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 02/23/2022

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

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 2/14/22 to 2/23/22. The survey was prompted by complaint intakes WY00003361 and WY00003362. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the complaint investigation. In addition, a focused COVID-19 infection control survey, including review for compliance with the Omnibus COVID-19 Health Care Staff Vaccination requirements, was conducted by Healthcare Licensing and Surveys from 2/14/22 to 2/23/22.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		4/8/22

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

Electronically Signed | 03/16/2022

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.

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F 690	Continued From page 1 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, policy and procedure review, and review of professional standards, the facility failed to ensure appropriate indwelling catheter care was performed for 1 of 3 sample residents (#3) with an indwelling catheter. The findings were: 1. Review of the current physician orders showed resident #3 was admitted to the facility on 11/22/21 with diagnoses that included multiple sclerosis, benign prostatic hyperplasia with lower urinary tract symptoms, neuromuscular dysfunction of the bladder, and personal history of urinary tract infections (UTI). Further review showed orders for suprapubic catheter care and maintenance that included: changing the catheter every 30 days; cleansing and assessing the stoma site daily, as needed, and every 30 days with catheter change; and changing the urinary drainage bag every 7 days. Continued review showed two medication orders related to urinary discomfort and bladder spasms, as well as an order for a bacterial-minimizing bladder irrigation	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI Corrective Action: Wound Nurse was educated by DON/Designee on proper placement of suprapubic down drain bag while providing wound care and repositioning a resident to prevent urine backflow. Identification: Residents with suprapubic catheters who reside at Laramie Care Center are at potential risk. An audit of residents with suprapubic catheters was performed by the DON/Designee and no concerns were noted. System Changes: Licensed staff will be re-educated on or before the alleged date of compliance, yearly and upon hire by the DON/Designee on proper placement of suprapubic down drain bags to prevent urine back flow.	

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F 690	Continued From page 2 to be performed twice per week related to the resident's history of UTIs. The following concerns were identified: a. Observation on 2/16/22 at 7:13 AM showed the wound care nurse and licensed practical nurse (LPN) #1 entered the resident's room to perform wound care to the resident's buttocks. The resident was in his/her bed, with the head of the bed slightly elevated. The catheter tubing was observed extending from out from under the resident's blankets near the foot of the bed, connected to the catheter bag that was hanging inside a privacy bag on the lower right side of the bed; urine was observed to be in a majority of the tubing that was exposed. LPN #1 positioned herself on the left side of the bed, while the wound care nurse stayed on the right. The two staff members then rolled the resident up onto his/her left side, with LPN #1 holding the resident in position. The wound care nurse then removed the catheter bag from the privacy bag, lifted it up above the resident, and placed it on the surface of the bed in the lower left corner; the backflow of urine towards the resident's bladder was observed during the bag transition. After the completion of the cares, the wound care nurse reached across the resident to retrieve the catheter bag that was still lying on the bed to the left of the resident's feet. Again he lifted the bag above the resident, the backflow of urine was observed flowing towards the resident's bladder, and the bag was placed back into the privacy bag hanging off the lower right portion of the bed. b. Interview on 2/16/22 at 7:38 AM with the wound care nurse and LPN #1 revealed they did not note the urine present in the tubing, and neither were paying attention to urine backflow during the positioning of the catheter bag. Both staff members confirmed having the bag above	F 690	System Maintenance: DON/Designee will perform suprapubic down drain bag proper placement audits 3x weekly for 60 days then 1x weekly for 30 days and as needed thereafter. All findings of non-compliance will be addressed immediately and reported to the QAPI committee for further review and recommendations.	

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F 690	Continued From page 3 the resident can result in the backflow of urine in the tubing towards the resident. c. Review of facility policy "Urinary Tract Infection", last revised 10/1/09, showed "Prevention ... 6. Maintain gravity drains at all times ..." d. Review of "Nursing Interventions and Clinical Skills" by Perry, Potter, and Ostendorf (2020), seventh edition, showed " ... Keeping the collection bag below the level of the bladder at all times prevents backflow in bladder which can cause risk for CAUTI [catheter acquired urinary tract infection] ..."	F 690		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or	F 888		4/8/22

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F 888	Continued From page 4 other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of	F 888		

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F 888	Continued From page 5 all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be	F 888		

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F 888	Continued From page 6 temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on review of policies and procedures and staff interview, the facility failed to develop policies and procedures for COVID-19 vaccination of staff which included all of the required components. The findings were: 1. Review of the facility's policy "COVID-19 Vaccination Policy" (updated 9/13/2021) showed the policy did not include the following components: A process for tracking and documenting COVID-19 vaccination status of all staff, or a process for ensuring the implementation of additional precautions for all staff who were not fully vaccinated. 2. During an interview on 2/15/22 at 4:49 PM the assistant director of nursing (ADON) confirmed	F 888	F888 Vaccination of Facility Staff Corrective Action: The community has revised their COVID-19 vaccination policy to include: a process for tracking and documenting COVID-19 vaccination status of all staff, or a process for ensuring the implementation of additional precautions for all staff who were not fully vaccinated. Identification: Residents who reside at Laramie Care Center are at potential risk. Systemic Changes: Staff will be re-educated on or before the date of compliance and upon hire by the DON/Designee on the COVID-19 Vaccination Policy.	

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F 888	Continued From page 7 the facility's policies did not include a process for tracking and documenting the vaccination status of staff, nor did it include additional precautions for staff who were not fully vaccinated.	F 888	System Maintenance: DON/Designee will monitor vaccination status and reconcile with the staff roster monthly and upon hire until compliance is achieved. All findings of non-compliance will be addressed immediately and reported to the QAPI Committee for further review and recommendations.	