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 12/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	503 S 18TH ST LARAMIE, WY 82070

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 12/16/18 through 12/19/18. Also reviewed in the course of the survey were complaint intakes WY00002567 and WY00002626. The following common abbreviations are used throughout this document. ADL: Activities of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing EMR: Electronic Medical Record LPN: Licensed Practical Nurse MDS: Minimum Data Set mEq: Milliequivalent mg: Milligrams ml: Milliliters RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		2/2/19

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

Electronically Signed | 01/17/2019

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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on medical record review, family	F 580	F580 Notify of Changes	

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F 580	Continued From page 2 interview, and staff interview, the facility failed to notify the resident's representative of a change of condition for 1 of 20 (#6) sample residents. The findings were: Review of a 11/27/18 physician communication note showed resident #6 "continues with edema to left hand, middle finger bent down. No obvious signs of trauma." An order for an x-ray of the hand was requested. Review of the radiology report showed the x-ray was completed on 11/29/18 and the results reviewed by the physician on 12/3/18. Interview with the resident's representative on 12/16/18 at 7:35 PM revealed the resident had an x-ray about "two weeks" ago and she had not heard what the results were. Interview with the DON on 12/18/18 at 5:45 PM confirmed there was no documentation the resident's representative had been notified of the x-ray result.	F 580	Corrective Action: Radiography results for resident #6 were communicated to family member on 12/17/19. Identification On or prior to the allegation of compliance the DON/Designee conducted a review of resident records over the last 30 days to identify any x-ray/ radiography results that were not communicated to the family/significant other/interested party and/or physician. Identified changes were promptly communicated to the family/significant other/interested party and/or physician for evaluation. Systemic Changes On or prior to the allegation of compliance the DON/Designee will ensure nurses will be re-educated regarding reporting/notifying family member changes of condition to include notifying family member of test results. An attendance sheet will be kept and reconciled with the active nursing staff roster to ensure nurses have been reeducated. Monitoring NHA & DON/designees will receive a weekly random audit and as needed from the Unit Managers, to include changes of condition and notification of test results, and will validate that appropriate follow-up action has been taken. The QA&A Committee will meet monthly to review the DON's summary of	

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F 580	Continued From page 3	F 580	compliance with this plan of correction to review compliance until the committee determines that compliance has been sustained. Compliance date: February 2, 2019	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		2/2/19

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F 584	Continued From page 4 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure areas utilized by residents were clean and in good repair for 2 of 3 units (unit 1, unit 2). The findings were: 1. Observation on 12/16/18 at 4:21 PM showed a recliner in room 73 had soiled arm rests and food crumbs on the seat cushion. Observation on 12/18/18 at 8:42 AM showed the recliner had a dried white substance on the arm rests and seat cushion, food crumbs on the seat cushion, and tears on the lower edges of the right and left side of the chair. The tears exposed the underlying white padding. 2. Observation on 12/16/18 at 11:03 AM showed the bathroom near the activities room which was used by residents, staff, and visitors had visible stains on the toilet seat and floor. Further, there was a sticky substance noted on the floor. 3. Observation on 12/16/18 at 3:12 PM showed a piece of metal that measured 3 feet by 4 inches near an emergency door and room 7, was unsecured and exposed a sharp edge.	F 584	F 584 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.Recliner in room 73 was shampooed by housekeeping, removing the food crumbs on arm rest and seat cushion. 2.Bathroom near Activity Room was deep cleaned by housekeeping. The floor s of bathroom was striped and waxed and the toilet seat was cleaned by housekeeping. 3.The metal piece by exit door was removed by maintenance during survey.	

