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| LIFE CARE CENTER OF CASPER | 4041 SOUTH POPLAR STREET CASPER, WY 82601 |

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| F 164 SS=D | 483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY<br><br>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.<br><br>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.<br><br>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.<br><br>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, facility staff failed to ensure privacy was maintained for one (#36) of 20 sample residents. The findings were:<br><br>Observation on 7/15/08 at 9:35 AM revealed | F 164 | F 164<br><br>The facility will ensure privacy is maintained for all residents. This will be accomplished by:<br><br>A) Staff members will knock on resident #36 bathroom door before entering and acknowledge the resident before entering the resident's bathroom.<br><br>B) Facility staff members will ensure the privacy of residents while in their bathroom by knocking and acknowledging the resident's presence.<br><br>C) The Staff Development Coordinator will provide education to facility staff regarding knocking and acknowledging resident's presence in their bathroom.<br><br>D) A quality improvement monitoring tool will be developed to track observations of staff members as they enter a resident's bathroom. The tracking will be performed by the director of nursing or | 8/22/08 |

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

Executive Director 8/10/08

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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designee. The results of the monitor will be reported quarterly to the facility's performance improvement committee by the director of nurses.

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| F 164 | Continued From page 1<br>resident #36 was seated on the toilet with the door closed. Continued observation revealed certified nurse aide (CNA) #1 opened the door and entered the bathroom twice without knocking or acknowledging the resident's presence. Interview with the CNA on 7/17/08 at 9:20 AM revealed she should have knocked prior to entering the resident's bathroom when the door was closed. | F 164 | F 226<br><br>The facility will ensure that allegations of abuse are reported to the state survey agency immediately as well as the Department of Family Services or law enforcement. This will be accomplished by: | 8/22/08 |
| F 226 SS=D | 483.13(c) STAFF TREATMENT OF RESIDENTS<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on policy review, staff interview, and review of facility abuse investigations, the facility failed to develop a policy to assure allegations of abuse were reported to the state survey agency and other officials in accordance with state law for three of three abuse investigations reviewed. The findings were:<br><br>1. Review of the facility's "Reporting Alleged Abuse" and "Abuse and/or Neglect Investigation" policies (undated) revealed the policies did not address notifying the state survey agency immediately of allegations of abuse. In addition, the policies did not address notifying the Department of Family Services (DFS) or law enforcement immediately of allegations in accordance with Wyoming law. According to the Rules and Regulations, Department of Family Services, Adult Protective Services, Chapter 2, Section 1: "...Any person or agency who knows or | F 226 | A & B) The facility will revise and update their abuse policy to include immediate notification of an allegation of abuse to the WY State Department of Health - survey agency, Department of Family Services or law enforcement.<br><br>C) The executive director and the local ombudsman will provide an inservice to the department managers on abuse and review the revised abuse policy.<br><br>D) A quality improvement monitoring tool will be developed to track the appropriate reporting of all allegations of abuse to the required agencies. The results of the tracking will be reported monthly to the facilities performance improvement committee by the executive director. | |

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| F 226 | Continued From page 2<br>has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected...shall report the information immediately to a law enforcement agency or the Department...pursuant to Wyo. Stat. 35-20-103..."<br><br>2. Review of facility abuse investigations revealed the following concerns:<br>a. An allegation of staff abuse by resident #96 dated 2/11/08 was not reported to DFS or law enforcement in accordance with Wyoming law.<br>b. An allegation of staff abuse by resident #61 dated 1/17/08 showed the allegation was not reported to the state survey agency until 1/20/08. In addition, the allegation was not reported to DFS or law enforcement in accordance with Wyoming law.<br>c. An allegation of staff verbal abuse by resident #102 dated 12/3/07 was not immediately reported to DFS or law enforcement in accordance with Wyoming law. However, the facility sent the results of their investigation to DFS on 12/7/07.<br><br>3. During an interview on 7/16/08 at 5:30 PM the administrator confirmed DFS or law enforcement was not immediately notified of allegations. | F 226 | F241<br><br>The facility will ensure that care provided to residents is given in such a manner and environment that promotes and maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This will be accomplished by:<br><br>A) Facility staff caring for resident #37 will communicate with the resident directly during resident cares in a manner that promotes dignity and respect and full recognition of the resident's individuality.<br><br>B) Facility staff will communicate directly with all residents during resident cares in a manner that promotes dignity and respect and full recognition of the resident's individuality.<br><br>C) Staff Development Coordinator or designee will provide education at the monthly all staff meeting and nurses meetings of the importance of promoting dignity and respect and full recognition of the resident's | 8/22/08 |
| F 241 SS=D | 483.15(a) DIGNITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, facility staff failed to preserve the dignity of one | F 241 | | |

F241

individuality while providing cares to residents. This education will be ongoing.

A quality improvement monitoring tool will be developed to track observations of staff members respectful and dignified conversations to residents while providing cares. The tracking will be performed by the director of nursing or designee. The results of the monitor will be reported quarterly to the facility's performance improvement committee by the director of nurses.

