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 06/09/2022

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 recertification survey was conducted by Healthcare Licensing and Surveys from 6/6/22 to 6/9/22. Also reviewed in the course of the survey was complaint intakes WY00003411, WY00003412, and WY00003413. In addition, a review for compliance with the Omnibus COVID-19 Health Care Staff Vaccination requirements was conducted. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the vaccine requirements. The following common abbreviations are used throughout this document: ADON: Assistant Director of Nursing BIMS: Brief Interview for Mental Status CDC: Centers for Disease Control and Prevention CMS: Centers for Medicare and Medicaid Services CNA: Certified Nursing Assistant DON: Director of Nursing MA-C: Medication Aide - Certified Nurse Aide MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,	F 580		7/13/22

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

Electronically Signed | 07/03/2022

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F 580	Continued From page 1 consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in	F 580		

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F 580	Continued From page 2 §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on resident representative interview, medical record review, staff interview, and policy and procedure review, the facility failed to notify the resident's representative for 1 of 7 sample residents (#35) reviewed for hospitalization. The findings were: 1. Review of the 1/19/22 quarterly MDS assessment for resident #35 showed the staff assessment for mental status was coded as severely impaired. The following concerns were identified: a. Review of the Situation, Background, Assessment, Recommendation (SBAR) form which was not dated, showed the resident had fallen on 4/2/22 at 10:34 PM. The name, date, and time the resident's representative was notified was blank. b. Interview with the resident's representative on 6/9/22 at 11:41 AM revealed he had not been informed of the resident's fall until the resident had been taken to the hospital on 4/8/22. c. Interview with the DON on 6/9/22 at 2:40 PM confirmed the section documenting the notification of the resident's representative was blank and the facility was unable to provide additional documentation of notification. 2. Review of the "Fall Management and Investigation" policy with the effective date of 9/1/18 showed "...III POLICY GUIDELINES ...F.	F 580	F580 Notification of Change Corrective Action: Resident # 35□s changes in condition, specifically falls will now be communicated to her responsible party per policy, if the agent is unreachable a progress note with be documented for every attempt. Identification On or prior to the allegation of compliance the DON/Designee conduct a record review of residents to identify changes of condition that may have occurred over the last 2 weeks that were not communicated to the family/significant other/interested party specifically falls. Identified changes were promptly communicated to the family/significant other/interested party and/or physician for evaluation. Systemic Changes On or prior to the allegation of compliance the Nursing staff will be re-educated by DON/designee regarding reporting changes of condition to the charge nurse, the physician, and the family, specifically falls. On or prior to the allegation of compliance the Licensed nurses will be re-educated by DON/designee regarding the use of the E Interact and the 24-hour	

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F 580	Continued From page 3 The resident's family members/responsible persons and physician are notified of Falls..."	F 580	report as a means of communication and documentation for changes of condition. Monitoring A nursing supervisor/unit manager/designee will conduct daily reviews on their assigned residents to validate follow-up has been initiated on any recognizable changes. DON/Nursing supervisor/unit manager/designee will review the 24-hour reports and validate changes of condition reports were completed and validate those changes have been communicated as appropriate. Each business day, DON/designees will review report, to include changes of condition and notification, and will validate that appropriate follow-up action has been taken. The QA&A Committee will meet monthly to review the DON□s summary of compliance with this plan of correction to ensure the plan has been implemented, until sustained compliance is achieved.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		7/13/22

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F 656	Continued From page 4 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, medical record review, and policy and procedure review, the facility failed to develop and implement a comprehensive person-centered care plan for 4 of 23 sample residents (#32, #34, #42, #155). The findings were:	F 656	Corrective Action: The community will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to met a	

