Reviewed & approved after discussion c Harvey Carmichael, NHA 1 c changes noted on pages 1, 3, 5, 7, 8, 10, 11, 12, 13, 14, 15

DEPARTMENT OF HEALTH AND HUM ERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/22/2006
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 |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ Linda Brown RN 10/26/06 17, 18, 19, 21, 22 & 23+25 | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 176 SS=D | 483.10(n) SELF ADMINISTRATION OF DRUGS<br><br>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, staff interview, and review of policies and procedures, the facility failed to assess two (#4, #15) of four residents observed during the medication pass for self-administration of medications. The findings were:<br><br>Review of the facility's 11/28/05 policy and procedure, "Self Administration of Medications" showed all residents would be given the opportunity to self-administer medications if they desired. However, further review showed "Medications will be administered by the LPN [licensed practical nurse] or RN [registered nurse] until the resident's ability to self-administer has been assessed." The following concerns with failure to follow this policy were identified:<br>a. Observation on 9/12/06 at 8:42 AM showed LPN #11 prepared and administered medications, including Miralax (a laxative), to resident #4. The LPN mixed Miralax powder into a glass of juice and left it with the resident. The LPN went back around the corner and continued passing medications to other residents. The resident did not drink all the juice and Miralax before leaving the dining room. Review of the medical record showed an assessment for self-administration of medications was lacking.<br>b. Observation on 9/12/06 at 9:02 AM showed LPN #11 prepared medications and then handed | F 176 | This Plan of Correction constitutes our allegation of compliance.<br><br>F 176 An individual resident may self-administer drugs if the interdisciplinary team, as defined by 483.20 (d) (2) (ii), has determined that this practice is safe. The Resident Care Manager will review with all licensed staff the Facility's policy on "Self Administration of Medication". The review will include clarification of the intent of the policy, the interdisciplinary approach and the interventions related to the timing of the assessment and levels identified. This will be reviewed by October 29,2006. This policy will become part of a new employee's orientation packet and will be reviewed with all new licensed employees and agency staff prior to their administering medications, by the Resident Care Manager or the designee. Evidence of this orientation will be included on the orientation check list. This will be completed by October 29, 2006.<br><br>a. Resident #4 will be assessed for self-administration of medications by the Resident Care Manager, Occupational Therapist and Pharmacist. The interdisciplinary team will communicate to the staff through shift report, on the plan of care and the medication administration record (MAR) the residents level (I, II, or III) to self administer. The level will be highlighted on the MAR. This will be completed by October 29, 2006. The Resident Care | 10/29/06<br><br>10/29/06 |

The policy includes physicians involvement as follows: once screening is completed regarding the resident's ability or inability to self administer medications, a referral to the physician will be sent to the physician with resident's determination. If able to self administer the physician will copy to the pharmacist.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: CEO

(X6) DATE: 10/4/06

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.

OCT 05 2006

WYOMING DEPARTMENT OF HEALTH HEALTH FACILITIES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 176 | Continued From page 1<br>them to resident #15 who was seated at a dining room table. The medications included an antidepressant and an anxiolytic, a narcotic, and Prednisone. The LPN did not observe the resident take the medications, but left the area and continued passing medications to other residents. Review of the medical record showed an assessment for self-administration of medications was lacking.<br>Interview with the resident assessment coordinator, RN #28, on 9/13/06 at 3:30 PM confirmed the assessments were not done. The RN stated that without the assessment, nurses were not supposed to leave medications with the residents to take independently. | F 176 | Manager and MDS Coordinator will review all residents for evidence that Self Administration of Medication has been offered. Any residents found not to have had self administration offered will be assessed by October 29, 2006. All new residents will be assessed by the RN and Occupational Therapist on admission. The care plan team will ensure the self administration of medication assessment is done by the 14 day plan of care meeting. The Resident Care Manager will observe the medication pass periodically on all shifts to assess that licensed staff are appropriately following the facility "Self-Administration of Medication" policy. This monitoring will be initiated by October 29, 2006 and documented on the staff's competencies. | 10/29/06 |
| F 253 SS=D | 483.15(h)(2) HOUSEKEEPING/MAINTENANCE<br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain the environment and resident care equipment in a sanitary manner. The findings were:<br>1. During an observation on 9/12/06 at 7:58 AM, certified nurse aide (CNA) #14 provided care for resident #18 then transferred the resident into bed. The resident's oxygen cannula had been removed prior to providing care, and it fell onto the floor during the transfer. The CNA picked it up and, without cleaning it, replaced it on the | F ~~253~~ 176 | b. Resident #15 will be assessed for self-administration of medications by the Resident Care Manager, Occupational Therapist and Pharmacist. The interdisciplinary team will communicate to the staff through shift report, on the plan of care and the medication administration record (MAR) the residents level (I, II, or III) to self administer. The level will be highlighted on the MAR. This will be completed by October 29, 2006. The Resident Care Manager and MDS Coordinator will review all residents for evidence that Self Administration of Medication has been offered. Any residents found not to have had self administration offered will be assessed by October 29, 2006. All new residents will be assessed by the RN and | 10/29/06 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 253 | Continued From page 2<br><br>resident when care was completed. On 9/14/06 at 10:05 AM, the resident care manager stated her expectation was that the cannula should have been cleaned before being placed on the resident.<br><br>2. Observation on 9/12/06 at 10:43 AM showed CNA #14 assisted resident #17 with dressing. During the process, the resident's oxygen cannula fell onto the floor. The CNA picked it up, placed it on the resident's bed, and continued assisting the resident. Before completing the resident's care, the CNA left for a few moments and licensed practical nurse (LPN) #11 entered the room. The LPN picked up the nasal cannula and replaced it on the resident's face. On 9/14/06 at 10:05 AM, the resident care manager stated her expectation was that the cannula should have been cleaned.<br>3. Observations on 9/12/06 at 11:23 AM and again on 9/14/06 at 8:18 AM revealed the ceiling air vent located directly over the toilet in the shared bathroom between the resident lounge and resident room 114 was coated with dirt and grime. In addition, observation on 9/12/06 at 11:33 AM and on 9/14/06 at 8:36 PM revealed the ceiling air vent in the resident bathing room in the main hall was also coated with dirt and grime. Interview on 9/12/06 at 11:35 AM with the long term care secretary and housekeeper #1 on 9/14/06 at 8:38 PM confirmed the vents were dirty and needed to be cleaned. | F ~~253~~ 176<br><br>F253 | Occupational Therapist on admission. The care plan team will ensure the self administration of medication assessment is done by the 14 day plan of care meeting. The Resident Care Manager will observe the medication pass periodically on all shifts to assess that licensed staff are appropriately following the facility "Self-Administration of Medication" policy. This monitoring will be initiated by October 29, 2006 and documented on the staff's competencies.<br><br>F 253 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>1. All oxygen tubing for Resident #18 and O2 dependant resident's was replaced. The Resident Care Manager instructed all nursing staff to wipe contaminated oxygen tubing with sani-wipes and allow to air dry before placing in resident's nose. This was completed by September 18, 2006. The Resident Care Manger and Infection Control Practitioner will review and update the facility policy for oxygen tubing practices to include care for resident's cannula. This will be implemented and reviewed with all staff by the Infection Control Practitioner by October 29, 2006.<br>This policy will become part of a new employee's orientation packet and will be reviewed with all new employees and agency staff prior to them providing care by the Resident Care Manager or the | 10/29/06<br><br>10/29/06 |