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| F 241 | Continued From page 3<br>non-sample (#37) resident during one random observation. The findings were:<br><br>Observation on 7/15/08 at 9:45 AM revealed certified nurse aide (CNA) #1 was assisting resident #37 to bed. During the observation, the resident asked where s/he was several times. Each time the CNA either hesitated and did not answer for a period of time, or she told the resident "you know where you are." In addition, the resident asked what time it was and the CNA stated, "I don't know; what time do you think it is?" During an interview with the CNA on 7/17/08 at 9:20 AM, she stated she knew the resident really well and always talked to him/her that way. Attempted interview with the resident on 7/15/08 at 2 PM revealed s/he was unable to respond to the question as to whether or not it was all right for the CNA to speak with him/her in such a manner. Based on the reasonable person scenario, the CNA's responses did not preserve the resident's dignity. | F 241 | F250<br><br>The facility will ensure that medically-related social services are provided to attain or maintain the highest practicable physical, mental and psychosocial well-being of residents. This will be accomplished by:<br><br>A) Counseling and psychosocial evaluations were requested of a licensed counselor for residents #66 and #86<br><br>B) Physician recommendations for counseling will be referred for supportive counseling. If the Geriatric Depression Scale indicates the need for further intervention to meet the psychosocial needs of the resident a referral will be made for supportive counseling.<br><br>C) A new social service director has been hired and sent to another Life Care facility for training in the social service functions.<br><br>A standardized interdisciplinary communication tool and procedure has been | 8/22/08 |
| F 250 SS=D | 483.15(g)(1) SOCIAL SERVICES<br><br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to provide counseling and a psychological evaluation to meet the psychosocial needs for 2 (#66, #86) of 20 sample residents who required such support. The findings were: | F 250 | | |

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| F 250 | Continued From page 4<br><br>According to the 3/26/08 significant change and the 6/17/08 quarterly Minimum Data Set (MDS) assessment, resident #86 exhibited multiple indicators of depression daily or almost daily. In both assessments, these indicators were documented as not easily altered, and the resident's mood status was described as having "deteriorated." Medical record review showed a psychiatric evaluation, completed on 10/11/07, with the recommendation "Consider arranging regular, supportive counseling..." in the nursing home. Review of the social services note, dated 3/18/08, showed another psychiatric evaluation was ordered and scheduled for 3/26/08. However, the resident refused to go and stated s/he "...wants to be left alone to die in peace." The following concerns were identified:<br>a. Review of the social services notes revealed none were related to counseling after 3/18/08.<br>b. Review of the Geriatric Depression Scale (GDS) test conducted on 6/13/08 showed the resident's score was 8 "which suggests depression and warrants a follow up interview." That interview was also done on 6/13/08 and the counselor documented the GDS score had "doubled in the last 90 days."<br>c. Interview on 7/17/08 with the social worker at 8:25 AM and the director of nursing at 11:25 AM confirmed regular counseling had not been attempted since March 2008.<br><br>2. Review of the physician's orders for resident #66 revealed s/he was prescribed Seroquel (antipsychotic) for aggressive and assaultive behaviors towards other residents and staff. A physician's order dated 6/26/08 documented the resident was to have a psychiatric evaluation due | F 250 | established by which<br>departments will be made aware of a physician's order or other needs of the resident that pertain to an individual department.<br><br>The facility staff will be educated on the importance of communicating orders to the appropriate departments and the new communication process as well as reapproach techniques to use when addressing resident needs.<br><br>D) A quality improvement monitoring tool will be developed to monitor the efficacy of the new communication tool and facility compliance with following doctor's orders. | |

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| F 250 | Continued From page 5<br>to increased aggressive behaviors and lack of effectiveness of Seroquel. Review of the medical record revealed no evidence the psychiatric evaluation was conducted. Interview with the assistant director of nursing on 7/17/08 at 9:08 AM confirmed the evaluation had not been done. She stated the order "slipped through the cracks" during a change in social workers. | F 250 | F253<br><br>The facility will ensure proper housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This will be accomplished by:<br><br>A) The wheelchair cushion on resident #24 was cleaned of all debris and spills.<br><br>Ceiling air vents located in the janitor's closet located near the unit #2 nurses' station, bathing room located near the unit #2 nurses' station, linen room located near the unit #1 nurses' station, soiled utility room located in the special care unit were cleaned.<br><br>B) All soiled wheelchair cushions will be inspected and cleaned by nursing staff.<br><br>All air vents will be checked by the housekeeping staff quarterly and cleaned.<br><br>C) Nursing staff will receive an inservice on cleaning of wheelchair cushions by the director of nursing or designee. | 8/22/08 |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING/MAINTENANCE<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain a clean and sanitary environment. The findings were:<br><br>1. Observation on 7/15/08 at 8 AM revealed the cushion in the wheelchair for resident #24 was visibly soiled with dried debris and spills. Observation again on 7/16/08 at 3 PM revealed the wheelchair cushion remained in the same soiled condition.<br><br>2. Observation beginning on 7/14/08 at 3:48 PM and periodically through 7/17/08 revealed the ceiling air vents in the following locations were coated with dirt and grime.<br>a. The janitor's closet located near the unit #2 nurses' station.<br>b. The bathing room located near the unit #2 nurses' station.<br>c. The linen room located near the unit #1 nurses' station.<br>d. The soiled utility room located in the | F 253 | | |

F253

Housekeeping staff will receive an inservice by the executive director and housekeeping supervisor of the importance of keeping the ceiling air vents clean.

D) A quality improvement monitoring tool will be developed to track the cleanliness of wheelchair cushions. The random monitoring will be conducted by the director of nursing or designee and reported quarterly to the facility's performance improvement committee by the director of nursing or designee.

A quality improvement monitoring tool will be developed to track the cleanliness of the ceiling air vents. The random monitoring will be conducted by the housekeeping supervisor or designee and reported quarterly to the facility's performance improvement committee.

