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 04/22/2021

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

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F 000	INITIAL COMMENTS A recertification survey which included a COVID-19 focused infection contol survey was conducted by Healthcare Licensing and Surveys from 4/19/21 to 4/22/21. Also reviewed in the course of the survey were complaint intakes WY00003053, WY00003057, WY00003134, and WY00003191. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimun Data Set LPN- Licensed Practical Nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 563 SS=F	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;	F 563		5/11/21

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

Electronically Signed | 05/16/2021

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F 563	Continued From page 1 (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on review of Centers for Medicare and Medicaid Services (CMS) guidance, staff interview, resident interview, review of facility infection control and testing documentation, and review of policy and procedure, the facility failed to ensure residents were allowed indoor visitation from 4/9/21 to 4/22/21. The census was 54. The findings were: Review of the CMS memo "Nursing Home Visitation - COVID-19 (REVISED)" revised on 3/10/21 and in effect at the time of the survey showed the following: "Indoor Visitation during an Outbreak An outbreak exists when a new nursing home onset of COVID-19 occurs (i.e., a new COVID-19 case among residents or staff). This guidance is intended to describe how visitation can still occur when there is an outbreak, but there is evidence that the transmission of COVID-19 is contained to a single area (e.g., unit) of the facility. To swiftly	F 563	F563 Right to Receive/ Deny Visitors Corrective Action: Facility restarted communal dining and restarted indoor visits on 5/11/2021. Resident #25 had his spouse move into the same room together in the facility on 5/11/2021. Resident #3 was informed of facility opening to visitors, communal dining and group activities on or before date of compliance. Identification: All residents currently residing at Laramie Care Center are at risk. No further issues identified Systemic Changes: On or prior to the allegation of compliance the Director of Nursing / Designee will ensure staff will be educated on QSO-20-39-NH (revised) in regards to visitation/ indoor visits and communal dining. Investigate with cooperate office	

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F 563	Continued From page 2 detect cases, we remind facilities to adhere to CMS regulations and guidance for COVID-19 testing, including routine staff testing, testing of individuals with symptoms, and outbreak testing. When a new case of COVID-19 among residents or staff is identified, a facility should immediately begin outbreak testing and suspend all visitation (except that required under federal disability rights law), until at least one round of facility-wide testing is completed. Visitation can resume based on the following criteria: · If the first round of outbreak testing reveals no additional COVID-19 cases in other areas (e.g., units) of the facility, then visitation can resume for residents in areas/units with no COVID-19 cases. However, the facility should suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing. For example, if the first round of outbreak testing reveals two more COVID-19 cases in the same unit as the original case, but not in other units, visitation can resume for residents in areas/units with no COVID-19 cases. · If the first round of outbreak testing reveals one or more additional COVID-19 cases in other areas/units of the facility (e.g., new cases in two or more units), then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing." Review of the facility's infection control documentation and testing results showed an outbreak was identified on 4/7/21 related to a single staff member testing positive. Further review showed testing was completed for all residents and staff. The first round of testing was completed by 4/9/21, and no additional cases were identified among facility residents or staff.	F 563	about Covid-19 testing and screening policy in regards to a covid-19 outbreak defined as 3 or more Covid-19 positive team members or residents in the absence of state/ health guidance. Monitoring: The Director of Nursing/ Designee will do random weekly audits for two months, with residents to verify they are being offered communal dining and indoor visits. Issues identified will be corrected at that time. Issues will be tracked and trended. The DON/ Designee will report the results to QAPI monthly as needed to assure the plan is implemented, correction is achieved and sustained and monitored for its effectiveness until sustained compliance is noted. The QAPI committee may modify this plan as needed to ensure that the facility remains in compliance. Compliance Date: June 7, 2021	

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F 563	Continued From page 3	F 563		

The following concerns were identified:

1. Interview with resident #3 on 4/19/21 at 4 PM revealed all meals were served in resident rooms. The resident stated s/he felt "not very good" about this, and added s/he liked to be able to visit with others. The resident also stated s/he was vaccinated, and s/he didn't understand why they couldn't get back to going to the dining room and rec center [activity room]. The resident also confirmed residents were not being allowed indoor visitors. The resident had to visit through the outside window the previous day when his/her grand-daughters came to visit. The resident stated this had been ongoing for a couple of weeks. Review of the 1/6/21 quarterly MDS assessment showed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15/15.