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F 656	Continued From page 5 1. Review of the 3/18/22 admission MDS assessment showed resident #32 was admitted to the facility on 3/11/22 with diagnoses which included major depressive disorder and cognitive communication deficit. The resident was cognitively intact with a BIMS score of 15/15. Further review showed it was very important to the resident to have books, newspapers, and magazines to read, as well as keeping up with the news and going outside to get fresh air when the weather was good. It was somewhat important to the resident to be around animals such as pets, as well as participating in religious services or practices. The following concerns were identified: a. Interview with the resident on 6/6/22 at 4:54 PM revealed s/he "...had nothing to do except watch television and roll around in this chair." b. Review of the current care plan, last revised 6/8/22 showed no documentation of the resident's interests or activities. c. Interview with the NHA, DON, and ADON on 6/9/22 at 11:47 AM confirmed the care plan was not individualized to the resident's needs and preferences. 2. Review of the 5/5/22 annual MDS assessment showed resident #42 was admitted to the facility on 5/7/21 with diagnoses which included macular degeneration and cognitive communication deficit. The resident was cognitively intact with a BIMS score of 15/15. Further review showed it was very important to the resident to have books, newspapers, and magazines to read, to listen to music s/he liked, to be around animals such as pets, to keep up with the news, to do his/her favorite activities, and to go outside to get fresh air when the weather was good. The following concerns were identified:	F 656	residents medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The IDT with the Life Enrichment coordinator reviewed the care plan for Resident #32 and #42 to include individual Activity interests The IDT reviewed the care plan for Resident #34 and #42 to include individual individualized interventions to address residents Behaviors The IDT reviewed the care plan for Resident #155 to include individual individualized interventions to address residents Behaviors Identification: The facility currently has 53 residents who could be impacted. On or before the allegation of compliance, Activity and Behavior care plans will be reviewed by the facility IDT to ensure they contain goals and needs that are identified in the comprehensive assessment and ensuring care plans include personalized and current updated interventions for Activities and Behaviors. Correction will be made at that time Systemic Changes: Residents will be reviewed upon admission, quarterly, annually, and with significant change of condition utilizing the admission/MDS/RAI/ Care planning process. Care plans will be developed to include services provided to attain or maintain their highest practicable physical, mental, and psychosocial well-being, including ensuring a care plan is in place to address current, individualized interventions for each Resident□s Activity	

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F 656	Continued From page 6 a. Interview with the resident on 6/6/22 at 3:38 PM revealed the residents " ...just watch television since there isn't anything else to do. There's no activities for [the residents] in the COVID unit. I like to build my models and puzzles, but don't have any or anywhere to work on [them]." b. Review of the current care plan, last revised 6/6/22, showed a focus area for activities; however, documentation did not reflect the resident's preferences from the MDS or his/her interest in the models or puzzles. c. Interview with the NHA, DON, and ADON on 6/9/22 at 11:47 AM confirmed the care plan was not individualized to the resident's needs and preferences. 3. Review of the 4/20/22 quarterly MDS assessment showed resident #34 was admitted to the facility on 11/1/19 with diagnoses which included bipolar disorder, major depressive disorder, and other specified mental disorder due to known physiological condition. Review of the current physician orders showed the resident was started on aripiprazole (an antipsychotic medication) on 5/26/22 related to bipolar disorder. Review of a 5/29/22 nurse progress note showed " ...Has been noted to be easier to redirect when behaviors start ..." The following concerns were identified: a. Review of the current care plan showed no documentation related to the identified behaviors that resulted in the administration of the new medication, or non-pharmacological interventions. b. Interview with the NHA, DON, and ADON on 6/9/22 at 11:47 AM confirmed the care plan was not individualized to the resident's needs and preferences.	F 656	interests and Behaviors. Beginning on July 5, 2022 and continuing up until the allegation of compliance the DON/Designee will in-service the IDT and Nursing staff on care plan preparation. An attendance sheet will be utilized. Nursing staff unable to attend will be provided with one on one in- servicing. Monitoring: The MDS Coordinator/Designee will audit 10% of care plans, weekly, for three months. Audits will demonstrate compliance with the facility policy and procedure for Care Planning, specifically for ensuring care plans address all residents identified needs. Audit results will be reviewed by the DON/ED/Designee and areas of non-compliance will be addressed at the time they are identified. Audit trends will be reported to the facility QAPI committee monthly, for review and further corrective action when negative trends are identified. The DON/Designee will be delegated responsibility for assuring compliance with this plan of correction for this self-identified deficient practice	

