Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0022	A. BUILDING: _____ B. WING _____	03/03/2016

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

SA 4/26/16

(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) COMPLETE DATE
S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Nursing Care Facilities, Chapter 11, effective 06/26/2000 Rules and Regulations for Licensure of Nursing Care Facilities, Chapter 19, effective 06/26/2000 The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse RN: Registered Nurse MDS: Minimum Data Set ADON: Assistant Director of Nursing Less commonly used abbreviations will be annotated in each deficiency. A recertification survey was conducted by Healthcare Licensing and Surveys on 2/29/16 through 3/3/16. Also reviewed in the course of this survey was complaint intake WY00002141 and WY00002028.	S 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.	
S2910	Ch 11 Sec 5 (b)(iv) Organization and Administration (b) Personnel policies and procedures. The governing body or its equivalent, through the Nursing Home Administrator, shall be responsible for implementing and maintaining written personnel policies and procedures that support sound resident care and personnel practices.	S2910		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3/28/16

STATE FORM 6899 VHF011

RECEIVED
WY Dept of Health
APR 22 2016
Healthcare Licensing and Surveys

7015 1520 0000 3110 8567

POC accepted. Spoke with Shane Filipi 4/26/16 10:30 am.
State surveyor

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S2910	Continued From page 1 (iv) Written policies shall ensure a safe and sanitary environment for residents and personnel. (A) Tuberculin testing shall be accomplished for each employee upon employment and before resident contact begins and annually thereafter. (B) Employees having known positive skin test shall provide a certificate of noninfectiousness for a physician, recommendations, if any, for treatment, and evidence that they have complied with such recommendations. (C) Individuals providing documentation of negative skin tests administered within the last year need no physician follow-up at this time. (D) Individuals never having had a skin test or who do not have written proof of skin test results, shall have an intradermal Mantoux using 5TU PPD. This shall be accomplished via the two (2) step procedure. If the first test is negative and the employee is asymptomatic, the employee may engage in resident contact prior to the results of the second skin test. (I) A negative reaction requires no follow-up by a physician at this time. (II) A positive reaction (10mm induration using 5TU PPD) requires a referral to a physician for x-ray and certification of noninfectiousness and appropriate treatment if needed. Follow-up shall comply with recommendations of the attending physician.	S2910	S2910 - PCMNH policy and procedure on "Tuberculosis, Employee Screening for" was reviewed and updated according to the newly published CDC Guidelines for Preventing the Transmission of *Mycobacterium Tuberculosis* (TB) in Health-Care Settings 2005 on 3/22/16. Each newly hired employee will be screened for TB infection and disease after an employment offer has been made but prior to the employee's duty assignment. The facility's Employee Health Coordinator will administer a two-step TST to all newly hired employees except those who have documented positive TST or BAMT results, and those who provide documented verification of having had a negative TST or BAMT within the preceding 12 months. Employee #1, #2, and #3 will have completion of their TB test by 4/5/16. The facility will implement and maintain procedures for ensuring all newly hired employees, volunteers, and	4/16/16

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S2910	Continued From page 2 (E) If symptoms occur, a new certificate of noninfectiousness is required from the physician. This State Rule and Regulation is not met as evidenced by: Based on employee record review, facility policy and procedure review, and staff interview, the facility failed to ensure newly hired employees completed TB (tuberculosis) testing prior to first resident contact for 3 of 5 employee records (#1, #2, #3) reviewed. The findings were: 1. Review of the employee record for employee #1 showed the date of hire (DOH) was 11/4/15. Further, it showed a TB test was completed on 3/29/12 and the first date of resident contact was on 11/10/15. 2. Review of the record for employee #2 showed the DOH was 11/16/15. Further it showed her last TB test/screening was completed on 8/13/14 and the first date of resident contact was on 11/16/15. 3. Review of the record for employee #3 showed her DOH was 1/13/16. Further, it showed the TB test was completed on 2/18/16 and the first date of resident contact was on 2/5/16. 4. An interview with the infection control nurse on 3/1/16 at 6:10 PM revealed employee #1 had previously worked for the facility and when she returned 4 to 5 months later, only a screening was completed for TB. In addition, she confirmed there was no documentation to show employee #2 had a TB test done at the time of hire. 5. Review of the policy and procedure titled "Tuberculosis, Employee Screening for" last	S2910	contract personnel meet with the Employee Health Coordinator (or designee)to be screened for TB infection and disease prior to employees duty assignment. All staff was given education on tuberculosis employee screening on 4/5/16 and all new employees will be given education on date of hire. An audit will be conducted of all employees by the Infection Control nurse or designee to ensure all employees have received the appropriate TB screen/test. Employee health record reviews/audits will be done quarterly to ensure that employee health records are updated with appropriate screens for TB. Any employees missing the appropriate TB screens will be given an assessment for active signs and symptoms of TB. All findings will be taken to QA&A quarterly for one year for further review and analysis.	