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| F 253 | Continued From page 6<br>special care unit.<br>Interview with the facility maintenance manager confirmed the air vents were in need of cleaning. | F 253 | F272<br><br>The facility will ensure initial and periodic comprehensive, accurate, standardized reproducible assessment are conducted for each resident's functional capacity<br><br>This will be accomplished by:<br><br>A) Resident #86 has been assessed for bowel incontinence and the care plan updated as appropriate.<br><br>Resident #86 has had a comprehensive activity assessment and the care plan updated as appropriate.<br><br>Resident #80 has been assessed for bowel incontinence and the care plan updated as appropriate.<br><br>B) Ensure that all residents with bowel incontinence are reassessed with a comprehensive bowel assessment. Residents with bowel incontinence will be assessed periodically with quarterly assessment or upon significant change.<br><br>Ensure that all residents have comprehensive activity assessment annually and upon significant change. | 8/22/08 |
| F 272 SS=D | 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by: | F 272 | | |

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| F 272 | Continued From page 7<br>Based on medical record review and staff interview, the facility failed to provide comprehensive assessments in various areas for 2 (#80, #86) of 22 sample residents. The findings were:<br><br>1. Review of the admission Minimum Data Set (MDS) assessment dated 3/26/08 showed resident #86 required comprehensive assessments for total bowel incontinence and involvement in activities less than 1/3 of the time. Review of the medical record showed a comprehensive bowel assessment was lacking. Interview with registered nurse (RN) #1 on 7/17/08 at 10:05 AM confirmed a bowel assessment was not completed for the resident. The RN stated the facility was in the process of changing the assessment forms but had not gotten to the resident.<br>Review of the 6/13/08 note from a licensed professional counselor showed the resident stated s/he had lost interest and did not participate in planned activities. Review of activity notes dated 4/8/08 revealed the activity department was aware of the resident's loss of interest as they had documented the resident "continues to decline invitations to attend group programs." However, a comprehensive activity assessment had not been completed for the significant change assessment. On 7/17/08 at 11:35 AM, the director of nursing confirmed the facility had not completed a comprehensive activity assessment for the resident.<br><br>2. According to the 5/10/08 significant change MDS assessment, resident #80 was totally incontinent of bowel and required a comprehensive assessment of that area. Review of the information provided with the bowel | F 272 | C) MDS training will be provided to interdisciplinary team regarding comprehensive bowel assessments and comprehensive activity assessment. The education will be provided the MDS coordinators.<br><br>D) A quality improvement monitoring tool will be developed to ensure comprehensive bowel assessments and comprehensive activity assessments are completed as required. The results of the monitoring will be reported quarterly to the facility's performance improvement committee by the MDS nurses or designee. | |

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| F 272 | Continued From page 8<br>assessment showed the causative and contributing factors were not addressed. The assessment failed to include the information the resident was on continuous tube feedings, required extensive assistance from two staff members with dressing, ambulation, and toilet use, and had experienced a decline in cognitive function. On 7/17/08 at 10:05 AM RN #1 confirmed the lack of a comprehensive bowel assessment. | F 272 | F281<br><br>The facility will ensure that services provided or arranged will meet professional standards of quality. This will be accomplished by:<br><br>A) The Ambien for Resident #28 has been discontinued.<br><br>Resident #5's narcotics will be documented on both the MAR and the narcotic record.<br><br>Resident #80 received a dietary consult.<br><br>Resident #117 is no longer residing in the facility<br><br>B) All residents receiving psychotropic medications will be reviewed at the pharmacy review committee monthly and concerns will be communicated to the resident's attending physician.<br><br>Nurses will document on the MAR as well as the narcotic record for all dispensed narcotics.<br><br>An interdisciplinary communication procedure has been established by which resident's needs are | 8/22/08 |
| F 281 SS=E | 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, and medical record review, the facility failed to ensure professional standards were followed in regard to following physician/s orders for four (#5, #28, #80, #117) of 20 sample residents. The findings were:<br><br>1. Review of physician orders for resident #28 showed an order dated 5/28/08 for Zolpidem (Ambien- a sedative/hypnotic) 10 milligrams (mg) at bedtime as needed for sleep. Review of nursing notes showed that on 5/31/08 at 1 AM the nurse administered Ambien to the resident for inability to sleep. The next nursing note dated 5/31/08 at 2:30 PM documented the resident was "sleeping all day"and fell two times trying to go to the bathroom. A fax to the physician on 5/31/08 at 11:45 AM documented that at 11:15 AM the resident was found on the bathroom floor. There lacked evidence nursing staff communicated to the physician or pharmacist the apparent adverse | F 281 | | |

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| F 281 | Continued From page 9<br>effect of the Ambien. Although the medication administration record (MAR) showed no Ambien had been given since 5/31/08, there was still a current order for the Ambien to be given as needed. During an interview on 7/17/08 at 11:05 AM, the director of nursing (DON) stated the facility completed a fall assessment as part of quality improvement and identified the Ambien as a contributing factor to the fall. The DON stated the Ambien was "a big concern." However, the DON confirmed there was no documentation to show nursing staff communicated that to the physician or pharmacist and verified that there was still a valid order for the Ambien in this resident's chart.<br><br>REFERENCES: According to "Nursing Malpractice" by Ann Helm, 2003, Lippincott, Williams, & Wilkins, "...As a nurse, you must communicate changes in the patient's condition to the physician, even if you aren't sure how important those changes may be."<br><br>According to "Nursing & The Law" by Kammie Monarch, 2002, published by ANA, "...Nurses are in the best position to promptly detect changes in a patient's condition. Detection, however, is only the first step. Nurses are required to promptly communicate troublesome patient findings."<br><br>2. On 7/15/08 review of the July 2008 Medication Administration Record (MAR) showed resident #5 had received Lorazepam 5 times for severe tremors. However, interview with registered nurse (RN) #2 on 7/15/08 at 1:30 PM revealed that this was not the case. The RN obtained the narcotic record and showed documentation the resident had already received Lorazepam 13 times in July. The RN stated staff were forgetting to sign out on | F 281 | addressed in a standardized process.<br><br>Residents discharged will have a nurses note documenting disposition upon discharge.<br><br>C) Pharmacy review committee will meet monthly to review all psychotropic medications and communicate concerns with the resident's attending physician<br><br>Nurses will be inserviced by the director of nursing or designee of requirement for documenting on the medication administration record of all medications<br><br>A standardized interdisciplinary communication tool and procedure has been established by which departments will be made aware of a physician's order or other needs of the resident that pertain to an individual department.<br><br>The facility nursing staff will be educated on the importance of communicating orders to the appropriate departments and the new communication process ,Nursing staff will be | |

