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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
535053 Y1	A. Building B. Wing Y2	6/14/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY LEGACY HOME	100 19TH ST WHEATLAND, WY 82201

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0155	Correction	ID Prefix F0166	Correction	ID Prefix F0309	Correction
Reg. # 483.10(b)(4)	Completed	Reg. # 483.10(f)(2)	Completed	Reg. # 483.25	Completed
LSC	04/16/2016	LSC	04/16/2016	LSC	04/16/2016
ID Prefix F0325	Correction	ID Prefix F0327	Correction	ID Prefix F0329	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.25(j)	Completed	Reg. # 483.25(l)	Completed
LSC	04/16/2016	LSC	04/16/2016	LSC	04/16/2016
ID Prefix F0387	Correction	ID Prefix F0388	Correction	ID Prefix F0406	Correction
Reg. # 483.40(c)(1)-(2)	Completed	Reg. # 483.40(c)(3)-(4)	Completed	Reg. # 483.45(a)	Completed
LSC	04/16/2016	LSC	04/16/2016	LSC	04/16/2016
ID Prefix F0428	Correction	ID Prefix F0502	Correction	ID Prefix F0514	Correction
Reg. # 483.60(c)	Completed	Reg. # 483.75(j)(1)	Completed	Reg. # 483.75(l)(1)	Completed
LSC	04/16/2016	LSC	04/16/2016	LSC	04/16/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	7/20/16	6/16/16		
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		☐ YES ☐ NO

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

PRINTED: 06/28/2016
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 _____	R-C 06/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY LEGACY HOME	100 19TH ST WHEATLAND, WY 82201

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{F 000}	INITIAL COMMENTS On 6/13/16 - 6/14/16 a follow-up to a 3/3/16 recertification survey was conducted by Healthcare Licensing and Surveys. The following common abbreviations were used throughout this document: CNA: Certified Nurse Aide DON: Director of Nursing	{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 225} SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the	{F 225}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/1/16

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
WY Dept of Health
JUL 01 2016
Healthcare Licensing and Surveys

POC accepted. Message left for Shane Filipi, NHA on 7/1/16 @ 1:16 p.m. Janelle

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{F 225}	Continued From page 1 Investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on grievance log review, daily staff posting review, staff record review, staff interview, State survey agency log review, and policy and procedure review, the facility failed to ensure 1 of 1 allegation of staff to resident abuse (unknown resident) was thoroughly investigated and reported to the State survey agency. The findings were: Related to Investigating: Review of a 5/15/16 grievance note typed and signed by licensed practical nurse (LPN) #1 revealed the following information: "On Sunday, May 15, 2016, [CNA #1] came to me and stated that a family member of a resident was upset with [CNA #2]. They felt that [CNA #2] was forcing their family member to eat even after the family member would state no. It was stated that [CNA #2] had force fed their family member, and they were upset that they felt [CNA #2] was verbally abusive to the residents. This family voiced concerns about [CNA #2] being too loud and having an inappropriate tone with their family member. It was reported that this family was going to report it to state. [CNA #1] further	{F 225}	F225- The facility will ensure that all allegations of abuse are reported to the appropriate state agencies. All grievances from the last 3 months will audited to ensure no allegations of abuse. Any potential abuse found will be investigated promptly and thoroughly with a full report of findings sent to the appropriate state agency. Staff was educated on 6/21/16 regarding the abuse policy, reporting requirements, and documentation requirements. The abuse policy was reviewed and updated on 6/21/16. Staff will be suspended with any allegations of abuse. Audits will be conducted by Social Services or designee on all grievances on a weekly basis x 3 months and monthly thereafter to ensure compliance. All potential abuse will be reported to the appropriate state agency according to policy and current regulations. All findings from audits will be brought monthly to QA&A for one year for further review and analysis.	7/7/16

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{F 225}	Continued From page 2 informed me that this family did not feel comfortable going to management because they felt management would not do anything about it. I did not further ask questions as I felt [CNA #1] was not comfortable revealing whom the family was or resident." The following concerns were identified: a. Review of the corresponding 5/15/16 "Grievance Form", completed by the social services director, showed the accused CNA denied the claim of abuse and acknowledged "she can be a bit loud and sound like she is yelling at times-she will work on this." The Nature of Resolution showed "[CNA #2] knows she can be a bit too loud and sound like she is yelling at times-she will work on this." The facility failed to investigate this grievance as an allegation of abuse. b. Review of the staff posting for the timeframe of the grievance through the start of the survey showed the CNA accused in the grievance was routinely on the work schedule. c. Review of [CNA #2] staff record showed the following documentation on 5/17/16: "Spoke with [CNA #2] regarding her tone of voice, [CNA #2] verbalizes she does have a loud voice and has been trying to keep it down. She states Sunday she asked [resident #13] to eat her food and felt like she was encouraging her-'if you don't eat you won't get stronger' etc [CNA #2] states she did not feel like she was being mean or intimidating. Discussed with [CNA #2] how residents and visitors can hear tone of voice and feel differently even if the person speaking does not realize how they are coming across. [CNA #2] verbalized understanding of this." The facility failed to document a thorough investigation of this incident. d. Interview with the administrator on 6/13/16	{F 225}		