2. Interview with resident #25 on 4/19/21 at 3:44 PM revealed s/he was unable to visit with his/her spouse who was also a resident a few doors down. The resident stated "The rules are no one gets to leave their room and no one in separate rooms are allowed to talk." Review of the 2/12/21 admission MDS assessment showed the resident was cognitively intact with a BIMS score of 14/15.

3. Review of 3/19/21 facility policy and procedure entitled COVID-19 Testing and Screening for New Admissions/Move-ins and Readmissions showed " ... a COVID-19 outbreak is defined as 3 or more COVID-19 positive residents or team members."

4. Review of 3/26/21 facility policy and procedure entitled "Visitation During COVID-19" showed "Outbreak testing - Testing occurring in response

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F 563	Continued From page 4 to a positive resident or team member COVID-19 case ... communities test all team members and residents every 5-7 days until there are no positive test results for 14 consecutive days." Further review of the policy regarding indoor visitation showed visitation may be offered if " ... There are no new resident or team member COVID-19 positive cases within the last 14 days ... If outbreak testing reveals no additional COVID-19 cases, visitation may resume in areas of the community where there are no COVID-19 cases." The policy did not include provisions for resuming visitation after the first round of testing showed all negatives. 5. Interview on 4/21/21 at 2:17 PM with RN #1 who was also the infection preventionist revealed a facility staff member was identified and tested positive for COVID-19 on 4/7/21, and the facility went into outbreak protocol. Testing of all facility staff and all residents began on 4/8/21, with all tests producing negative results. Further interview revealed the facility remained on outbreak protocol, with residents requested to stay in their rooms, no communal dining or activities, and no indoor visitation allowed. She also confirmed that only one staff member and no residents had tested positive, and the positive staff member had been isolated at home and had not returned to work. The RN further revealed it was her understanding that 14 days of outbreak testing needed to be completed prior to indoor visitation resuming.	F 563		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in	F 582		5/25/21

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F 582	Continued From page 5 writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the	F 582		

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F 582	Continued From page 6 facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the appropriate Notice of Medicare Provider Non-Coverage (NOMNC) and Advance Beneficiary Notice (ABN) forms were issued timely for 2 of 3 sample residents (#25, #45). The findings were: 1. Review of the medical record showed resident #25 discharged from Medicare Part A services on 4/16/21, and used fewer than the 100 days covered by Medicare Part A. Review of the NOMNC and ABN forms issued to the resident representative showed they were not signed until 4/19/21. 2. Review of the medical record showed resident #45 discharged from Medicare Part A services on 12/8/20, and used fewer than the 100 days covered by Medicare Part A. Review of the NOMNC and ABN forms issued to the resident representative showed they were not signed until 12/16/20. 3. Interview with the social services director on 4/21/21 at 3:30 PM revealed the denial notices were sent to the resident's family members via	F 582	F582 Corrective Action: Residents #25 and #45 were reissued NOMNC and ABN forms on or before the alleged date of compliance. Identification: All residents with Medicare coverage ending have the potential to be affected by late letters. Systemic Changes: The Social Service Director, Business Office Manager, Admissions Director, Medical Records and DON who are all members of the interdisciplinary team (IDT) will be re-educated by the NHA and or qualified person on or before the date of alleged compliance. This education includes but is not limited to ensuring the appropriate Notice of Medicare Provider Non-Coverage (NOMNC) an Advance Beneficiary Notice (ABN) forms are issued and delivered at least two calendar days before Medicare covered services end or, the second to last day of service if care if not being provided daily.	