called per phone request of JHFA on 10/23/06

This process will be monitored by the IP on a quarterly basis for at least one year. JB 10/23/06

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 272 SS=E | 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review and staff interview, the facility failed to complete a comprehensive assessment for all needed areas for five of 11 sample residents (#4, #10, #18, #26, | F 272 253 | designee. This will be in place by October 29, 2006.<br>The Resident Care Manager and Infection Control Practitioner will periodically observe staff for appropriate handling of oxygen tubing.. This will be documented on the staff competency. This will be in place by October 29, 2006.<br><br>2. All oxygen tubing for Resident #17 and O2 dependant resident's was replaced. The Resident Care Manager instructed all nursing staff to wipe contaminated oxygen tubing with sani-wipes and allow to air dry before placing in resident's nose. This was completed by September 18, 2006.The Resident Care Manger and Infection Control Practitioner will review and update the facility policy for oxygen tubing practices to include care for resident's cannula. This will be implemented and reviewed with all staff by the Infection Control Practitioner by October 29, 2006.<br>This policy will become part of a new employee's orientation packet and will be reviewed with all new employees and agency staff prior to them providing care by the Resident Care Manager or the designee. This will be in place by October 29, 2006.<br>The Resident Care Manager and Infection Control Practitioner will periodically observe staff for appropriate handling of oxygen tubing. This will be documented on the staff competency. | 10/29/06<br><br>10/29/06 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 272 | Continued From page 4<br>#41). The findings were:<br><br>1. Review of the 7/6/06 admission Minimum Data Set (MDS) assessment revealed resident #41 had moderate pain daily. Review of nursing notes showed the resident complained of pain on the following dates: 7/2/06, 8/28/06, 9/5/06, 9/9/06 and 9/11/06. Review of nursing notes showed on 9/11/06 the resident was put on "comfort measures only". Review of a 9/11/06 physician order showed the resident was prescribed Morphine Sulfate 2-4 milligrams (mg) every two hours as needed. Observation on 9/12/06 at 8:12 AM revealed the resident was medicated for pain. Review of the medical record revealed no comprehensive assessment for pain. The pain assessment in the 6/23/06 nursing assessment was blank. During an interview on 9/12/06 at 1:52 PM, the resident assessment coordinator and resident care manager both stated there was no pain assessment for this resident, but there should have been.<br><br>2. Review of the 6/15/06 quarterly MDS assessment showed resident #4 had daily pain, which was at times excruciating. Review of the medical record revealed no comprehensive assessment for pain. On 9/12/06 at 4:45 PM, the resident assessment coordinator stated the resident did have pain at times. The resident assessment coordinator looked through the medical record, and stated the pain assessment in the 6/14/06 nursing assessment was not completed, therefore there was no assessment.<br><br>3. Review of the 7/6/06 quarterly MDS assessment revealed resident #26 had pain less than daily, which was at times excruciating. | F 272 263<br><br>F272 | This will be in place by October 29, 2006.<br><br>3. The ceiling air vent directly over the toilet in the shared bathroom between the resident lounge and resident room 114 was cleaned by Environmental Service on September 14, 2006. The ceiling air vent in the resident bathing room in the main hall was cleaned by September 14, 2006.<br>The Environmental Services Manager will review these findings with the staff by October 3, 2006. Ceiling air vents will be checked on a weekly basis. Check will be documented on Environmental Services form. 4. All monitoring of the above process will be presented to IOP committee for at least 1 year.<br><br>F 272 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. added per phone request of VHH team 10/23/06 LB<br><br>1. Resident #41 is no longer in the facility. The Resident Care Manager and MDS Coordinator will review all residents for evidence of initial pain assessments. Any residents identified as not having an initial comprehensive pain assessment, will have the assessment completed. The new Pain Management policy will be reviewed with all staff on October 9 and 10, 2006. All staff will have a pain management in-service by the Resident Care Manager, including the initial comprehensive and periodic | 10/3/06<br><br>10/29/06 |



LB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 272 | Continued From page 5<br><br>Review of a 5/16/06 psychotropic medication review note showed the resident was having increased outbursts which may be due to pain. The note documented "...will inform staff to assess for pain..." Review of the medical record revealed there was no assessment for pain. On 9/13/06 at 2:24 PM, the resident care manager stated there was no assessment.<br>4. Review of the 7/20/06 annual MDS assessment showed resident #10 had daily pain of moderate intensity and required a comprehensive assessment in this area. However, review of the entire medical record showed the last pain assessment was dated 7/11/05, and it was incomplete. Interview with the resident assessment coordinator on 9/13/06 at 2:55 PM verified the lack of a comprehensive pain assessment.<br><br>5. According to the 8/17/06 quarterly and 2/16/06 annual MDS assessments, resident # 18 required a comprehensive assessment for daily pain of moderate intensity. Review of the entire medical record revealed the last pain assessment was completed on 11/7/05. Further review of the record showed that since then, the resident had fractured the left iliac wing and was having increased pain. Interview with the resident assessment coordinator on 9/13/06 at 3:20 PM confirmed the lack of a current comprehensive pain assessment. The coordinator stated it was a weak area for the facility. | F 272 | assessments for pain, during staff meetings on October 9 and 10. An initial pain assessment will be completed on all new admissions with-in 24 hours. This will be implemented by October 29, 2006. Orientation for new employees and agency staff will include pain management policy, including assessment for verbal and non-verbal adults. This will be completed by the Resident Care Manager or the designee. This will be implemented by October 29, 2006.<br>2. The MDS coordinator completed a comprehensive pain assessment for Resident #4 on September 14, 2006. The Resident Care Manager and MDS Coordinator will review all residents for evidence of initial pain assessments. Any residents identified as not having an initial comprehensive pain assessment, will have the assessment completed. The new Pain Management policy will be reviewed with all staff on October 9 and 10, 2006. All staff will have a pain management in-service by the Resident Care Manager, including the initial comprehensive and periodic assessments for pain, during staff meetings on October 9 and 10. An initial pain assessment will be completed on all new admissions with-in 24 hours. This will be implemented by October 29, 2006. Orientation for new employees and agency staff will include pain management policy including assessment for verbal and non-verbal adults. This will be completed by the Resident Care<br>(Continued on 3 attached Sheets) | 10/29/06 |

