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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043 8/5/11 klr	A. BUILDING _____ B. WING _____	C 06/30/2011

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 The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing MAR-Medication Administration Record MDS- Minimum Data Set RN-Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	**F244** Preparation and/or execution of this plan of correction does not constitute 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.	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to ensure resident grievances were acted upon concerning hot and/or cold water surges in 2 of 4 shower/bath rooms available for resident use. The findings were: During interviews on 6/29/11 with non-sample residents #31 at 8:30 AM and #39 at 9:35 AM, each resident stated that water in the two shower rooms closest to the dining area had surges of hot and/or cold water frequently when in use. Furthermore, those surges had occurred for at least a year and staff members were aware of	F 244	When a resident or family group exists, the facility will listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Residents #31 and #39 and all other residents who take showers in the 2 shower rooms will have water that does not fluctuate in temperature. The maintenance staff will monitor and log the water temperatures and will give a copy to the administrator weekly. The Maintenance Director will provide a report monthly to the Resident Council. The Maintenance Director will report to the QAPI Committee monthly until the residents indicate through resident council they are satisfied with the water temperatures. The Administrator will monitor for compliance. Plumber will place a direct line between the heater and shower room providing direct pressure. klr 8/5/11	8/14/11

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

Ronda Nelson — Administrator — 7-25-11

POC attached with additions 8/5/11 a 2:30 PM Ronald Weisen Kathryn Mary

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
Wyoming Dept of Health
JUL 26 2011
Office of Healthcare Licensing and Surveys

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F 244	Continued From page 1 this issue. The residents described the water surge as an irritant, though the water was not hot enough for injury. During an interview with the maintenance director on 6/30/11 at 9:20 AM, he said the water surge issue had been brought to his attention, and an attempt was made to address this issue. He stated that a water tank was needed to stop the surges, but the facility had not established a timeframe to order the tank or complete the work. The facility also failed to communicate with residents on the status of this problem.	F 244	**F253** Preparation and/or execution of this plan of correction does not constitute 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.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide adequate maintenance to ensure that resident rooms in 4 of 5 hallways were in good repair. The findings were: 1. During observations on 6/29/11 from 11:20 AM through 12:15 PM the following issues related to building maintenance were found: a. In room 73, the bathroom door had a three inch hole near the hinges on the inside, located four inches from the floor. b. In room 60, the front door frame had a 13 inch scuffed area with chips out of the paint one foot from the floor. c. The heat radiator in rooms 1 and 12 were bent, warped, and extended across the entire	F 253	The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The facility will repair or replace the bathroom doors in rooms 105, 228 and 107. In room 260 the front door frame will be painted. The heater covers will be covered or replaced in rooms 101 and 112. In rooms 103, 116, and 228, the bathroom doors will be repaired or replaced. The walls in room 107 will be repaired. The assisted dining room door frame will be repaired and painted. The heater in the hall between room 106 and room 107 will be covered with an appropriate cover. A facility sweep will be completed to identify any other areas that need repair. Any issues identified will be repaired by 8/14/11. The maintenance department will make monthly rounds to monitor doors, heaters and walls for need of repair. Door kickplates will be repaired/ painted in rooms 48 and 57. Bath-/ room wall will be painted/repaired in room 48. Bathroom heater repaired/ room 48. klr 8/5/11	73, klr 8/5/11

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F 253	Continued From page 2 wall. d. In rooms 3,16, and 28, the bathroom door had a 36 inch scuffed area located one foot from the floor. e. The bathroom door in room 28 had a six inch hole in the door. f. In room 5, the bathroom door had a 3 inch by 10 inch hole on the inner side located one foot from the floor. g. The walls in room 7 had plaster scraped off. The area was one foot wide and one foot from the floor. h. The assisted dining room door frame opposite the main dining entrance had chipped plaster and paint on both sides from the floor to 18 inches high. i. The heat radiator in the hallway between rooms 6 and 7 was bent, warped, and extended across the entire wall. 2. During observations on 6/30/11 from 8 AM through 8:30 AM the following issues related to building maintenance were found: a. On the inside of the front door of room 57, the kick plate had a 30 inch scraped area on the inside. b. In room 49, the bathroom wall had a narrow scrape that was four feet and five inches across. Another scrape was located on the wall two feet from the floor that was two feet across and 36 inches from the floor. c. In room 48, the bathroom heater was pulled from the wall. In addition, the front door kick plate was chipped on the inner edge from the floor to 36 inches high. 3. During an interview with the maintenance director on 6/30/11 at 9:20 AM, he stated he was	F 253	Director of Maintenance will report findings to QAPI Committee monthly and will monitor for compliance.	8/14/11

