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	535053	A. BUILDING _____ B. WING _____	11/06/2019

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 A recertification survey was conducted by Healthcare Licensing and Surveys on 11/3/19 through 11/6/19. The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide DON: Director of Nursing Services LPN: Licensed Practical Nurse MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to ensure nursing assessments were completed on identified skin concerns for 1 of 6 sample residents (#14) with skin concerns. The findings were:	F 684	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	12/20/19

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

Electronically Signed | 11/27/2019

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F 684	Continued From page 1	F 684		

Review of the 2/22/19 care plan showed resident #14 required assistance with activities of daily living, and skin inspections were included under the interventions with cares and bathing.
Observation on 11/3/19 at 3:23 PM showed the resident had bruises to the tops of both hands and forearms. Interview with the resident at that time revealed s/he had been on blood thinning medication in the past, and s/he bruised easily.
The following concerns were identified:

a. Review of the skin observation records from October 2019 showed CNAs documented skin issues including "discoloration, "scratched", "red area", "skin tear", and "open area." There were multiple entries for most dates. On 10/18, 10/25 and 10/26 the record showed "open area." On 10/28 the record showed "skin tear." Discoloration was documented 14 times, and scratches were documented 12 times. There was no additional information as to the location of these skin issues on the CNA documentation, and review of the nursing notes and evaluations failed to show any additional information from the nurse related to the skin conditions noted on these dates.

b. Review of the skin observation records for 11/1/19 to 11/5/19 showed discoloration was documented on 11/1/19 and 11/2/19. The record did not include information on the location. Review of nursing notes and evaluations failed to show any acknowledgement of these skin conditions by a nurse.

c. Interview with the DON on 11/6/19 at 9:59 AM revealed when a skin issue was identified there should be follow up from a nurse to assess and treat the issues as needed. She stated the resident had been taken off a blood thinning medication months ago, and the resident had scratches related to a skin infection which was

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.
F684
The facility will ensure nursing assessments are completed for any identified skin concerns.
A skin assessment was completed on resident #14 on November 5, 2019. The resident's physician was consulted and evaluated the resident on 11/25/19. Resident #14's care plan has been reviewed and updated to reflect his/her current medical status related to skin integrity.
An audit will be complete by the DON or designee on all residents with identified skin issues to ensure a skin assessment has been completed by nursing.
The policy and procedure entitled Skin Condition management –Non pressure was reviewed and updated on November 27, 2019. The facilities EMR system notifies the charge nurse via an alert of any skin concerns observed by the CNA. Any alerts triggered by the CNAs skin observations will be assessed by the charge nurse within 24 hours. Nursing staff will be educated by December 6th 2019 on the policy Skin Condition management –Non pressure and the EMR skin alerts.
The DON or designee will conduct weekly random audits of skin observation alerts assessments to ensure compliance. The audits will be conducted for no less than 3 months. Any problems identified will

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F 684	Continued From page 2 now resolved.	F 684	result in immediate education and corrective action. The DON or designee will report the results of the audits at the QA&A meeting. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure indications of pain were acted on for 1 of 2 sample residents (#13) with pain. The findings were: Review of the 8/13/19 quarterly MDS assessment showed resident #13 had frequent pain and received scheduled and as needed (PRN) pain medications. A numeric pain scale of 1 to 10 scale (10 being the worst) was to be utilized when addressing pain with a verbal resident; no value was entered to rate the pain intensity, but instead there was a verbal description rating of mild pain. Review of the 2/21/19 care plan for pain showed the interventions included the RN and LPN to monitor/record pain characteristics every shift and as needed (PRN). This intervention included the elements that were to be addressed to include:	F 697	F697 The facility will ensure any indications of pain are acted upon for residents with pain. A comprehensive pain assessment was completed on Resident #13 on November 12, 2019 to ensure adequate pain management consistent the resident's goals and preferences. The physician will review resident #13's pain medication to ensure effectiveness and proper frequency. Resident #13's care plan has been reviewed to ensure pain management is provided that is consistent with the resident's goals and preferences. All residents with acute pain or a history of chronic pain will have a pain assessment completed to ensure each resident's pain	12/20/19