Completion Date

**F 272** (cont.)Manager or the designee. This will be implemented by October 29, 2006.

3. The MDS coordinator completed a comprehensive pain assessment for Resident #26 on October 3, 2006. The Resident Care Manager and MDS Coordinator will review all residents for evidence of initial pain assessments. Any residents identified not having an initial comprehensive pain assessment, will have the assessment completed. The new Pain Management policy will be reviewed with all staff on October 9 and 10, 2006. All staff will have a pain management in-service by the Resident Care Manager, including the initial comprehensive and periodic assessments for pain, during staff meetings on October 9 and 10. An initial pain assessment will be completed on all new admissions with-in 24 hours. This will be implemented by October 29, 2006. Orientation for new employees and agency staff will include pain management policy including assessment for verbal and non-verbal adults. This will be completed by the Resident Care Manager or the designee. This will be implemented by October 29, 2006. 10/29/06

The Care Plan Team will conduct periodic reviews of the presence of comprehensive pain assessments, re-assessments and interventions for all residents in pain. This will be reported quarterly to the Resident Care Manager and LTC Medical Director. This will be initiated by October 29, 2006.

4. The MDS coordinator will update 10/29/06

fb

Completion Date 10/29/06

**F 272** (cont.)the comprehensive pain assessment for Resident #10 by October 10, 2006 The Resident Care Manager and MDS Coordinator will monitor the re-assessments for timeliness and appropriate interventions. The Resident Care Manager and MDS Coordinator will review all residents for pain needs. Any residents identified with pain will receive a comprehensive pain assessment and periodic assessment. Interventions including periodic assessments will be included in the Plan of Care, and shift report. All staff will have an initial pain in-service by the Resident Care Manager, including the initial comprehensive and periodic assessments for pain, during staff meetings on October 9 and 10. The Resident Care Manager, Care Coordinator and an LPN developed an updated Admission Assessment including a separate pain assessment. The assessments will be completed on all new admissions with-in 24 hours. This new process will be implemented by October 29, 2006. Orientation for new employees and agency staff will include pain management policy including assessment for verbal and non-verbal adults. This will be completed by the Resident Care Manager or the designee. This will be implemented by October 29, 2006.

The Resident Care Manager and MDS Coordinator will conduct periodic reviews of the presence of comprehensive pain assessments, re-assessments and interventions for all residents in pain. This will be reported quarterly to the Resident Care Manager

Completion Date

F 272(cont.)and the LTC Medical Director. This will be initiated by October 29, 2006. 10/29/06

