STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535053	A. BUILDING _____ B. WING _____	01/27/2011

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PLATTE COUNTY MEMORIAL NURSING HOME	204 15TH STREET WHEATLAND, WY 82201

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document. DON - Director of Nursing RN - Registered Nurse MDS - Minimum Data Set CNA - Certified Nurse Aide NHA - Nursing Home Administrator	F 000	F 226 a. Corrective action taken: Unable to complete investigation at this time of injury to Resident #31. Seven months have passed and accuracy of investigation of injury at this time would be questionable.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policy and procedures, the facility failed to implement procedures related to reporting and investigation for 1 of 5 (#31) resident incidents reviewed. The findings were: Review of the medical record for resident #31 revealed the resident had suffered from an incident resulting in a fractured toe. Review of the physician progress note dated 7/14/10 showed the resident had a sore bruised right toe. The note further showed there was no story on what happened or when. The physician ordered an x-ray, and review of the x-ray report showed there was an acute fracture. Further review of the medical record failed to show any details as to what may have happened to the resident's toe. Interview with the DON on 1/26/11 at 1 PM revealed she did not know how the resident's toe	F 226	b. How others identified that could be affected and corrective action taken: All injuries of unknown origin will be investigated and reported. c. Measures taken to ensure deficient practice does not recur: Staff was reminded at Feb 15 All-Staff Meeting that any injury of unknown origin requires completion of an incident report. DON or designee will report all injuries of unknown origin to administrator and all such injuries will be investigated and reported to the appropriate parties. d. How corrective action will be monitored: One chart review will be conducted monthly to identify any injury not reported by incident report. Findings will be reported quarterly to the QA Committee.	03/01/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Faulke — TITLE: Administrator — (X6) DATE: 2/17/11

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.

RECEIVED
Wyoming Dept of Health

Accepted as is. Message left for NHA on 3/3/11. DOC - 3/15/11.

FEB 17 2011

Office of Healthcare Licensing and Surveys

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F 226	Continued From page 1 got broken, and there was no investigation completed to determine what had happened. She was not sure why the injury of unknown origin was not investigated. According to the facility's policy and procedure, injuries of unknown origin would be reported immediately to the administrator or designee and be investigated.	F 226	F 241 #1 and #4 a. Corrective action taken: DON and Administrator have discussed resident dignity with staff at February 15 All-Staff meeting. DON will direct staff to identify and clean and/or change residents as soon as possible after becoming soiled, and to immediately assist with cleaning mucous or saliva from nose or mouth of resident.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observations, staff, resident, and family interview, the facility failed to ensure the dignity was maintained for 6 of 9 (#2, #7, #14, #18, #21, #31) sample residents and 1 (#25) non-sample resident. The findings were: 1. Observation on 1/24/11 at 1:45 PM showed CNA #1 assisted resident #21 to bed. The resident was incontinent of urine. While performing perineal care and changing the resident's incontinence brief, the CNA pulled the resident's slacks down around the ankles. The slacks were left down around the resident's ankles until s/he was transferred from bed to a wheelchair for dinner at 5:31 PM. The resident was left in bed with his/her slacks around the ankles for three hours and forty six minutes. In addition, the slacks the resident was wearing were soiled. There was a white substance dried in two spots on the left leg of the slacks and another area with a dried white substance on the left	F 241	All incontinent and dependent residents will have slacks pulled up completely after peri-care. At night, slacks will be removed unless resident requests otherwise. If the resident's preference is outside of these guidelines the variation will be added to the Plan of Care. b. How others identified that could be affected and corrective action taken: All staff have been directed to monitor residents for undignified appearance, including soiled clothing, general hygiene including hands, face, mouth and hair, and to either correct immediately or report to appropriate staff for immediate correction. c. Measures taken to ensure deficient practice does not recur: Charge nurse will monitor resident appearance at meal time. Social Services will monitor and interview residents during the monthly rounds. Charge nurse and Social Services will communicate findings weekly. d. How corrective action will be monitored: Social Services will report to the QA Committee monthly for 3 months, then if compliance has improved, report quarterly.	