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F 697	Continued From page 3 "Quality...Severity (1 to 10 scale)...location; Onset; Duration...". Review of the October 2019 MAR showed the resident had scheduled Norco (opiod pain medication) one tablet 5-325 mg at 7 AM for pain; and Gabapentin (anti-convulsant medication) 300 mg twice daily for pain at 7 AM and 4:30 PM. In addition, there were orders for Tylenol (pain medication) 500 mg 2 tablets every 6 hours PRN and Norco 5-325 one tablet every 4 hours PRN. The following concerns were identified: a. Review of the "Pain Level Summary" showed there were no entries for November 2019. There were 17 entries in October 2019 and 8 of these entries included a pain rating greater than zero. Some days there were multiple entries. The following entries showed a pain rating greater than zero: 10/26 at 10:02 AM (10 out of 10); 10/22 at 12:06 AM (7 out of 10); 10/14 at 7:38 AM (7 out of 10); 10/12 at 10:24 AM (6 out of 10); 10/11 at 5:52 PM (6 out of 10); 10/11 at 2:12 PM (3 out of 10); 10/11 at 12:29 PM (8 out of 10); 10/5 at 7:26 AM (6 out of 10). The information did not include any additional information regarding the location of the pain, or that any treatment or intervention was provided for these ratings. b. Review of the PRN medications on the October 2019 MAR showed these medications were not administered with the exception of 10/11/19, when the PRN Norco pain medication was given for a corresponding pain level of 8 out of 10, and 10/22/19, when the PRN Tylenol was administered for a pain score of 7 out of 10. c. Review of the nurse's notes did not show any information related to pain treatments for the dates and times on the pain level summary. d. Interview with the DON on 11/5/19 at 1:31 PM revealed she was unaware of any shift assessment done to assess pain, she stated if	F 697	management interventions are consistent with the resident's goals and preferences by December 20, 2019. These resident's care plans will be reviewed and updated as needed to ensure interventions are in place that meet the resident's pain management goals by December 20, 2019. The policy and procedure entitled Pain Assessment and Management will reviewed and updated by November 27, 2019, to ensure pain management is provided to residents who require such services. Residents with acute pain will be assessed for pain every shift and as needed and residents with stable chronic pain will be assessed for pain weekly or as needed. All residents will be assessed for pain with a comprehensive pain assessment completed upon admission, at the quarterly review or when there is a significant change in condition to include a worsening or new on-set of pain. The DON or designee will provide education to nursing staff regarding pain management to ensure pain management is provided to residents that require it by December 6, 2019. The DON or designee will conduct weekly random audits of pain assessments and interventions to ensure compliance. The audits will be conducted for no less than 3 months. Any problems identified will result in immediate education and corrective action. The DON or designee will report the results of the audits at the QA&A meeting. The report will include any problems	

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F 697	Continued From page 4 the resident was experiencing pain s/he could let staff know and an intervention would be completed. Additionally, she confirmed if pain was being identified with a pain scale, there should be nursing documentation to show what was done. She stated the CNAs asked residents about pain while completing weekly vital signs. She stated they would ask for a pain rating and this would be documented along with the vital signs, and the nurse would enter these findings into the Pain Level Summary on the electronic medical record. She stated the entry of the data was not always immediate or concurrently after the CNA assessed the pain.	F 697	identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		12/20/19

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F 758	Continued From page 5 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents were free from unnecessary medications for 1 of 2 residents (#144) reviewed for unnecessary psychotropic medications. The findings were: 1. Review of the medical record showed resident #144 was admitted on 10/10/19 with diagnoses which included chronic obstructive pulmonary disease, atrial fibrillation, and generalized anxiety disorder. Review of the physician's orders showed a psychotropic medication, alprazolam	F 758	F758 The facility will ensure residents are free from unnecessary psychotropic medications. Resident #144 received the psychotropic medication on two occasions beyond the fourteen day limit. The physician reviewed these administrations on November 5th, 2019 and discussed rationale for its continued use on the DRR dated November 5th 2019. The	

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F 758	Continued From page 6 0.25 milligrams (mg) three times a day as needed (PRN) for anxiety, with a start date of 10/10/19 and no stop date. The following concerns were identified: a. Review of the MARs for October 2019 and November 2019 showed the resident continued to receive the PRN medication beyond 14 days from the start date. The resident received the medication on 10/28/19, 4 days past the 14 day limit, and on 11/2/19, 9 days past the 14 day limit. b. The Drug Regimen Review Form dated 10/30/19 and signed by the pharmacist showed "Time to review use of alprazolam." The physician signed the form on 11/5/19, 12 days past the 14 day limit. c. Interview on 11/6/19 at 11:47 AM with the DON revealed they did not address the continued use of alprazolam until the drug regimen review meeting (6 days past the 14 day stop date).	F 758	physician re-evaluated the PRN psychotropic medication during the clinic visits on November 18th and November 25th 2019. The physician has determined that continued use of this psychotropic medication is appropriate due to resident #144's disease process and prognosis. The physician has addressed and documented the rationale for the use of the psychotropic medication beyond fourteen days, along with the expected duration of the PRN order. All PRN psychotropic medication orders were reviewed by the physician November 19, 2019 to ensure duration does not go beyond fourteen days. The rationale for any PRN psychotropic medication that the physician believes will be appropriate beyond fourteen days was documented by the physician on November 19, 2019. All PRN psychotropic medications that have been extended by the physician beyond fourteen days, will be re-evaluated by the physician at the residents sixty day review or at the end of the term of the extension whichever comes first. All medications are reviewed monthly by the pharmacist and any irregularities are brought to the physician□s attention. Policy and procedure entitled Antipsychotic Medication Use will reviewed and updated by November 27, 2019. DON or designee will provide education to medical and nursing staff by December 6t,	