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F 584	Continued From page 5 4. Observation on 12/17/18 at 10:14 AM showed a floral-patterned couch outside room 252, and 2 floral-patterned couches in the unit 2 television area had visible discoloration and stains on the cushions and arms. 5. Observation on 12/19/18 between 10:32 AM and 10:45 AM showed the following concerns: a. 14 floor tiles that measured 12 inches by 12 inches, located by the dietary supply closet, were cracked and/or chipped and created a surface that could not be cleaned effectively. b. 12 floor tiles that measured 5 inches by 12 inches and 8 tiles that measured 12 inches by 12 inches, located near the library/chapel area, were cracked or chipped and created a surface that could not be cleaned effectively. c. 3 floor tiles that measured 12 inches by 12 inches, located outside room 172, were cracked and/or chipped and created a surface that could not be cleaned effectively. 6. Interview with the maintenance director on 12/19/18 at 2 PM revealed the facility did not have a plan to fix the damaged floors. Further, it was revealed the facility contracted services for cleaning furniture and floors. He confirmed the floral sofas were stained and discolored and the metal vent cover on the 100 hall would need to be fixed.	F 584	4.The floral pattern couch outside of room 252 was shampooed by housekeeping. The floral pattern couch in the Unit 2 television area was shampooed by housekeeping. 5.A. Fourteen tiles located by dietary closet will be replaced by maintenance on or before date of compliance. B. Twelve tiles located near library chapel area were replaced by maintenance on 1/10/2019. C. Three tile outside room 172 will be replaced by maintenance on or before date of compliance. The NHA/Designee in-serviced the Housekeeping and Maintenance Director on or before date of compliance to ensure that the facility maintains a sanitary, orderly, and comfortable interior. Beginning at the time of survey and up to the date of compliance, the NHA/Designee in-serviced facility staff on communication of maintenance and housekeeping concerns/issues via log books located throughout the facility. On or before the date of compliance, the NHA/Designee in-serviced the housekeeping department on the importance of cleanliness of the facility. The housekeeping director, the maintenance director, and the facility management team will conduct visual rounds to ensure compliance. NHA will provide oversight to ensure identified issues have been addressed.	

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F 584	Continued From page 6	F 584	The maintenance director, housekeeping director, and NHA/Designee will conduct monthly environmental rounds in order to identify outstanding housekeeping and maintenance issues with overall oversight provided by the NHA/Designee. Further monitoring through Resident Council, facility grievance process, ombudsman, and family feedback. Any issues identified will be addressed at that time and issues identified will be reported to the monthly QAPI committee meeting to ensure the corrections have been implemented, achieved, sustained and evaluated for its effectiveness. Date of compliance February 2, 2019	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 604		2/2/19

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F 604	Continued From page 7 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure 1 of 20 sample residents (#39) was free from unnecessary physical restraints. The findings were: 1. Review of the quarterly MDS assessment dated 11/3/18 showed resident #39 had severely impaired cognition, and required extensive assistance with ADLs such as bed mobility, transfers, dressing, toilet use, and personal hygiene. The following concerns were identified: 2. Observation on 12/17/18 at 10:01 PM showed resident #39 was sitting in a recliner in the main entrance lobby with a blanket covering her/him. The resident was reclined back with the foot rest out. The foot rest of the recliner had a four-leg metal chair sitting under the foot rest preventing the foot rest from being lowered. Interview with CNA #2 at that time revealed, "I have always been told to put the chair under the foot rest. Because [s/he] will fall out otherwise. If we put	F 604	F604 Restraints 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 CORRECTIVE ACTION: On 12/17/18 resident # 39 was reclined back with the footrest out. The foot rest of the recliner had a four-leg metal chair sitting under the foot rest. The D.O.N.	