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F 241	Continued From page 2 buttock of the slacks. The CNA did not try to clean the substance off or dress the resident in clean slacks prior to assisting him/her to dinner in the main dining room where multiple other residents were dining. Observation on 1/26/11 at 11:05 AM showed the resident was again wearing soiled clothing. The resident had on a brown shirt with a dried substance all across the front of it and on the inner side of the left sleeve. The resident's brown slacks were also soiled on both thigh areas. Review of the MDS assessments showed the resident was not interviewable, however, interview with a family member on 1/26/11 at 7 PM revealed this resident was always an "immaculate dresser" and felt the soiled clothing would have embarrassed the resident. Observation on 1/25/11 showed this resident's breakfast meal was placed on the table at 8:15 AM. Continued observation showed the resident was not assisted into the dining room to eat until 9:10 AM, 55 minutes later. Even though the plate was covered with a lid, it sat on the table for 55 minutes and was not re-heated when the resident arrived for the meal. The meal consisted of a poached egg and toast. The resident was not interviewable; interview with the DON on 1/27/11 at 11:15 AM revealed the CNA should have ordered the resident a new, hot breakfast. 2. Observation on 1/24/11 at 12:30 PM showed CNA #2 was assisting residents #2 and #7 at the same time. The CNA held a drink up to resident #2's mouth and at the same time placed a bite of meat into the mouth of resident #7 with the fork turned upside down. Both residents were alert and oriented and interview with resident #2 on 1/27/11 at 10:37 AM and with resident #6 on 1/27/11 at 11:50 AM revealed they felt demeaned	F 241	F241 #2 and #5 a. Corrective action taken: All hot meals not served to residents (including but not limited to Resident #21) within ½ hour of the meal arrival to the dining room will be discarded and a fresh meal provided from the continental basket or ordered from the Kitchen. If a meal served within the appropriate time is cold, or not at the desired temperature, staff will offer to reheat the food to the resident's desired temperature or order a new tray. This will be offered to all residents, including but not limited to Residents #2 and #7. Meal servers will be reminded to review all meal cards, including allergy information, prior to serving residents, including but not limited to Resident #18. b. How others identified that could be affected and corrective action taken: Dining Room monitoring during meal pass will be conducted 4x/month. Residents will be asked during Resident Council if there are any dining room issues that need to be addressed. Results will be forwarded to Dietary Manager and Administrator. c. Measures taken to ensure deficient practice does not recur: Residents #2, #7, and #18 will be interviewed weekly for 1 month. If improvements noted, the monitoring will continue during the dining room observation using the audit tool.	

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F 241	Continued From page 3 by the way the meal was fed to them by the CNA. During interviews, both also said they were always left to last to eat because both were totally dependent upon staff for eating assistance and their meals were frequently cold. Both residents said the mashed potatoes served for lunch on 1/27/11 were cold. Observation of that meal revealed both residents told the staff the mashed potatoes were cold but staff did not offer to re-heat them. In addition, observation on 1/27/11 of the lunch meal showed dietary assistant #1 assisted these two residents with their meals left the table to assist others five different times. Interview with resident #7 at 11:50 AM on 1/27/11 revealed s/he was offended and irritated because just when s/he was about to take a bite of food, the dietary aide would stop and leave to attend to someone else. 3. During an interview with resident #14 on 1/26/11 at 3:25 PM, a staff member was passing out afternoon snacks. As the resident and surveyor were involved in conversation, the staff member came into the residents room without knocking or permission and asked the resident if s/he wanted a snack. The resident stated at that time, "No, we are in a meeting." S/he then told the surveyor that respect was an issue in the facility, and referred to this as an example. 4. Observation on 1/25/11 at 9:15 AM revealed after breakfast resident #31 was taken into the resident lounge and was waiting for an activity. From 9:20 AM until 9:30 AM the resident was noticed to have food/mucous hanging out of his/her mouth dripping onto the pillow that was propped under his/her arm. During this ten minutes the activity assistant was bringing other residents into the activity and failed to notice or	F 241	F241 #2 and #5, continued: Dietary Manager and PCMNH Managers are monitoring meal pass at least 4x/month using audit tool. A sample representative of residents are asked about the meal, including taste and temperature, during the meal monitor. Interruptions of meal and re-order fresh meals after 30 minutes will be added to the audit tool. Results are forwarded to Dietary Manager and Administrator. d. How corrective action will be monitored: Results will be reported to QA Committee monthly for 3 months. If improvement seen, then reported quarterly. F241 #3 and #6 a. Corrective action taken: Staff was reminded at all-staff meeting and through payroll communication letter to knock and/or ask permission before entering a resident's room and to always be conscious of the tone of voice used. Role playing education was done at the February 15 all-staff meeting. b. How others identified that could be affected and corrective action taken: This pertains to all staff entering any resident room unless emergent or urgent situation.	