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F 582	Continued From page 7 mail, and she was unable to ensure the notices would be received at least two days prior to the last covered day. Further interview revealed she was unaware of the time restrictions related to the completion of the denial notices.	F 582	If Laramie Care Center is unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the facility will telephone the representative to advise him/her when the enrollee□s services are no longer covered. The date of the conversation will be documented and a written notice will be mailed. Monitoring: When a resident is nearing a discharge, members of the IDT will discuss during the daily meeting Monday through Friday. The NHA/designee will review the Advance Notice and NOMNC letters with the Social Service Director/Designee prior to the date the letter is given to the affected resident(s) and that the signature is dated per the requirement. The NHA/designee will present the findings of the Advance Notice letters reviewed to the Quality Assurance committee monthly for a minimum of three months. Any recommendations made by the QAPI committee will be followed until compliance is sustained. Date of compliance: June 7, 2021	
F 661 SS=E	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes,	F 661		5/25/21

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F 661	Continued From page 8 but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on resident record review and staff interview, the facility failed to ensure the completion of a discharge summary for 3 of 3 sample residents (#52, #54, #103). The findings were: 1. Review of the 3/31/21 discharge summary showed resident #52 discharged home with home health services. Further review failed to show the completion of a recapitulation of the resident's stay to ensure continuation of care following discharge.	F 661	F661 Corrective Action: A recapitulation of stay was completed for residents #52, #54 and #103 on or before date of compliance on or before the alleged date of compliance. Identification: Residents who reside at Laramie Care Center who might discharge have the potential to be affected by this practice. On or before the date of compliance, the Social Services Director (SSD)/ Designee will audit the medical records of residents who have	

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F 661	Continued From page 9 2. Review of the 2/2/21 discharge summary showed resident #54 went home with home health services. Further review failed to show the completion of a recapitulation of the resident's stay to ensure continuation of care following discharge. 3. Review of the 4/24/20 discharge summary showed resident #103 discharged home with home health services. Further review failed to show the completion of a recapitulation of the resident's stay to ensure continuation of care following discharge. 4. Interview with RN #1 on 4/22/21 at 11:51 AM verified the recapitulation of stay had not been completed for the three sample residents. She identified the change in forms used in the electronic medical record system as a potential cause for the missing documentation.	F 661	discharged within the last 30 days to ensure that they have a recapitulation of stay in place. Residents missing a recapitulation will have one completed on or before the date of alleged compliance by the SSD/ Designee. Systemic Changes to Ensure Compliance On or before the alleged date of compliance, the NHA or another qualified person will provide education to the SSD, Medical Records Director, Admission Director and DON on completing a recapitulation of the resident□s stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results. System Maintenance The NHA or designee will review each known discharge as they occur and when reasonable to ensure that a recapitulation of stay has been completed. All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review and recommendations. The committee will revise monitoring agenda to ensure that compliance is achieved and sustained. The QAPI committee may modify this plan as needed to ensure that the facility remains in compliance. Date of compliance: June 7, 2021	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		5/25/21

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F 677	Continued From page 10 §483.24(a)(2) 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, resident and staff interview, and medical record review, the facility failed to ensure assistance with activities of daily living (ADLs) was provided to meet resident needs for 3 of 21 sample residents (#30, #35, #154). The findings were: 1. Review of the admission MDS assessment with an assessment reference date of 4/8/2021 showed showed resident #154 was admitted to the facility on 4/2/21 with diagnoses which included pressure ulcer of the sacral region, stage 4; pressure ulcer of other site, stage 2; pressure ulcer of left heel, unstageable; multiple sclerosis; weakness; muscle spasm of the back; and neuromuscular dysfunction of the bladder. Further review of the MDS assessment showed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15. Review of the resident's physician orders showed an order dated 4/2/21 for occupational therapy (OT), with therapy to include treatment approaches to self-care. Interview with the resident on 4/19/21 at 4:18 PM revealed " ... today is the first day I've had a shower since I've been here." The following concerns were identified: a. Review of the resident's activities of daily living (ADL) care plan, last revised 4/20/21, showed the resident had " ... increased risks for actual/potential limitation(s) in my ability to perform my ADLs r/t [related to] Multiple	F 677	F677: ADL Care Provided for Dependent Residents Corrective Action: The Activities of Living (ADL) care plans for residents #30 and #35 ADL□s were updated to reflect resident preferences and behaviors in regards to current ADL status. The MDS will be updated upon next scheduled review. Resident #154 no longer resides at Laramie Care Center. Identification: Dependent residents that reside at Laramie Care Center are potentially at risk. The Don/designee will perform audits of dependent residents to identify those whose choice is to not accept ADLs and cross check for reasonable interventions. Any issues identified will be corrected at that time. Systemic Changes: The DON/ Designee will educate CNAs regarding documentation of ADLs, specifically including resident choices to not accept offered cares , not applicable and what actions to take if a pattern develops on or before the date of compliance. The DON/ Designee will regularly check CNA documentation weekly for the documentation of resident	