5. The MDS coordinator will complete a significant change pain assessment for Resident #18 by October 10, 2006.Periodic pain assessments will be identified on the Plan of Care and communicated through shift report to all staff. The Resident Care Manager and MDS Coordinator will monitor the re-assessments for timeliness and appropriate interventions. The Resident Care Manager and MDS Coordinator will review all residents for pain needs. Any residents identified with pain will receive a comprehensive pain assessment and periodic assessment. Interventions including periodic assessments will be included in the Plan of Care, and shift report. All staff will have an initial pain in-service by the Resident Care Manager, including the initial comprehensive and periodic assessments for pain, during staff meetings on October 9 and 10. The Resident Care Manager, Care Coordinator and an LPN developed an updated Admission Assessment including a separate pain assessment. The assessments will be completed on all new admissions with-in 24 hours. This new process will be implemented by October 29, 2006. Orientation for new employees and agency staff will include pain management policy including assessment for verbal and non-verbal adults. This will be completed by the Resident Care Manager or the designee. This will be implemented by October 29, 2006.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 281 SS=E | 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and review of policies and procedures, the facility failed to assure staff maintained professional standards of practice related to medication administration and following physician orders. The findings were:<br><br>1. Observation on 9/12/06 from 8:55 AM until 9:40 AM showed registered nurse (RN) #10 left the medication cart unlocked while administering medications in the dining room. The RN was frequently turned away from the cart or completely across the room and out of sight of the cart. In addition, at 9:15 AM licensed practical nurse (LPN) #11 left the second cart unlocked and out of her line of sight while she administered medications. That cart remained unsecured for the rest of the observation period. Numerous staff and residents had the opportunity to access the medication carts during that time period. Furthermore, observation on 9/12/06 at 12:02 PM showed a medication cart in the dining room was unattended and unlocked. On 9/13/06 at 4:03 PM, observation revealed the front hall medication cart was also unattended and unlocked.<br>During an interview on 9/13/06 at 2:25 PM, the resident care manager stated the medication carts should be locked when unattended or out of the line of sight of the nurses. Review of the facility's 3/20/03 policy and procedure, "Safe Medication Practice," showed "Medications...will be stored securely to prevent access or tampering by patients, visitors and unauthorized | F 281 272<br><br>F281 | The Resident Care Manager and MDS Coordinator will conduct periodic reviews of the presence of comprehensive pain assessments, re-assessments and interventions for all residents in pain. This will be reported quarterly to the Resident Care Manager and the LTC Medical Director. This will be initiated by October 29, 2006.<br><br>**F281** The services provided or arranged by the facility must meet professional standards of quality.<br>1. The Resident Care Manager will review the "Safe Medication Practice Policy" with all licensed staff at the October 9, 2006 staff meeting. This review will include the need to keep all unattended medication carts locked. The Resident Care Manager will conduct random monthly medication cart checks, including all shifts and all licensed staff, every three months to ensure that the carts are locked when unattended or out of line of sight of the nurses. Results will be recorded on the individual staff competencies. This will be initiated by October 29, 2006.<br>2. The Resident Care Manager shared the findings of state survey with licensed staff on September 18 regarding the process of removing pharmacy labels. The facility policy related to labeling of medication will be revised by October 5, 2006. The Pharmacist will attend the staff meeting on October 9, 2006 to review the updated policy and procedure revised October 5, 2006 regarding | 10/29/06<br><br>All processes will be monitored by TOP for at least one year<br><br>added phone requirement 10/23/06 BB<br><br>10/29/06<br><br>10/29/06 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 281 | Continued From page 7<br>staff." According to the 3rd edition of "Nursing Interventions & Clinical Skills" by Elkin, Perry, and Potter, "Medication carts must be kept locked when unattended..."<br><br>2. During an observation on 9/12/06 at 8:52 AM, RN #10 obtained a medication bottle with a white pharmacy label covering the manufacturer's name and dose of the medication. When questioned, the RN removed the pharmacy label to read the manufacturer's label which included the name and dose of the medication. After removing the pharmacy label, the RN tried to stick it back on the bottle. According to the facility's policy and procedure, "Labeling of medications" last revised 9/98, "The Labeling of medications shall be restricted to Pharmacist..."<br>3. Physician diagnoses found in the medical record for resident #35 revealed several diagnoses including Meniere' s disease. According to the 19th edition of Taber' s Cyclopedic Medical Dictionary, Meniere' s disease is defined as a recurrent and usually progressive group of symptoms including progressive deafness, ringing in the ears, dizziness, and a sensation of fullness or pressure in the ears. Review of the medical record also revealed a physician clinic note dated 6/7/06 requesting the resident obtain a " hearing evaluation " . Interview with the long term care secretary on 9/12/06 at 11:48 AM revealed the hearing evaluation was not done. According to the Wyoming Nursing Practice Act 2005 and Administrative Rules and Regulations, page 3-6, the nurse shall function under the direction of a licensed physician. | F 281 | "Labeling of medications". All licensed staff will receive a copy of the policy and meet one on one with the pharmacist by October 29, 2006.<br>3. The physician for Resident #35 was informed that the hearing evaluation was not obtained due to the resident's refusal. The Resident Care Manager and CNO will review the "Scope of Practice" as outlined in the Wyoming Nursing Practice Act 2005 and Administrative results and Regulations, page 3-6 related to the nurse functioning under the direction of a licensed physician at the October 9, 2006 staff meeting. This information will be shared with all staff by October 29, 2006. All employees will be provided with the Wyoming Nurse Practice Act 2005, with pages 3-6 as a handout. This will be completed and kept in employee's file. All new employees including agency will receive a copy of the Wyoming Nurse Practice Act in their orientation packets. This process will be monitored quarterly & reviewed with the IDT team & Medical Director for a year. (10/29/07)<br><br>F 282 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>1. The MDS Coordinator will review resident #10's plan of care with the LTC staff by October 10, 2006. Staff providing care for resident #10 will be informed of the toileting interventions for the resident. Staff will document toileting on the worksheets.<br>The Resident Care Manager and RN will review toileting interventions with all staff. This will be completed by | 10/29/06<br><br>10/29/06 |



above information was added per request of the NHA via phone on 10/23/06 JS

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 282 SS=D | 483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to assure staff followed the care plan for two (#10, #18) of 10 sample residents. The findings were:<br><br>1. Review of the annual 7/20/06 Minimum Data Set (MDS) assessment showed resident #10 was totally incontinent of bladder and was on a scheduled toileting plan. Review of the 7/20/06 care plan revealed staff were to toilet the resident upon arising, before and after meals, and at bedtime. During an interview on 9/12/06 at 4:50 PM, certified nurse aide (CNA) #18 stated she assisted the resident out of bed after checking and changing the resident's brief. When asked if she took the resident to the bathroom, the CNA replied that she had not as the resident was "soaked." Interview with resident care manager on 9/13/06 at 9:53 AM revealed "toilet" meant to take the resident to the bathroom. In addition, observation on 9/13/06 at 3:45 PM showed nursing assistant #3 also assisted the resident out of bed but failed to toilet him/her or ask the resident if s/he needed to use the bathroom.<br><br>2. According to the 8/17/06 MDS assessment, resident #18 was totally incontinent of bladder and was on a scheduled toileting plan. Review of the 8/17/06 care plan showed staff were to place | F 282 | October 29, 2006. The Resident Care Manager will direct Licensed staff to team with CNA's to ensure the toileting plan is followed. The Resident Care Manager will monitor all worksheets and will periodically monitor staff providing care to residents for appropriateness of care. Those staff not providing care as outlined will be evaluated for ability to provide outlined care and trained or counseled as appropriate. This will be included in the employee's competency. This will be implemented by October 29, 2006.<br>2. The MDS Coordinator will review resident #10's plan of care with the LTC staff by October 10, 2006. Staff providing care for resident # 10 will be informed of the toileting interventions for the resident. Staff will document toileting on the worksheets<br>The Resident Care Manager and RN will review toileting interventions with all staff. This will be completed by October 29, 2006. The Resident Care Manager will direct Licensed staff to team with CNA's to ensure the toileting plan is followed. The Resident Care Manager will monitor all worksheets and will periodically monitor staff providing care to residents for appropriateness of care. Those staff not providing care as outlined will be evaluated for ability to provide outlined care and trained or counseled as appropriate. This will be included in the employee's competency. This will be implemented by October 29, 2006.<br>NOTE: POC for resident #18 is attached on last page LB | 10/29/06 |