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{F 225}	Continued From page 3 at 3:15 PM showed he interviewed 4 additional staff regarding this incident. Interview with the administrator on 6/13/16 at 4:03 PM showed the facility failed to take any additional actions to ensure resident safety. Interview with the administrator and social services director on 6/14/16 at 7:55 AM revealed other residents were interviewed; however, the facility failed to document those interviews. Related to Reporting: Review of the state survey agency logs showed the facility failed to report the 5/15/16 abuse allegation. Interview with the administrator on 6/14/16 at 7:55 AM confirmed the allegation was not reported to the state. Review of the undated policy and procedure titled "Abuse Prevention" showed the following requirements under Identification Procedure: "1. If abuse or injuries of unknown origin is suspected: The Nursing Home staff will immediately (including nights, weekends, and holidays) report all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source...to the Administrator or his or her designee. 2. The Administrator/designee will make notification of reported allegations within 24 hours of the occurrence or within 24 hours of receiving information of an alleged occurrence to: a. Wyoming State Survey Agency..." Under the heading "VI. Protection" included was the following, "1. During abuse investigations, residents will be protected by the following measures: a. Employees accused of alleged abuse will immediately be suspended without pay until the administrator has reviewed the findings of the investigation." The facility failed to follow their policy regarding abuse investigation,	{F 225}		

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{F 225}	Continued From page 4 reporting, and ensuring resident safety during the process.	{F 225}		
F 367 SS=E	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of manufacturer's instructions, the facility failed to ensure residents received a therapeutic diet of thickened liquids as prescribed for 8 of 8 residents (#8, #12, #13, #21, #22, #35, #43, #45) with physician orders for thickened liquids. The findings were: 1. Review of the physician's orders for residents #8, #12, #13, #21, #22, #35, #43, #45 showed orders for nectar-thickened liquids. Observations on 6/13/16 of the lunch meal at 11:59 AM and the dinner meal at 5:51 PM showed at each meal there were 7 glasses of thickened water on the tables. Review of the manufacturer's instructions for using powdered thickener revealed 1 tablespoon of powder was needed for every 4 ounces of liquid to achieve a "nectar-like" consistency. The following concerns were identified: a. With both meal observations, 3 of the 7 glasses of thickened water contained ice cubes. Further observation showed the ice cubes were melting into the thickened water, which had the potential to diminish the therapeutic value of the thickened water.	F 367	F367- On 6/15/16 the physician discontinued thickened water on residents #8,12,13,21,22,35,43, and 45. Remaining thickened liquids will be purchased pre mixed if available to ensure proper consistency. Charge nurses will be responsible for thickening all other liquid as ordered. The facility policy and procedure for Dysphagia – Clinical Protocol was reviewed and updated with physician input on 6/21/16. Staff was educated on the thicken liquid policy and procedure on 6/21/16. Utilizing an audit tool, audits will be conducted by DON or designee, of nurses mixing thickened liquids to ensure appropriate consistency. Audits will be conducted weekly for 4 weeks and monthly thereafter for one year. All results will be taken to QA&A monthly until compliance is determined during the QA&A process and quarterly thereafter for one year for further review and analysis.	7/7/16

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F 367	Continued From page 5 b. Interview with CNA #4 at 8:21 AM on 6/14/16 revealed the dietary aides prepared the thickened water and the CNAs prepared other thickened liquids as needed. Interview with the dietary manager (DM) at 9:05 AM on 6/14/16 revealed powder thickener is used to thicken liquids when needed; however, she "does not know how the staff does it." Further, she revealed she had not considered that adding ice cubes to thickened liquids would alter the consistency. She added that nursing services trained the staff members to thicken the liquids. c. Interview with the assistant DON at 9:15 AM on 6/14/16 revealed she did not know who trained the staff and would ask the DM for educational training documents related to thickened liquids. Further, she stated that adding ice cubes to thickened liquids may alter the consistency. d. Interview on 6/14/16 at 11:06 with CNA #3 revealed she used 1 tablespoon of powdered thickener for an 8 ounce glass and 1 teaspoon for a 4 ounce glass to make nectar thickened liquids. Interview on 6/14/16 at 11:16 AM with CNA #4 revealed she also used 1 tablespoon of powdered thickener for an 8 ounce glass and 1 teaspoon for a 4 ounce glass. She further revealed she was a traveling CNA, and was provided instruction on thickening liquids by a dietary aide. e. Observation on 6/14/16 at 11:30 AM showed two unidentified dietary aides preparing thickened water, using 1 heaping tablespoon for each 8 ounce glass of water. f. Review of dietary audits dated between	F 367		

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F 367	Continued From page 6 5/11/16 and 6/10/16 showed 47 meals were audited, and 21 of those meal audits showed concerns or a need for education related to thickened liquids. g. Interview on 6/14/16 at 2:10 PM with the DON revealed the facility trained the dietary staff on how to properly thicken liquids; however, there was no documented evidence of formal training. She further verified the aides and CNAs were not following manufacturer's recommendations for using the powdered thickener to thicken liquids. She added that the staff "need more education."	F 367		