STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0008	A. BUILDING: _____ B. WING _____	C 03/11/2019

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) COMPLETE DATE
S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Nursing Care Facilities, Chapter 11, effective 06/26/2000 Rules and Regulations for Licensure of Nursing Care Facilities, Chapter 19, effective 06/26/2000 A complaint survey was conducted by Healthcare Licensing and Surveys on 3/11/19. The survey was prompted by complaint intake WY00002793. The following common abbreviations are used through this document: DON: Director of Nursing Less commonly used abbreviations will be annotated in each deficiency.	S 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the 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	5/8/2019
S2928	Ch 11 Sec 6 (b)(iii) Physical Environment (b) Sanitary Environment. The Nursing Care Facility shall establish policies and procedures for investigating, controlling and preventing infections. (iii) The facility shall report the required diseases/conditions to the Wyoming Department of Health, Epidemiology Unit as per W.S. §35-4-107. In addition, those conditions classified as nosocomial where two (2) or more persons, either residents or employees, are affected shall be reported immediately to the State Health Officers, the County Health Officer, and the Licensing Division. The Nursing Care Facility Administrator or his/her designated representative shall furnish all available pertinent	S2928		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrea Stannard | TITLE: NHA | (X6) DATE: 4/4/2019

Accepted by Loralee Rees on 4/17/19
Andrea Stannard, NHA was notified DOC: 5/8/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0008	A. BUILDING: _____ B. WING _____	C 03/11/2019

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) COMPLETE DATE
S2928	Continued From page 1 information related to such disease or condition to the Licensing Division This State Rule and Regulation is not met as evidenced by: Based on observation, medical record review, staff interview, and review of the State Survey Agency incident report database, the facility failed to ensure an outbreak of infectious disease was reported for 2 sample residents (#1, #2) who tested positive for influenza. The findings were: 1. Observation on 3/11/19 at 10:50 AM showed the facility had a sign posted at the front entrance which identified an outbreak of influenza at the facility. 2. Review of a progress note dated 2/28/19 and timed 9:51 AM showed resident #1 tested positive for influenza A and was placed on droplet precautions. 3. Review of a progress note dated 2/28/18 and timed 3:05 PM showed resident #2 was "... readmitted to facility this AM with diagnosis of influenza A..." 4. Interview with the administrator and DON on 3/11/19 at 1 PM revealed the facility had 2 residents who had tested positive for influenza and the facility had contacted the State epidemiology office. Further, the administrator believed the State Survey Agency was contacted as well. 5. Interview with infection preventionist via telephone on 3/11/19 at 1:09 PM revealed she	S2928	**Correction:** on 3-11-2019 the State Survey Agency was notified by the Director of Nursing of the two residents who had tested positive for the flu. **Identification:** Residents that reside at Laramie Care Center are at risk. **Systemic Changes:** On or before the date of compliance the Infection Control Nurse and other nurse managers will be re-educated by the Director of Nursing on reporting diseased conditions where two (2) or more persons, either residents or employees who are affected shall be reported immediately to the Licensing Division.	5/8/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0006	A. BUILDING: _____ B. WING _____	C 03/11/2019

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) COMPLETE DATE
S2928	Continued From page 2 contacted the state epidemiologist to report the residents confirmed with influenza; however, she did not notify the State Survey Agency. 6. Review of the State Survey Agency incident report database showed an infectious disease report was not submitted for the residents with influenza.	S2928	**Monitoring:** NHA/Designees will review the infection control log monthly and all reports of an outbreak to ensure the Licensing Division was notified. Issues identified will be reviewed monthly by QAPI Committee to assure the plan is implemented, sustained and evaluated for effectiveness. Date of alleged compliance May 8, 2019.	5/8/2019