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	535053	A. BUILDING _____ B. WING _____	C 07/21/2022

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 from 7/18/22 to 7/21/22. Also reviewed in the course of the survey was complaint intake WY000003436. In addition, a review for compliance with the Omnibus COVID-19 Health Care Staff Vaccination requirements was conducted. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the vaccine requirements. The following common abbreviations are used throughout this document: BIMs- Brief Interview for Mental Status CNA- Certified Nursing Aide DON- Director of Nursing MDS- Minimum Data Set PPE- Personal Protective Equipment PTA- Physical Therapy Assistant OTA- Occupational Therapy Assistant RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		9/2/22

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

Electronically Signed | 08/12/2022

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F 656	Continued From page 1 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record review, the facility failed to ensure care plans were developed with resident specific interventions to reflect individual needs for pain management for 1 of 12 sample residents (#29).	F 656	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	

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F 656	Continued From page 2 The findings were: 1. Review of the 6/3/22 admission MDS assessment showed resident #29 was cognitively intact with a BIMS score of 15 out of 15. The resident was admitted with diagnoses which included non-infective gastroenteritis and colitis. Review of the Care Plan Conference Summary dated 6/23/22, showed the resident had pain that bothered him/her; however, the resident stated "non-medical interventions have not helped decrease the pain in the past." Review of the medication administration record (MAR) showed orders for Tylenol Extra Strength (analgesic) 500 mg, give 1000 mg by mouth every morning and at bedtime for pain. The following concerns were identified: a. Interview on 7/19/22 at 9:35 AM with the resident revealed s/he had quite a bit of pain and the only intervention provided was pain medication. b. Review of the chronic back and shoulder pain care plan last revised 7/15/22 showed the resident's pain "...will remain at an acceptable level with the current pain regimen without adverse side effects from pain medication..." Interventions included evaluate the effectiveness of pain interventions, observe for/record pain characteristics, and report any signs/symptoms of non-verbal pain. Further review showed no indication of an acceptable level of pain or non-pharmacological interventions to help alleviate pain. c. Interview on 7/20/22 at 2:06 PM with the DON revealed they could try heat or massage to help decrease the pain. She confirmed the care plan did not have non-pharmacologic interventions to treat pain.	F 656	submission of this plan does not constitute agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied. F 656- The facility will ensure that comprehensive care plans reflect the residents individual needs for pain management. A Comprehensive pain assessment was completed on resident #29 on August 12, 2022 Resident #29s care plan was reviewed and updated on August 12, 2022, to reflect pharmacological and non-pharmacological interventions to meet his individual pain control goals and preferences. All residents will have a comprehensive pain management assessment with review of their individual plan of care, completed by DON or designee, to ensure pain management interventions including non-pharmacological interventions are in place to meet each residents individual pain control goals and preferences by September 2, 2022 The policy and procedure entitled Comprehensive care planning will be reviewed and updated on August 19, 2022. 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.	

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F 656	Continued From page 3	F 656	The care plan team and nursing department will be educated on the Comprehensive care plan policy regarding pain control by August 26, 2022 The DON or designee will conduct monthly random audits of care plans for pain management including non-pharmacological 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 identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	
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, resident and staff interview, medical record review, and policy review, the facility failed to ensure residents	F 684	F 684- The facility will ensure residents receive care and treatment in accordance with	9/2/22

