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

RECEIVED WY Dept of Health FEB 02 2012 Healthcare Licensing

PRINTED: 01/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535053	A. BUILDING B. WING	01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY MEMORIAL NURSING HOME	204 16TH STREET WHEATLAND, WY 82201

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADL-Activities of Daily Living CAA-Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set NSA-Nutrition Support Assistant RN-Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied.	
F 170 SS=E	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and interview with post office personnel, the facility failed to deliver mail to residents on Saturdays. The findings were: During an interview on 1/4/12 at 1 PM two sample residents (#8, #32) and twelve non-sample residents (#1, #3, #5, #7, #9, #11, #17, #18, #24, #26, #27, #30) stated the facility failed to deliver mail to residents on Saturdays. Interview with post office personal on 1/23/12 at 2:35 PM revealed the post office delivered mail on Saturdays to the community. The residents stated	F 170	F170 – The facility has put up a mail box and contacted the Post Office to start receiving mail at the facility on Saturdays. Activities will deliver mail to the residents on Saturday. Administrator or designee will monitor weekly x 4 weeks and monthly thereafter. Results will be taken to QA&A for further review and analysis.	01/14/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 1/31/12

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.

This POC accepted without change on 2/7/12 with a discussion of 2/7/12 between Tony Malfa and Christine Kinney, DON
2/7/12

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F 170	Continued From page 1 they wanted to receive their mail on Saturdays like other residents of the community. Interview with administrative assistant #1 on 1/4/12 at 3:10 PM revealed she picked up the mail each day on Monday through Friday, but not on the weekends. She confirmed the Saturday mail was delivered to residents with the Monday mail.	F 170		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and review of the facility activity calendars, the facility failed to offer adequate meaningful activities to residents on Sundays. The findings were: Review of the September, October, November, December 2011, and January 2012 activity calendars showed, with the exception of December 11th of 2011, church was the only activity provided on Sundays. During an interview on 1/4/12 at 1 PM with two sample residents (#8, #32) and twelve non-sample residents (#1, #3, #5, #7, #9, #11, #17, #18, #24, #26, #27, #30), the residents revealed the facility failed to offer adequate activities to residents on Sundays. The residents stated that church services were the only activities offered on Sundays, and additional activities were preferred. They further stated that residents who chose not to attend church	F 248	F248 – The facility does and will offer activities on Sunday. The facility will be offering a morning activity and church service in the afternoon. Attendance will be taken at Sunday morning activities and facility will follow up with residents on Monday to ensure that their needs are being met. At the monthly Resident Council meetings, the residents will be asked if they are satisfied with the activities offered and suggestions and ideas will be discussed. All results will be taken to QA&A for further review and analysis.	02/05/12

2/17/12

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F 248	Continued From page 2 services did not have any alternative on Sundays. Interview with the activity director on 1/6/12 at 9 AM revealed the facility failed to routinely offer activities other than church on Sundays. She also confirmed the resident council had requested additional Sunday activities during the facility's mock survey between 10/17/11 and 10/20/11.	F 248	F274 – Significant change was completed on Resident #15 on January 6th, 2012 and the care plan updated to reflect these changes. A significant change for resident #19 was not completed due to	01/26/12
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure significant change MDS assessments were completed for 2 of 4 sample residents (#15, #19) who required that type of assessment. The findings were: Review of the 8/16/11 admission MDS assessment for resident #15 showed s/he had the ability to eat independently, required	F 274	hospitalization and subsequent death. The MDS coordinator will identify residents who may require a significant change in status MDS during medical clinics and/or by interview with direct care staff. Daily nursing huddle will incorporate discussion of potential changes in condition and these residents will be monitored by the MDS coordinator for the possibility of significant change in condition. Information will be brought to the weekly care plan team meetings to review for potential significant changes. DON will audit at risk residents (identified by medical clinic, staff interview and daily nursing huddle) for necessity of significant change and accurate completion of MDS. Audits will be done, using audit tool on a minimum of one resident weekly x 1 month if no recurrence of deficient practice	