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F 677	Continued From page 11 Sclerosis, CML [chronic myeloid leukemia], weakness, multiple wounds, UTI [urinary tract infection] history, glaucoma, cardiac/respiratory issues, pain issues ..." Further review showed interventions included "Encourage the resident to use bell to call for assistance." The care plan did not indicate the resident's bathing or showering preferences, schedule, necessary accommodations, or interventions if the schedule or needs were not able to be met. b. Review of certified nursing assistant (CNA) ADL documentation showed the resident was scheduled for showers during the day shift (6 AM - 2 PM) every Tuesday and Friday. Review of the "ADL - Bathing/Showering" documentation for April showed the resident did not receive a shower for 14 days from 4/2/21 to 4/16/21. 2. Review of the 3/3/21 annual MDS assessment showed resident #35 was admitted to the facility on 3/15/2019 with diagnoses which included type 2 diabetes mellitus without complications, chronic obstructive pulmonary disease with (acute) exacerbation, muscle weakness (generalized), difficulty in walking, edema, repeated falls, and low back pain. Further review showed the resident was cognitively intact with a BIMS score of 15, and required supervision of one person physical assistance for personal hygiene, and supervision with setup assistance for bathing. The following concerns were identified: a. Observation on 4/19/21 at 10:50 AM showed the resident in his/her room and appeared unkempt. The resident's hair appeared greasy and uncombed, and s/he was wearing clothing which was visibly dirty and stained. Observation of the resident on 4/20/21 at 11:52 AM showed the resident remained in the same clothing observed on 4/19/21, and his/her hair	F 677	refusals and when to use the term of not applicable. Monitoring: The Director of Nursing/ Designee will do random audits of CNA documentation of resident refusals/not applicable and care plans for resident preference and behaviors in regards to current ADL status; audits to be done two times a week for one month, then monthly for two months and as needed thereafter. Issues identified will be corrected at that time. Issues will be tracked and trended. The DON/ Designee will report the results to QAPI monthly as needed to assure the plan is implemented, correction is achieved and sustained and monitored for its effectiveness until sustained compliance is noted. The QAPI committee may modify this plan as needed to ensure that the facility remains in compliance. Compliance Date: June 7, 2021	

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 04/22/2021

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F 677	Continued From page 12	F 677		

remained unkempt. Observation on 4/21/21 at 8:53 AM showed the resident remained in the same clothing observed on 4/19/21, and his/hair remained unkempt. Observation on 4/22/21 at 1:36 PM showed the resident remained in the same clothing observed on 4/19/21 and his/her hair remained unkempt.

b. Interview with the resident on 4/22/21 at 1:36 PM revealed s/he had a skin sensitivity or allergy related to water, and that staff hadn't done much to accommodate the issue except " ... argue with me about it all the time." S/he continued saying " ...since we always used to argue about it, they just stopped asking me to shower a long time ago. I can't remember the last time someone asked me about doing it." Further interview revealed since staff didn't ask him/her about bathing, s/he used incontinence wipes to clean up, if needed. The resident revealed staff did not check on him/her or assist with ADLs because the resident was able to perform the tasks independently.

c. Review of the CNA ADL documentation showed the resident was scheduled for showers during the evening shift (2 PM - 10 PM) every Wednesday and Saturday. Review of the "ADL - Bathing/Showering" record showed the resident last received a shower on 3/3/21. No documentation was identified providing explanations of any exceptions, refusals, or accommodations for the refusals on the scheduled shower days.

d. Review of the resident's care plan, last revised 4/20/21, showed the resident required staff assistance with ADLs with interventions that included " ... use short, simple instructions such as hold your washcloth in your hand; Put soap on your washcloth; Wash your face; to promote independence as I will allow. Offer wipes if I am

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F 677	Continued From page 13	F 677		

not willing to shower or bathe." and " ...Staff to set up and encourage res [resident] to wash hands and face." as well as " ...Staff to provide assist with incontinent care ..."

