Platte C NHA 1/21/14 0910 PoC accepted 1/21/14 Linda Brown RN

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

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
	535063	A. BUILDING _____ B. WING _____	01/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY MEMORIAL NURSING HOME	204 15TH STREET WHEATLAND, WY 82201

RECEIVED
WY Dept of Health
FEB 14 2014
Health Facility Licensing

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: DON-Director of Nursing MAR-Medication Administration Record PRN-As Needed 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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to maintain accurate medication administration records in accordance with professional standards for 2 of 9 sample residents (#2, #10). The findings were: 1. Medical record review showed resident #2 was admitted to the facility on 5/29/13 with diagnoses that included cerebrovascular accident. Review of a Psychotropic Drug Review Form dated 8/14/13 showed a notation from the pharmacist, "On Haldol 5 mg IM [intramuscularly] PRN - has not used.. " with the signed physician response showing, "DC [discontinue] Haldol." The form was signed as having been reviewed by nursing in the course of a 24-hour chart check. The following concerns were identified: a. Review of the December 2013 MAR showed an order for Haldol (an anti-psychotic) 5	F 281		

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

Administrator 2/14/14

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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F 281	Continued From page 1 mg IM every 12 hours PRN for severe agitation, despite the discontinuation of the medication in August 2013. b. Review of the Physician's Orders recapitulation for January 2014, signed as reviewed by nursing on 12/30/13, showed an order dated 7/16/13 for Haldol 5 mg IM every 12 hours PRN [as needed] for severe agitation, despite the order to discontinue the medication in August 2013. 2. Review of the medical record for resident #10 showed s/he most recently re-admitted to the facility on 11/2/13 with diagnoses that included cancer, arthritis, and Alzheimer's disease. On 10/26/13, lidocaine (generic for Lidoderm) 5% patches (a topical/local anesthetic for pain relief) were prescribed to be administered once daily for 30 days. The order did not specify where on the body the patch was to be applied. Review of the October 2013 MAR revealed lidocaine 5% patches were administered beginning on 10/27/13. Review of re-admission orders dated 11/2/13 showed an order for "Lidoderm 5% patch to lower back on AM off PM 3 patches to rib fx [fracture]." Long Term Care Physicians Orders dated 11/6/13 showed "Clarify - Lidoderm patches up to 3 on side over R [right] rib fx [fracture] - 1 on lower back. Use PRN pain - please do regular for next week then PRN." This order was signed as noted by nursing on 11/6/13, and additionally signed 11/7/13 as having been reviewed by another nurse in the course of a 24-hour chart check. The following concerns were identified: a. Review of the resident's November 2013 MAR showed 3 lidocaine 5% patches administered daily to the resident's right side from 11/2/13 through 11/30/13 rather than regularly for a week and then as needed. Similarly, one	F 281	F281 - Resident #2's order to discontinue Haldol written on 8/14/13 was noted on 1/23/14. The MAR and the monthly order reconciliation were updated at that time. Resident #10's Lidoderm patches were discontinued on 1/22/14, the order was noted appropriately on the MAR and monthly order reconciliation. All active chart physician orders written over the last quarter to current will be reviewed by the DON or designee to ensure all orders have been noted and accurately transcribed by 2/28/14. New orders will be reviewed by DON or designee weekly x 12 weeks then monthly ongoing to ensure accuracy of transcription. Nursing staff will be re-educated on noting orders, clarifying orders, and procedure of PCMNH review with 2nd nurse at the 2/11/14 nursing department meeting. Nursing staff will be re-educated on the	3/10/14