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F 253	Continued From page 3 aware of the issues with the doors, door frames, and heaters. He further stated the facility intended to replace the doors and repair the door frames and heaters. However, he said there was no specific plan or timeline for these repairs.	F 253	**F278** Preparation and/or execution of this plan of correction does not constitute 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. The assessment will accurately reflect the resident's status. For Resident #7 the MDS was corrected to include her colostomy, her pressure ulcers and missing diagnoses. For Resident #33 the MDS was not coded as a quarterly because the quarterly was completed on 5/9/11. Residents who reside at facility are at risk. On or before the allegation of compliance the MDS Coordinator/Designee will review Resident's MDS's to ensure that colostomies, diagnoses, and pressure ulcers are appropriately coded and the assessment type is accurately coded. For issues identified the MDS will be corrected at that time. On or before the allegation of Compliance the MDS Coordinator/Designee will in-service the MDS Staff and Interdisciplinary Team on the importance of accurately assessing the Resident's status to include accurate identification on the MDS of colostomies as well as pressure ulcers and diagnoses.. The	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced	F 278		

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F 278	Continued From page 4 by: Based on medical record review, staff interview, and observation, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 2 of 13 sample residents (#7, #33). The findings were: 1. Review of the 6/6/11 quarterly MDS assessment for resident #7 showed s/he was frequently incontinent of stool and had an open lesion, but no pressure ulcers on admission. In addition, the following diagnoses were recorded: urinary tract infection, diabetes, depression and vascular myelopathy (vascular disease of the spinal cord). The following information regarding the condition of the resident was not identified and coded on the MDS assessment: a. Review of the medical record revealed the resident had a colostomy placed on 2/11/11 to promote wound healing. Review of the 6/27/11 care plan showed the resident continued to have the colostomy. Yet, colostomy was not recorded on the MDS assessment. b. Review of the 3/9/11 significant change MDS assessment showed the resident was admitted to the facility with three stage 4 pressure ulcers. However, the 6/6/11 MDS assessment showed the resident had no pressure ulcers on admission. c. Review of the medical record showed the resident had the following diagnoses in addition to those aforementioned: hypertension, congestive heart failure, and was a paraplegic. These diagnoses were not recorded on the MDS assessment. d. Interview with the MDS coordinator on 5/30/11 at 9:55 AM revealed she has had problems with coding and with the software	F 278	in-service will also address accurately coding the type of MDS being completed. An attendance sheet will be utilized and reconciled to the list of IDT Members and staff who code MDS's and the staff who were unable to attend will be given individual education. The MDS Coordinator and/ or Designee will bring the Resident's MDS to the Care plan meetings and prior to Filing MDS in the Resident's Record the MDS Coordinator and/ or Designee will review for accurate reflection of colostomies, pressure ulcers, diagnoses, and to ensure the type of MDS is accurately coded. Trends will be identified by the MDS Coordinator who will report to the QAPI committee to ensure the plan is implemented, sustained, and evaluated for its effectiveness.	8/14/11

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F 278	Continued From page 5 inputting information. She said she especially had problems determining how to code pressure ulcers. 2. Review of the medical record for resident #33 showed s/he was due for a quarterly MDS assessment when a 6/11/11 Medicare re-entry MDS assessment was completed. During an interview with the MDS coordinator on 6/28/11 at 3:15 PM, she stated that the 6/11/11 MDS assessment should have been coded as a quarterly assessment, as well as the Medicare re-entry.	F 278	**F280** Preparation and/or execution of this plan of correction does not constitute 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. The comprehensive care plan must be periodically reviewed and revised by a team of qualified persons after each assessment.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	The MDS Coordinator has corrected the care plan for Resident #24 to ensure that his/her communication board is an intervention on the resident's plan of care. Residents who reside at facility are at risk. On or before the allegation of compliance the Interdisciplinary Team will review Resident's care plans to ensure that any communication devices if in use are on the care plan. Issues Identified will be corrected at that time. Resident's Care plans will be reviewed quarterly, annually, and with significant changes in status, Revisions if indicated will be completed at that time. RN's and LPN' will place Resident status changes on the 24 hour Report, and the Interdisciplinary Team will review the 24 hour report and the telephone orders from the prior day each business day and identified status changes will be care	