LB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 282 | Continued From page 9<br>the resident on the commode upon arising, after breakfast, before lunch, before lying down and after his/her nap, and at bedtime. Observation on 9/12/06 showed the resident was not placed on the commode from 8 AM until 2 PM, and at 2 PM CNA #14 only changed the resident's incontinence brief. Interview with CNA #14 at that time revealed she forgot to toilet the resident. | F 282 | This process will be monitored quarterly & reviewed @ the IDP team & Medical Directs for a year. | |
| F 286 SS=B | 483.20(d) RESIDENT ASSESSMENT - USE<br><br>A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to maintain 15 months of assessment information in the active records for 2 (#24, #35) of 11 sample residents. The findings were:<br>1. Review of medical records showed the following assessment information was missing from each resident's active record:<br>a. The 6/16/05 significant change Minimum Data Set (MDS) assessment was not available for resident #35.<br>b. The 9/22/05 significant change MDS assessment for resident #24 was not available. Interview with the long term care secretary on 9/12/06 at 3:48 PM revealed the assessment information was in the MDS coordinator's office.<br><br>2. Interview with the resident assessment coordinator on 9/13/06 at 10:20 AM revealed | F 286 | F 286 a facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.<br><br>1. a. The significant change MDS was found and placed on resident #35's active medical record .<br>The Resident Care Manager will develop a medical record management protocol for the Long Term Care (LTC) facility. The protocol will outline the information stored in the active LTC medical record. This protocol will be completed by October 20, 2006. The protocol will be implemented by October 29, 2006. The Long Term Care Secretary will be responsible for maintaining the medical records based on the protocol. The LTC Secretary will monitor the resident medical records monthly for completeness and report findings to the Resident Care Manager. This will be completed by October 29, 2006.<br><br>b. The significant change MDS was found and placed on resident #24's active medical record. | 10/29/06<br>updated per request of the surveyor via phone 10/23/06 RB<br><br>10/29/06 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 286 | Continued From page 10<br>purged information was kept in files in her office. According to the coordinator, the office was unlocked when the she was not there, but the files were locked and staff did not have the key. | F 286 | The Resident Care Manager will develop a medical record management protocol for the Long Term Care (LTC) facility. The protocol will outline the information stored in the active LTC medical record. This protocol will be completed by October 20, 2006. The protocol will be implemented by October 29, 2006. The Long Term Care Secretary will be responsible for maintaining the medical records based on the protocol. The LTC Secretary will monitor the resident medical records monthly for completeness and report findings to the Resident Care Manager. This will be completed by October 29, 2006. | |
| F 311 SS=D | 483.25(a)(2) ACTIVITIES OF DAILY LIVING<br><br>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to provide treatment and services to maintain the ability to use the toilet for two (#10, #18) of nine sample residents who demonstrated that ability. The findings were:<br><br>1. Review of the annual 7/20/06 Minimum Data Set (MDS) assessment showed resident #10 had moderate cognitive impairment (decisions poor, required cues/supervision), was totally incontinent of bladder, and was on a scheduled toileting plan. Review of the 7/20/06 care plan revealed staff were to toilet the resident upon arising, before and after meals, and at bedtime. Observation on 9/12/06 at 8:16 AM showed the resident was placed on the toilet and did urinate. However, during an interview on 9/12/06 at 4:50 PM, certified nurse aide (CNA) #18 stated she assisted the resident out of bed after checking and changing the resident's brief. When asked if she took the resident to the bathroom, the CNA replied that she had not as the resident was | ~~F 311~~<br><br>F311 | 2. The LTC medical record management protocol will include that all resident assessments within the previous 15 months will remain in the record at the nurse's station. This information will be maintained and monitored by the Long Term Care Secretary and findings reported to the Resident Care Manager monthly. This will be implemented by October 29, 2006.<br><br>**F 311** a resident is given the appropriate treatment and services to maintain or improve his or her abilities.<br><br>1. The Resident Care Manager and MDS coordinator will meet with the staff providing Resident #10's care to review the toileting plan. This review will include the intent to maintain or improve the resident's ability to toilet and remain continent. This will be completed by October 10, 2006. The Resident Care | 10/29/06<br><br>10/29/06 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 311 | Continued From page 11<br>"soaked." Interview with resident care manager on 9/13/06 at 9:53 AM revealed "toilet" meant to take the resident to the bathroom. In addition, observation on 9/13/06 at 3:45 PM showed nursing assistant #3 also assisted the resident out of bed but failed to toilet him/her or ask the resident if s/he needed to use the bathroom.<br><br>2. According to the 8/17/06 MDS assessment, resident #18 was totally incontinent of bladder and was on a scheduled toileting plan. Review of the 8/17/06 care plan showed staff were to place the resident on the commode upon arising, after breakfast, before lunch, before lying down, after his/her nap, and at bedtime. Observation on 9/12/06 showed the resident was assisted from the commode at 8 AM. Further observation showed the resident was not placed on the commode from 8 AM until 2 PM, and at 2 PM CNA #14 only changed the resident's incontinence brief instead of placing him/her on the commode. Interview with CNA #14 at that time revealed she forgot to toilet the resident. | F 311 | Manager and MDS coordinator will review with all staff the bladder policy including the goals for each individual resident and the plan for meeting the resident's goal to maintain or improve their incontinence. Licensed staff will monitor the residents' toileting to ensure the residents' opportunity to maintain or improve their continence. The MDS Coordinator will monitor each resident's progress monthly and will report results to the Resident Care Manager. This will be implemented by October 29, 2006.<br>Those staff not providing care as outlined will be evaluated for ability to provide outlined care and trained or counseled as appropriate. This will be included in the employee's competency. This will be implemented by October 29, 2006. This process will be monitored by ICP team for at least one year<br><br>2. The Resident Care Manager and MDS coordinator will meet with the staff providing Resident #18's care to review the toileting plan. This review will include the intent to maintain or improve the resident's ability to toilet and remain continent. This will be completed by October 10, 2006. The Resident Care Manager and MDS coordinator will review with all staff the bladder policy including the goals for each individual resident and the plan for meeting the resident's goal to maintain or improve their incontinence. Licensed staff will monitor the residents' toileting to ensure the residents' opportunity to maintain or improve their continence. The MDS Coordinator will monitor each residents | added per request of written 10/25/06 JB<br>10/29/06 |
| F 312 SS=D | 483.25(a)(3) ACTIVITIES OF DAILY LIVING<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of clinical reference material and staff interview, the facility failed to | F ~~312~~ 311 | | |