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F 656	Continued From page 7 4. Review of the 5/19/22 admission MDS showed resident #155 was admitted to the facility on 5/12/22 with diagnoses which included unspecified mood [affective] disorder, generalized anxiety disorder, and unspecified dementia without behavioral disturbance. Review of the 5/18/22 admission physician orders showed an order for buspirone (antianxiety) 5 milligrams (mg) daily and 10 mg daily, and fluoxetine (antidepressant) 60 mg daily. Review of the treatment administration record for June 2022 showed an area to monitor behavior and document intervention codes for buspirone and fluoxetine. The following concerns were identified: a. Review of the admission care plan showed the resident had a focus area for mood related to generalized anxiety. The interventions included administer medications as ordered and encourage and reassure as needed; however, there were no specific individualized non-pharmacological interventions identified. b. Interview with the DON on 6/9/22 at 9:48 AM revealed the care plan was not individualized to the resident's needs and preferences. 5. Review of the Care Plan Development and Communication Policy, revised 1/4/19, showed "1. Policy Statement...The overall plan of care (POC) is oriented towards: ...2. Person-centered interventions that honor the resident's preferences....Please note: Both baseline and comprehensive plans of care include a problem statement developed as a result of comprehensive review; measurable resident-centered goals; time frames for meeting those goals; and interventions designed to assist the resident in meeting the goals."	F 656		
F 657 SS=D	Care Plan Timing and Revision	F 657		7/13/22

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F 657	Continued From page 8 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure the care plan was revised to identify resident specific approaches for 2 of 23 sample residents (#15, #35). The findings were: 1. Review of the 3/16/22 annual MDS assessment for resident #15 showed diagnoses	F 657	Corrective Action: The community will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident□s medical, nursing and mental	

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F 657	Continued From page 9 which included unspecified dementia with behavioral disturbance, and anxiety disorder. Review of the medication administration record for June 2022 showed the resident received apiprazole (antipsychotic) 5 mg daily, quetiapine (antipsychotic) 25 mg daily, and Celexa (antidepressant) 30 mg daily. Review of the treatment administration record for June 2022 showed target behaviors to monitor and the interventions included redirection and remove from the environment. Interview on 6/8/22 at 11:36 AM with MA-C #1 revealed some behavioral interventions were on the care plan. He further stated the resident liked to watch the Catholic channel and wanted to hold a rosary for comfort. The following concerns were identified: a. Review of the care plan with a revision date of 3/23/22 showed focus areas for mood and behaviors; however, the care plan failed to identity specific resident centered interventions. b. Interview on 6/9/22 at 9:48 AM with the DON confirmed there were some interventions on the care plan; however, it lacked the interventions regarding television show preference, and holding the rosary. She further stated the interventions were something they needed to work on. 2. Review of the 4/20/22 quarterly MDS assessment showed resident #35 was admitted to the facility on 10/19/21 and was at risk for pressure ulcers. Observation throughout the survey timeframe showed the resident wore a foam boot on his/her right foot. Review of a nurse progress note dated 4/10/22 showed "Boggy area with dark coloration found on medial side of right heel...skin prep applied to the area and is showing signs of improvement." Review of a 4/11/22 Skin/Wound note showed "New wound evaluation. Blistered area from pressure between	F 657	and psychosocial needs that are identified in the comprehensive assessment and ensure Revisions/updates are completed to ensure the care plan is current to the resident□s needs. The IDT updated the care plan for Resident #15 to include individual behavioral interventions such as Television show preferences and holding the rosary The IDT updated the care plan for Resident #35 to include use of the foam boot to her heel. Identification: The facility currently has 53 residents who could be impacted. On or before the allegation of compliance, Wound and Behavior care plans will be reviewed by the facility IDT to ensure they personalized and current updated interventions are current. Correction identified will be made at that time Systemic Changes: Residents will be reviewed upon admission, quarterly, annually, and with significant change of condition utilizing the admission/MDS/RAI/ Care planning process. Care plans will be developed to include services provided to attain or maintain their highest practicable physical, mental, and psychosocial well-being, including ensuring a care plan is in place to address current, individualized interventions for each Resident□s Behavior and wound prevention care plans. Beginning on (Date) and continuing up until the allegation of compliance the DON/Designee will	