3. Review of the 3/3/21 quarterly MDS assessment showed resident #30 was admitted to the facility on 5/17/2017 with diagnoses which included unspecified dementia with behavioral disturbance, cognitive communication deficit, complete traumatic amputation of left lower leg, chronic obstructive pulmonary disease with (acute) exacerbation, difficulty walking, muscle weakness (generalized), blindness, cerebral infarction, and hypersomnia. Further review showed the resident had a BIMS score of 5 (indicating severe cognitive impairment), and required the extensive physical assistance of one person with dressing and personal hygiene. The following concerns were identified:

a. Observation on 4/19/21 at 11:54 AM showed the resident sitting in his/her wheelchair just outside the doorway to his/her room. The resident's clothing was visibly dirty and stained and his/her hair appeared greasy and uncombed. Further observation showed the resident had sour odor.

b. Review of the resident's care plan, last updated 3/19/21, showed the resident required assistance with ADLs, with interventions which included " ...assist with what ever res is unable to complete." and " ...re approach if I [resident] decline getting up or cares."

c. Review of CNA ADL documentation showed the resident was scheduled for showers during the AM shift (6 AM - 2 PM) every Wednesday and Saturday. Review of "ADL - Bathing/Showering" shower record documentation showed the received a shower on

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F 677	Continued From page 14 2/27/21, 3/31/21, and 4/7/21. There was documentation or explanation of any exceptions, refusals, accommodations, or re-approach attempts for the refusals on the scheduled shower days. 4. Interview with the DON on 4/21/21 at 3:33 PM revealed CNA documentation can be charted by exception. Each CNA had shift documentation and they may chart differently, which may be the reason for charting 'not applicable.' She further stated she was unsure how CNAs charted exceptions or PRN tasks.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure an effective plan was developed and implemented to prevent falls for 1 of 4 sample residents (#40) with falls. The findings were: Review of the 3/3/21 significant change MDS assessment showed resident #40 required the extensive assistance of two or more staff persons with transfers, was frequently incontinent of bladder, had a urinary tract infection in the previous 30 days, and had a fall with major injury	F 689	F689: Free of Accident Hazards/ Supervision/ Devices Corrective Action: Care plan interventions were updated for resident #40 to reflect interventions to help prevent falls. Identification: Residents residing at Laramie Care Center are potentially at risk. The last 30 days of current resident falls will be	5/25/21

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F 689	Continued From page 15 since the last assessment. Review of a progress note dated 2/18/21 at 10:20 AM showed the resident had a fractured right arm and a 2 centimeter skin tear to the right forearm as a result of a fall that occurred on 2/17/21. Review of the progress note dated 2/17/21 at 11:09 AM showed the resident had an unwitnessed fall on 2/17/21 at approximately 9:30 AM. It was determined that the fall occurred when the resident was attempting to exit the bathroom. Interview with the DON on 4/22/21 at 9:43 AM revealed the resident's fall on 2/17/21 was likely due to attempts to self-transfer. Since that time, the resident was not safe to use a walker at all, despite the care plan stating s/he was safe to use a walker. Further interview revealed the IDT team reviewed the resident for fall risk until 3/2/21, before determining that the resident's fall was an isolated event. Review of a progress note dated 4/16/21 showed the resident had an unwitnessed fall into a bedside table at approximately 5:50 PM which resulted in new skin tears on his/her right forearm and right calf. Review of the resident care plan updated 4/16/21 showed the resident was identified as a fall risk, with interventions that included "anti-rollbacks to wheelchair...encourage me to wait for staff and use walker when ambulating...staff to check frequently and ask if I need help...ensure I am wearing appropriately fitting foot wear (sic) and clothing...make sure that my assistive devices (SPECIFY), call device are in reach...provide me with a safe environment free of clutter...caregivers will remind me to use my call device ..." The following concerns were identified: 1. Observation on 4/19/21 beginning at 3:19 PM showed resident #40 was in his/her wheelchair with no call light in reach and had his/her oxygen	F 689	reviewed on or before compliance date for appropriate fall interventions. Any issues identified will be corrected on or before the date of compliance. Systemic Changes: The facility will ensure that resident□s environment remains free of accident hazards, and that each resident receives adequate supervision and assistance devices to prevent accidents. The facility to the extent possible, will reduce the possible risk of accident hazards to include educating nurses and IDT, along with residents where possible on or before the date of compliance. Nurses and IDT will be educated by the DON and or a qualified individual on developing and implementing interventions to help prevent falls on or before the date of compliance. Monitoring: The DON/ Designee will monitor falls of residents residing at the facility weekly for one month, then monthly for two months and as needed thereafter. Issues identified will be corrected at that time. Issues will be tracked and trended. The DON/ Designee will report the results to QAPI committee monthly for a minimum of three months to ensure that the plan is implemented; correction is achieved, and monitored for its effectiveness until sustained compliance is noted. The QAPI committee may modify this plan as needed to ensure that the facility remains in compliance.	