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S2910	Continued From page 3 revised on July 2010, showed "1. The facility's Employee Health Coordinator will administer a TST [Tuberculin Skin Test] to all newly hired employees except those who have documented positive TST or BAMT [Blood Assay for Mycobacterium Tuberculosis] results, and those who provide documented verification of having had a negative TST or BAMT within the preceding 12 months."	S2910		
S3007	Ch 11 Sec 11 (a)(vii) Dietetic Services The facility shall provide dietetic services that meet the nutritional needs of residents according to the science of nutrition. The dietetic service shall operate with safe food handling practices from receipt through service in accordance with the most current edition of the FOOD CODE from the U.S. Department of Health and Human Services, Public Health Service, Food and Drug Administration. (a) Dietary Supervision. Overall supervisory responsibility for the dietetic service shall be assigned to a full-time qualified dietetic supervisor. (vii) The consultant or staff dietitian shall maintain interdisciplinary communication and act as the dietetic service's chief liaison to the medical and nursing staffs. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, medical record review, and review of policies and procedures, the facility failed to ensure nutritional interventions were implemented for 3 of 4 sample residents (#2, #9, #34) with identified nutritional	S3007	S3007 - The facility will ensure proper nutritional interventions are in place for all residents. Registered Dietitian has evaluated residents #2's, #9's and #34's nutritional status and determined if further interventions are necessary on 3/25/16. Dietary manager /MDS coordinator or designee will audit resident intake and weights on all residents for significant weight loss to ensure dietary interventions are in place. Dietary manager /MDS coordinator or designee will audit resident intake and weights on all residents for significant weight loss. Any residents identified for significant weight loss or nutritional needs will be evaluated by the Registered Dietitian by 4/1/16 to ensure proper	4/16/16

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S3007	Continued From page 4 needs. The findings were: 1. Review of the 2/29/16 quarterly MDS assessment for resident #9 showed diagnoses that included diabetes and schizophrenia. Further review showed the resident weighed 155 pounds. Review of the care plan showed the resident was at risk for skin breakdown, with interventions to include "Provide [resident's] diet as ordered. Record food intake % [percentage] at each meal... Dietitian will evaluate [resident's] nutritional status quarterly." The following concerns were noted: a. Review of the weight log showed on 11/22/15, the resident weighed 175 pounds. Further review showed on 2/22/16, the resident weighed 155 pounds, a loss of 20 pounds (11.4%) in 3 months. b. Review of dietary notes showed the last assessment was completed on 7/15/15. c. Review of a "Care Plan Conference Summary" dated 12/3/15 showed the resident ate 89% to 95% of meals. There was no documentation to show the weight was discussed. Review of a "Care Plan Conference Summary" dated 12/18/15 showed the resident ate 97% of meals and was on a 1500 mL fluid restriction. There was no documentation to show the weight was discussed. Review of a "Care Plan Conference Summary" dated 1/21/16 showed the resident ate 98.8% of meals, drank an average of 1454 mL of fluids, weighed 158.8 pounds, and was stable. Further review showed "Nutrition and hydration no problem." Review of a "Care Plan Conference Summary" dated 2/25/16 showed the resident ate 100% of meals, drank on average 1325 mL of fluids, and weighed 155 pounds. d. Interview with the MDS coordinator on 3/3/16 at 8:10 AM revealed he tracked weights to	S3007	interventions are put in place. Staff was educated on 4/5/16 on proper nutritional interventions. A documentation tool has been developed and implemented to track weight loss/gain, current BMI, altered diets and chewing or swallowing difficulties as identified on section K of the MDS. MDS coordinator will email this document to the Registered Dietician weekly for review. Registered Dietitian will evaluate and recommend interventions as necessary. Facility will follow up with physician regarding RD recommendations. Weights will be reviewed weekly on all residents by dietary manager or designee to ensure all residents are maintaining acceptable nutritional parameters. RD or Dietary Manager will review each resident at their quarterly MDS assessment for nutritional needs. Dietary manager will estimate the calorie, nutrition, and fluid needs and confer with RD and/or	