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F 657	Continued From page 10 feet. Skin prep applied to area to help toughen skin." Review of a physician order dated 4/10/22 showed "WOUND ORDER: skin prep to bilat (bilateral) heels, float heels every shift." Review of the 4/21/22 skin and wound evaluation showed "Wound resolved. Will continue wound prevention to bilateral heels." The following concerns were identified: a. Review of the resident's entire care plan, last revised 5/29/22, failed to include the wound prevention intervention. b. Interview with the ADON on 6/8/22 at 4:33 PM confirmed the care plan had not been updated to include the use of the foam boot. An additional interview with the DON on 6/8/22 at 4:51 PM confirmed the wound prevention interventions should be on the care plan. 3. Review of the Care Plan Development and Communication policy with a revision date, 9/1/18, showed "I. Policy Statement...The overall plan of care is oriented towards: ...2. Person centered interventions that honor the resident's preferences...II. Definitions 1...Person-centered care includes making an effort to understand what each resident is communicating verbally and non-verbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to the community. It incorporates the resident's personal and cultural preferences in developing the goals of care..." 4. Review of the Behavioral Health Management policy, revised on 9/1/18, showed "...III. Policy Guidelines... E. Person-centered approaches and their outcomes are recorded on the plan of care. IV. Provision(s) and Procedure(s)...N.	F 657	inservice the IDT and Nursing staff on care plan revisions and/ updates. An attendance sheet will be utilized and reconciled with the current active staff roster. Nursing staff unable to attend will be provided with one on one inservicing. Monitoring: The MDS Coordinator/Designee will audit 10% of care plans, weekly, for three months. Audits will demonstrate compliance with the facility policy and procedure for Care Planning, specifically for ensuring care plans address all residents current identified needs. Audit results will be reviewed by the DON/ED/Designee and areas of non-compliance will be addressed at the time they are identified. Audit trends will be reported to the facility QAPI committee monthly, for review and further corrective action when negative trends are identified. The DON/Designee will be delegated responsibility for assuring compliance with this plan of correction for this self-identified deficient practice	

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F 657	Continued From page 11 Interventions are person-centered and incorporated as part of the overall care environment that supports physical, functional and psychosocial needs. O...5. Non-pharmacological approaches that are person-centered will be optimally utilized at a maximum..."	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, and policy and procedure review, the facility failed to provide an ongoing program of activities for 3 of 3 sample residents (#8, #32, #42) isolated in the COVID-19 unit. The COVID-19 unit census was 20. The findings were: 1. Review of the 3/18/22 admission MDS assessment showed resident #32 was admitted to the facility on 3/11/22 with diagnoses which included major depressive disorder and cognitive communication deficit. The resident was cognitively intact with a BIMS score of 15/15. Further review showed it was very important to	F 679	Corrective Action: The facility will provide an ongoing program to support residents in their choice of individual activities and independent activities, designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident while on a COVID-19 unit and or in isolation. The care plan for residents #8, #32, and #42 will include activities that promote self-esteem, pleasure, comfort, education, creativity, success and independence, based on the comprehensive assessment and preferences of each resident.	7/13/22

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	535043	A. BUILDING _____ B. WING _____	C 06/09/2022

