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 _____	02/21/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 2/18/20 through 2/21/20. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident	F 640		3/22/20

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

Electronically Signed | 03/16/2020

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F 640	Continued From page 1 contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the CMS Resident Assessment Instrument (RAI) version 3.0 manual, the facility failed to ensure a discharge MDS assessment was transmitted to CMS as required for 1 of 18 sample residents (#2). The findings were: Review of the MDS assessment record for resident #2 showed s/he was admitted to the	F 640	1) Corrective action: A) For resident #2, MDS discharge assessment was submitted and accepted 2/20/2020 2) Identification: Residents that reside at Laramie Care Center are at risk. No further issues identified in a house wide MDS submission audit.	

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F 640	Continued From page 2 facility on 8/26/19. Review of a discharge summary dated 9/30/2019 and timed 2:17 PM showed "[Resident's name] discharged home with [his/her] significant other today." The following concerns were identified: a. Review of the MDS history showed a discharge assessment was completed on 9/30/19; however, there was no indication it was submitted or accepted. b. Interview with the MDS coordinator on 2/20/20 at 3:12 PM revealed all submitted assessments should indicate the assessment was accepted and she was unsure why the assessment did not show as being submitted. c. Review of the September 2019 and October 2019 transmission reports showed no evidence the resident assessment was transmitted. d. Interview with the MDS coordinator on 2/20/20 at 3:56 PM revealed she had to unlock the assessment and mark a box to submit the assessment. Further interview revealed the program administrator was reviewing the assessment to determine why it was not transmitted and she confirmed the assessment was submitted on 2/20/20 at 4:15 PM. e. Review of the "CMS RAI version 3.0 manual, October 2019," showed "...OBRA-required tracking records and assessments consist of the Entry tracking record, the Discharge assessments, and the Death in Facility tracking record. These include the completion of a select number of MDS items in order to track residents when they enter or leave a facility. They do not include completion of the CAA process and care planning. The Discharge assessments include items for quality monitoring...Discharge Assessment-Return Not Anticipated...Must be submitted within 14 days	F 640	3) Systemic Changes: DON/ designee will educate MDS staff on the transmittal requirements: Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System. 4. Monitoring: DON/ designee will do a weekly random audit for one month, then monthly for one month and as needed to cross check submitted MDS discharges against an in progress report for MDS. Any issues will be tracked and trended. DON/designee will report the results to QAPI monthly as needed to assure the plan is implemented, sustained and evaluated for its effectiveness. 5) Date of alleged compliance: March 22, 2020	

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F 640	Continued From page 3 after the MDS completion date..."	F 640		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) level I & II was performed for 1 of 2 sample residents (#50) with a qualifying diagnosis. The findings were: Review of the admission MDS assessment dated 10/12/18 showed resident #50 admitted to the facility on 10/5/18 and had diagnoses which included cardiovascular accident, diabetes mellitus, and hypertension. There was no evidence the resident had a qualifying diagnosis	F 644	Corrective Action: A PASARR Level II was requested for residents #50 on 2-20-2020 with change in mental illness diagnosis. Identification: Residents residing at Laramie Care Center that require a level II PASARR are at risk. NHA/Designee completed a house wide audit of PASARR Level II and mental illness diagnosis for compliance. No other residents were identified. Systematic Changes: On and up to date of compliance the Administrator/Designee	3/22/20

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F 644	Continued From page 4 for a PASARR level II at that time. Review of a PASARR level I dated 10/5/18 showed the resident had no diagnoses related to mental illness or mental retardation and was not triggered for a PASARR level II. Review of the significant change MDS assessment dated 1/6/19 showed the resident had diagnoses which included psychotic disorder with delusions due to known physiological condition. The following concerns were identified: a. Review of the medical record showed no evidence a PASARR level I or level II was completed for the resident related to the psychotic disorder with delusions diagnosis. b. Interview with the administrator, admissions director, and regional clinical director on 2/20/20 at 9:41 AM revealed the facility identified the PASARR level II was not completed and had submitted a new level I at that time. Further interview revealed the facility identified concerns with PASARR assessments and had initiated an action plan on 1/7/20 with a date of compliance of 3/1/20; however, it was confirmed the the plan had not been fully implemented at that time.	F 644	will in-service admissions, business office manager, social services and medical records on requesting a PASARR level II for residents with mental illness diagnosis. Monitoring: The Administrator/Designee will review each PASARR level I request to ensure a level II if required was requested by the facility. Findings will be tracked, trended and the Administrator will 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.	
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;	F 806		3/22/20