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F 604	Continued From page 8 [him/her] to bed [s/he] will crawl out and get hurt." 3. Interview with the DON on 12/17/18 at 10:24 PM confirmed the resident was restrained in the recliner. In addition, the resident was placed in the recliner so staff could monitor and help the resident as needed. Interview with the DON on 12/18/18 at 9:30 AM confirmed there was no safety assessment related to restraints done on the resident. In addition, she stated the facility did not conduct an education program related to restraints due to the facility being restraint free. 4. Review of the resident's medical record showed no evidence an assessment was completed related to the placement of a chair under the recliner foot rest. 5. Review of the facility policy and procedure on restraints with an issue date of 4/2/07 showed "IV Provision (s) and Procedure (s) ...1. Prior to utilizing a safety device/Physical Restraint, the following risk evaluation is completed by a designated healthcare professional in conjunction with the resident and/or family to identify the least resistive devices to used. ... iv. An individualized care plan is developed and includes goals/interventions related for physical restraint and safety device usage and reduction..."	F 604	removed the chair at that time the surveyor asked about the chair. Immediate 1:1 education was provided by D.O.N. / designee to staff member that used chair under foot of recliner and other staff working on shift at that time. On December 18, 2018 all other nursing staff was educated in person or via phone in regards to restraint policy by D.O.N. / designee. Identification of other residents potentially affected: Residents residing in the facility are a potential for risk. . No further issues identified. System Changes: The facility will ensure that measures and/or systemic changes are put into place that will include but not be limited to providing facility education upon hire and as needed. Prior to utilizing a safety device/Physical Restraint, a risk evaluation is completed by a designated healthcare professional in conjunction with the resident and/or family. An individualized care plan is developed and includes goals/interventions related for physical restraint and safety device usage and reduction. On or prior to the allegation of compliance the D.O.N./Designee will in-service facility staff on Restraint management policy. Monitoring: The Director of Nursing or designee will do random visual rounds, weekly for one month and as needed to ensure restraints	

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F 604	Continued From page 9	F 604	are not being utilized without accompanied evaluation and documentation. Any issues identified will be corrected at that time and any patterns/trends will be presented by the DON/Designee in QAPI to ensure the plan has been implemented, sustained, and evaluated for its effectiveness. Compliance date: February 2, 2019	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of the MDS 3.0 RAI (Resident Assessment Instrument) manual, the facility failed to ensure a significant change assessment was completed for 1 of 20 (#52) sample residents. The findings were: Review of the 11/17/18 quarterly MDS assessment showed resident #52 was independent with eating, did not have a catheter,	F 637	F637 Comprehensive Assessment after Significant Change Corrective Action: On 12/17/2018 a significant change in status assessment was completed on resident # 52. Identification of other residents potentially	2/2/19

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F 637	Continued From page 10 was not prescribed a mechanically altered diet, and was not using oxygen therapy. Further review showed the resident was hospitalized with a diagnosis of urosepsis on 11/27/18 and was readmitted to the facility on 12/3/18. The following concerns were identified: a. Observation on 12/16/18 at 12 PM showed the resident was being assisted with eating by CNA #1. The resident was served a pureed diet with thickened liquids; had a catheter; and was using oxygen. b. Review of the December 2018 physician order recapitulation report showed the physician ordered 3 liters/minute of continuous oxygen; a dysphagia I diet (pureed foods) with nectar thickened liquids, total feed; and a Foley catheter on 12/4/18. c. Interview with MDS coordinator #1 on 12/17/18 at 3:01 PM confirmed the resident had declined in the eating ADL, but she had not considered the oxygen, diet consistency, and catheter in determining the need for a significant change MDS assessment. Review of the "CMS RAI version 3.0 Manual, October 2017, showed "...04. Significant change in status assessment (SCSA) (A0310A=04)...other conditions may not be permanent but would have such an impact on the resident's overall status for more than two weeks that they would require a comprehensive assessment and care plan revision. For example, a hip fracture may be viewed as a transient condition but it would generally have a major impact on the resident's functional status in more than one area (e.g. ambulation, toileting, elimination patterns, activity patterns)..." Continued review showed "...Decline in two or more of the following...any decline in an ADL	F 637	affected: Residents residing at Laramie Care Center are found to be potentially affected by the deficient practice. Residents currently residing at Laramie have been reviewed to determine if a significant change in the resident's physical or mental status has occurred. If a significant change in status was determined a significant change in status assessment has been completed. System Changes: The Interdisciplinary Team will review the status of residents each quarter. If the team determines that a significant change has occurred the assessment will be completed by the 14th calendar day following the determination. The Interdisciplinary Team has been in-serviced with regards to this process. The DON/Designee will oversee this process. Monitoring: The MDS Nurse//Designee will review 3 records of residents each month to determine if there is a decline or improvement consistently noted on two or more areas of decline or two or more areas of improvement for 3 months. The Interdisciplinary Team will review the twenty-four hour report for and significant changes and follow up as needed. Issues identified will be corrected at that time. The DON/Designee will report her findings	