JB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 312 | Continued From page 12<br><br>assure staff completed perineal (incontinence) care appropriately for two (#6, #21) of nine residents dependent on staff for assistance. The findings were:<br><br>1. Observation on 9/11/06 at 5:55 PM showed certified nurse aide (CNA) #4 transferred resident #6 into the bathroom using a sit-to-stand lift. The resident was continent of bowel, but the CNA provided perineal care by cleansing the resident's buttocks and anus and then the perineal area (back to front) with the same area of the wipe. Interview with the resident care manager on 9/13/06 at 2:25 PM revealed the facility lacked specific policies and procedures for perineal care, but her expectation was that it should be completed from front to back. The manager stated this was discussed at a recent staff inservice. Review of the 11/2001 "Nurse Aide Written (or Oral) Examination and Skills Evaluation Candidate Handbook" showed perineal care must be provided by "...moving from front to back..."<br><br>2. Observation on 9/12/06 at 7:20 AM revealed resident #21 was seated on a bedside commode. CNA #14 provided perineal care; however, she cleansed the resident by using a back and forth motion with the same area of the wipe. Further observation on 9/12/06 at 11:03 AM showed the resident was incontinent of bowel. CNA #14 again cleansed the resident by using a back and forth motion with the same area of the wipe. Interview with the resident care manager on 9/13/06 at 2:25 PM revealed the facility lacked specific policies and procedures for perineal care, but her expectation was that staff should use only one area of a wipe per stroke. Review of the 11/2001 | F ~~312~~ 311<br><br>F312 | progress monthly and will report results to the Resident Care Manager. This will be implemented by October 29, 2006.<br>Those staff not providing care as outlined will be evaluated for ability to provide outlined care and trained or counseled as appropriate. This will be included in the employee's competency. This will be implemented by October 29, 2006. This process will be monitored by the IDP team for at least 1 year<br><br>**F 312** A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>1. The Resident Care Manager and designee will complete a perineal care competency for each of the staff providing care to Resident #6. The Resident Care Manager and designee will complete perineal competencies for all staff by October 29, 2006. This information will be documented in the employee's records. The Resident Care Manager and Infection Control Practitioner will monitor perineal care periodically over various shifts among various staff members. The results will be reviewed quarterly. Perineal care competencies will be conducted yearly and when results from monitoring indicate. This will be implemented by October 29, 2006.<br>2. The Resident Care Manager and designee will complete a perineal care competency for each of the staff providing care to Resident #21. The | added per request of SURVEYOR FB<br><br>10/29/06<br><br>10/29/06<br><br>10/29/06 |



FB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 312 | Continued From page 13<br>"Nurse Aide Written (or Oral) Examination and Skills Evaluation Candidate Handbook" showed perineal care must be provided by "...using a clean area of the washcloth or clean washcloth for each stroke." | F 312 | Resident Care Manager and designee will complete perineal competencies for all staff by October 29, 2006. This information will be documented in the employee's records. The Resident Care Manager and Infection Control Practitioner will monitor perineal care periodically over various shifts among various staff members. The results will be reviewed quarterly. Perineal care competencies will be conducted yearly and when results from monitoring indicates. This will be implemented by October 29, 2006. This process will be monitored by the IC team for at least 1 year. | |
| F 315 SS=D | 483.25(d) URINARY INCONTINENCE<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and medical record review, the facility failed to assure staff provided treatment and services to attain or maintain as much bladder continence as possible for one (# 18) of eight sample residents who were incontinent. The findings were:<br><br>Review of the 8/17/06 Minimum Data Set assessment showed resident #18 had moderate cognitive impairment (decisions poor, required cues/supervision), was totally incontinent of bladder, and was on a scheduled toileting plan. According to the 8/17/06 care plan, staff were to place the resident on the commode upon arising, after breakfast, before lunch, before lying down | F 315 312 | **F 315** Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriated treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>The Resident Care Manager will review resident # 18's goal to prevent urinary tract infections and to restore normal bladder function with all LTC staff. This review will include the individual plans to meet the goal. This will be completed by October 29, 2006.<br>The facility's Bowel and Bladder policy is to maintain as much bladder continence as possible and toileting plans are developed with that goal. Toileting a | added per request of NHA on 10/3/06 10/29/06 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 315 | Continued From page 14<br>and after his/her nap, and at bedtime. Observation on 9/12/06 showed the resident was assisted from the commode at 8 AM. Further observation showed the resident was not placed on the commode, or the incontinence brief checked or changed, until 2 PM (6 hours later). At that time, the resident's incontinence brief was saturated, and his/her slacks were wet. Interview with Certified Nurse Aide #14 on 9/12/06 at 2 PM revealed she forgot to toilet the resident. | F 315 | resident on a commode in accordance to their care plan will be documented on the employee's worksheet and reinforced at report.<br>Resident Care Manager will review worksheets. Licensed staff will randomly observe toileting on commode and document on worksheet. Results will be shared with the Resident Care Manager. This will be implemented by October 29, 2006. This process will be monitored by the IOP team for at least one year. LB | |
| F 323 SS=D | 483.25(h)(1) ACCIDENTS<br>The facility must ensure that the resident environment remains as free of accident hazards as is possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure the environment was safe and chemicals were not accessible to residents. The findings were:<br><br>Observation of the resident bathing room in the back hallway on 9/13/06 at 3:45 PM and again on 9/14/06 at 8:22 AM revealed the door leading from the general hallway into the bathing room was open and no staff was in the vicinity. On the counter in the bathing room was a quart aerosol container of " Omega " Detergent - Disinfectant. The label on the container stated " Causes eye irritation. May be harmful if swallowed. " The label also listed the active ingredient as ammonium chloride. In addition, an unlocked wall cabinet was also in the bathroom. Inside the | F 323 | **F 323** The facility must ensure that the resident environment remains as free of accident hazards as is possible.<br>1. The facility will ensure that the environment is safe and chemicals are not accessible to residents. The chemicals will be in the locked wall cabinet in the bathroom. Plant Operations/Resident Care Manager will monitor this area daily to insure they are kept in compliance with these regulations.<br><br>The wainscoting was repaired 9/14/2006. The facility will ensure that a safe environment is provided at all times. Maintenance staff will do regular safety check rounds and repair or replace items found on these rounds. The Plant Maintenance Manager will also do safety rounds of the LTC facility. This process will be monitored by the IOP team for at least one year.<br>info added per request of NHA on 10/5-31-06 LB | 9/14/06 |