FEB-14-2014 16:23 From: To:13077777127 Page:12/18

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F 281	Continued From page 2 lidocaine 5% patch was administered topically to the resident's lower back daily from 11/2/13 through 11/30/13 instead of regularly for one week and then as needed. b. Review of the Physician's Orders recapitulation for December 2013, signed as reviewed by nursing on 11/26/13, showed an order, dated 11/6/13, for "lidocaine 5% (Lidoderm) 3 patches to rib fx [fracture] R [right] side." The recapitulation had not been updated to reflect the complete contents of the 11/6/13 physician's order. Review of the December 2013 MAR showed 3 lidocaine 5% patches were applied daily to the resident's right side throughout the month, instead of as needed for pain as ordered. Additionally, the facility failed to update the order as required for a lidocaine 5% patch to be applied to the lower back as needed. c. Review of the Physician's Orders recapitulation for January 2014, signed as reviewed by nursing on 12/30/13, showed it continued to show the incorrect lidocaine 5% patch order, and review of the January 2014 MAR showed 3 lidocaine 5% patches continued to be applied daily. 3. Interview with the DON on 1/24/14 at 10:55 AM confirmed these orders had not been properly transcribed onto the MAR, and further revealed the facility did "have a problem with orders being taken off correctly." 4. According to the Wyoming Nursing Practice Act (NPA) of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-3, nurses "must practice within the legal boundaries for nursing through the scope of practice authorized in the NPA and the Board Rules."	F 281	24 hour check procedure process at the 2/11/14 nursing department meeting. Order accuracy will be reviewed in QA monthly x 12 months to ensure the process is sustained.	

fb 2/21/14

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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 activity documentation review and staff interview, the facility failed to promote safe food handling practices for 1 of 1 "carry-in" events reviewed where food was brought from outside of the facility and shared with the residents. The findings were: Interview with the activities director on 1/24/14 at 10 AM revealed the facility held periodic "carry-in" meals for facility residents, during which family and friends may bring desserts or covered dishes from home to share with the residents. The activities director revealed the facility did not have a heating system for hot dishes, and did not temperature test any of the food provided by friends and family to ensure food safety. Review of facility activity documentation for December 2013 revealed 35 residents attended the most recent "Family Night" which included a "carry-in," and was held on 12/3/13. Interview with the activities director on 1/24/14 at 12:20 PM revealed the facility census on 12/3/13 was 37.	F 371	F371- The facility will ensure that safe food handling practices are promoted for all events when the food is brought in from outside the facility. The Administrator or designee will establish policies and procedures to ensure food safety. Staff will be educated on proper food handling procedures on 2/18/14. New employees will be educated during new employee orientation. Visitors will receive a food safety brochure before every event. Administrator or designee will log all food contributions and food temperatures. Administrator or designee will track each residents food selection. Food temperatures will be monitored by Activities or designee and will be maintained at proper serving temperatures. Results will be taken to QA&A for further review and analysis after each facility event for one year.	3/10/14

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F 371	Continued From page 4 Interview with the administrator and DON on 1/24/14 at 11:40 AM confirmed the facility failed to have a system in place to help visitors understand and use safe food practices.	F 371		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to maintain accurate medication administration records for 2 of 9 sample residents (#2, #10). The findings were. 1. Review of the medical record for resident #2 showed s/he was admitted to the facility on 5/29/13 with diagnoses that included cerebrovascular accident. Review of a Psychotropic Drug Review Form dated 8/14/13 showed a notation from the pharmacist, "On Haldol 5 mg IM PRN - has not used..." with the signed physician response showing, "DC [discontinue] Haldol " The form was signed as	F 514	F514- Resident #2's order to discontinue Haldol written on 8/14/13 was noted on 1/23/14. The MAR and monthly order reconciliation were updated at that time. Resident #10's Lidoderm patches were discontinued on 1/22/14, the order was noted appropriately on the MAR and monthly order reconciliation. All active chart physician orders written over the last quarter to current will be revicwed by the DON or designee to ensure all orders have been accurately transcribed by 2/28/14. New orders will be reviewed by DON or designee weekly x 12 weeks, then monthly ongoing to ensure accuracy of transcription of transcription, completeness and clarity of the orders received. Nursing staff will be re-educated on noting orders, clarifying orders, ensuring orders are complete and the 2nd nurse review process at the 2/11/14 nursing department meeting.	3/10/14