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F 637	Continued From page 11 (activities of daily living) physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment." Further, the RAI stated a significant change assessment is appropriate when "...There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments..."	F 637	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. 5. Compliance date: February 2, 2019	
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 by: Based on medical record review and staff interview, the facility failed to ensure MDS assessments were accurately completed for 1 of 20 (#19) sample residents reviewed. The findings were: Review of the medical record for resident #19 showed s/he was prescribed risperidone (an antipsychotic) 1 mg daily for unspecified psychosis not due to a substance or known physiological condition on 8/9/18. The following concerns were identified. a. Review of the 10/3/18 quarterly MDS assessment showed the resident received an antipsychotic 7 days of the 7-day look-back period. Further review showed the medication was coded as being received on a PRN (as needed) basis.	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.	2/2/19

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	535043	A. BUILDING _____ B. WING _____	C 12/19/2018

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F 641	Continued From page 12 b. Interview on 12/18/18 at 5:11 PM with MDS coordinator #1 revealed the facility did not have any residents taking antipsychotic medications PRN and confirmed the MDS assessment was marked in error.	F 641	Corrective Action: On 12/18/18 the MDS for Resident #19 was modified to accurately reflect "Yes - Antipsychotics were received on a routine basis only". Identification of other residents potentially affected: Residents currently residing at Laramie are found to be potentially affected by the deficient practice. On or before 2/2/19 the MDS nurse/designee reviewed assessments for residents currently residing at facility to ensure use of antipsychotic Medications is appropriately assessed on the MDS .There were no other issues identified System Changes: The Interdisciplinary Team will review the status of the resident's assessment for those residents taking psychotropic 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. The DON/Designee will oversee this process. Monitoring: The MDS Nurse//Designee will review 3 records of residents each month for three months and then prn to determine if the	

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F 641	Continued From page 13	F 641	MDS assessment is accurate. Issues identified will be corrected at that time. The MDS-Nurse/Designee will report the 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. Compliance date: February 2, 2019	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental	F 645		2/2/19

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F 645	Continued From page 14	F 645		

condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3)

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F 645	Continued From page 15 or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a PASARR level II was performed for 1 of 3 sample residents (#76) with a qualifying diagnosis. The findings were: Review of the 3/24/18 admission MDS assessment showed resident #76 was admitted from the community on 3/17/18. Review of the PASARR Level I showed it was completed on 3/15/18, two days prior to admission. Based on the answers to the screening questions the summary referred to a Level II evaluation, however the Level II process was not completed prior to admission. Interview with the administrator on 12/19/18 at 10:13 AM revealed the Level I PASARR questions had not been answered correctly related to the categorical determination, and had the questions been answered correctly, the date for completion of the Level II screening may have been extended.	F 645	F 645 PASARR The facility will complete required PASARR screenings prior to admission. Corrective Action: A PASARR was completed on 3/27/2018 for Resident #76. On or before date of compliance the admission, social services and medical records members were in-serviced by NHA/designee to ensure PASARR□s were completed correctly prior to admission to determine if further screenings are necessary. Identification: Residents residing at Laramie Care Center are at risk. No further issues identified. Systematic Changes: Starting 1/14/2018 and up to the allegation date of compliance the Administrator/Designee will in-service admission and medical records members on the importance of completing the PASARR Level I screening prior to admission to determine if further screenings are needed in order for admission to take place to facility. Monitoring: The Administrator/Designee will review each PASRR Level I completed prior to committing to admission. Findings will be tracked, trended and the Administrator will	