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F 689	Continued From page 16 tubing in his/her hand. S/he began calling out for help, but was not loud enough to draw attention. The resident made repeated attempts to stand up prior to staff being summoned for safety reasons by the surveyor at 3:29 PM. 2. A follow-up interview with the DON on 4/22/21 at 10:46 AM revealed she was unaware of the resident fall that occurred on 4/16/21. The DON revealed the resident's call light should always be in reach.	F 689		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and review of recipes and menus, the facility failed to ensure food was palatable in taste and temperature for items in 2 of 2 meals observed. The census was 54. The findings were: 1. Review of the menu for 4/21/21 showed Glazed Pork Medallions or Peppercorn Chicken were the two options for the noon meal. Review of the recipes showed the glaze for the pork included maple syrup, balsamic vinegar, and Dijon mustard. Review of the peppercorn chicken recipe showed it included paprika, garlic powder,	F 804	F804 Corrective Action: Resident #154 was discharged from facility. Resident #13 was offered food and drink that is palatable, attractive, and at a safe and appetizing temperature. Identification: Residents who reside at Laramie Care Center have the potential to be affected by alleged deficient practice. Systemic Changes: The Dietary Manager and Dietary Services team members were	5/25/21

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F 804	Continued From page 17 peppercorns, butter, cream, and fresh rosemary. The following concerns were identified: a. Observation of a test tray done on 4/21/21 at 1:11 PM revealed the temperature of the baked chicken was 138.2 degrees fahrenheit (F) and the taste was bland. There was no noticeable salt or other seasoning flavor. b. The pureed pork temperature was 129.4 degrees F, it tasted barely warm, and did not have any seasoning or flavor. At that time the certified dietary manager (CDM) also tasted the pureed pork and agreed it was not warm or flavorful, was bland and had no flavor other than slight pork flavor. She then checked with cook #1 to see if any of the maple glaze had been added. The cook reported it had not been added. Additionally, observation on 4/21/21 at 12:01 PM showed during the preparation of the pureed pork, hot water was used to thin the mixture to achieve the needed texture. c. The test tray also included a couscous pilaf which was not warm when tasted, the temperature of the pilaf was measured at 107 degrees F. 2. Observation on 4/20/21 at 8:35 AM showed resident #13 was seated at a table in the assisted dining room. The pancakes on the resident's plate were cut up into bite-size pieces and visibly black/burned. Interview with CNA #2 at that time confirmed the pancakes looked burned. She further said they were wheat pancakes, but they were burned on the outside. She asked the resident, who was no longer eating, if s/he wanted more and the resident declined. It appeared only a few bites had been eaten. No new or different food was requested or offered by the aide.	F 804	re-educated on providing food by methods that conserve nutritive value, flavor, and appearance, food and drink that is palatable, attractive, and at a safe and appetizing temperature. Education is being provided by the NHA/Designee and will be completed on or before the date of compliance. Monitoring Test Tray Audits will be completed three 3 times weekly x 12 weeks by the Interdisciplinary Team /designee. (IDT). NHA/designee will interview 3 residents weekly on food and beverage satisfaction. All reasonable option for immediate satisfaction will be offered. All results will be reported and discussed in IDT meetings weekly with interventions as deemed appropriate. Findings will be reported to the Quality Assurance Performance (QAPI) committee for review and recommendations. The administrator/designee will present results of the audits to the QAPI committee x 3 months and or until compliance is sustained. The QAPI committee may modify this plan as needed to ensure that the facility remains in compliance. Date of compliance 6-7-2021	