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F 806	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on resident interview, medical record review, review of diet card information, and staff interview, the facility failed to adequately assess food preferences for 3 of 4 sample residents (#45, #48, #122) reviewed for food concerns. The findings were: 1. Interview with resident #45 on 2/18/20 at 3:51 PM revealed s/he was "picky" about food and did not think there was enough variety in what the facility provided. However, the resident stated the staff honored his/her preferred choice of spaghetti when requested. The resident stated s/he had many dislikes. The following concerns were identified: a. Review of the 1/1/20 admission dietary profile showed with the exception of spaghetti, the areas designated for comments and information about food likes and dislikes remained blank. b. Review of the diet card for 2/20/20 showed "Note: Send Spaghetti on request", however, there was no other information for the staff to know the resident's preferences related to food and beverages. 2. Interview with resident #122 on 2/19/20 at 9:36 AM revealed s/he liked a small breakfast usually "just coffee and cereal." At that time, the resident was seated at the dining table in the main dining room with a large plate of eggs, bacon, and a muffin. It appeared not much of the food had been eaten. The certified dietary manager (CDM) was nearby and overheard the resident's comments and offered to get the coffee and cereal instead. When the CDM came back with the cereal and coffee, the resident was grateful	F 806	F806: Corrective Action: For Resident #45, #48, #122 food preference assessments were completed by the Certified Dietary Manager and dietary profiles updated on or before the date of compliance. Identification: Residents without food preferences are at risk. Dietary Manager interviewed all residents without food preferences and updated their dietary preference profiles before date of compliance. Systemic Changes: On or before the date of compliance the Dietary Manager will be educated on Resident Food preferences and proper documentation by the NHA. Monitoring: The NHA/Designee will do random audits of new admissions dietary profiles for completion for three months and quarterly thereafter when compliance is achieved.	

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F 806	Continued From page 6 and also told the CDM s/he can't drink much milk because it had a "laxative effect." The CDM stated she had not known and would check into that. The following concerns were identified: a. Review of the 2/12/20 admission dietary profile showed the areas available to document food likes and dislikes was blank. b. Review of the 2/20/20 diet card showed it had been updated to capture the resident's preference for "Corn Flakes" and "No fish." 3. Interview with resident #48 on 2/18/20 at 11:28 AM revealed the food was "not good" and was "very institutional." S/he further stated they did not have items s/he enjoyed. The following concerns were identified: a. Review of the 1/1/20 annual dietary profile showed the areas available to document food likes and dislikes was blank. b. Review of the diet card for 2/20/20 showed a note to send milk with breakfast, and no milk at lunch and dinner. There were no other preferences identified on the diet card. 4. Interview with the CDM on 2/20/20 at 12:01 PM revealed the dietary profile was done on admission, annually, and if there was a significant change. She was aware that information was lacking related to residents' likes and dislikes. She stated that more work was needed to capture the comments for these profiles. Further, she stated when she heard specifics from residents between assessments, she updated the diet cards with the information.	F 806		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		3/22/20

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F 880	Continued From page 7	F 880		

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;
(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

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F 880	Continued From page 8 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, medical record review, staff interview, policy and procedure review, and professional standard review, the facility failed to ensure effective infection control practices were followed for 2 of 2 wound care observations (#27, #48). The findings were: 1. Observation on 2/18/20 at 5 PM showed LPN #2 performed a dressing change for resident #48. The LPN donned gloves and cleaned the wound (which had a visible red and bloody perimeter with a dark area in the center of the wound) with saline wound cleanser and applied Santyl to the	F 880	1) Corrective action: A) For resident #48, the nurse removed his/hers soiled gloves and performed hand hygiene prior to touching or applying the clean dressing. B) For resident #27, the nurse used clean scissors prior wound care. The nurse removed the dirty dressing and washed his/her hands and wore clean gloves before providing wound care. Nurses that were involved in wound care on 2/18/20 and 2/19/20 were educated on 3/9/20, on Clean Dressing Change	