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F 241	Continued From page 4 assist the resident (who was totally dependant) to wipe his/her mouth. At 9:30 AM a CNA who was passing by noticed and cleaned the resident's mouth and pillow. 5. Interview with resident #18 on 1/26/11 at 1 PM revealed s/he was upset because s/he was served oranges at the lunch meal. The resident was also upset on Monday 1/24/11 for being served orange juice. The resident stated s/he was allergic to oranges. Review of the medical record showed the resident had sensitivities to several things including oranges. In addition, the care plan dated 8/26/10 showed the resident had many food dislikes and should not be given these items including oranges. Review of the diet card showed the list of dislikes including oranges. Interview with cook #1 on 1/27/11 at 12:05 PM revealed sometimes things were missed, and resident #18 received an item that was listed as a dislike on the diet card. The cook stated kitchen staff and the CNAs that passed the trays should pay attention to the diet cards to ensure this doesn't happen. 6. Observation of the lunch meal on 1/27/11 at 12:20 PM showed dietary aide #1 placed the meal items for resident #25 on the table. The resident said "I don't want it, take it away." While the dietary aide started to pick the dishes up to place them back on the tray, CNA #3, who was standing on the opposite side of the table, said "Oh leave them there, [the resident]never knows what [s/he] wants." The CNA's statement was made in a tone of voice indicating irritation and loud enough for other residents, staff, and surveyors to hear. The dietary aide left the dishes on the table and the resident got up and left the dining room.	F 241	F241 #2 and #5, continued: c. Measures taken to ensure deficient practice does not recur: Compliance will be monitored by observation, resident interview during Social Service rounds, and residents will be asked at Resident Council meetings. d. How corrective action will be monitored: Results will be reported to QA Committee monthly.	03/15/11

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F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and review of facility documents, the facility failed to ensure 1 of 1 unresolved resident grievances was acted on. The findings were: Review of the July, August, September, October, November, and December 2010 resident council minutes revealed residents had requested new menus and were told their request would be honored. The following concerns were identified: a. Review of the January 2011 resident council minutes and confidential interview with 18 residents on 1/25/11 at 2 PM revealed the new menus were not yet developed. Review of the minutes from a special resident council meeting held on 1/14/11 at 3 PM (specifically related to the menu issue) revealed the dietary manager had been working on them but was "too busy" with other duties to finish developing them. Further review of these minutes showed residents would like seasonal fruits and vegetables as well as soft cheetos and soups. To this request, the dietary manager said she was unable to provide those items because she was restricted to the inventory from her current supplier. During the confidential meeting on 1/25/11 at 2 PM, the residents expressed they were frustrated at the delay in	F 244	F 244 a. Corrective action taken: Residents have been informed of the new menus and the progress. Comments from residents have been shared with the Dietary manager. b. How others identified that could be affected and corrective action taken: Residents will be informed of any progress made, of any changes or options the facility is considering, and they will be updated on the grievance resolution progress at the monthly resident council meetings. The President of Resident Council will be consulted/informed of any progress or changes as they occur. c. Measures taken to ensure deficient practice does not recur: Meetings between the Dietary Manager and the Residents to discuss menus, special meals and other dietary issues will be held monthly. Residents will be asked during Resident Council if there are any grievances that have not been addressed. d. How corrective action will be monitored: Dietary Manager and PCMNH Managers are monitoring meal pass at least 4x/month using audit tool. Residents are asked their likes/dislikes during the meetings and a sample representative of residents are asked about the meal during the meal monitor. Results are forwarded to Dietary Manager and Administrator. Minutes of Resident Council meetings will document all comments and concerns. Social Services will notify Administrator of any unresolved grievance.	03/15/11