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F 804	Continued From page 18 3. Interview with resident #154 on 4/19/21 at 4:38 PM revealed the food was often "cold" and s/he had started ordering groceries and having them delivered to the facility so s/he "didn't go hungry." 4. Interview with the CDM on 4/21/21 at 1:11 PM verified the food should be at least 135 degrees F when served, and should remain at a palatable temperature when received by the residents. Also, she stated burned food should not be served to residents. She was not aware of the burned pancakes from the morning before. She also verified there were 5 residents who had orders for pureed diets.	F 804		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		5/21/21

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F 880	Continued From page 19 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 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.	F 880		

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F 880	Continued From page 20 §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, and staff interview, the facility failed to ensure staff donned appropriate personal protective equipment (PPE) for 1 of 2 rooms on transmission-based precautions (room #47), failed to ensure staff performed appropriate hand hygiene during 5 random observations, and failed to ensure appropriate infection control techniques were used during 1 of 1 observations of wound care (resident #154). The findings were: 1. Observation on 4/19/21 at 10:16 AM showed room #47 was on transmission-based precautions due to new admission to the facility, which required the use of full personal protective equipment (PPE) prior to entering the rooms. Interview with the admissions director at that time revealed the facility was on quarantine protocol, and residents had been asked to remain in their rooms due to a staff member testing positive for COVID-19. Further interview revealed all staff were required to wear an N95 mask, along with either a face shield or other proper eye protection. The following concerns were identified: a.Observation on 04/19/21 at 4:18 PM showed an unidentified staff member entered room #47 wearing eyewear and a mask, gave the resident a piece of paper, had a brief conversation, exited the room, and left the unit. The room was on precautions, and required full application of PPE upon entry. The staff member did not DON appropriate PPE and did not perform	F 880	F880: Infection Prevention and Control Corrective Action: The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements identified in the deficiency. Staff and/ or residents were educated by the DON/ Designee on or by the date of compliance on hand hygiene procedures, personal protective equipment (PPE), transmission-based precautions and equipment and environment cleaning procedures. Nurses educated on wound care procedure (as related to infection control). Nurse providing wound care was re-educated on date of concern immediately after concern was identified. Staff will utilize appropriate PPEs when providing care to residents, will implement appropriate TBP when providing care to residents and implement appropriate equipment and environmental cleaning procedures when cleaning residents□ equipment and/or environment. Identification: Resident #154 no longer resides in facility. Residents at Laramie Care Center are at risk. No further issues identified after the IP, DON and IDT reviewed current Covid-19 facility guidelines from CDC and CMS.	