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

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F 679	Continued From page 12 the resident to have books, newspapers, and magazines to read, as well as keeping up with the news and going outside to get fresh air when the weather was good. It was somewhat important to the resident to be around animals such as pets, as well as participating in religious services or practices. Review of the line listing of COVID-positive residents showed the resident was admitted to the COVID unit on 5/31/22. The following concerns were identified: a. Observation on 6/6/22 at 4:54 PM showed the resident self-propelling in his/her wheelchair in the hallway. Interview at that time revealed the resident had " ...nothing to do except watch TV and roll around in this chair." 2. Review of the 5/5/22 annual MDS assessment showed resident #42 was admitted to the facility on 5/7/21 with diagnoses which included macular degeneration and cognitive communication deficit. The resident was cognitively intact with a BIMS score of 15/15. Further review showed it was very important to the resident to have books, newspapers, and magazines to read, to listen to music s/he liked, to be around animals such as pets, to keep up with the news, to do his/her favorite activities, and to go outside to get fresh air when the weather was good. Review of the line listing of COVID-positive residents showed the resident was admitted to the COVID unit on 5/31/22. The following concerns were identified: a. Observation on 6/6/22 at 3:38 PM showed the resident's room contained completed wooden models. Interview with the resident at that time revealed the residents "just watch TV since there isn't anything else to do. There's no activities for [the residents] in the COVID unit." The resident stated s/he liked to build models and do puzzles; however, s/he did not "have any or any place to	F 679	Identification: Residents on a COVID-19 unit and or in isolation could be impacted. Residents will be interviewed to determine preferences for activities that reflect each person's interests and lifestyle, are enjoyable to the person, help the person to feel useful and provide a sense of belonging. Care plans will be developed and revised to reflect the results of the resident activity preference interviews. Systemic Changes: The facility policy and procedure for resident Activities was reviewed. On or before the date of compliance the IDT team and Life Enrichment department will be educated on individual activities and in room visit program for residents residing on a Covid-unit were educated by ED/DON. The Life Enrichment Director/Designee will initiate the COVID-19-unit Individual Activities and Room Visit Program for residents residing on the unit. Monitoring: The Life Enrichment Director/Designee will audit 50% of activity participation documentation, daily, for one month. Activity participation audits will include one-one activities, self-directed activities and residents who are on insolation on a COVID-19 unit and or in isolation. After one month, the DON/Designee will audit 20% of activity participation documentation weekly, for two months. The Life Enrichment Director/Designee will communicate with nurse on the COVID-19 unit weekly to validate activity material and interests are provided to the	

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F 679	Continued From page 13 work on them." 3. Review of the 3/9/22 quarterly MDS assessment showed resident #8 was admitted to the facility on 12/31/14 with diagnoses which included cerebral palsy, cognitive communication deficit, and other intellectual disabilities. The resident was cognitively intact with a BIMS score of 15/15. Review of the current care plan, last revised 6/2/22, showed the resident preferred group activities and socializing with other residents. Further review showed s/he liked the news, watching television, listening to music, and going on outings. Interventions included providing the resident with a new activities calendar at the beginning of each month. Review of the line listing of COVID-positive residents showed the resident was admitted to the COVID unit on 5/31/22. The following concerns were identified: a. Observation on 6/8/22 at 3:39 PM showed the resident was seated in a recliner watching television. At that time the resident stated s/he was "bored since there is nothing to do besides watch TV." 4. Interview with activities assistant (AA) #1 on 6/9/22 at 11:36 AM revealed the activities director was out of the facility and he was handling the day-to-day activities in the director's absence. AA #1 stated the facility was limited to what activities could be provided for the facility, especially the COVID unit, and had canceled most activities for the month for the whole facility. 5. Review of the posted activities calendar for June 2022 showed from 6/2/22 through 6/10/22, 35 of the 58 offered activities had been canceled for the entire facility. There was not an alternative calendar or activities available for the residents	F 679	residents. Anyone requesting a change in activity materials or needing activity material will be provided with the said material by the Life Enrichment Department/Designee once avliable. Audit results will be reviewed by the ED/Designee and areas of non-compliance will be addressed at the time they are identified. Audit trends will be reported to the facility QAPI committee monthly, for review and further corrective action when negative trends are identified.	

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F 679	Continued From page 14 isolated in the COVID unit. 6. Interview with the NHA, DON, and ADON on 6/9/22 at 11:47 AM revealed activities were at a minimum due to the COVID outbreak in the facility and the activities director was out of the facility. In addition, the activity director had prepared activity packets and baskets for the residents prior to his departure; however, they were not aware if the packets and baskets had been provided to residents in the COVID unit. 7. Review of the policy titled "Activities Policy", effective 9/1/14, showed "The community will provide space, supplies, equipment and the staff support necessary for social, physical, educational and leisurely activities, both within and outside the Community, that are planned according to the preferences, needs and abilities of residents ...the Community will encourage participation in independent or self-directed activities, as well as offer group activities at least three times per week ..."	F 679		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 732		7/13/22