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F 244	Continued From page 6 having new menus. They said the old menus had been the same for more than five years and they wanted something new and different. Review of the menu spreadsheet used during the survey week showed it was dated March 1995. b. Interview with the RD (Registered Dietitian) on 1/25/11 at 11:15 AM revealed she was responsible to develop the new menus, had completed them, and expected to start them on Sunday that week. She stated the residents had been requesting a new menu for some time, and it was not done sooner based on time constraints. The RD also mentioned the residents were not aware the menus were now completed, and she planned to surprise them on Sunday (1/30/11). c. Interview with the administrator on 1/25/11 at 4:10 PM revealed there was a significant concern expressed by the residents regarding development of new menus. The new menu project had been ongoing for several months and several options were considered; however, residents were not provided feedback from the facility related to the resolution of their concerns.	F 244		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		

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F 278	Continued From page 7 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure the accuracy of the MDS assessments for 2 of 9 (#6, #21) sample residents. The findings were: 1. Review of the 3/18/10 annual, the 6/17/10, 9/16/10, and 12/9/10 quarterly MDS assessments for resident #21 showed s/he had no upper extremity limitation in range of motion (ROM). However, observations from 1/24/11 through 1/27/11 showed the resident had a contraction of the left hand. During an interview with the MDS coordinator on 1/27/11 at 11:05 AM, she verified the MDS assessments were inaccurate in regard to the resident's left hand contracture and limited ROM in that hand. 2. Review of the 11/11/10 MDS assessment for resident #6 showed s/he was able to make self understood, and usually understood others. Further review of the MDS assessment showed	F 278	F 278 a. Corrective action taken: 1. O.T. evaluation and recommendation was completed for Resident #21 on February 9, 2011. Orthotic device has been ordered per OT recommendation. MDS has been corrected to reflect no functional use of the left hand. 2. A quarterly MDS was completed February 10, 2011 on Resident #6. The interview was attempted but answers were nonsensical. MDS corrected and submitted to CMS by MDS Coordinator. b. How others identified that could be affected and corrective action taken: DON and MDS Coordinator will identify any other residents that may have been affected by the discrepancy (residents that are understood but may not have been able to complete the interview) to verify MDS was completed correctly. c. Measures taken to ensure deficient practice does not recur: MDS Coordinator and the Care Plan Team will read and complete MDS according to written instructions including, but not limited to, interview portions of Sections D & F. At least three MDS audits for accuracy will be completed monthly by DON. d. How corrective action will be monitored: Results will be reported to the QA Committee monthly for 3 months, then quarterly.	03/15/11

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F 278	Continued From page 8 the resident was not interviewed for the mood section. According to the written instructions on the MDS assessment "Section D Mood" all residents should be attempted to be interviewed unless they are rarely or never understood. In addition, the same instructions applied to the interview for section F, "Preferences for Customary Routine and Activities." Although the resident was able to make him/herself understood, the interview with the resident was not conducted. Interview with the MDS coordinator on 1/27/11 at 11:05 AM revealed she had misunderstood the instructions, and the resident interviews should have been completed in these sections.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F 279 a. Corrective action taken: The care plan for Resident #21 has been updated to include measurable goals to turn and reposition, or offload. b. How others identified that could be affected and corrective action taken: All dependent residents' care plans will be reviewed by DON and MDS Coordinator for measurable turn/reposition goals and updated by February 28, 2011. c. Measures taken to ensure deficient practice does not recur: At least three care plans will be audited monthly to ensure risks are identified, with measurable goals, and timelines established to meet resident needs. d. How corrective action will be monitored: Results will be reported to the QA Committee monthly for 3 months, then quarterly.	02/28/11

