pneumococcal immunizations were offered for 1 of 5 sample residents (#60). The findings were: 1. Review of the medical record showed resident #60 was admitted to the facility on 11/23/16 at the age of 95. Further review revealed the resident	F 883	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	

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F 883	Continued From page 15 had diagnoses on admission which included pneumonia. The following concerns were identified: a. Review of the 11/30/16 admission MDS assessment and the 8/26/17 significant change MDS assessment showed section O (Special Treatments, Procedures, and Programs) was left blank. Review of the 11/25/17 significant change MDS assessment showed the pneumococcal vaccine was not given and was not offered. Review of the medical record showed no evidence staff had offered the pneumococcal immunization, or assessed the resident for medical contraindication. Further review of the medical record revealed a phone call had been placed to the resident's physician on 12/14/17 requesting an order for the vaccine (386 days after the resident's admission date.) Interview with the DON on 12/21/17 at 10:16 AM confirmed there was no documentation available regarding the administration of the vaccine. 2. Review of the Policy titled "Resident Health Program," last revised 10/1/17, showed under "Policy Guidelines...C. Residents at risk for pneumonia should receive pneumococcal polysaccharide vaccine. These are persons older than 65,...Provisions and Procedures...G. Obtaining consent for both pneumococcal vaccine and influenza vaccine upon admission and maintaining the consent with the Resident Immunization Record form; H. Determining if the resident has previously received the pneumococcal vaccine and documenting that information on the consent in the Resident Immunization Record..."	F 883	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. On or before date of compliance, Resident #60 was offered the pneumococcal immunization along with request for physician orders which both were declined. The resident declined receiving the pneumococcal immunization which is documented in the residents record. The Physician declined ordering the pneumococcal immunization for the resident. The record was updated by licensed nursing staff. 2. Residents that reside at the facility are at potential for risk. On or before the allegation of compliance the DON/ designee will review records for those residents currently residing at Laramie Care center to identify if the pneumococcal immunization was offered and/ or refusal is documented in Residents immunization records. For Residents identified as not having a pneumococcal vaccine the facility will offer the vaccine and/ or refusal will be documented in the resident□s medical record. 3. On or before date of compliance SDC/Designee will track and trend resident immunizations to ensure the resident was offered the vaccine and the outcome was properly documented in the	

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F 883	Continued From page 16	F 883	resident□s immunization record. SDC/designee will educate licensed nursing staff on offering residents the pneumococcal immunization and documentation. 4. The SDC/Designee will do random audits 3 times weekly for 1 month, weekly for 1 month, monthly for 3 months and as needed to ensure that Pneumococcal immunizations were offered and/ or refusal documented. SDC/Designee will track and trend residents to ensure immunizations have been offered to them. Any issues identified will be addressed at that time and issues identified will be reported to the monthly QAPI committee meeting. January 26, 2018	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a sanitary environment in 1 of 1 kitchens. The findings were: Observation on 12/20/17 at 11:30 AM showed the following non-food areas of the kitchen were in need of cleaning: a. The wheels and bases of equipment stands including the convection oven, a stand the	F 921	Corrective Action: The Dirty Electrical cord in dining room was cleaned on 12/21/2017. The kick plate on the door was replaced on 12/21/2017. The area under the food rack in the walk in was cleaned on 12/21/2017. Corrective Action Completion date 12/21/2017	1/26/18

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F 921	Continued From page 17 large mixer was on, and the wheels of a tray cart were soiled. b. A cord which hung from the ceiling was encrusted with dried-on food and debris. c. The threshold on the floor at the entry of the walk-in refrigerator had gaps on both sides with a build-up of dirt and debris. d. Interview with the dietary manager on 12/21/17 at 10:02 AM revealed these items needed to be cleaned more frequently, and the cord was no longer used and could be removed.	F 921	Identification: Residents that reside at the facility are at potential risk. Systemic Changes: Prior to the allegation of compliance the Dietary manager instructed the Dietary Staff on proper cleaning schedules and techniques, and the importance of communicating environmental issues in the kitchen to the maintenance department via the maintenance log in order ensure a clean, safe and sanitary environment for the preparation of meals for our residents. The Dietary Manager will continue to conduct rounds of the kitchen to ensure proper compliance with policies and procedures as they pertain to the environment and sanitation. The results of these audits will be given to the Administrator for review. An attendance sheet will be utilized and reconciled with an active staff roster. 1:1 education will be provided to those staff unable to attend. Monitoring: The Dietary Manager/designee will monitor compliance through weekly and prn kitchen observation rounds utilizing the Sanitation Check List form. The Registered Dietitian will perform a sanitation evaluation monthly utilizing the Sanitation Check List form. Issues identified will be presented by the Dietary Manager at QA & A indefinitely to ensure	

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F 921	Continued From page 18	F 921	plan has been implemented, sustained and evaluated for effectiveness.	