LB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 323 | Continued From page 15<br><br>cabinet was a 100 fluid ounce plastic bottle of disinfectant " Cen-Klen " . On the label was written " Danger. Corrosive. Keep out of the reach of children. " The active ingredient was also ammonium chloride. According to the Columbia Encyclopedia 6th edition, 2004, ammonium chloride is harmful if swallowed and causes skin and eye irritation. Also in the wall cabinet was a one gallon container of " Septisoft. " On the label was written " Exterior use only. May cause eye irritation. " Interview with Licensed Practical Nurse #16, on 9/13/06 at 4:11 PM confirmed the " Omega " detergent/ disinfectant should be locked up and the cabinet doors where the other three containers were located should be locked at all times when staff was not in the room.<br><br>Random observations throughout the survey on 9/11/06 through 9/14/06 revealed a one inch wide strip of loose wainscot wall molding in two locations. The molding was located directly behind the hand rail on the wall between resident rooms 105 and 106 and also on the hallway wall directly opposite the entry to the resident ' s lounge. Interview with the long term care secretary on 9/14/06 at 8:48 AM confirmed the loose molding represented a potential safety hazard to fingers and hands of residents and staff using the handrails. | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 364 SS=D | 483.35(d)(1)-(2) FOOD<br><br>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interviews, and medical record review, the facility failed to provide one (#5) of 10 sample residents with a warm, palatable meal. In addition, seven residents stated meals could sometimes be warmer. The findings were:<br><br>According to information provided by the facility, breakfast was served at 8 AM and 8:15 AM. Observation on 9/12/06 at 9 AM showed a covered meal remained on a dining room table. The meal was identified by certified nurse aide (CNA) #12 as being for resident #5, who went for laboratory tests before breakfast that morning. Further observation showed the resident did not come into the dining room until 9:20 AM. At that time, s/he was taken to the table by CNA #13 who uncovered, but did not warm, the meal which consisted of a poached egg and toast. When asked at 9:25 AM if the food was warm, the resident replied, "No." When asked how the egg tasted, the resident said, "terrible... the rest is pretty bad, too." Interview with the CNA on 9/14/06 at 8:10 AM confirmed she did not ask the resident if s/he wanted the meal warmed. Review of the meal consumption records showed the resident only ate 25 percent of that meal.<br><br>During a confidential group interview on 9/12/06 | F 364 | Resident #5 will have hot/fresh meals served when she/he is to have lab tests 10/29/06 LB<br>**F364** To ensure meals are served at appropriate temperatures those residents unable to attend meals due to laboratory test, w x-rays, and outings, etc. will have their meals cancelled until they return. Upon the return of the resident, they will receive a meal tray served at the appropriate temperature.<br><br>At time of serving staff will ask residents if their meal is hot enough and offer to heat it.<br>On the occasion that a resident arrives to meals shortly after it is served, the meals is to be left covered and hot beverages will not be poured. Upon the arrival of the resident staff will ask the resident if the meal is hot enough and offer to heat it.<br><br>On a quarterly basis temperatures of "test" trays will be taken and documented to ensure proper temperature of trays. This will be completed for the tree week menu cycle. On a daily bases the temperatures of food in the steam table will be taken and documented prior to the start and at the completion of tray line service.<br><br>On a monthly basis a sample of residents will be interviewed by dietary staff for appropriateness of the food temperatures. This will be documented, monitored with the TQP team for one year. LB<br>Education of LTC and dietary staff will take place at monthly staff meetings. | |