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F 732	Continued From page 15 vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of the nursing staff postings, and staff interview, the facility failed to ensure the information on the posted 24-hour nursing staff information was maintained and updated to reflect the actual hours worked for 23 of 23 days reviewed. The census was 55. The findings were: 1. Observation on 6/7/22 of the posted 24-hour nursing staff information showed only the number of hours each care level was scheduled to work. 2. Review of the posted 24-hour nursing staff	F 732	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction	

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F 732	Continued From page 16 information from 5/15/22 to 6/7/22 failed to show the actual hours worked by the registered nurses, licensed practical nurses, and the CNAs responsible for resident care per shift. 3. Interview on 6/8/22 at 5:39 PM with the ADON confirmed the posted 24-hour nursing staff information failed to include the actual hours worked, of the resident care staff.	F 732	constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. The facility will post the nurse staffing data at the beginning of each shift in a clear and readable format and will be posted in a prominent place readily accessible to residents and visitors. The post will include facility name, current date, total number and actual hours worked, registered nurses, licensed practical nurses, certified nurse aides, and resident census. Identification: Residents who reside at Laramie Care Center are at risk. Systematic Changes: On or before June 25, 2022, the Administrator and ADON re-constructed the "Declaration of Direct Care Staffing" Posting to include both scheduled hours and actual hours. Monitoring: ADON or designee will monitor weekly for one month, then prn to ensure the use of the appropriate form which displays total hours worked is displayed. Issues identified will be tracked and corrected at that time. Trends will be presented in the monthly Quality Assurance Performance Improvement Meeting by the ADON or designee to ensure plan has been implemented, and sustained.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		7/13/22

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F 758	Continued From page 17	F 758		

but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic

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F 758	Continued From page 18 drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure appropriate behavior monitoring and interventions were in place for 1 of 6 sample residents (#34) reviewed for psychotropic medications. The findings were: 1. Review of the 4/20/22 quarterly MDS assessment showed resident #34 was admitted to the facility on 11/1/19 with diagnoses which included bipolar disorder, major depressive disorder, and other specified mental disorder due to known physiological condition. Review of current physician orders showed a 5/25/22 order for 5 milligrams of aripiprazole (an antipsychotic medication) to be administered once daily, related to bipolar disorder, current episode depressed, and other specified mental disorder due to known physiological condition. Review of a nurse progress note dated 5/29/22 showed "...Has been noted to be easier to redirect when behaviors start..." The following concerns were identified: a. Review of daily progress notes from 5/26/22 through 5/30/22 addressing the resident's new medication showed "...no adverse effects..." associated with the medication. Further review showed no relevant behaviors were documented. b. Review of the current physician orders showed no orders of documentation related to behavior monitoring or non-pharmacological interventions. c. Review of the current care plan, last revised 4/24/22, showed no documentation	F 758	F-758 CORRECTIVE ACTION Resident #34 has behavior monitoring in place and the care plan was updated by the IDT on July 1, 2022 to include behaviors and monitoring of those behaviors IDENTIFICATION A review of records for resident's receiving psychoactive medications will be conducted prior to the allegation of compliance By the Social Service Director/DON/Designee. Issues identified behavior monitoring will be reviewed and corrected at that time. SYSTEMIC CHANGES Each resident is reviewed on admission, quarterly, annually, and with significant change for the use of psychoactive medications (antidepressants, anti-psychotics, sedatives/hypnotics, and anti-anxiety agents). For residents who are prescribed psychoactive medications, clinical record documentation will Behaviors, interventions, and behavior, medication side effects are monitored for residents receiving anti-psychotic, anti-depressants anti-anxiety, and sedative/hypnotic medications using the behavior monitoring form. On or before the allegation of compliance the Social	