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S3007	Continued From page 5 determine weight loss or gain. He added the parameters he used for determining weight loss was 5% weight loss in 1 month or 10% weight loss in 6 months. He further revealed he was unaware of the resident's 20 pound weight loss over 3 months. 2. Review of the admission MDS assessment dated 8/24/15 showed resident #34 had a weight of 165 pounds. Review of the weekly weight log dated 1/24/16 and timed 8 AM showed the resident weighed 134 pounds, a 31 pound or 18.7% loss since the time of admission. Review of the quarterly MDS assessment dated 2/18/16 showed the resident's weight increased to 140 pounds; a 25 pound or 15.1% loss since the time of admission. Review of the care plan conference summary dated 11/24/15 showed no identification or discussion of weight loss or need for nutritional interventions. Review of the care plan conference summary dated 2/25/16 showed the weight was "stable in the 140's." Review of the medical record showed there was no evidence the resident was assessed by a dietitian or that nutritional interventions were implemented to prevent weight loss or stabilize the resident's weight. 3. Review of the admission MDS assessment dated 10/16/15 showed resident #2 had a weight of 152 pounds. Review of the weekly weight log dated 1/10/16 and timed 8 AM showed the resident weighed 131 pounds, a 21 pound or 13.8% loss since the time of admission. Review of the quarterly MDS assessment dated 1/15/16 showed the resident weighed 131 pounds and the weight loss was not physician-prescribed. Review of the care plan conference summary dated 1/21/16 showed the resident "likes mighty shakes" and staff will "cut up" the resident's food.	S3007	physician to ensure the resident is on the appropriate diet. Dietary Manager or designee will audit RD documentation to ensure proper interventions are in place weekly for 4 weeks, monthly thereafter for 3 months, and quarterly thereafter. All findings will be brought to QA&A monthly for one year for review and further analysis.	

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S3007	Continued From page 6 Review of the medical record showed there was no evidence the resident was assessed by a dietitian or that nutritional interventions were implemented to prevent weight loss or stabilize the resident's weight. 4. Interview with the dietary manager on 2/29/16 at 11:15 AM revealed she was a registered dietitian and had performed the dietician's duties at the facility up until October 2015. 5. Interview with the DON on 3/1/16 at 3:43 PM revealed the current consultant registered dietitian was based out of another city and did not come to the facility often. She further added that the MDS coordinator kept track of the residents' weights. She stated the facility monitors each resident's nutrition status using the "Care Plan Conference Summary" forms. 6. Interview with the MDS coordinator on 3/3/16 at 8:10 AM revealed he tracked weights to determine weight loss or gain. He further stated if a concern was identified, he discussed with the resident's nurse options such as supplements or increased assistance with eating, or would refer to the physician if needed. He stated the consultant dietitian was available, but he had not utilized her services since the previous dietitian left that position. 7. Interview with the DON on 3/3/16 at 10:15 AM revealed she was unsure if any interventions had been implemented to increase resident's weights when identified to have a weight loss. Further, it was confirmed that there had not been a dietitian consult for the residents. 8. Review of the policy titled "Nutrition (Impaired)/Unplanned Weight Loss" revised	S3007		

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S3007	Continued From page 7 09/12 showed "Assessment and Recognition...3. The threshold for significant unplanned and undesired weight loss will be based on the following criteria (where percentage of body weight loss = [usual weight-actual weight / [usual weight] x 100): a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 month - 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe...Cause Identification 1. The Physician will review possible causes of anorexia or weight loss with the nursing staff and/or Dietitian before ordering interventions. a. The Dietitian will estimate calorie, nutrient and fluid needs and, with the physician, will identify whether the resident's current intake is adequate to meet his or her nutritional needs...Treatment/Management...b. Nutritional needs: The Dietitian will help the physician determine the appropriate diet for the resident based on the resident's degree of nutritional impairment, expressed wishes, and underlying causes and conditions. If the resident's nutritional or caloric needs have changed, but the diet has not, this may help to clarify the appropriate interventions."	S3007		