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F 880	Continued From page 9 darkened area. The LPN opened a clean dressing and applied it to the wound. The following concerns were identified: a. Continued observation showed the LPN did not remove the soiled gloves or perform hand hygiene prior to touching or applying the clean dressing. b. Interview with the ADON on 2/20/20 at 4:28 PM revealed gloves should be changed and hand hygiene should be performed between the removal of the dirty dressing, wound cleaning, and application of the clean dressing. c. Review of the policy titled "Clean Dressing Change Technique" last revised on 3/10/15 showed "...7. Carefully loosen and remove dressing; place in waste bag for disposal. Note the wound appearance and type; amount, color and odor of any drainage on the dressing. Note the status of any sutures or staples if present. 8. Remove gloves and dispose of properly; wash hands...11. Apply clean gloves and other PPE as needed. 12. Cleanse the wound with solution and gauze/applicator as ordered and/or following manufacturer's recommendations. a. Cleanse from top to bottom and from center to outer edges b. Use new gauze/applicator for each wipe, and place used gauze in waste receptacle. c. If cleansing spray is used, spray is applied from top to bottom making sure not to touch wound with bottle...14. Remove gloves and dispose of them properly; was hands. 15. Apply clean gloves and other PPE if needed. Apply other treatment, ointment as ordered following manufacturer's recommendations. 16. Carefully remove dressing from protective package, making sure to touch only the corner of the gauze so as not to contaminate the dressing. Cover wound making sure entire area is covered...18. Remove gloves and dispose of them properly; wash hands..."	F 880	Technique which includes hand washing 2) Identification: A) Residents at Laramie Care Center with wounds are at risk. No further issues identified. 3) Systemic Changes: A) On or prior to the allegation of compliance the DON/Designee will ensure nurses will be re-educated regarding Clean Dressing Change Technique. Nurses will be educated yearly and as needed. Nurses will follow infection control policy. 4) Monitoring: A) The DON/ designee will do random audits of Clean Dressing Change Techniques with nurses, 2 times a week for one month then monthly for 3 months and then as needed. Any 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. 5) Date of alleged compliance: March 22, 2020	

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2. Review of the significant change MDS assessment dated 12/9/19 showed resident #27 had diagnoses including ulcerative colitis, septicemia, bacteremia, and presence of a surgical wound. Review of the physician's orders showed "Cleanse area with generic wound cleanser, apply calzinc [sic] ointment to excoriated area. Apply [calcium] alginate dressing to [the] draining area. Cover the entire area with 4x4's [gauze pads] and an ABD [abdominal gauze pad] secure with mefix tape. Change BID [twice a day] and PRN [as needed]." Observation on 2/19/20 at 1:30 PM showed LPN #1 performed the dressing change to the abdominal wound. The following concerns were identified:

a. The nurse gathered supplies and placed a clean barrier on the table with the supplies. The nurse pulled scissors from his scrub pocket and added them to the clean supplies without cleaning the scissors.

b. The nurse removed the dirty dressing and then cleaned the wound with the 4 X 4 gauze pads and sterile wound cleaner. After removing the old dressing and cleaning the wound, the nurse removed the soiled gloves and with no hand hygiene donned new gloves to apply the Calazinc to the wound.

c. After applying the Calazinc treatment the LPN removed the gloves and donned new gloves. The nurse then handled the un-clean scissors and with no change of gloves or hand hygiene the nurse opened the un-opened dressing packets and dressed the wound.

d. Interview with LPN #1 on 2/19/20 at 1:50 PM revealed this was his usual practice for dressing changes.

e. Interview with the DON on 2/20/20 at 3:25 PM revealed it was the facility's expectation for

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F 880	Continued From page 11	F 880		

the nurse to clean their hands and change gloves between dirty and clean when doing wound care.

3. Review of Elkin, Perry, and Potter, "Nursing Interventions & Clinical Skills," Sixth Edition, 2016. "Implementation for Treatment of Pressure Ulcers and Wound Management showed: "1. Standard Protocol - [hand hygiene]. Gather supplies as ordered. ...4. Open packages and topical solution containers. 5. Position patient... 6. Apply clean gloves. Remove old dressings and discard them in a plastic bag. Discard gloves; perform hand hygiene... 7. Apply clean gloves. Cleanse wound with prescribed solution...wound dressed. ...10. Reposition patient. ...14. Dispose of used supplies and equipment. 15. Remove and dispose of gloves, Perform hand hygiene..."

4. According to the Journal of Wound, Ostomy and Continence Nursing March/April 2012, Volume 39, Issue 2S, pages S30 to S34, "Clean technique. Clean means free of dirt, marks, or stains. 3 Clean technique involves strategies used in patient care to reduce the overall number of microorganisms or to prevent or reduce the risk of transmission of microorganisms from one person to another or from one place to another. Clean technique involves meticulous handwashing, maintaining a clean environment by preparing a clean field, using clean gloves and sterile instruments, and preventing direct contamination of materials and supplies. No "sterile to sterile" rules apply. This technique may also be referred to as non-sterile. Clean technique is considered most appropriate for long-term care, home care, and some clinic settings; for patients who are not at high risk for infection; and for patients receiving routine dressings for chronic wounds such as venous

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	535043	A. BUILDING _____ B. WING _____	02/21/2020

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 880	Continued From page 12 ulcers, or wounds healing by secondary intention with granulation tissue."	F 880		