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F 280	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and observation, the facility failed to ensure resident care plans were updated to accurately reflect current interventions for 1 of 13 sample residents (#24). The findings were: Review of the current care plan for resident #24 showed s/he was hard of hearing and had hearing aids but chose not to wear them. Observation on 6/27/11 at 5:05 PM showed the resident had a communication board at the bedside for communication. The following concerns were identified: a. Observation on 6/27/11 at 5:05 PM showed staff tried to introduce the surveyor to the resident by speaking loudly into his/her ear. The resident did not respond to the staff member. However, when the staff member used the communication board the resident did respond. After the staff member left the resident's room, the surveyor used the communication board and was able to have a conversation with the resident. The resident responded appropriately and visited with the surveyor using a combination of verbal responses and the communication board. Observation on 6/27/11 at 5:20 PM revealed staff again entered the resident's room, spoke loudly into his/her ear and asked if s/he was ready for dinner. Once again, the resident initially did not respond so staff just assisted him/her to the dining room in a wheel chair. Staff did not use the communication board to interact with the resident; nor did staff take the communication board to the dining room so s/he could interact with staff during the meal. Review of the care plan showed it had not been updated to include the	F 280	planned at that time. On or before the allegation of compliance the MDS Coordinator/Designee will in-service the interdisciplinary team members and the licensed Nursing Staff on Care plan Revisions. An attendance sheet will be utilized and reconciled with the Interdisciplinary Team and the Licensed Nursing Staff. Those staff unable to attend will be provided individual education The Resident Care plans will be reviewed on admission, each quarter, and/or with significant change in status at time of care plan meeting to ensure any appropriate care plan revisions have been made. Issues identified will be corrected at that time and the MDS Coordinator will report issues in QAPI Committee to ensure the plan is implemented, sustained, and evaluated for its effectiveness. **F282** Preparation and/or execution of this plan of correction does not constitute 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. Care will be provided by qualified persons in accordance with each resident's written plan of care.	8/14/11

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F 280	Continued From page 7 communication board as an approach to addressing the resident's hearing problems. b. Interview with the DON on 6/30/11 at 2:45 PM revealed the care plan should include the communication board as an intervention to address the resident's hearing deficiency.	F 280	Resident #69 is now toileted before and after meals per his/her plan of care. The DON/designee has re-educated the staff on his plan of care . Resident #13 is now toileted before and after meals per her plan of care. The DON/designee has re-educated the staff on his/her plan of care.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff followed the established care plan for 3 of 13 sample residents (#13, #32, #69). The findings were: 1. Refer to F315 for details regarding failure of staff to follow the toileting care plan for resident #69. 2. Refer to F315 for details in regard to the staff's failure to follow the toileting care plan for resident #13. 3. Refer to F314 regarding failure of the facility to reposition resident #32 according to his/her care plan. Additionally, refer to F315 regarding failure of the facility to check resident #32 for urinary incontinence according to his/her care plan.	F 282	Resident #32 is being turned and repositioned as well as checked and changed per her plan of care Residents who reside at facility are at risk. On or before the allegation of compliance the DON/Designee will re-educate the Licensed Nursing Staff and the CNAs on the importance of following the Resident's plan of care to include providing incontinent care and/or toileting per the plan of care and repositioning per the plan of care The Resident's individual Toileting Plan and Skin integrity plan of care if indicated will be included on the CNAs care sheet. The CNAs care sheet is updated by the MDS Coordinator/designee when indicated. On or before the allegation of compliance the DON/Designee will re-educate the Licensed Nursing Staff and the CNAs on the CNAs care sheet and the importance of following the Resident's plan of care specifically, toileting and repositioning per the resident individual care plan. An attendance sheet will be utilized and reconciled with the CNAs and the Licensed Nursing Staff and those staff	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	Continued From page 8 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure adequate perineal care was provided for 1 of 5 sample residents (#47) who required staff assistance with personal care. The findings were: Review of the medical record for resident #47 showed s/he had diagnoses which included dysuria. Review of the resident's 5/6/11 annual MDS assessment showed s/he was coded for supervision with one staff assist for toileting. Further review showed the resident was frequently incontinent of urine and was on a toileting program. The following concerns were identified: a. Observation on 6/27/11 at 4:15 PM showed the resident was incontinent of urine. Observation of perineal care provided by CNA #1 showed she did not cleanse the entire anterior perineum which was in contact with urine. b. During an interview immediately after the observation, the aide stated the proper way to perform perineal care was to wipe front to back and observe the areas wiped, which should include all areas in contact with urine.	F 312	unable to attend will be provided individual education The DON/Designee will do facility rounds 3 times weekly and prn observing care to ensure staff are following the resident's toileting plan of care and repositioning residents according to the plan of care. Issues identified will be corrected at that time and the DON/designee will review trends in QAPI Committee to ensure the plan is implemented, sustained, and evaluated for its effectiveness **F312** Preparation and/or execution of this plan of correction does not constitute 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. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Corrective action; Resident #47 is provided incontinent peri care per her plan of care using appropriate infection control techniques while maintaining dignity to the extent possible.	8/14/11
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314	Residents that reside at Laramie Center and who are incontinent are at risk.	