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F 880	Continued From page 21 hand hygiene during the observation. b. Observation on 4/19/21 at 11:18 AM showed CNA #4 entered room #27, repositioned the resident in bed, and left the room. The CNA did not don gloves and no hand hygiene was performed upon entry or exit of the room. c. Observation on 4/19/21 at 11:54 AM showed CNA #4 enter room #27, moved the resident's tray table to the side to be closer while speaking to the resident, and exited the room. The CNA entered room 49 across the hall, obtained a mechanical lift, and returned to room 27. The CNA did not perform hand hygiene during the observation, and the mechanical lift was not cleaned prior to use in room 27. d. Observation on 4/19/21 at 12:54 PM showed CNA #5 delivered a meal tray to room #48, set up the meal tray, moved the resident's personal items to accommodate the meal tray, and left the room. The staff member obtained another meal tray, delivered the tray to room 29, set up the tray, moved the resident's personal items to accommodate the tray, and exited the room. No hand hygiene was performed during the observation. e. Observation on 4/19/21 at 1:00 PM showed CNA #5 delivered a meal tray to room #50, moved the resident's personal items to accommodate the meal tray, set up the meal, and left the room. The staff member went to the kitchen area to retrieve a clean towel/drop cloth, returned to room 50, applied cloth to the resident's chest, and exited the room. The staff member went down the hall and entered the HR/payroll office. The staff member exited the office at 1:10 PM, went to the assisted dining area in the dining room, sat down next to an unidentified resident, and began to assisting him/her with their meal. No hand hygiene was	F 880	Systemic Changes: On or before 5/21/2021 the facility will complete root-cause analysis to identify and address reasons for non-compliance related to: hand hygiene procedures, use of personal protective equipment (PPE) procedures, transmission-based precautions procedures, equipment and environmental cleaning procedures. On or prior to the allegation of compliance the Director of Nursing / Designee will ensure staff will be re-educated regarding hand hygiene procedures, use of personal protective equipment (PPE) procedures, transmission-based precautions procedures, equipment and environmental cleaning procedures. Staff and Nursing staff will be educated upon hire, yearly and as needed. On 5/12/2021 the facility met with Mountain Pacific Quality Improvement Organization about the assistance and services available along with review of facilities 4-22-2021, 2567 and F880 DPOC. Monitoring: The Director of Nursing/ Designee will do random audits of hand hygiene, donning appropriate PPEs, transmission-based precautions, equipment and environmental cleaning procedures; audits to be done two times a week for one month, then monthly for two months and as needed thereafter. Issues identified will be corrected at that time. Issues will be tracked and trended. The DON/ Designee will report the results to QAPI monthly as needed to assure the	

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(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 22 performed during the observation. f. Interview with the Infection preventionist (IP) on 4/21/21 at 2:17 PM revealed the expectation for staff was to perform hand hygiene in and out of every room, every time. She further revealed she expected full PPE (N95 mask, eye protection, face shield, gown, and gloves) application into every room on transmission-based precautions, regardless of how long staff were in the room. She also stated she expected all residents to wear masks while out of their rooms, and residents should be at least 6 feet apart while under the quarantine protocol. 2. Review of the admission MDS assessment dated 4/2/21 showed resident #154 was admitted to the facility with diagnoses which included pressure ulcer of the sacral region, stage 4; pressure ulcer of other site, stage 2; pressure ulcer of left heel, unstageable; multiple sclerosis; weakness; muscle spasm of the back; and neuromuscular dysfunction of the bladder. The following concerns were identified: a. Observation on 4/21/21 at 8:03 AM showed CNA #3, the IP, and RN #2 provided incontinence care and wound care. At that time, the resident was lying on his/her right side, with his/her left leg over his/her right. RN #2 removed the dressing to expose the large wound. After cleansing the outer edges of the wound with wound cleanser sprayed onto gauze, she then performed perineal care for the resident using a wipe. She wiped from the resident's genitals, across the anus, and towards the open wound. Continued observation showed the wipe made contact with the wound, and the soiled absorbent pad also made contact with the wound bed. The wound was not cleaned again	F 880	plan is implemented, correction is achieved and sustained and monitored for its effectiveness until sustained compliance is noted. After 12 weeks of monitoring, provided that such monitoring demonstrates expectations are met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months, All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring which demonstrates sustained compliance as approved by the QAPI committee and medical director. The QAPI committee may modify this plan as needed to ensure that the facility remains in compliance. Compliance Date: June 7, 2021	

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 04/22/2021

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F 880	Continued From page 23 after perineal care, or after contact with contaminated surfaces. b. Interview with the IP on 4/21/21 at 2:17 PM revealed there was potential for infection with contamination of the wound due to the perineal care without a dressing on the wound, as well as contacting a contaminated surface. She confirmed the nurse should have performed perineal care prior to removing the wound dressing, and also should have cleansed the wound after the incontinence care was provided, and after the wound contacted the soiled absorbent pad.	F 880		