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F 645	Continued From page 16	F 645	present the results in a report to Quality Assurance Performance Improvement Committee monthly for 3 months then as needed for review and suggestions as needed to ensure plan is implemented, sustained and evaluated for its effectiveness. Compliance Date: February 2, 2019	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		2/2/19

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F 758	Continued From page 17 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents were free from unnecessary psychotropic medications for 1 of 5 (#31) sample residents reviewed for medications. The findings were: 1. Review of the 10/27/18 quarterly MDS assessment showed resident #31 had diagnoses which included Alzheimer's disease, dementia, and lumbago with sciatica. Further review showed the resident had a BIMS score of 15/15 (cognitively intact); a mood score of 5/27 (mild depression); did not exhibit any behaviors; and received an antidepressant 7 days of the 7-day look-back period. Review of the physician's orders showed the resident was prescribed duloxetine hydrochloride (an antidepressant) 40	F 758	-F758 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.	

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F 758	Continued From page 18 mg daily for sciatica with a start date of 12/6/17. The medication was increased to 60 mg daily on 1/4/2018. The following concerns were identified: a. Review of the physician's order for duloxetine hydrochloride showed "Medication has boxed warning...May cause drowsiness, dizziness. Call MD if mood change occurs..." b. Review of the medical record showed no evidence a gradual dose reduction (GDR) had been attempted, or the physician provided justification for continued use in the last 12 months. c. Review of the care plan initiated 2/15/18 showed a focus of "Potential for SE (side effects) from use of antidepressant daily." Interventions included monitoring for nausea, dry mouth, sleepiness, fatigue, constipation, loss of appetite, increased sweating, or dizziness every shift and as needed. In addition, "will be reviewed at the drug committee to assure that the lowest effective dose is used." d. Review of the November and December 2018 treatment administration record showed no evidence side effects of the medication were being monitored. e. Interview with the social worker on 12/18/18 at 4:11 PM revealed it was her understanding since the medication was being used for pain it was not necessary to attempt a GDR or obtain a risk/benefit statement from the physician.	F 758	1) Corrective action: For Resident #31The facility now reviews The Potential for SE (side effects) from use of the antidepressant daily. The resident is on the lowest dose appropriate for the treatment of her Neuropathic pain. 2) Identification: A review of records for resident's receiving antidepressant medications will be conducted by the IDT on or prior to the allegation of compliance utilizing the psychoactive medication documentation audit tool. Issues identified concerning monitoring for side effects and ensuring resident is on lowest possible dose will be reviewed at that time. Issues identified will be corrected at that time. 3) Systemic Changes: Each resident is reviewed on admission, quarterly, annually, and with significant change for the use of antidepressants, For residents who are prescribed Antidepressant medications, clinical record documentation will be reviewed to ensure: Nursing/Clinical documentation includes interdisciplinary notes, signed consents, care plans and nursing notes that reflect the specific condition, targeted behavior, and interventions and behavior monitoring and side effect monitoring when indicated. Medication side effects are monitored daily for residents receiving antidepressant medications using the behavior monitoring form. The pharmacy consultant will evaluate and make	

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F 758	Continued From page 19	F 758	recommendations each month to the M.D. regarding dose reductions. On or before the date of alleged compliance, the DON/Designee will in-service staff on monitoring of side effects and the documentation of that monitoring The DON/designee will in-service all licensed nurses on the clinical documentation required as well as the above stated process. 4) Monitoring: Residents receiving antidepressant medications are reviewed quarterly to ensure the appropriateness on the medication is evaluated, target behaviors, interventions, side effects, and the effectiveness of the medication are being documented. The psychoactive documentation audit will be conducted quarterly on residents receiving antidepressants medications to ensure the effectiveness of medication is being monitored per facility policy and other required documentation is in place. Issues identified will be reviewed at QAPI for 3 months to ensure plan has been implemented, sustained and evaluated for effectiveness.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		2/2/19