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F 279	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure a care plan for the prevention of pressure ulcers was developed for 1 of 4 (#21) sample residents identified as high risk for pressure ulcers. The findings were:	F 279	F 312 a. Corrective action taken: Staff reminded to follow plan of care, sit with the resident #6 during meals and offer encouragement to eat.	
F 312 SS=D	Review of the "Braden Scale Skin Risk Assessment" completed on 11/5/10 and again on 12/3/10 for resident #21 showed s/he scored eleven and twelve respectively. Review of the directions for the Braden scale showed a score of 12 or lower indicated a "high to extreme risk" for the development of pressure ulcers. Interview with CNA #1 on 1/24/11 at 1:45 PM revealed this resident was a high risk for pressure ulcers. Review of the care plan, updated on 11/17/10 showed only "offload in bed or recliner." There were no specific goals, measurable objectives, or timetables established. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and medical record review, the facility failed to ensure adequate dining assistance was provided for 1 of 5 sample residents (#6) who required assistance with dining. The findings were:	F 312	b. How others identified that could be affected and corrective action taken: Residents will be observed for decreased appetite during meals and will be offered alternates. c. Measures taken to ensure deficient practice does not recur: Charge nurse will monitor at meal times. Dietary Manager and PCMNH Managers will also monitor meal pass at least 4x/month using audit tool. Residents needing assistance will be observed/monitored for proper and adequate assistance. Results are forwarded to Dietary Manager and Administrator. Staff will be inserviced on dignity, respect and abuse. d. How corrective action will be monitored: Results will be reported to QA Committee monthly for 3 months, then quarterly.	03/15/11

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	535053	A. BUILDING _____ B. WING _____	01/27/2011

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F 312	Continued From page 10 Review of the 7/7/10 care plan for resident #6 showed s/he had a history of significant weight loss, and also had vision problems requiring assistance at meals. According to the listed interventions, staff were to encourage the resident to eat and drink. During observations on 1/24/11 at 12:13 PM and 1/26/11 at 12:12 PM, the resident was served his/her meal and was provided set up help. During the two meals there were no staff at the resident's table, and the staff seated at an adjacent table did not provide any encouragement to the resident to eat or drink. During each of these meals, the resident ate independently for a while, and then would stop and begin to make negative statements. Both times when the resident began making negative statements, CNA #1 took the resident out of the dining room without any encouragement to eat or drink anymore.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure 1 of 4 (#21) sample residents at risk for pressure	F 314		