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| F 281 | Continued From page 10<br>the MAR and were only signing on the narcotic record; therefore, the medical record was not accurate. Review of "Nursing Interventions & Clinical Skills" 4th Edition, by Elkin, Perry, and Potter, 2007, revealed "The medical record is a legal document" whose purpose is to "provide information for communication, education, assessment, research, financial billing, auditing, and legal accountability" through accurate documentation.<br><br>3. Review of the "Physician Interim Orders" showed that on 6/25/08 the physician ordered a consult with a registered dietitian (RD) from another facility for resident #80. The order was noted on 6/26/08. However, as of 7/15/08 at 1:45 PM, the medical record lacked evidence the consult occurred. Interviews on 7/15/08 at 2:10 PM with the assistant director of nursing and RN #3 confirmed the consult had not been obtained. The RN stated she misread the order and thought the RD was supposed to call the physician. According to the July 2005 Wyoming Nursing Practice Act, nurses must practice under the direction of a physician<br><br>4. Review of the physician's orders showed resident #117 was discharged on 3/29/08. However, there were no further nursing notes after 3/26/08. Interview with the director of health information management on 7/17/08 at 9:40 AM confirmed lack of any additional nursing documentation. According to "Nursing Interventions & Clinical Skills" 4th Edition, by Elkin, Perry, and Potter, 2007, "The medical record is a legal document. Through accurate documentation the record serves as a description of exactly what happens to a client in the health care system." | F 281 | inserviced on proper documentation upon resident discharge from facility.<br><br>D) A quality monitoring tool will be developed to track psychotropic medication review by the pharmacy committee and will be reported quarterly to the facility's performance improvement committee by the director of nursing or designee.<br><br>A quality monitoring tool will be developed to track the documentation on the MARs of medications and will be reported quarterly to the facility's performance improvement committee by the director of nursing or designee.<br><br>A quality improvement monitoring tool has been developed to monitor the efficacy of the new communication tool and facility compliance with following doctor's orders. The results of the monitoring will be reported quarterly to the facility's performance improvement committee by the director of nursing or designee. | |

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A quality improvement monitoring tool will be developed to track nursing documentation upon discharge. The results of the monitor will be reported quarterly to the facility's performance improvement committee by the medical record director or designee

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| F 282 SS=D | 483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review and staff interview, the facility failed to provide care in accordance with the written plan of care for 1 (#29) of 20 open sample residents. The findings were:<br><br>Review of the current care plan dated 5/22/08 showed staff were supposed to assist resident #29 to the toilet before and after meals. In addition, the resident was supposed to be repositioned "frequently" and not allowed to remain in one position for "extended periods of time." Observation on 7/15/08 from 8:20 AM until 1:30 PM (5 hours 10 minutes) showed the resident was seated in a wheelchair and was not repositioned. In addition, staff did not make any attempt to assist the resident to the toilet after breakfast or before lunch. Finally at 1:30 PM the resident was assisted to the toilet. During an interview on 7/17/08 at 8:55 AM the director of nursing (DON) stated staff should follow the care plan and take the resident to the toilet before and after meals. The DON further stated it was her expectation that residents go "no longer than 2 hours" before being repositioned. | F 282 | F282<br><br>The facility will ensure that care plans are followed when providing care to residents. This will be accomplished by:<br><br>A) Restorative Nurse has reviewed Resident #29's care plan and made appropriate revisions.<br><br>B) Resident's bowel and bladder and repositioning care plans will be reviewed.<br><br>C) Staff development coordinator or designee will inservice nursing staff regarding<br><br>resident specific toileting and repositioning programs.<br><br>D) A quality monitoring tool will be developed to track nursing staff compliance with resident specific programs. This will be monitored by the staff development coordinator or designee and reported quarterly to the facility's performance improvement committee. | 8/22/08 |
| F 312 SS=D | 483.25(a)(3) ACTIVITIES OF DAILY LIVING<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to | F 312 | | |