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F 761	Continued From page 20 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of U.S. Food & Drug Administration (FDA) instructions, the facility failed to ensure medications available for use were not expired in 1 of 4 medication storage areas (100 hall medication cart). The findings were: 1. Observation on 12/19/18 at 1:29 PM of the 100 hall medication cart showed 1 Lantus (long lasting insulin) 100 unit/ml injectable flex pen with no written expiration date. 2. Interview with LPN #1 on 12/19/18 at 1:29 PM confirmed the medication was available for resident use. 3. Interview with the DON on 12/19/18 at 2:55 PM revealed it was the facility's expectation for staff	F 761	F761Label/Store Drugs and Biologicals Corrective Action: The 1 Lantus (long lasting insulin) 100 unit/ml injectable flex pen with no written expiration date was removed from cart. Identification: Residents residing in the facility have the potential to be affected by this practice. No further issues identified. Systematic changes: Prior to date of alleged compliance the DON/Designee will in-service Licensed Nurses on the requirement that all medications must be appropriately stored	

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F 761	Continued From page 21 to label the insulin with an expiration date when the insulin was placed into the medication cart. 4. Review of FDA instructions found at www.fda.gov/drugs/emergencypreparedness/ucm085213.htm (retrieved 1/3/18) showed insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59°F and 86°F for up to 28 days.	F 761	dated and labeled appropriately. Specifically outdated/ undated medications must be removed for destruction. Monitoring: DON/designee will do weekly medication room and cart reviews weekly for 4 weeks, then monthly for 2 months, then prn to monitor for ongoing compliance. Issues identified will be corrected at that time. Issues will be tracked and trended. DON/designee will report the results to QAPI monthly as needed to assure plan is implemented, sustained and evaluated for its effectiveness. Compliance Date: February 2, 2019	
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from	F 825		2/2/19

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F 825	Continued From page 22 participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure specialized rehabilitation services were provided to 1 of 3 sample residents (#6) who required these services. The findings were: 1. Review of a 11/27/18 physician communication note showed resident #6 "continues with edema to left hand, middle finger bent down. No obvious signs of trauma." An order for an x-ray of the hand was requested. Review of the radiology report showed the x-ray was completed on 11/29/18 and the results reviewed by the physician on 12/3/18. The following concerns were identified: a. Review of a physician order dated 12/12/18 showed occupational therapy was to evaluate and treat the left middle finger and fit for a brace to prevent contractures. b. Interview with the occupational therapist on 12/18/18 at 3:06 PM revealed she was unaware of the physician order for the resident. In addition, physician orders were given to the director of rehabilitation and the director would then schedule the evaluation. c. Interview with the director of rehabilitation on 12/18/18 at 3:51 PM revealed she was unaware of the physician order for the resident. In addition, she stated the facility did not have a "consistent process for getting orders to therapy." d. Interview with the DON on 12/19/18 at 10:18 AM revealed physician orders for therapy were either hand-delivered or put in a box.	F 825	F825 Provide/Obtain Specialized Rehab Services Correction: The facility failed to ensure specialized rehabilitation services to resident #6. On 12/18/18 therapy evaluated resident. Identification: Residents currently residing at Laramie Care Center are at potential risk. No further issues identified. Systemic changes: The Director of Rehab will be educated on 1/11/2019 by DON on how to look up orders in resident chart on or prior to alleged compliance. Monitoring: Don/designee will have rehab staff member acknowledge that orders have been received on business days by signing daily PPS sheet. DON/designee will do weekly random audits of new therapy orders to ensure that therapy has followed up on order. Issues identified will be corrected at that time. Issues will be tracked and trended. DON/designee will report the results to QAPI monthly as needed to assure plan is implemented, sustained and evaluated for its effectiveness. Compliance Date: February 2, 2019	