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F 758	Continued From page 19 related to the identified behaviors which resulted in the administration of the new medication or any non-pharmacological interventions. 2. Interview with the NHA, DON, and ADON on 6/9/22 at 11:47 AM confirmed the resident's medical record lacked documentation of behavior monitoring and interventions. 3. Review of the policy titled "Unnecessary Medications," last revised 4/9/07, showed "...IV. Provisions(s) and Procedures(s)...D. Monitoring Medications...1. The Community's Monitoring system includes observation, assessment and reporting of the following: a. Symptoms suggesting the need for medication (including initiated or continued use of Antipsychotic Medication)..." 4. Review of the policy titled "Behavioral Health Management" last revised 12/8/08 showed "...IV. Provisions(s) and Procedure(s)...K. Nursing staff identify, document and inform the physician immediately about specific details regarding changes in an individual's mental status, behavior or cognition in order to determine the root cause, including: ...1. Onset, duration, intensity and frequency of behavioral symptoms; ...4. A new onset or alteration in behavior is documented and communicated with the physician immediately... P. When psychoactive medications are prescribed for behavioral symptoms, the following are documented: ...2. Potential cause of the behavior...4. Target Behaviors...7. Monitoring for efficacy..."	F 758	Service Director/Designee will Inservice the IDT and licensed nurses on the above systemic changes. An attendance sheet will be kept and reconciled with the active licensed nurses roster and those unable to attend will be provided 1:1 reeducation. MONITORING Monthly for 3 months than quarterly the SSD/Designee will complete a psychoactive documentation audit on resident's receiving psychoactive medications to ensure effectiveness of medication is being monitored per facility policy. Issues identified will be corrected at that time and then trended to be reviewed at QAPI by the SSD/Designee to ensure plan has been implemented, sustained, and evaluated for effectiveness.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		7/13/22

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F 880	Continued From page 20 §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 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,	F 880		

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F 880	Continued From page 21 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. §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, staff interview, policy and procedure review, CMS Guidance review, CDC guideline review, facilty COVID line list review, and county transmission rate review. the facility failed to ensure adequate transmission-based precautions were implemented to prevent the spread of COVID-19 during 2 random observations, and failed to ensure infection control practices were implemented for 2 random observations. The census was 55. The findings were:	F 880	DPOC 1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent	

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F 880	Continued From page 22 Related to transmission-based precautions: 1. Observation on 6/6/22 at 11:23 AM showed an unmasked visitor was in the room of resident #105 and resident #107 interacting with both residents at a distance of less than 6 feet. Observation on 6/7/22 at 9:24 AM showed the same unmasked visitor was in the resident's room and interacting with both residents at a distance of less than 6 feet. During this time physical therapist #1 was in the room and then at 9:29 AM RN #1 entered the room. Neither staff member asked the visitor to don a mask. Interview with RN #1 at 9:33 AM revealed the visitor should have had a mask on. The nurse then returned to the room and asked the visitor to don a mask. Interview with the DON on 6/9/22 at 1:31 PM revealed she was aware the visitor was not compliant with wearing a mask and had educated him more than once. 2. Review of the policy titled "Coronavirus (COVID-19)" last revised 5/12/21 showed "...D. Visitors, Vendors, and Third-Party Contractors... 1. Refer to CDC and State for further guidance..." 3. Review of the CMS memo "QSO-20-39-NH" last revised on 3/10/22 showed "...Guidance... visitation can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, and outdoors. Regardless of how visits are conducted, certain core principles and best practices reduce the risk of COVID-19 Infection Prevention... Face covering or mask (covering mouth and nose) and physical distancing at least six feet between people, in accordance with CDC guidance..."	F 880	system for: (1) Ensuring visitors who visit residents in room don PPE and socially distance in accordance with Centers for Disease Control and Prevention (CDC) guidelines. (2) Ensuring staff have adequate knowledge of cleaning disinfecting practices for resident multi use equipment such as lifts (3) Educate CNA #2 on correctly completing hand hygiene after changing tasks, moving between residents, changing gloves, and touching potentially contaminated surfaces. To verify this staff understands hand hygiene and handwashing, this staff will perform a successful return demonstration of identifying the need and correct procedure for performing hand hygiene and handwashing. (4) Ensuring staff follow procedures for ensure foley catheters are not touching floors (5) Ensuring staff have adequate knowledge of infection control practices as they pertain to peritoneal care, specifically had hygiene between changing gloves. 2. Identification of Others All residents residing at Laramie Care , The IP and DON, in conjunction with the applicable interdisciplinary team (IDT) members, will review current Infection Control Program and current COVID-19	