2/1/12

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F 274	Continued From page 3 supervision with bed mobility and transfers, and walked in his/her room with limited assistance. This review also showed the resident's balance during transitions and walking was assessed as "not steady but able to stabilize without human assistance." Review of the resident's 11/09/11 quarterly MDS assessment showed the following changes had occurred: There was evidence of acute changes in mental status. The resident required extensive assistance with bed mobility, transfers, walking in his/her room and eating. This review also showed the resident's balance during transitions and walking was assessed as "not steady, only able to stabilized with human assistance." According to the care plan an approach dated 12/12/11 directed staff to provide total ADL care and encourage participation with task segmentation. Review of the CNA ADL tracking forms for September, October, November, and December 2011 showed the resident began to require extensive assistance with ADLs on 11/1/11 and this level of dependence was unchanged thereafter. On 1/3/12 from 10 to 10:30 AM CNAs #2 and #4 were observed with the resident and provided extensive assistance with transfer, bathing, and dressing. Interview with the CNAs at that time verified the information on the CNA ADL tracking forms regarding the resident's need for ADL assistance. During an interview on 1/4/12 at 4:20 PM, the MDS coordinator stated that even though the resident's mobility was affected after s/he fractured his/her hip on 12/1/11, the 8/17/11 MDS assessment was not an accurate assessment of the resident's status in August 2011. She further stated she should have completed a significant change assessment or corrected assessment instead of the 11/9/11 quarterly, because the	F 274	will review 1 resident monthly x 3 months to ensure compliance. DON will report to QA monthly.	

2/7/12

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F 274	Continued From page 4 CAAs were based on the 8/17/11 assessment and did not contain information regarding the resident's current needs and strengths. According to the care conference documentation a 6/30/11 significant change MDS assessment was completed for resident #19 due to a decline in communication, cognition and ADLs. Review of the 6/30/11 significant change and 9/28/11 quarterly MDS assessments showed the resident functioned independently in the areas of bed mobility, transfers, and walking with a walker. This review showed the resident was unsteady when moving from a seated to standing position, but his/her balance was steady during transitions and walking. This review also showed staff's assessment of the resident's mood was no "symptoms" present. Review of the 12/28/11 quarterly assessment showed the resident required limited and extensive assistance with ADLs, balance during transition and walking was unsteady, and three symptoms related to mood were assessed. According to the CNA ADL tracking form the resident required extensive and limited assistance with all ADLs in November, December, and January 2011. During an interview on 1/6/12 at 7:45 AM CNA #4 stated the resident had required extensive assistance with ADLs for over a month, mostly due to cognitive decline. During an interview on 1/5/11 at 4:40 PM, the MDS coordinator stated the 12/28/11 quarterly MDS assessment should have been a significant change assessment due to the changes in the resident's condition from September to December 2011.	F 274		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

1/27/12

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F 312	Continued From page 6 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, medical record review, and staff and resident interview, the facility failed to ensure ADLs were completed during random observations for sample resident #32 and non-sample resident #6 who required assistance with ADLs. The findings were: 1. Review of the 10/23/11 care plan for ADLs showed non-sample resident #6 was unmotivated to perform self care, and that staff were to encourage the resident to be independent with ADLs and provide assistance when needed. Observation on 1/3/12 at 7:30 AM showed the resident was wheeled to his/her room after the breakfast meal. The resident was noted to have dark, thick hair growth on his/her neck below the chin. Interview with the resident on 1/5/12 at 8:43 AM revealed s/he wished staff would shave the beard growth in a more timely manner. She revealed staff were supposed to shave the hair growth when s/he was given a shower twice a week. The resident stated they often times "passed the buck" and did not shave the residents chin/neck. The resident further stated his/her shower days were Mondays and Thursdays, and s/he was unable to shave without assistance. The resident revealed s/he received a shower on Monday 1/2/12, and was not shaved. When asked the last time s/he was shaved, the	F 312	F312- Resident #32 – will use Liko "Comfort Sling" as well as custom wrist support strap to support her affected side during transfers. Resident #32's primary staff has been educated in the use of the comfort sling/support strap combination for transfers as of 1/27/12. All hemiplegic residents and residents that require limb support, which require a sit to stand lift will use the Comfort Sling and wrist strap to support the affected side. These residents will be identified on the plan of care and the direct care staff daily care sheet. Staff will be educated on use of comfort sling/wrist support for residents who need limb support. Charge nurses will have authority to implement use of this combination as necessary and update in the plan of care. All direct staff will be trained in use by 2/1/12. Visual audits of hemiplegic residents using the sit to stand lift will be done once weekly x 1 month if no recurrence of the deficient practice will monitor once monthly x 3 months to ensure continued compliance. DON will report to QA monthly	02/01/12

