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

PRINTED: 07/25/2005
FORM APPROVED
OMB NO. 0938-0391

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 07/11/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure laboratory tests were performed in accordance with physician's orders for one (#22) of ten sample residents who received the medication Coumadin (anticoagulant). The findings were: Review of a physician's order dated 3/16/05 showed resident #22 received Coumadin 2 milligrams (mg) everyday. Review of a physician's order dated 6/9/05 revealed a PT/INR [prothrombin time/international normalized ratio] laboratory test should be done in one week. Review of the laboratory reports in the medical record revealed no PT laboratory report since 6/9/05. Review of a physician's progress note dated 6/21/05 showed the INR level was "over due...will check today." On 6/21/05 the physician changed the Coumadin to 2 mg six days per week, and 4 mg once per week. That same day (6/21/05), the physician ordered a PT laboratory test in one week. Previous medical record review revealed no PT laboratory report since 6/9/05. During an interview on 7/11/05 at 11:35 PM, the director of nursing (DON) confirmed no PT laboratory report since 6/9/05 was in the chart. The DON stated she called the laboratory, but there was no record of a PT lab since 6/9/05. On 7/11/05 at 1:10 PM, the nurse at the physician's office stated the physician had a PT drawn on 6/21/05, but the	F 502	The facility will provide laboratory services to meet the needs of its residents Upon varification that resident # 22 did not have an ordered laboratory test drawn, a current PT/INR was drawn as per MD order.(July 11, 2005) The facility will ensure that all lab tests will be drawn as ordered for all residents. The facility will implement a lab tracking form. The lab tracking form will be audited weekly by Medical records to assure all labs have been drawn and results back to the facility in a timely manner. If a lab is not completed in a timely manner, Medical records will notify the DON for follow up to assure the lab work is completed. These tracking forms will be reviewed monthly by the QA committee. 8/31/05	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ron Nelson — TITLE: Administrator — (X6) DATE: 8-3-05

Lou Nelson 8/5/05

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.

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

PRINTED: 07/26/2005
FORM APPROVED
OMB NO. 0938-0391

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 07/11/2005

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 502	Continued From page 1 facility was supposed to have re-checked the PT one week after that date. The nurse stated there were no laboratory reports since 6/21/05.	F 502		