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F 314	Continued From page 11 ulcers received care and services to reduce the potential of developing pressure ulcers. The findings were: Medical record review for resident #21 showed the resident's most recent comprehensive MDS assessment was completed on 12/9/10. Review of that assessment along with comparison to the resident's most recent quarterly MDS assessment dated 9/16/10 revealed the resident continued to require extensive assistance with bed mobility and transferring. Further review showed the resident was totally dependent upon staff for toileting and was always incontinent of urine and frequently incontinent of bowel. Review of the "Braden Scale Skin Risk Assessment" completed on 11/5/10 and again on 12/3/10 showed the resident scored eleven and twelve respectively. Review of the directions for the Braden scale showed a score of 12 or lower indicated a "high to extreme risk" for the development of pressure ulcers. Interview with CNA #1 on 1/24/11 at 1:45 PM revealed this resident was a high risk for pressure ulcers. The following concerns were identified: a. Observation on 1/24/11 from 1:45 PM to 5:31 PM showed the resident was lying on his/her right side and no staff member entered the resident's room to reposition him/her. The resident remained lying on the right side during the entire three hour and forty six minute observation. b. Review of the care plan, updated on 11/17/10 showed only "offload in bed or recliner." There were no specific goals, measurable objectives, or timetables established for the prevention of pressure ulcers.	F 314	F 314 a. Corrective action taken: The care plan for Resident #21 has been updated to include measurable goals, turning and repositioning before and after meals, mid-afternoon and every 2 hours at night. b. How others identified that could be affected and corrective action taken: Any resident who is high to extreme risk for development of pressure ulcers will be repositioned/offloaded according to plan of care. If the resident is incontinent, the brief and pad will be checked at the same time. c. Measures taken to ensure deficient practice does not recur: Any resident who is high to extreme risk for development of pressure ulcers will have repositioning guidelines/timelines in the plan of care. Daily C.N.A. Report Sheet will include more details of reposition/offload goals from care plan. At least 5 residents/week will be audited by the Charge Nurse using audit tool to verify repositioning/offloading is done according to care plan. d. How corrective action will be monitored: DON will review completed audit tools and results will be reported to the QA Committee monthly for 3 months, then quarterly.	03/15/11
F 318 SS=G	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		

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F 318	Continued From page 12 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interviews, the facility failed to ensure 2 of 4 (#2, #21) sample residents in need of restorative services received those services as planned. In addition, the facility failed to assess 1 of 1 (#21) sample residents who experienced a decline in functional status to determine the cause, contributing factors and potential for rehabilitation. This lack of assessment and services likely contributed to the decline in functional status and resulted in an avoidable decline in the physical capabilities of resident #21. The findings were: 1. Review of the admission facesheet for resident #21 revealed s/he had diagnoses including osteoporosis. Observation of the resident on 1/24/11 at 12 noon showed the resident's left hand was contracted. The following concerns were identified: a. Review of the restorative care plan showed the resident required a hand roll to be placed in the left hand every morning due to a contracture. Review of the restorative care flowsheets showed the resident had the hand roll placed only 13 of 30 days in November 2010, 25 out of 31 days in December 2010, and in January 2011 only 18 of	F 318	F 318 a. Corrective action taken: 1. O.T. evaluation and recommendation was completed for Resident #21 on February 9, 2011. Orthotic device has been ordered per OT recommendation. Charge nurse is to verify device is in place, is clean, hand is clean, and nails are trimmed. Documentation addressing this verification will be on the Treatment Sheet. 2. ROM activities will be done in evening according to Resident #2's plan of care. b. How others identified that could be affected and corrective action taken: 1. Nurses will assess ROM for all extremities and joints during completion of monthly summary. MD will be notified and PT/OT eval requested on any resident at risk for contracture. 2. All residents will receive ROM according to Care Plan.	