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F 314	Continued From page 9 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure that staff implemented measures to prevent skin breakdown for 1 of 5 sample residents (#32) identified as high risk for skin breakdown. The findings were: Review of the 5/19/11 Braden assessment for resident #32 showed s/he had a score of 11 (high risk) for skin breakdown. Review of the resident's 5/19/11 significant change MDS assessment showed s/he was at risk of developing pressure ulcers, and had a stage I and stage II pressure ulcer at the time of the assessment. Review of a 6/13/11 physician's order showed the resident's pressure ulcers had resolved, but the physician ordered a hydrocolloidal dressing to remain in place for protection. In addition, review of the 6/13/11 care plan showed instructions for staff to reposition the resident every two hours to prevent reoccurrence of pressure ulcers. Observation on 6/27/11 from 1:05 PM until 4:45 PM (3 hours and 40 minutes), revealed the resident was not repositioned. During an interview immediately after the observation, CNA #1 said the resident	F 314	Resident ADL needs will be identified using the admission data collection tool then quarterly, annually and with significant change using the RAI, MDS process. Identified ADL needs will be care planned during this process On or before the date of alleged compliance, The DON/Designee will in-service the CNAs on timely assistance with incontinent residents per their plan of care, specifically: providing peri care with appropriate infection control techniques while maintaining dignity to the extent possible. CNAs will be required to provide return demonstration for peri care. An active list of CNAs will be reconciled with the attendance list and those CNAs unable to attend will be provided will individual in-servicing. Nurse Management Team/Charge Nurses will observe 3-5 different CNAs provide peri care each week. Issues identified will be corrected at that time and trended for reviewed in QAPI Committee for purposes of process improvement and to ensure the plan has been implemented, sustained and evaluated for its effectiveness. **F314** Preparation and/or execution of this plan of correction does not constitute 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	8/14/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043 9/15/11 Rkm	A. BUILDING _____ B. WING _____	C 06/30/2011

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F 314	Continued From page 10 should be repositioned every two hours according to his/her care plan.	F 314	solely because it is required by the provisions of federal and state law. A resident who enters the facility without pressure sores will not develop pressure sores unless the Resident #32 will receive the care and services necessary to prevent the development of pressure sores, including positioning per his/her plan of care. The resident's most recent Braden Scale will be reviewed to identify residents at risk for skin breakdown. Residents identified as high risk will be placed on a turning schedule and the schedule will be documented on the residents' plan of care and communicated to staff per the CNA care sheets. On or before the allegation of compliance the DON/Designee will in-service the CNAs and the Licensed Nursing Staff on the importance of repositioning the residents per their plan of care. An attendance sheet will be utilized and reconciled with the active Roster and those unable to attend will be provided individual in-servicing. Nurse Management Team/Charge Nurses will conduct rounds 3 times weekly at random times to ensure residents are being repositioned per their plan of care. Issues identified will be corrected at that time. Trends will then be reported to the QAPI Committee to ensure the plan has	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff provided the necessary toileting and personal hygiene for 3 of 10 sample residents (#13, #32, #69) who were incontinent. The findings were: 1. Review of the 5/9/11 annual MDS assessment for resident #69 showed s/he was incontinent of bowel and bladder and required assistance from staff for toileting and personal cares. Review of the resident's care plan showed s/he should be toileted before and after meals. Observation on 6/27/11 from 1 PM until 3:55 PM revealed no staff checked to see if the resident needed to be toileted or changed. Furthermore, interview with CNA #2 on 6/27/11 at 3:55 PM revealed the resident was last checked and changed at 9:30 AM that morning, (a total of five hours and twenty	F 315		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043 8/15/11 KR	A. BUILDING _____ B. WING _____	C 06/30/2011