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F 758	Continued From page 7	F 758	2019, regarding the use of PRN psychotropic medication, including the fourteen day limit and/or documentation of the rationale by the physician if the need for PRN psychotropic medication would extend beyond fourteen days. The DON or designee will conduct weekly random audits of PRN psychotropic medication orders to ensure compliance. The audits will be conducted for no less than 3 months. Any problems identified will result in immediate education and corrective action. The DON or designee will report the results of the audits at the QA&A meeting. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident	F 803		12/20/19

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F 803	Continued From page 8 groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, menu review, and staff interview, the facility failed to follow the menu related to portion size for 1 of 1 meal service observations (evening meal on 11/5/19). The census was 48. The findings were: Review of the 11/5/19 menu showed "Ground Beef Stroganoff" was the main meal. The standard portion size for the meal was 6 ounces of stroganoff and 1/2 cup of noodles. The small portion for the meal was 6 ounces of stroganoff and 1/4 cup of noodles. These portions were the same for the mechanically-altered versions. The following concerns were identified: a. Observation on 11/5/19 at 4:57 PM showed cook #1 was dishing food onto plates for resident meals. At that time, the cook confirmed the portion size used for the stroganoff, which had been prepared with a combination of noodles, beef, and sauce, was a 4 ounce scoop. This was the size observed to be served for each resident that ordered the stroganoff. b. Interview on 11/6/19 at 10 AM with the certified dietary manager verified the menu showed the serving size for the stroganoff should have been more than 4 ounces. She stated more	F 803	F803 The facility will ensure food portions are served in a manner that meets the nutritional adequacy requirements reflected on menu and recipe serving size instructions. The following of portion size recommendations has the potential to affect all residents in the facility. The serving utensils in use at the facility were reviewed and it was noted not all utensils had clear markings designating the capacity of the utensil. The Dietary Manager will make available a chart providing a clear guide of each utensil's capacity in use at the facility. The Dietary Manager or designee will provide education to all food service employees by 12/06/2019 to ensure understanding of utensil capacity and meal portion sizes. The Dietary Manager or designee will conduct weekly random audits of serving sizes during meal plating to ensure compliance. The audits will be conducted for no less than 3 months. Any problems	

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F 803	Continued From page 9 education was needed related to following the menu.	F 803	identified will result in immediate education and corrective action. The Dietary Manager or designee will report the results of the audits at the QA&A meeting. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of diet orders, and review of temperature logs, the facility failed to ensure food temperatures were appropriate for mechanically-altered foods. The census of residents with altered texture diets was	F 812	F812 The facility will store, prepare, distribute, and serve food in accordance with professional standards for food service safety. The facility will ensure hot foods	12/20/19

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F 812	Continued From page 10 10. The Findings were: 1. Observation on 11/5/19 at 4:57 PM showed the food service had begun. Review of the food temperature log for November 2019 showed there were no temperatures recorded for mechanically-altered foods (the puree and mechanical soft/ground foods) for any meals on any days. the following concerns were identified: a. Interview with cook #1 on 11/5/19 at 5:05 PM revealed she took the temperatures of these foods prior to them being mechanically-altered in the kitchen. At that time, when the temperature was taken of the pureed ground beef stroganoff it was 145 degrees Fahrenheit (F), and the puree vegetables temperature was 135 degrees F. For this meal the "regular" and mechanical soft/ground was the same food and the temperature of the regular texture stroganoff was recorded as 155 degrees F. Although these temperatures were appropriate for serving, the temperature taking process did not usually occur. b. Review of the diet order sheet showed 5 residents who had orders for pureed foods and 5 residents who had orders for mechanical soft textured foods. c. Interview with the certified dietary manager on 11/06/19 at 10 AM revealed the cooks were taking the temperatures of the foods prior to blending, and they were not checking the temperatures again. She also stated the temperature log needed to be updated to reflect a place to record the temperatures for the altered texture foods. 2. According to Food Code 2017, U.S. Public Health Service: 3-501.16 "(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified	F 812	which are altered in texture are served at appetizing temperatures of 135 degrees Fahrenheit (F) or higher. The temperature of altered textured foods being served has the potential to affect all residents in the facility with altered textured diets. The pureed temperatures checked did meet regulation requirements, with the lowest temperature for hot food cited at 135 degrees Fahrenheit. The process for monitoring temperatures was reviewed and it was found there was potential for food to become below required temperatures during the process for altering food textures. The audit tool used to monitor food temperatures was modified to include checking altered textured foods. All hot food products which are altered in texture will be temped after the food has been modified to ensure they are served at appetizing temperatures of a minimum of 135 degrees. Textured food temp recordings have been added to the temperature log in the kitchen area. The Dietary manager will provide education to all food service employees regarding the change to the audit form by 12/06/2019 to ensure understanding of new temperature audits. The Dietary Manager or designee will conduct weekly random audits of food temperatures including altered textured foods to ensure compliance. The audits will be conducted for no less than 3	

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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 812	Continued From page 11 under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above...or (2) At 5ºC (41ºF) or less."	F 812	months. Any problems identified will result in immediate education and corrective action. The Dietary Manager or designee will report the results of the audits at the QA&A meetings. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	