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 F0157	Correction	ID Prefix F0274	Correction	ID Prefix F0280	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed
LSC	05/26/2016	LSC	05/26/2016	LSC	05/26/2016
ID Prefix F0281	Correction	ID Prefix F0309	Correction	ID Prefix F0311	Correction
Reg. # 483.20(k)(3)(i)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(a)(2)	Completed
LSC	05/26/2016	LSC	05/26/2016	LSC	05/26/2016
ID Prefix F0312	Correction	ID Prefix F0325	Correction	ID Prefix F0441	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.65	Completed
LSC	05/26/2016	LSC	05/26/2016	LSC	05/26/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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) 6/20/16	DATE	SIGNATURE OF SURVEYOR	DATE 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
4/15/16	

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 06/14/2016

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

(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 On 6/13/16 - 6/14/16 a follow-up to a Centers for Medicare and Medicaid Services comparative survey was conducted by Healthcare Licensing and Surveys.	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 241} SS=D	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 observation, resident interview, staff interview, and medical record review, the facility failed to promote the dignity of 1 non-sample resident (#17) during 1 of 2 meal observations. The findings were: 1. Review of the 5/18/2016 quarterly MDS assessment showed resident #17 had diagnoses that included Alzheimer's disease, dementia, and macular degeneration. In addition, it showed the resident had a BIMS (Brief Interview for Mental Status) score of 3/15 (indicating severe cognitive impairment), and required set up assistance for eating. Review of the resident's care plan updated on 2/18/2016 showed the resident was able to feed herself/himself. The following concerns were identified: a. Observation of the dinner meal on 6/13/2016 at 6:19 PM showed the resident was served a meal of tater tot casserole, mixed vegetables, and a bowl of pudding. Continued observed	{F 241}		

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 with Shane Filip, UHS on 7/14/16 @ 4:16 pm.

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{F 241}	Continued From page 1 showed the resident was eating the pudding with a table knife. The resident's utensils were enfolded in a napkin on the table next to the plate. At 6:20 PM, the resident was observed eating the casserole and vegetables with his/her fingers. At 6:25 PM, the DM (dietary manager) approached the table and conversed with the resident's tablemate, but not with the resident, and failed to offer assistance. At 6:28 PM the DM approached the resident and again failed to offer assistance. Observation at 6:35 PM showed the resident had eaten approximately 75% of the meal. The utensils remained folded in the napkin. b. Interview with the resident on 6/14/2016 at 9:30 AM revealed he/she did not want to eat with his/her fingers. c. Interview with the DON on 6/14/2016 at 2:19 PM verified, that for the meal served, eating with a table knife or fingers was not appropriate.	{F 241}	F241- The facility will ensure that all residents including resident #17 have appropriate silverware that is visible and accessible. Staff was educated on 6/21/16 to ensure residents have appropriate silverware that is visible and accessible. Utilizing an audit tool, audits will be conducted of the dining room to ensure proper eating utensils are visible and accessible to the residents by the DON or designee. 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