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F 318	Continued From page 13 26 days. Interview with the restorative nurse aide on 1/26/11 at 11:40 AM revealed she placed the hand roll in the resident's hand each morning when she was on duty. She further stated, the resident sometimes removed the roll and when that happened nursing staff should replace the roll. During an interview with the restorative RN on 1/26/11 at 11:05 AM revealed the facility had only one restorative CNA but the floor CNAs were supposed to carry out the restorative exercises when the restorative nurse aide was absent from the facility. b. Observations from 12 noon to 5:31 PM on 1/24/11 and again on 1/25/11 from 1:30 PM to 5 PM showed the hand roll was not placed in the resident's hand. When the surveyor asked the restorative RN to assess the condition of the resident's left hand on 1/26/11 at 11:05 AM the roll was not present, and when opened by the RN the hand had a pungent odor (verified by the RN) and was red. In addition, the index finger nail was long and had a sharp edge that left an indentation in the palm of the hand. c. Observation with the restorative RN on 1/26/11 at 11:05 AM revealed the resident's left hand was not too stiff to open, the resident just resisted doing so. However, review of the entire medical record showed no evidence an assessment was performed to determine the potential rehabilitation for this resident's left hand. During an interview with the DON on 1/27/11 at 11:15 AM, she verified no physical therapy or occupational therapy evaluation was ordered or performed to assess the rehabilitation potential. 2. Review of the admission facesheet for resident #2 showed s/he had diagnoses including multiple sclerosis. Review of the 10/14/10 quarterly and the 1/13/11 annual MDS assessments showed	F 318	F318, continued: c. Measures taken to ensure deficient practice does not recur: 1. The Nurse Physical Assessment will be audited monthly for documentation, including ROM and contractures. Treatment sheet will be audited to ensure treatment is done on any resident with contracture or brace. Audit of Treatment Sheets will be completed on 100% of residents identified as having contractures or brace for 1 month. Audit of 50% for next 2 months, then 1/month. 2. CNA's will be reeducated on proper completion of ROM and documentation to be done if no Restorative Aide is on duty. Five restorative documentation sheets/week will be audited for one month. If improvement is noted, 5 audits/month will be completed d. How corrective action will be monitored: Results will be reported to the QA Committee monthly for 3 months, then quarterly. _____	03/15/11

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F 318	Continued From page 14 this resident had limited range of motion in both upper and lower extremities. Review of the restorative care plan showed s/he required restorative range of motion (ROM) exercises to all four extremities, ten repetitions daily. Review of the December 2010 restorative care flowsheet showed the resident did not receive restorative services on 7 days in December 2010 and 7 out of 26 days in January 2011. Additional review of these flowsheets showed their were no resident refusals on the dates no services were provided. Interview with the restorative RN on 1/26/11 at 11:05 AM revealed the facility had only one restorative CNA but the floor CNAs were supposed to carry out the restorative exercises when the restorative nurse aide was absent from the facility.	F 318		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the ceiling tiles and a drain in the kitchen were maintained in a working and sanitary manner. The findings were: 1. Observations on 1/24/11 at 9:35 AM and on 1/26/11 at 11:45 AM showed six ceiling tiles above food preparation areas in the kitchen that were damaged. The covering of the ceiling tiles were torn and these torn pieces were hanging down off the tiles. Interview on 1/27/11 at 9:05 AM	F 465		

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F 465	Continued From page 15 with the hospital maintenance director who was in charge of the maintenance of the kitchen revealed he was aware of the damaged tiles. The maintenance director revealed the damage occurred 3 or 4 months ago, when a dust barrier was removed and the tape tore the cellulose covering on the tiles. He stated they had replacement tiles but had not had time to replace them yet. 2. Observations on 1/24/11 at 9:35 AM and on 1/26/11 at 11:45 AM showed a two compartment preparation sink with one side of the sink labeled out of service. The drain in the bottom of the sink was covered with red tape, and below the sink, the floor drain contained dark colored standing water. Interview with the Registered Dietician on 1/27/11 at 8:50 AM revealed the area was still used to prepare food, and the drain had not been working for about a year or more. She had placed a work order to have the drain repaired and it was still pending. Interview with the hospital maintenance director on 1/27/10 at 9:05 AM revealed the last work order he received for the drain was September 13, 2010. He stated it was not repaired yet due to a shortage of maintenance staff.	F 465	F 465 a. Corrective action taken: 1. Ceiling tiles have been replaced with vinyl covered fire-rated ceiling tiles 2. Kitchen floor drain—Concrete flooring was removed and the trap under the floor sink has been replaced. b. How others identified that could be affected and corrective action taken: 1. Any other ceiling tiles that become damaged in the future will be replaced. 2. Any future problems with the drain will be repaired in a timely manner. c. Measures taken to ensure deficient practice does not recur: PCMH (Platte County Memorial Hospital) Director of Plant Operations will monitor and report to PCMNH Maintenance Supervisor. d. How corrective action will be monitored: Results will be reported to the QA Committee quarterly.	02/16/11