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| F 312 | Continued From page 12<br>maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and medical record review, the facility failed to ensure staff provided adequate personal hygiene during three (#29, #36, #37) of 12 observations of perineal care. The findings were:<br><br>1. Review of the 5/30/08 quarterly Minimum Data Set (MDS) assessment for resident #36 revealed s/he was incontinent of bladder and bowel and required extensive assistance by staff for perineal care. Observation on 7/15/08 at 9:35 AM revealed the resident urinated into the toilet and had diarrhea. Observation of perineal care by certified nurse aide (CNA) #1 revealed she used the same area of the wipe six times to clean the anterior perineal area which was wet with urine. The CNA then discarded that wipe and used another wipe eight times to cleanse the posterior perineal area and buttocks, which was soiled with feces, without folding it to a clean area. During an interview with the CNA on 7/15/08 at 1:20 PM, she stated she used one wipe for the front and one wipe for the back when she performed perineal care. When the surveyor asked about folding the wipe to a clean area, the CNA stated she "didn't know anything about that."<br><br>2. Review of the 10/24/07 annual, and the 1/10/08, 3/10/08 and 6/17/08 quarterly MDS assessments for resident #37 revealed s/he was incontinent of bladder and bowel and required extensive staff assistance with personal hygiene. | F 312 | F 312<br><br>The facility will ensure that staff provides adequate personal hygiene to residents. This will be accomplished by:<br><br>A) Resident #36 will receive appropriate perineal care by all nursing staff providing care.<br><br>Resident # 37 will receive appropriate perineal care by all nursing staff providing care.<br><br>Resident #29 will receive appropriate perineal care by all nursing staff providing care.<br><br>B) All residents will receive appropriate perineal care by all nursing staff providing care.<br><br>C) The staff development coordinator will inservice all nursing staff on appropriate perineal care technique and staff competencies will be performed on nursing staff and re-educated provided as needed.<br><br>D) A quality monitoring tool will be developed to track perineal care observations | 8/22/08 |

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| F 312 | Continued From page 13<br>Observation on 7/15/08 at 9:45 AM revealed the resident's incontinence brief was wet with urine. Observation also revealed CNA #1 provided perineal care using the same area of the wipe five times while she cleansed the anterior perineal area. She then discarded that wipe and used another wipe six times to cleanse the posterior perineal area and buttocks. During an interview with the CNA on 7/15/08 at 1:20 PM, she stated she used one wipe for the front and one wipe for the back when she performed perineal care. When the surveyor asked about folding the wipe to a clean area, the CNA stated she "didn't know anything about that."<br><br>3. Review of the 5/21/08 annual MDS assessment for resident #29 revealed s/he was incontinent of urine and required extensive assistance of staff for perineal care. Observation on 7/15/08 at 1:30 PM revealed CNA #2 and CNA #3 assisted the resident to the toilet where s/he had a bowel movement. Further observation revealed CNA #2 used the same area of the wipe three times to cleanse the anterior perineal area. Observation also revealed the CNA wiped from the front to the back three times using the same area of a wipe which was soiled with feces after the second stroke. Observation revealed the CNA repeated the procedure exactly the same with another wipe. She then took a handful of paper towels from the dispenser and wiped the resident's buttocks with them. Interview with the CNA at the time revealed she always provided perineal care the same way. | F 312 | made by the staff development coordinator. The results of the monitor will be reported quarterly to the facility's performance improvement committee by the staff development coordinator. | |
| F 315 SS=D | 483.25(d) URINARY INCONTINENCE<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an | F 315 | | |

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| F 315 | Continued From page 14<br>indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record and policy review, and staff interview, the facility failed to assure care was provided in a manner to prevent urinary tract infections for 1 (#24) of 4 residents with an indwelling urinary catheter. The findings were:<br><br>Review of the admission diagnosis listing dated 6/4/08 showed resident #24 was admitted with a diagnosis of bacteremia [bacteria in the blood]. Observation on 7/15/08 at 8:05 AM revealed certified nurse aides (CNAs) #2 and #3 assisted the resident to the toilet using a mechanical lift [a sit to stand lift]. The collection bag for the catheter was hung on the upper bar of the lift [the bar the resident grabs]. When the resident was in a standing position, the bag was at the level of the resident's chest. The visible urine in the tubing was observed going back down the tube. During an interview on 7/16/08 at 3:15 PM the director of nursing, who was also the infection control coordinator, stated the catheter bag should be kept below the level of the bladder. Review of the facility's policy "Foley Catheter Drainage" (undated) showed "...keep the collecting bag below the level of the bladder." | F 315 | F315<br><br>The facility will ensure that care provided to residents with a catheter if given in such a manner that prevents urinary tract infections. This will be accomplished by:<br><br>A) Resident #24 will be transferred with the urine collection bag at a level below the resident's bladder .<br><br>B) All urine collection bags for residents will be kept at a level below the bladder.<br><br>C) The staff development coordinator or designee will inservice all nursing staff on appropriate transfer techniques with residents who have urine collection bags.<br><br>D) A quality monitoring tool will be developed to track observations made of resident's transfer who utilize urine collection bags. The results of the monitor will be reported quarterly to the facility's performance improvement committee on a quarterly basis by the staff development coordinator. | 8/22/08 |
| F 323 SS=E | 483.25(h) ACCIDENTS AND SUPERVISION | F 323 | | |