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F 880	Continued From page 23	F 880		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		2/2/19

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 12/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	503 S 18TH ST LARAMIE, WY 82070

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F 880	Continued From page 24 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure infection prevention practices were followed for 1 of 3 sample residents (#17) observed for perineal care and for 1 of 1 sample residents (#50) on isolation precautions. The following concerns were identified:	F 880	F880 Infection Prevention and Control Correction: The isolation yellow and red barrels were placed back into resident #30's room. Staff and family of resident were educated on infection waste barrel placement. Resident #17 received cares per the professional standards. Nursing staff	

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F 880	Continued From page 25 1. Review of the quarterly MDS assessment dated 9/8/18 showed resident #17 had diagnoses which included quadriplegia and traumatic brain injury. Further review showed the resident required total assistance of 2 or more people for bed mobility and personal hygiene. The following concerns were identified: a. Observation of incontinence care on 12/17/18 at 2:13 PM showed 2 staff members, CNA #3 and CNA #4, assisted resident #17 with incontinence care. During the care, the staff members donned gloves and CNA #4 obtained an incontinence pad and wipes. The CNAs removed the resident's brief and CNA #3 wiped the resident front to back and clean to dirty. The CNAs assisted the resident to roll toward the wall, and CNA #4 wiped the resident's buttocks and anus. After providing care, neither staff member removed their gloves and both touched the resident's sheets, shirt, clean brief, pillow, and the wipe with the contaminated gloves. 2. Observation on 12/16/18 at 10:07 AM showed resident #50 had an isolation cart, yellow barrel, and red barrel placed side by side outside of his/her room. A sign was located on the resident's door which indicated visitors must "report to nurse's station before entering resident room." Further observation showed an unidentified resident was self-propelling in his/her wheelchair and used the red barrel to assist by grabbing the barrel and pulling him/herself forward. 3. Interview with the infection preventionist on 12/19/18 at 9:15 AM revealed staff were expected to follow "universal precautions" during resident care and should wash their hands when they enter the room, move from dirty to clean, and when soiled. It was confirmed the staff should not	F 880	educated on hand washing, donning and doffing gloves after perineal care. Identification: Residents at Laramie Care Center are at risk. No further issues identified. Systemic changes: On or prior to the allegation of compliance the DON/Designee will ensure nursing staff will be re-educated regarding hand washing and perineal care. Nursing staff will be educated upon hire, yearly and as needed. Monitoring: The DON/ designee will do random hand washing and perineal care 2 times a week for one month then monthly for 3 months and then as needed. . Issues identified will be corrected at that time. Issues will be tracked and trended. DON/designee will report the results to QAPI monthly as needed to assure plan is implemented, sustained and evaluated for its effectiveness. Compliance Date: February 2, 2019	

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F 880	Continued From page 26	F 880		

have touched clean resident items with gloves used to provide incontinence care. Further, it was revealed the isolation carts should be stored in the isolation room to prevent cross contamination of staff, residents, and visitors.

4. Review of the policy titled "Hand Washing" last revised 2/15/11 showed "...5.0 Procedure Hand washing is performed:...before and after each resident contact. d. Wash hands if moving from a contaminated-body site to a clean-body site during resident care. e. After contact with soiled or contaminated articles, such as articles that are contaminated with blood or body fluids..."

5. Review of the policy titled "Routine Perineal Care" last revised on 9/1/18 showed "...III, Procedures....5. Wash hand and put on gloves...8. Female Resident:...i. change gloves and wash hands before applying ordered cream/ointment...9. Male Resident:...j. change gloves and was hands before applying ordered ointment/cream...10. After Care:...b. Clean equipment; store appropriately; discard gloves; and wash hands..."