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F 315	Continued From page 11 five minutes between incontinence cares). Observation at 3:55 PM on 6/27/11 showed the resident's incontinence brief was wet with urine. CNA #2 confirmed the resident was not checked or changed before or after lunch. 2. Review of the care plan for resident #13 showed s/he was to be toileted before and after meals. Observation on 6/28/11 from 9:45 AM to 12:55 PM, showed the resident was not checked for incontinence prior to lunch at 11:30 AM. The resident was returned to his/her room at 12:55 PM, was transferred via Hoyer lift to his/her bed and was then checked for incontinence by CNAs #3 and #4. Observation at that time showed the resident was incontinent of both urine and stool. Interview with CNA #3 at that time revealed she was not certain when the resident was last checked for incontinence, but confirmed s/he was not checked prior to lunch. The resident had a history of urinary tract infections with the most recent on 6/21/11. 3. Review of the 5/19/11 significant change MDS assessment for resident #32 showed s/he was totally dependent and required one staff member for incontinence needs. Further review showed the resident was always incontinent of urine. Review of the resident's care plan showed a 5/25/11 care plan that required staff to check the resident every two hours for incontinence. The following concerns were identified: a. Observation on 6/27/11 from 1:05 PM through 4:45 PM (3 hours and 40 minutes) showed the resident was not checked for incontinence. During the observation, CNA #1 checked and changed the resident at 4:45 PM when s/he was found to be incontinent of urine.	F 315	been implemented, sustained and evaluated for its effectiveness. **F315** Preparation and/or execution of this plan of correction does not constitute 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. A resident who is incontinent of bladder will receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Resident #69 is now toileted before and after meals per his/her plan of care. The DON/designee has re-educated the staff on his plan of care Resident #13 is now toileted before and after meals per her plan of care. The DON/designee has re-educated the staff on his/her plan of care. Resident #32 is being checked and changed per her plan of care. The DON/designee has re-educated the staff on his/her plan of care. DON/Designee will re-educate the Licensed Nursing Staff and the CNAs on the importance of following the Residents' plan of care to include providing incontinent care and/or toileting per the plan of care.	8/14/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043 8/15/11 klm	A. BUILDING _____ B. WING _____	C 06/30/2011

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F 315	Continued From page 12 b. During an interview immediately after the observation, the aide stated the resident should be checked for incontinence every two hours according to his/her care plan.	F 315	The Resident's individual Toileting Plan will be included on the CNAs care sheet. The CNAs care sheet is updated by the MDS Coordinator/designee when indicated. On or before the allegation of compliance the DON/Designee will re-educate the Licensed Nursing Staff and the CNAs on the CNAs care sheet and the importance of following the Residents' plan of care specifically, toileting and incontinence care per the resident individual care plan. An attendance sheet will be utilized and reconciled with the CNAs and the Licensed Nursing Staff and those staff unable to attend will be provided individual education Nurse Management Team/Charge Nurses will do facility rounds 3 times weekly and prn observing care to ensure staff are following the resident's toileting plan of care. Issues identified will be corrected at that time and the DON/designee will review trends in QAPI Committee to ensure plan is implemented, sustained, and evaluated for its effectiveness **F323** Preparation and /or execution of this plan of correction does not constitute 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	8/14/11
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe environment in 5 of 5 resident hallways. The findings were: 1. During an observation on 6/29/11 from 11:20 AM through 12:15 PM, the following safety issues were found: a. The inside of the front doors to rooms 6 and 7 had two-inch wide jagged edges that were 19 inches long when measured from the floor. b. The front door kick plate to room 6 had a jagged area 2 inches wide and 18 long. 2. During an observation on 6/30/11 from 8 AM through 8:30 AM, the following safety issues were found: a. Room 56 had a scraped and jagged area on the inside of the front door kick plate. The area was measured 30 inches long when measured from the floor.	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043 9/15/11	A. BUILDING _____ B. WING _____	C 06/30/2011

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F 323	Continued From page 13 b. The inside of the front door kick plate to room 58 had jagged area that was pulled away from the door. The area measured 30 inches in height from the floor. c. The bathroom heat radiator of room 60 was not covered, which exposed sharp metal areas. d. The floor at the entrance of room 49 had molding pulled loose at the front door with a sharp edge protruding upward. e. The front door kick plate to room 39 had a jagged area pulled loose from the door from the floor to 6.5 inches high. f. The heat radiator in room 35 was not covered, which exposed sharp metal areas. 3. During an interview with the maintenance director on 6/30/11 at 9:20 AM, he stated the facility had failed to address these safety issues. He further said the facility intended to replace the doors and heat radiator covers but did not have a specific plan or timeline for these repairs.	F 323	solely because it is required by the provisions of federal and state law. The facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The jagged edges on the inside and outside of the front doors to rooms 106 and 107 will be repaired or replaced. The scraped and jagged edge on the front door of room 256 will be repaired or replaced. The jagged area on the inside of the front door of room 258 will be repaired or replaced. The bathroom heater of room 260 will be covered. The molding at the entrance to room 249 will be repaired. The jagged area on the front door kick plate to room 339 will be repaired or replaced. The heater in room 335 will be covered. The maintenance Director will make monthly rounds to monitor doors, heaters and walls for need of repair. Director of Maintenance will report findings to the QAPI Committee monthly until substantial compliance has been met and will monitor for compliance. **F387** Preparation and/or execution of this plan of correction does not constitute 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	8/14/11
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record	F 387		