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| F 323 | Continued From page 15<br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure a safe environment for residents and staff by allowing a plugged in (hot) surge protector to sit directly on the floor in close proximity to standing water in one of three resident shower rooms. The findings were:<br><br>Observation on 7/15/08 at 9:13 AM and daily throughout the four day survey revealed a surge protector sitting on the floor in the resident shower room near nursing station unit #2. A curling iron, a hair blow drier and a radio were plugged into the surge protector on all four days. The three appliances were sitting on a vanity countertop next to the surge protector. Ten feet away from the surge protector was the resident shower stall. The stall was not constructed with a water retention lip on the floor and did not have a shower curtain. The concern was wet residents exiting the stall would be in close proximity to the electrical source on the floor. Interview with the assistant director of nursing on 7/15/08 at 10:00 AM revealed " the room was actively used by the facility to provide showers to the residents " . Interview with the facility maintenance manager on 7/17/08 at 10:48 AM confirmed there was a risk to both residents and staff. | F 323 | F323 The facility will ensure that the resident's environment remains as free of accidents hazards as possible. This will be accomplished by:<br><br>A) The surge protector has been removed from the shower room near nurses station on unit 2.<br><br>B) All surge protectors that would be in close proximity to a water source will be removed.<br><br>C) Staff will be provided an inservice by the maintenance director concerning the dangers of an electrical source being in close proximity to water.<br><br>D) A quality monitoring tool will be developed to ensure electrical sources are not in close proximity to a water source. The maintenance director will report the findings of the monitor quarterly to the performance improvement committee | 8/22/08 |
| F 371 | 483.35(i)(2) SANITARY CONDITIONS - FOOD | F 371 | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 371 SS=F | Continued From page 16<br>PREP & SERVICE<br><br>The facility must store, prepare, distribute, and serve food under sanitary conditions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and review of internal logs and manufacturer's instructions, the facility failed to prepare and serve food under sanitary conditions. Dishware and utensils were not consistently sanitized, frozen food was not thawed correctly, cold foods were not maintained at the correct temperatures, and infection control practices were not followed. The findings were:<br><br>1. During the tour of the kitchen on 7/14/08 at 3:50 PM, review of the "Dish Machine Temperature Log" showed the dish machine's temperatures during the final rinse ranged from 125 degrees Farenheit (F) to 171 degrees F between 7/8/08 and 7/14/08. During the tour, interview with employee #10, who was the person operating the machine, revealed reading the temperature gauge was the only method the facility utilized to monitor proper sanitization. The employee stated the machine's gauge had not been working correctly for the past week. The employee further stated he had been instructed to put a capful of bleach in the machine to ensure sanitization. He reported he ran several loads of dishes through the machine for each capful of bleach, but did not ever test the bleach concentration with a chemical test strip. In addition, the employee said ECOLAB staff had come that morning, but left before 11:30 AM, after | F 371 | F 371<br><br>The facility will ensure that food is prepared and served under sanitary conditions. This will be accomplished by:<br><br>A) The thermostat on the dish machine was replaced on 7/16/2008 by Ecolab.<br><br>B) Temperatures are taken via temperature test strips of the utensil surface and by monitoring the temperature reading on the gauge at the manifold and recorded in a log three times a day, prior to dishes being washed for each meal.<br><br>Employees will thaw potentially hazardous food by completely submerging the food under running water at a water temperature of 70 degrees F. or below and with sufficient water velocity to agitate and float off loose particles in a colander or other appropriate device to float off loose particles.<br><br>Potentially hazardous hot food shall be maintained at 135 degrees F or above and cold foods shall be | 8/22/08 |

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| F 371 | Continued From page 17<br>fixing the dish machine so the gauge showed a temperature above 180 degrees for the final rinse. However, the employee stated he recorded the temperature for the final rinse at 11:30 AM that morning, and it was 171 degrees F. At this point in the tour, the employee ran the machine several times. Observation revealed the initial rinse temperature was 128 degrees F. With each successive cycle the temperature increased, but the gauge never registered 180 degrees F. At 4:50 PM, the administrator instructed the dietary staff to use paper products for the meal. Observation in all dining areas at 5:15 PM that evening showed the meal was served on paper plates; however, non-disposable silverware, glasses, cups, and carafes continued to be used. The following problems were identified:<br>a. Review of the manufacturer's instructions posted on the dish machine showed the temperature on the gauge at the manifold during the rinse cycle was supposed to be 180 degrees F. Since temperatures were not being obtained at the dish level, no one knew whether or not the dishes were actually being sanitized. According to the "Food Code U.S. Public Health Service FDA, 2005, Chapter 4, Part 7, Subpart 4-703.11 "After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED IN: (B) Hot water mechanical operations by being cycled through EQUIPMENT that is set up as specified...and achieving a UTENSIL surface temperature of...160 degrees F as measured by an irreversible registering temperature indicator..."<br>b. The low temperature readings from the dish machine's gauge were not reported in a timely manner. During an interview on 7/15/08 at 8:45 AM, employee #10 stated he did not report the low temperatures until 7/13/08 or 7/14/08. On | F 371 | maintained at 41 degrees F or below. Tray line temperatures will be taken prior to the food being served and at 30-minute intervals while food is being served..<br><br>Employees will wash their hands after handling soiled equipment or utensils. Employees will cleanse the food thermometer between each food item.<br><br>C) The dietary policy for monitoring dish washing temperatures will be reviewed and revised to reflect daily testing of dish washer temperatures, logging the temperatures daily, actions to be taken when the temperatures dip below 180 degrees F. on the gauge at the manifold during the rinse cycle or if the temperature test strips do not achieve a utensil surface temperature of 160 degrees F.<br><br>All members of the dietary department will attend a Serve Safe class.<br><br>Dietary manager and dietary supervisor will update or obtain their Food Handler's | |