info added per request of WHA on 10/25/06 LB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 364 | Continued From page 17<br>at 3 PM, seven residents stated the food could be warmer, and at times was cold. | F 364 | | |
| F 431 SS=D | 483.60(d) LABELING OF DRUGS AND BIOLOGICALS<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and review of policies and procedures, the facility failed to assure all medications were labeled in accordance with accepted professional standards. The findings were:<br><br>During a random observation on 9/12/06 at 8:52 AM, Registered Nurse #10 obtained a medication bottle with a white pharmacy label obscuring the name and strength of the medication on the manufacturer's label. The pharmacy label read "Stock - give as directed." However, it did not include the name or strength of the medication. During the observation, the RN stated that the name and strength of the medication on the manufacturer's label should not be covered by the pharmacy label. According to the facility's policy and procedure, "Labeling of medications" last revised 9/98, "When unit dose packaging is not available, multiple dose containers will be used containing medication name, strength,..." | F 431 | **F 431** Drugs and biological are used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Pharmacy inspected all stock medication for proper labeling. Pharmacy will update "Labeling of Medications Policy" and review with Licensed Nurses at a staff meeting on October 9, 2006. Staff unable to attend will meet one on one with the pharmacist prior to October 29, 2006 during monthly area inspection pharmacy will check for proper labeling. Any improper labeling found will be reported to the Resident Care Manager and will be monitored and reviewed with quarterly IDP for one year.<br><br>added per request of NTH on 10/23/06 AB | 10/29/06 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 444 SS=D | 483.65(b)(3) PREVENTING SPREAD OF INFECTION<br><br>The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, and review of policies and procedures, the facility failed to assure staff washed their hands as indicated by accepted professional standards after providing care for two (#10, #18) of 10 sample residents. The findings were:<br><br>Review of the facility's 6/27/05 policy and procedure, "Hand Hygiene," revealed "Hands must be washed or sanitized before and after contact with any patient or items in the patient environment." Indications for hand washing were listed as "After using the bathroom." Indications for hand sanitization with an alcohol-based hand rub included "Before donning and after removing gloves." According to the information sheet provided by the facility, "Do You Know the Components for Hand Hygiene?", gloves do not eliminate the need for hand hygiene. The following concerns with failure to follow the policy and procedure were identified:<br>a. Observation on 9/12/06 at 8:16 AM showed resident #10 was transferred into the bathroom with a sit-to-stand lift. The resident had a bowel movement and certified nurse aide (CNA) #12 completed perineal care. However, the CNA failed to remove her gloves before transferring | F 444 | **F 444** The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>1. a. The Infection Control Practitioner will review the "Hand Hygiene" competencies with all LTC staff including the donning of gloves, by October 29, 2006. The competencies will be recorded and placed in each employees file. All staff will review the facilities policy and procedure regarding "Hand Hygiene". The Resident Care Manager and Infection Control Practitioner will periodically monitor hand hygiene practice. Ongoing observation will be documented at least quarterly.<br>2. b. The Infection Control Practitioner will review the "Hand Hygiene" competencies with all LTC staff including washing hands after removing gloves by October 29, 2006. The competencies will be recorded and placed in each employees file. All staff will review the facilities policy and procedure regarding "Hand Hygiene". The Resident Care Manager and Infection Control Practitioner will periodically monitor hand hygiene practice. Ongoing observation will be documented at least quarterly.<br>This process will be monitored by the IOP team for one year. added per request of WHPCR 10/25/06 KB | 10/29/06<br><br>10/29/06 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 444 | Continued From page 19<br>the resident back into a wheelchair and fastening the seat belt. In addition, after removing the gloves, the CNA failed to wash or sanitize her hands before wetting a washcloth and assisting the resident to wash his/her face. The CNA then combed the resident's hair and put his/her glasses on the resident.<br>b. Observation on 9/12/06 at 7:58 AM showed CNA #14 cleansed resident #18 who had had a bowel movement. The CNA removed her gloves, and without washing or sanitizing her hands, assisted the resident to dress, then transferred the resident onto the bed using a mechanical lift. During the transfer, the CNA handled the sling, the lift, and the lift controls. After the transfer, the CNA washed her hands, donned gloves, and completed perineal care. Without removing the gloves, the CNA then removed the resident's shoes and slacks and redressed him/her.<br>During an interview on 9/13/06 at 3:25 PM, the infection control practitioner stated staff should remove gloves after providing perineal care and wash or sanitize their hands before doing other things. | F 444 | | |
| F 492 SS=D | 483.75(b) ADMINISTRATION<br><br>The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.<br><br>This REQUIREMENT is not met as evidenced by: | F 492 | **F 492** The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.<br><br>1. All staff will receive their scope of practice as stated in the "Nursing Practice Act and Administrative Rules and Regulations". Each staff member | 9/18/06 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 492 | Continued From page 20<br><br>Based on observation and staff interviews, the facility failed to assure staff adhered to state nursing regulations and requirements, as defined by the Wyoming State Board of Nursing, for non-sample resident #3. In addition, non-licensed staff adjusted the oxygen liter flow rates, which were not posted, for one (#10) of four sample residents and one (#15) non-sample resident. The findings were:<br><br>1. Observation on 9/13/06 at 1:30 PM showed certified nurse aide (CNA) #23 requested Bacitracin (an antibiotic ointment) from licensed practical nurse (LPN) #21. The LPN gave an individual packet of Bacitracin to the CNA and instructed her to "let me know if it's changed." The CNA went into the room of resident #3 and assisted him/her to bed. As the CNA changed the resident's brief, the LPN entered the room and asked if the CNA needed any help. The CNA opened the packet of Bacitracin and squirted it onto the LPN's fingers; the LPN applied the Bacitracin to reddened areas on the resident's scrotum and penis. Both staff members explained the areas had been open but were now healed. During an interview on 9/13/06 at 1:41 PM, the CNA stated she usually applied the Bacitracin. When told of this on 9/14/06 at 10:05 AM, the resident care manager and director of nursing service just shook their heads "no." They agreed the action was outside the scope of practice for both the CNA and the LPN.<br>Review of the July 2005 Wyoming "Nursing Practice Act and Administrative Rules and Regulations" November 2003 showed applying medications was not a task which could be delegated to CNAs as it was not within their scope of practice. | F 492 | will sign a statement saying they received this information and will read and work within the scope of their practice. Staff received information regarding this finding at the September 18, 2006 staff meeting and for those not in attendance, this information is in the minutes.<br>2. All oxygen concentrators and/or oxygen tanks will be clearly marked by the nurse. The safety team lead by a RN will monitor monthly, or licensed staff will change as needed. The flow rate of oxygen will be posted on the residents care plan in the resident's closet. This will be implemented by October 29, 2006.<br><br>added per request of NHA on 10/23/06<br>Only licensed staff will apply the Bacitracin ointment to resident #3. | 10/29/06 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 492 | Continued From page 21<br><br>2. Review of the May 2001 opinion paper published by the Wyoming State Board of Nursing showed CNAs could adjust oxygen liter flow rates "if the liter flow is clearly marked by the nurse on the concentrator &/or oxygen tank or over the client's bed." Failure to adhere to that requirement was identified for the following residents:<br>a. On 9/12/06 at 11:50 AM, as CNA #5 explained that resident #15 required oxygen at 4 liters per minute (LPM) while on the portable oxygen tank, observation revealed the liter flow rate was not posted. The CNA set the rate at 4 LPM.<br>b. Observation on 9/13/06 at 3:45 PM showed the liter flow rate was not posted on the oxygen concentrator for resident #10; instead it was posted "Cont" (continuous) and the rate was set at 3 LPM. When questioned, nursing assistant (NA) #3 did not know what the rate should be, but he stated it was as set on the gauge. The NA changed the gauge and reset it to 3 LPM while trying to show the surveyor how to operate the concentrator. The NA finally stated the flow rate was posted on the care plan, which was inside the resident's closet. Review of the care plan showed the flow rate was not specified. | F 492 | Residents #10 and #15 have both had the liter flow posted on their $O_2$ tanks & concentrators.<br><br>added per request of WHA 10/23/06 & BCH on BB | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 493 SS=C | 483.75(d)(1)-(2) GOVERNING BODY<br><br>The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, review of an Internet database, and review of facility documentation, the governing body failed to appoint an administrator who was licensed by the state of Wyoming. The findings were:<br><br>During the entrance conference on 9/11/06 at 4:50 PM, the clinical nursing officer (CNO) identified employee #27 as the administrator of the facility. Review of the facility staff listing provided by the facility revealed employee #27 was the administrator. Review of a letter dated 9/6/06 from the Wyoming Board of Nursing Home Administrators provided by the facility showed the board had received the application from employee #27, but did not provide a license. Review of the Wyoming Board of Nursing Home Administrators Internet database (http://nha.state.wy.us) on 9/12/06 at 6 PM showed employee #27 did not have a license. During an interview on 9/13/06 at 4:35 PM, employee #27 stated he had been acting as the administrator for 60 days. He confirmed he did not have a license. | F 493 | **F493** Employee # 27 has submitted to the State of Wyoming for consideration of waving the nursing home internship requirement. If accepted, employee #27 will schedule and sit for the Long Term Care Administrator's examination at the earliest possible date. We will work towards getting another Long Term Administrator licensed. To ensure further compliance, we will add this requirement to the official job description of the CEO of the facility.<br><br>Will be Completed within the required 6 mth period from the date of the temporary license issue<br><br>Gavin Carmichael received a temporary WTN license on 10/26/06 and is pursuing a permanent license<br><br>added per request of Jean Mc Kean State Agent on 10/26/06 10/26/06 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING _____ B. WING _____ | 09/14/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLATTE COUNTY MEMORIAL NURSING | 201 14TH ST WHEATLAND, WY 82201 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 |
|---|---|---|---|---|
| | | | | |