2/11/14

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F 514	Continued From page 5 having been reviewed by nursing in the course of a 24-hour chart check. The following concerns were identified: a. Review of the December, 2013 MAR showed an order for Haldol 5 mg IM every 12 hours PRN for severe agitation, despite the discontinuation of the medication in August 2013. b. Review of the Physician's Orders recapitulation for January 2014, signed as reviewed by nursing on 12/30/13, showed an order dated 7/16/13 for Haldol (an anti-psychotic) 5 mg IM [intramuscularly] every 12 hours PRN [as needed] for severe agitation, despite the order to discontinue the medication in August 2013. 2. Review of the medical record for resident #10 showed s/he most recently re-admitted to the facility on 11/2/13 with diagnoses that included cancer, arthritis, and Alzheimer's disease. On 10/26/13, lidocaine (generic for Lidoderm) 5% patches (a topical/local anesthetic for pain relief) were prescribed to be administered once daily for 30 days. The order did not specify where on the body the patch was to be applied. Review of the October 2013 MAR revealed lidocaine 5% patches were administered beginning on 10/27/14. Review of re-admission orders dated 11/2/13 showed an order for "Lidoderm 5% patch to lower back on AM off PM 3 patches to rib fx [fracture]." Long Term Care Physicians Orders dated 11/6/13 showed "Clarify - Lidoderm patches up to 3 on side over R [right] rib fx [fracture] - 1 on lower back. Use PRN pain - please do regular for next week then PRN." This order was signed as noted by nursing on 11/6/13, and additionally signed 11/7/13 as having been reviewed by another nurse in the course of a 24-hour chart check. The following concerns were identified: a. Review of the resident's November 2013	F 514	Nursing staff will be re-educated on the 24 hour check procedure process at the 2/11/14 nursing department meeting. Order accuracy, clarity and completeness will be reviewed in QA monthly x 12 months to ensure the process is sustained.	

2/21/14

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F 514	Continued From page 6 MAR showed 3 lidocaine 5% patches administered daily to the resident's right side from 11/2/13 through 11/30/13 rather than regularly for a week and then as needed. Similarly, one lidocaine 5% patch was administered topically to the resident's lower back daily from 11/2/13 through 11/30/13 instead of regularly for one week and then as needed. b. Review of the Physician's Orders recapitulation for December 2013, signed as reviewed by nursing on 11/26/13, showed an order, dated 11/6/13, for "lidocaine 5% (Lidoderm) 3 patches to rib fx [fracture] R [right] side." The recapitulation had not been updated to reflect the complete contents of the 11/6/13 physician's order. Review of the December 2013 MAR showed 3 lidocaine 5% patches were applied daily to the resident's right side throughout the month, instead of as needed for pain as ordered. Additionally, there was no order for a lidocaine 5% patch to be applied to the lower back as needed. c. Review of the Physician's Orders recapitulation for January 2014, signed as reviewed by nursing on 12/30/13, showed it continued to show the incorrect lidocaine 5% patch order, and review of the January 2014 MAR showed 3 lidocaine 5% patches continued to be applied daily. 3. Interview with the DON on 1/24/14 at 10:55 AM confirmed these orders had not been properly transcribed onto the MARs, and further revealed the facility did "have a problem with orders being taken off correctly."	F 514		
F 516 SS=D	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS	F 516		

2/11/14

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F 516	Continued From page 7 A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure only staff with a need to know had access to medical records. The findings were: Observation on 1/24/14 at 8:45 AM showed the facility had a secure off-site storage area for medical records. Interview with the maintenance director at that time showed he, his assistant, and the activities director had the 3 keys to the storage area. He further stated that he or his assistant brought medical records to that location for storage. Interview with the administrator on 1/24/14 at 11:40 AM showed the maintenance director and his assistant did not have a need to know information contained in the medical records. He also confirmed they both transported medical records for storage in the facility's off-site storage area.	F 516	F516- The facility will ensure that clinical records are safeguarded against unauthorized use. The facility has moved medical records to a secure location on site. Access has been restricted to only those who need to know by replacing the lock and only allowing keys to authorized staff. The number of keys to medical records will be limited and have to be signed out to monitor and restrict access. Access will be reviewed in QA&A monthly for three months and quarterly thereafter to ensure that clinical records are safeguarded against unauthorized use.	3/10/14

2/21/14