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

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F 387	Continued From page 14 review, the facility failed to ensure a physician or physician's extender assessed 2 of 10 sample residents (#41, #69) every sixty days as required. The findings were: 1. Review of the physician's progress notes for resident #41 showed s/he was not seen or examined by a physician or physician extender from 10/18/10 to 2/8/11 (112 days). 2. Review of the physician's progress notes for resident #69 revealed the physician did not see or examine the resident from 10/29/10 until 2/2/11 (96 days). 3. Interview with the DON on 6/30/11 at 9 AM revealed this particular physician had been having a difficult time keeping up with all of his residents.	F 387	correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The residents will be seen by a physician at least every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. Resident #41 and Resident #69 have a current physician visit on their record. This problem was identified through the facility QAPI program and had been addressed and corrected at the time of the survey. The Medical Records Director keeps a complete audit of the active residents to monitor and ensure that physician visits are timely. All residents had current visits at the time of the survey. Physician visits are monitored weekly and the facility follows up with physicians who are delinquent in their visitation schedule to ensure that each resident receives the required amount of visits. The Medical Records Director will monitor physician visits weekly. Issues identified will be corrected at that time and trended in QAPI Committee to ensure the plan is implemented, sustained, and evaluated for its effectiveness.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	**F441** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts	8/14/11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043 8/15/11 klm	A. BUILDING _____ B. WING _____	C 06/30/2011

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F 441	Continued From page 15 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the facility's policy and procedures for hand washing, the facility failed to ensure staff followed appropriate infection control practices regarding hand hygiene for 2 of 3 units. The findings were: 1. During a random observation on 6/27/11 at 2:50 PM CNA #5 removed water pitchers from resident rooms on station one (rooms 1-12). After each dirty pitcher was removed, she replaced it with a clean pitcher. She then proceeded to the next room without first washing or cleansing her hands after handling the dirty pitcher. The CNA used this same procedure for each resident in rooms 1 through 12.	F 441	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. The facility does require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. The facility procedure for passing ice water and exchanging water pitchers was reviewed. The facility now collects the dirty water pitchers and delivers them to the Dietary staff then washes their hands prior to proceeding with passing fresh ice water in clean water pitchers. The water pitchers in the residents' rooms will be collected by the staff and delivered to be cleaned in the dietary kitchen. The CNA staff will then wash their hands, collect the clean water pitchers and then begin the fresh ice water pass. Employees are expected to practice standard precautions including hand washing to reduce both the risk of transmitting infections and the likelihood of blood borne pathogens. Staff is in-serviced on infection control, including hand washing on hire and annually thereafter. Managers will perform periodic general observation rounds to ensure staff is practicing standard precautions including hand washing. Nurse Management Team/Charge Nurses	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043 8/5/11 KBM	A. BUILDING _____ B. WING _____	C 06/30/2011

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F 441	Continued From page 16 2. Observation on 6/27/11 at 2:35 PM revealed two CNAs were passing water to residents on station three. Observation showed the CNAs entered resident rooms and returned with a dirty water pitcher which they placed on the bottom shelf of a cart. Then, without washing or sanitizing their hands, each picked up a clean water pitcher and took it into the residents' rooms. 3. Interview with the infection control coordinator (ICC) on 6/29/11 at 4:05 PM revealed staff should not immediately take dirty water pitches out of resident rooms and replace them with clean pitchers. Further, staff should take all the dirty pitchers out of rooms in an area; then after washing their hands, replace them with clean pitchers. 4. Review of the policies and procedures for handwashing number CL-NUR-1722 dated 1/1/01 revealed the following instructions: Handwashing is performed "After contact with an object (e.g. door knobs) or source where there is a concentration of microorganisms such as mucous membranes, non-intact skin, body fluids or wounds."	F 441	will monitor ice water pass at least weekly to ensure compliance. Issues identified will be corrected at that time. Trends will be identified and be reported to the QAPI Committee for the purpose of process improvement to ensure that the system is implemented, maintained and evaluated for its effectiveness.	8/14/11
F 467 SS=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and	F 467		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043 8/15/11 LRR	A. BUILDING _____ B. WING _____	C 06/30/2011