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| F 371 | Continued From page 18<br>7/15/08 at 8:50 AM the dietary manager (DM) confirmed she was unaware of the gauge's low temperature readings.<br>c. By not using all disposable culinary items, the facility failed to react appropriately to the possibility the dishes were not being properly sanitized. On 7/15/08 at 8:50 AM, the DM stated they should have used disposable products for all dishware and utensils, not just paper plates.<br><br>2. Observation with the DM on 7/15/08 at 8:48 AM showed unwrapped individual chicken patties thawing in a sink filled with water. During the observation, the DM stated the patties should have been left wrapped and placed in a colander to thaw under cold, running water.<br>According to the "Food Code U.S. Public Health Service FDA, 2005, Chapter 3, Part 5, Subpart 3-501.13 "POTENTIALLY HAZARDOUS FOOD...shall be thawed: (B) Completely submerged under running water" at a water temperature of 70 degrees F or below and "(2) with sufficient water velocity to agitate and float off loose particles in an overflow..."<br><br>3. Observation of food temperatures taken on the tray line before the evening meal on 7/15/08 revealed the following:<br>a. Ground chicken at 120 degrees F.<br>b. Diced ham and turkey at 42 degrees F.<br><br>c. Juice at 44 degrees F.<br>d. Shredded lettuce at 47 degrees F.<br>Review of the "Food Code U.S. Public Health Service FDA, 2005, Chapter 3, Part 5, Subpart 3-501.16 "...Hot and Cold Holding" revealed potentially hazardous hot foods shall be maintained at 135 degrees F or above and cold foods shall be maintained at 41 degrees F or | F 371 | Card at the next available class in Casper.<br><br>A policy will be developed regarding the testing of tray line food temperatures and proper procedures to use if the food or beverages are not at the appropriate temperature.<br><br>All dietary staff will receive education on proper infection control procedures to follow in the kitchen. This education will be given by the dietician and the facility's infection control nurse.<br><br>D) A quality improvement monitoring tool will be developed to check staff's compliance following the dish washer temperatures policy.<br><br>A quality improvement monitoring tool will be developed to track compliance with properly thawing potentially hazardous food.<br><br>A quality improvement monitoring tool will be developed to track food and beverage temperatures. | |

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| | 535049 | A. BUILDING _____ B. WING _____ | 07/17/2008 |

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| LIFE CARE CENTER OF CASPER | 4041 SOUTH POPLAR STREET CASPER, WY 82601 |

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| F 371 | Continued From page 19<br>below.<br><br>4. Observation in the kitchen on 7/15/08 during preparation for the evening meal revealed the following infection control issues:<br>a. At 4:27 PM cook #1 used her bare hand to pick up a control knob from the range that had fallen onto the floor. Without washing her hands, the cook then removed the pasta from the range and drained it. Following that, she finished taking and recording the temperatures of the french fries, corn, broccoli, and mashed potatoes.<br>b. At 4:45 PM the cook laid her temperature clipboard on top of the inside edges of two plate covers. The contaminated covers were later placed over plates served to two residents.<br>c. While taking and recording the temperatures of all the foods, the cook failed to cleanse the thermometer between each food item.<br>Review of the "Food Code U.S. Public Health Service FDA, 2005, Chapter 2, Part 3, Subpart 2-301.14 showed employees should wash their hands "(E) After handling soiled EQUIPMENT OR UTENSILS." Review of Chapter 4, Part 6, Subpart 4-602.11 revealed "(A) EQUIPMENT FOOD-CONTACT SURFACES AND UTENSILS shall be cleaned: (4) Before using or storing a FOOD TEMPERATURE MEASURING DEVICE; and (5) At any time during the operation when contamination may have occurred."<br>Interview with the registered dietitian on 7/16/08 at 11:30 AM confirmed the thermometer should have been cleansed between each food item. | F 371 | A quality monitoring tool will be developed to track observation of dietary staff members in the kitchen and their adherence of proper infection control practices.<br><br>The results of the monitors will be reported monthly at the facility's performance improvement meeting by the dietary manager. | |
| F 431 SS=D | 483.60(b), (d), (e) PHARMACY SERVICES<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all | F 431 | | |

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| F 431 | Continued From page 20<br>controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of stored medications and staff interview, the facility failed to remove expired mediations from two of three nursing medication storage areas. The findings were: | F 431 | F431<br><br>The facility will ensure that all expired medications are removed from the medication storage areas. This will be accomplished by:<br><br>A) Expired Ambien, Rocephin powder and 0.45% sodium chloride were removed from the medication storage areas.<br><br>B) All expired medications will be removed from the medication storage areas on an ongoing basis.<br><br>C) Director of Nursing will educate nurses on identification and removal of expired medications from the medication storage areas.<br><br>D) A quality improvement monitoring tool will be developed to monitor medication storage areas for expired drugs. The results will be reported quarterly to the facility's performance improvement committee by the director of nursing or designee. | 8/22/08 |

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| F 431 | Continued From page 21<br>1. On 7/16/08 at 3:55 PM observation and review of stored medications at nursing station #1 revealed the following expired medications were available for resident use:<br>a) Twenty-five 10 mg tablets of Ambien labeled with an expiration date of June 2008.<br>b) Two bottles of injectable 1 gram Rocephin powder with an expiration date of 4/1/08.<br><br>2. On 7/17/08 at 9:50 AM observation and review of stored medications at nursing station #2 revealed a one liter bag of intravenous solution of 0.45% sodium chloride with an expiration date of 7/1/08.<br><br>The DON was interviewed on 7/17/08 at 12:05 PM. She stated the facility's system for checking expired medications was currently being revised, because it was not effective. | F 431 | F441<br><br>The facility will ensure the ongoing infection control program is in place to prevent the transmission of potentially infectious agents in the facility. This will be accomplished by:<br><br>A) Red and yellow bag system has been set up for resident # 24.<br><br>Resident #36's nasal cannula has been replaced.<br><br>B) All residents with a positive MRSA test results will follow the red and yellow bag protocol until otherwise reviewed by the infection control and performance improvement committee.<br><br>A infection control tracking form will be placed in front of each month's MARS at each nurses station and will be maintained by nursing staff throughout the month.<br><br>All resident labs will be tracked via a lab tracking system to confirm receipt of results in a timely fashion.<br><br>All residents whose nasal cannula falls to the floor will be replaced immediately. | 8/22/08 |
| F 441 SS=D | 483.65(a) INFECTION CONTROL<br><br>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to ensure there was an ongoing infection control program in | F 441 | | |