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	535043	A. BUILDING _____ B. WING _____	C 06/09/2022

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F 880	Continued From page 23 4. Review of the CDC guidance titled "Interim Infection Prevention and Control Recommendations for Health Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" last updated 2/2/22 showed "... Patient Visitation: Indoor visitation (in single-person rooms; in multi-person rooms, when roommates are not present; or in designated visitation areas when others are not present): The safest practice is for patients and visitors to wear source control and physically distance, particularly if either of them are at risk for severe disease or are unvaccinated. If the patient and all their visitor(s) are up to date with all recommended COVID-19 vaccine doses, they can choose not to wear source control and to have physical contact. Visitors should wear source control when around other residents or HCP (Healthcare Personnel), regardless of vaccination status. 5. Observation on 6/7/22 at 2:13 PM showed CNA #1 and CNA #2 used a mechanical lift to transfer resident #48 to bed. Further observation showed the CNAs rolled the mechanical lift to the hallway and did not disinfect it. Interview with CNA #1 confirmed the mechanical lift was not disinfected after use. She stated there were disinfecting wipes at the nurses' station; however, she was not sure when the lift should be disinfected. Interview with the DON on 6/8/22 at 2:14 PM revealed her expectation was to disinfect the lifts after each resident use. Review of the Cleaning & Disinfection of Nursing Equipment policy, revised 6/1/18, showed "...III Procedures, nursing responsibility include cleaning and disinfecting equipment between patient uses: a. Hand hygiene performed b. Use of approved disinfection products per manufacturers'	F 880	nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before July 13, 2022 the facility shall complete the following actions: (1) The DON, SDC, IP or suitable designee will ensure the following: a. Educate all staff whose normal duties include entering resident rooms on ensure visitors to resident room are wearing masks and practicing social distancing b. All staff will receive education on keeping hands clean between tasks, contacts with potentially contaminated surfaces and between residents. c. All staff will receive education on ensuring Foley catheters do not touch the floor d. Educate all staff who perform lifts using the mechanical lifts on ensuring the lift is properly sanitized between residents e. Educate all staff whose job duties include perineal care procedures the importance of hand hygiene between changing gloves. 4. Monitoring Weekly for no less than 12 weeks, the	

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F 880	Continued From page 24 guidelines in between resident use...." 6. Review of the facility's line list of active COVID-19 cases provided by the facility on 6/6/22, showed 20 residents were confirmed positive for COVID-19 infection. 7. Review of the CDC's "COVID-19 Integrated County View" showed the level of community transmission was "High" at the time of the survey. Related to implementation of infection control practices: 1. Observation on 6/8/22 at 2:47 PM showed resident #42's catheter bag was lying on the ground under his/her wheelchair. The privacy bag was torn down the seam on the right side of the bag. Interview at that time with RN #2 confirmed the bag should not be on the ground due to potential infection control issues. RN #2 stated when the catheter bags get too full the privacy bags tear. Interview with the NHA, DON, and ADON, on 6/9/22 at 11:47 AM confirmed catheter bags should not be on the ground. 2. Observation on 6/7/22 at 2:13 PM showed CNA #2 perform perineal care for resident #48. The CNA removed her gloves and did not perform hand hygiene before donning a clean pair of gloves. The CNA then put clean briefs on the resident. Interview with the CNA confirmed she was supposed to perform hand hygiene after performing perineal care, and before donning clean gloves. Review of the Hand Washing policy, revised 10/1/17, showed "...1. Hand washing is performed: 4. If moving from a contaminated-body site to a clean-body site during resident care..."	F 880	DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of visitors to ensure correct donning of PPE mask when entering resident rooms (2) Observations of staff across all shifts to ensure staff are completing hand hygiene in accordance with CDC guidelines and professional standards when changing tasks, perineal care, changing gloves, passing medications, etc (3) Observations of staff utilizing lifts to ensure staff perform proper sanitation between residents (4) Observations of residents with foley catheters to ensure catheters are not on floor Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the	

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F 880	Continued From page 25	F 880	quality assurance performance improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director.	