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F 467	Continued From page 17 staff interview, the facility failed to provide adequate ventilation in bathrooms for 5 of 5 hallways and 4 of 4 shower/bath rooms available for use. The findings were: During interviews with residents #31 at 8:30 AM and #39 at 9:35 AM on 6/29/11, each resident stated that the women's shower room closest to the main dining room had noticeable odors of stool most of the time when they showered. Both residents stated that the air did not circulate in the room, and combined with the warm and moist air the odor was quite offensive. These residents also stated that hallway areas sometimes had odors of stool and urine. The following concerns were identified: a. On 6/29/11 from 11:20 AM through 12:15 PM, the following bathroom ceiling vents were checked for ventilation adequacy (using a piece of tissue) in resident rooms 1, 2, 3, 5, 7, 9, 11, 12, and 28. In each case, the tissue failed to cling to the vent, and there was no noticeable air movement. On 6/30/11 from 8 AM through 8:30 AM, the following bathroom ceiling vents were checked for ventilation adequacy in rooms 34, 35, 36, 38, 39, 40, 41, 42, 46, 48, 52, 53, 54, 55, 56, 57, 58, 59, and 60. In addition, the shower/bath room ceiling vents were checked in the following areas: the tub room across from the station two nursing desk, the shower/tub room across from nursing station three, the women's shower room near the main dining room, and the men's shower room near the main dining room. In each case the vents failed to move any air. b. During the observation at 8:15 AM, housekeeping employee #1 was observed spraying the hallway outside of rooms 55, 56, 57, and 58 with a fragrant deodorizer. The	F 467	**F467** Preparation and/or execution of this plan of correction does not constitute 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. The facility will have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. Adequate ventilation will be provided to the tub room, the women's shower room and the men's shower room by the main dining room. Adequate ventilation will be provided to the following room bathrooms; 101, 102, 103, 105, 107, 109, 111, 112, 228, 334, 335, 336, 338, 339, 340, 341, 342, 346, 248, 252, 253, 254, 255, 256, 257, 258, 259, 260. Maintenance staff will repair or replace the ventilation equipment that is not working. A facility sweep will be completed to identify any other areas that need adequate ventilation. Any issues identified will be repaired by 8/14/11. Maintenance staff will make monthly rounds to assure that all HVAC equipment is operating as required. Maintenance Director will report to QAPI Committee monthly until substantial compliance has been met.	

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

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 06/30/2011

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LARAMIE CARE CENTER	503 S 18TH ST LARAMIE, WY 82070

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F 467	Continued From page 18 housekeeper said s/he used the spray to keep the odors down, and would have to spray again later. The housekeeper stated this was done several times daily, and had been facility practice "for a while." c. During an interview with the maintenance director on 6/30/11 at 9:20 AM, he stated that many of the air vents in the building did not work and were not vented to the roof. He also stated the facility had failed to establish a plan or timeframe to complete the work.	F 467	Administrator will monitor for compliance. **F503** Preparation and/or execution of this plan of correction does not constitute 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.	8/14/11
F 503 SS=E	483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.	F 503	If the facility provides its own laboratory services, the services will meet the applicable requirements for laboratories specified in part 493 of this chapter. The undated Glucometer control solution was removed when identified by the surveyor. It was replaced with a bottle of dated solution. The DON/Designee will view all open bottles of Glucometer solution to ensure each is dated when opened. Issues identified will be corrected at that time. On or before the allegation of compliance the DON/Designee will inservice the nursing staff on the importance of dated the glucometer solution when it is open as it expires 90 days after opening. The DON/designee will view all open glucometer solutions weekly to ensure they have been dated. Trends or other issues will be reviewed by the QAPI committee to ensure that	

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

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	535043 8/5/11 KLM	A. BUILDING _____ B. WING _____	C 06/30/2011