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| F 441 | Continued From page 22<br>place to prevent the transmission of potentially infectious agents in the facility. The findings were:<br><br>1. Review of the medical record for resident #24 revealed a genital culture laboratory report dated 7/6/08 that was positive for MRSA [methicillin-resistant Staphylococcus aureus]. The nurse documented "MRSA precautions" on the laboratory and stated the physician had been notified, but did not want to treat the infection. Nursing notes dated 7/8/08 showed "precautions being taken." The following concerns were identified:<br>a. During an interview on 7/16/08 at 3:15 PM, when asked about MRSA infections in the facility, the DON who was also the infection control coordinator, was unable to identify the residents in the facility that had MRSA. The DON stated if a resident did have MRSA, an isolation stand was set-up in the resident's room. This set-up contained a red biohazard bag for trash and a yellow bag for linen. The DON also stated the same procedures were to be used for a colonized MRSA infection. Observation on 7/15/08 from 7:50 AM until 8:15 AM revealed CNAs #2 and #3 provided care for the resident #24. However, no red or yellow bags were observed in the resident's room, and the CNAs threw wipes and gloves in the resident's trash can.<br>b. During an interview on 7/16/08 at 3:15 PM, the DON stated infections were tracked on a form that was located in front of the medication administration record (MAR) book. However, review of the MAR book showed no infection log. Interview with RN #4 on 7/16/08 at 4 PM revealed there was supposed to be an infection log in the MAR, but "we haven't got to that yet." The nurse showed the surveyor a small piece of paper in the front the MAR that listed some antibiotic use, but | F 441 | C) Review and revise as necessary the current MRSA policy. Educate all staff on the MRSA policy and proper precautions to be taken by all care providers. Education will be given by the staff development coordinator.<br><br>A lab tracking has been developed to ascertain timely return of lab results.<br><br>The staff development coordinator will educate nursing staff on appropriate infection control interventions to be used with resident's nasal cannula.<br><br>D) A quality improvement monitoring tool will be developed to monitor compliance to the MRSA policy by all care providers, accuracy of the lab tracking log as well as promptness of returned labs, and nursing staff compliance with proper infection control interventions with nasal cannulas. The results of these monitors will be reported quarterly to the performance improvement committee by the infection control nurse or designee. | |

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| F 441 | Continued From page 23<br>the MRSA infection for this resident was not documented.<br>c. Review of a physician's communication fax showed an order for a culture of the percutaneous endoscopic gastrostomy (PEG) tube site dated 6/30/08 for this resident. The physician also ordered Clindamycin [antibiotic] 300 mg three times a day for 7 days. Nursing notes showed the culture was sent to the laboratory on 6/30/08. Further review of the medical record showed no laboratory results of the culture. During an interview on 7/17/08 at 10:04 AM the DON stated the facility had not received results yet, so she called the laboratory and they were going to fax the results. On 7/17/08 at 11:05 AM the DON provided the results of the culture, which showed the PEG tube site was positive for MRSA. The DON stated the laboratory had not communicated the results of the culture to the facility or the physician. Further review of the laboratory results showed the MRSA was resistant to Clindamycin. The DON stated the physician was contacted on 7/17/08 regarding the results, but the physician did not want to order another antibiotic.<br><br>2. Observation on 7/15/08 at 9:35 AM revealed resident #36 was assisted to the toilet by CNA #4. During the transfer from the wheelchair to the toilet seat, the resident's nasal cannula fell to the floor. The CNA picked up the cannula and placed it over the back of the wheelchair. Observation at 1:20 PM revealed the resident had the nasal cannula placed in his/her nose again. Interview with the CNA at the time of the observation revealed the cannula was replaced after lunch. When asked if the nasal cannula had been cleansed or changed after being on the floor, the CNA stated, "No." She further stated the nasal | F 441 | | |

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| F 441 | Continued From page 24<br>cannula should have been replaced after falling on the floor. | F 441 | F444 | 8/22/08 |
| F 444 SS=D | 483.65(b)(3) PREVENTING SPREAD OF INFECTION<br><br>~~The facility must require staff to wash their hands~~ after each direct resident contact for which handwashing is indicated by accepted professional practice.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure staff followed accepted handwashing practices during one of two meal observations. The findings were:<br><br>Observation of the evening meal on 7/14/08 at 5:45 PM revealed dietary aide #1 assisted two residents out of the dining room by pushing their wheelchairs while wearing gloves on her hands. Continued observation revealed the dietary aide then went into the kitchen area, picked up a clean meal tray and delivered it to a resident. Observation also revealed the dietary aide went to the cereal dispenser and filled a bowl with cereal for another resident. The dietary aide performed all the above noted tasks while wearing the same pair of gloves. Interview with the dietary manager on 7/17/08 at 10 AM revealed the dietary aide should have removed her gloves, washed her hands, and put on new gloves after assisting the two residents out of the dining room. | F 444 | The facility will ensure that staff follows accepted hand washing practices. This will be accomplished by:<br><br>A& B) Staff will follow accepted infection control practices at all times.<br><br>C) The staff development coordinator will educate all staff about appropriate infection control practices including proper handwashing and glove changing<br><br>D) The SDC will monitor staff's compliance to the handwashing and glove changing policy via random visual audits. The results of the audit will be reported quarterly to the facility performance improvement committee by the infection control nurse or designee. | |