2/1/12

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F 312	Continued From page 6 resident responded it had been more than a week. Observation on 1/6/12, a Friday, at 9:06 AM showed the resident remained unshaved. Interview at that time with the resident stated the shower was given the previous evening; however, the aides did not offer to shave him/her. Interview with CNA #3 on 1/6/12 at 9 AM revealed men and women who needed assistance with shaving were provided the care when showed or bathed. She further verified it was the responsibility of all CNAs to notice if a resident was not well groomed and provide or assist with the necessary grooming. 2. Review of the medical record for resident #32 showed s/he had diagnoses which included old cerebral vascular accident with right sided hemiplegia (immobility). Review of the resident's 9/15/11 annual MDS assessment showed s/he required extensive assistance of one staff member for transfers, and had impaired range of motion to both the upper and lower body on one side. Review of the care plans for the resident showed staff was required to use the sit/stand lift for transfers, and support and protect the resident's right arm. The following concerns were noted: a. On 1/3/12 at 8:40 AM, CNAs #1 and #2 were observed using a mechanical lift to provide the toileting assistance the resident needed. Continued observation revealed the aides did not support the resident's right arm at any time during the transfers to and from the bathroom or while the resident was positioned on the bathroom commode. b. Interview with CNA #2 on 1/5/12 at 4:45 PM revealed the CNAs knew the resident's care plan directed them to support the resident's arm	F 312	Resident #6 has purchased electric razors to assist in self care of facial hair removal. Resident #6 will be encouraged to shave herself. If Resident #6 does not wish to perform her own facial hygiene, staff will offer to shave her, if consent obtained from resident, staff will shave her at bath/shower times at least 2 times weekly- more often if indicated due to hair growth. All residents male or female (as indicated) will be offered assistance with facial hair removal at bath times and/or as needed. If male (or female) residents require daily shave this will continue to be done daily at AM/ HS cares. All direct care staff has been informed of this requirement as of 1/25/12. Visual audits of resident's facial hair will be conducted by DON or designee weekly x 1 month. If no recurrence of deficient practice will monitor once monthly x 3 months to ensure compliance. DON will report to QA monthly	02/01/12

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F 312	Continued From page 7 during transfer, but they failed to do it on the 1/3/12 observation due to nervousness.	F 312		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the ice machine operated in a safe and sanitary manner. The findings were: Observation on 1/3/12 at 10:56 AM revealed the drain line hose from the ice machine located near the DON's office was resting on the floor without a hose connection backflow preventer to prevent the backflow of liquid materials and potential contaminants into the machine. Random observations during survey from 1/2/12- 1/6/12 showed ice from this machine was used in resident beverages. Interview with the maintenance supervisor at that time revealed he did not realize the attached drain line hose was not designed to prevent backflow contamination. According to Food Code 2009, U.S. Public Health Service, 5-203.14; "A plumbing system shall be installed to preclude backflow of a solid, liquid, or gas contaminate into the water supply system at	F 371	F371 – The facility has installed an air gap on the ice machine to prevent backflow contamination. An audit will be conducted of all food areas to ensure proper back flow prevention is in place. Maintenance will monitor monthly or when any repairs are needed in those areas. All results will be taken to QA&A for further review and analysis.	01/25/12

2/7/12

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F 371	Continued From page 8 each point of use at the food establishment by... (A) Providing an air gap as specified under 5-202.13 or (B) Installing an approved backflow prevention device as specified under 5-202.14." According to Food Code 2009, U.S. Public Health Service, 5-202.14: "A backflow or backsiphonage prevention device installed on a water supply system shall meet American Society of Sanitary Engineering (A.S.S.E) standards for construction, installation, maintenance, inspection, and testing for that specific application and type of device."	F 371		
F 517 SS=F	483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. This REQUIREMENT is not met as evidenced by: Based on review of policies and procedures and staff interview, the facility failed to ensure a plan for evacuation was developed and implemented in their disaster preparedness program. The findings were: A review of the facility's disaster plan and emergency policies and procedures revealed issues regarding an evacuation plan had not been addressed. Interview with the maintenance supervisor and administrator on 1/5/12 at 4 PM confirmed the lack of an evacuation plan and expressed the needed for this to be added to their overall disaster preparedness program.	F 517	F517 - The facility will ensure that there is an appropriate policy and procedure for evacuation of the facility. The Administrator or designee will update the evacuation policy and procedure. Staff will be educated on 2/7/12 about the evacuation procedure. The Safety Committee will review the evacuation procedure quarterly x 1 year and annually thereafter. Results will be reported to QA&A for further review and analysis.	02/07/12

2/7/12