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 503	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of package inserts for laboratory supplies, the facility failed to comply with manufacturer's requirements for whole blood glucose testing at 3 of 3 testing locations that involved 16 available glucometers. The findings were: 1. During observations on 6/30/11 from 10 AM through 11 AM, each of three nursing stations had Optimum E2 glucometers. Each of the three stations had two solution bottles for quality control testing, one bottle for high and another bottle for low (6 total). Each of the bottles had been opened, but not dated. 2. During an interview with RN #1 on 6/30/11 at 10 AM, she stated the night shift nurses tested the glucometers using the high and low solution available at each nursing station. She further stated she did not realize open quality control testing solution needed to be dated. 3. Review of the package insert located with the glucometers showed the following in chapter 4, "When you open a control solution bottle for the first time, count forward 90 days and write this date on the control solution bottle using a pen that won't smear or wipe off. Throw away remaining solution after this date."	F 503	systemic changes are implemented, sustained and evaluated for its effectiveness. **F507** Preparation and/or execution of this plan of correction does not constitute 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. The facility will file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. Resident #32 and Resident #64's lab results are now in the medical record Residents' medical records have been reviewed for compliance with lab orders to include that lab results are filed in the medical record In-service nursing staff on quality and timely services with emphasis on the system for laboratory services including ensure lab results are appropriately filed in the resident's medical record. Telephone orders/physicians orders are reviewed	8/14/11
F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.	F 507	in the morning meeting. Lab orders are logged and followed up on daily by Nursing Management/Medical records. A lab book is kept at each Nursing station. A 24-hour chart review is done by night shift to ensure lab orders have corresponding requisitions	

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	535043 8/15/11 KLM	A. BUILDING _____ B. WING _____	C 06/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	503 S 16TH ST LARAMIE, WY 82070

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F 507	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to file laboratory results in the medical record for 2 of 10 sample residents (#32, #64). The findings were: 1. Review of the medical record for resident #64 showed a doctor's laboratory order was written on 4/15/11 for a CMP (complete metabolic profile) and uric acid to be drawn on 5/18/11. Review of the chart showed the laboratory results were not available. Interview with the DON on 6/30/11 at 9 AM verified the laboratory report was not located in the chart. The results were obtained from the physician's office on 6/30/11 at 9:32 AM and placed in the chart. 2. Review of the medical record for resident #32 showed s/he had a 3/20/10 physician's order for the following laboratory tests to be performed every six months: CBC (complete blood count), CMP (complete metabolic panel), TSH (thyroid stimulating hormone), T3 (triiodothyroxine), and free T4 (thyroxine). Further review showed there were no laboratory results in the record from the 3/20/10 results until the 3/20/11 results (1 year). During an interview with the DON on 6/29/11 at 3 PM, she stated the laboratory tests were completed, but not in the record. She further stated the (outside) laboratory was notified on 6/29/11 when she realized the results were not in the record, and results of the 9/10 laboratory tests would be placed in the record as soon as the faxed results were received.	F 507	completed for the lab draws. RN's LPN's and Medical Records have been in-serviced on this system. Doctor notification and follow up has been added to the tracking form to ensure completed. Follow up will be completed through the 24-hour reporting process. The DON/designee will track and trend lab services. Trends or other issues will be reviewed by the QAPI committee to ensure that systemic changes are implemented, sustained and evaluated for its effectiveness. **F514** Preparation and/or execution of this plan of correction does not constitute 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. The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are – complete, accurately documented, readily accessible, and systematically organized. Resident # 7 now has a corresponding order for his/her multi vitamin. The facility will conduct a MAR to Cart review to ensure all resident medications have a corresponding	8/14/11
F 514	483.75(l)(1) RES	F 514		

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F 514 SS=D	Continued From page 21 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to ensure the medical record was complete and accurate for medication use for 1 of 13 sample residents (#7). The findings were: Observation during medication pass on 6/28/11 at 10:35 AM showed RN #2 gave resident #7 one multivitamin tablet. Review of the MAR for June 2011 showed the resident was scheduled to receive the multivitamin each day. Reconciliation of medications showed there was no current order for the multivitamin. Interview with the DON on 6/28/11 at 1:10 PM confirmed there was no current order for the multivitamin.	F 514	Physicians order. Any issues identified will be corrected at that time. The IDT will conduct review of 24-hour reports, as well as review medical record audits, completed upon admission, and quarterly, to identify problems with complete, accurate and accessible/organized medical records including ensuring medications have corresponding orders Licensed nurses have been in-serviced on maintaining clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized including accurate transcription of physician orders and communication of physician-orders via the medication administration record and the 24-hour report. The IDT will conduct a review of the 24-hour report and telephone orders during their daily administrative meeting. The DON will provide follow up with the appropriate caregivers on identified problems, as deemed necessary. The DON/designee will track and trend any issues identified. Trends or other issues will be reviewed by the QAPI committee to ensure that systemic changes are implemented, sustained and evaluated for its effectiveness.	8/14/11