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F 684	Continued From page 4 received care and treatment in accordance with professional standards for 1 of 4 sample residents (#32). The findings were: 1. Review of the 6/10/22 admission MDS assessment showed resident #32 was cognitively intact with a BIMS score of 14 out of 15. The resident had diagnoses which included chronic obstructive pulmonary disease and required nebulizer breathing treatments. Review of the order summary report dated 7/21/22 showed the resident was receiving albuterol sulfate nebulization solution (2.5 mg (milligrams)/3 ml (milliliters) 0.083% via nebulizer every 6 hours as needed, and aformoterol tartrate nebulization solution 15 mcg (micrograms) 2 ml via nebulizer two times a day (BID). Further review of the order summary showed a physician note dated 7/14/22 "FYI Pt.[patient] wanted to go to [his/her] prior Serevent BID and prn (as needed) Albuterol. When [s/he] goes off skilled we can stop the budesonide and formoterol and go to Advair BID and Combivent BID and see how [s/he] does...." Review of the Self Administration of Medication form dated 6/3/22 showed the resident required assistance with inhalants/inhalers. The following concerns were identified: a. Observation on 7/18/22 at 3:28 PM showed the resident retrieved 3 inhalers, Albuterol, Advair, and Serevent from a white bag that was in a basket on her bed. Interview with the resident at that time revealed the facility said s/he could use her own inhalers. b. Review of the MAR for July 2022 showed there were no orders for the resident to receive Albuterol, Advair, or Serevent inhalers. c. Interview on 7/21/22 at 2:04 PM with the DON revealed they were not aware the resident had the inhalers at his/her bedside and confirmed	F 684	professional standards. Albuteral, Advair and Serevent MDIs were removed from resident #32□s bedside on July 22, 2022. The resident□s physician along with the IDT will reassess resident #32 for self-administration of MDI□s upon discharge from skilled level of care. All other residents with medications at the bedside will be reviewed by DON or designee by September 2, 2022 to ensure the proper physician□s orders and self-administration of medication assessments are in place. All newly admitted residents that have the potential to safely administer their own medication and have a desire to do so, will have a self-administration of medication assessment completed within five days of admission. If the resident is determined to have the ability to safely manage medication at the bedside a physician order will be obtained to do so. Policy and procedure entitled Administering Medications will be reviewed and updated by August 19, 2022 Nursing staff will receive education regarding the self-administration of medications policy by August 26, 2022 The DON or designee will conduct monthly random audits of self-administration of medication assessments and physician orders if determined appropriate. The audits will be conducted for no less than 3 months. Any problems identified will result in immediate education and corrective action.	

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F 684	Continued From page 5 the resident received nebulizer treatments. She further stated the physician had a conversation with the resident about switching to inhalers when the resident goes off skilled nursing care; however, there were no orders to stop the nebulizer breathing treatments, and start the inhalers. d. Review of the "Administering Medications" policy, last revised on 6/15/21 showed, "...21. Residents may self-administer their own medication only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely..."	F 684	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 resident and staff interview, and medical record review, the facility failed to develop and implement non-pharmacological interventions to manage pain for 1 of 7 residents reviewed (#29). The findings were: 1. Review of the 6/3/22 admission MDS assessment showed resident #29 was cognitively intact with a BIMS score of 15 out of 15. The resident was admitted with diagnoses which included non-infective gastroenteritis and colitis. Review of the Care Plan Conference Summary dated 6/23/22, showed the resident had back	F 697	F 697- The facility will develop and implement non-pharmacological interventions to manage pain. A Comprehensive pain assessment was completed on resident #29 on August 12, 2022. Resident #29□s care plan was reviewed and updated on August 12, 2022, to reflect pharmacological and non-pharmacological interventions to meet his individual pain control goals and preferences. The policy and procedure entitled Pain	9/2/22

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F 697	Continued From page 6 pain that bothered him/her; however, the resident stated "non-medical interventions have not helped decrease the pain in the past." Review of the MAR showed orders for Tylenol Extra Strength (analgesic) 500 mg, give 1000 mg by mouth every morning and at bedtime for pain. Further review of the MAR showed an order to complete pain assessments once weekly. The following concerns were identified: a. Interview on 7/19/22 at 9:35 AM with the resident revealed s/he had quite a bit of pain and s/he only received pain medications to alleviate pain. b. Review of the chronic back and shoulder pain care plan last revised 7/15/22 showed the resident's pain "...will remain at an acceptable level with the current pain regimen without adverse side effects from pain medication..." Interventions included evaluate the effectiveness of pain interventions, observe for/record pain characteristics, and report any signs/symptoms of non-verbal pain. Further review showed no indication of an acceptable level of pain or non-pharmacological interventions to help alleviate pain. c. Review of the MAR for July 2022 showed no evidence the pain medication was evaluated for effectiveness after administration. d. Review of the weekly pain assessment tool dated 6/25/22, 7/2/22, 7/9/22 and 7/16/22 showed pain medication administration was the method of alleviating pain, and non-pharmacological interventions were not documented. Further review failed to show an evaluation of the effectiveness of the medication administration. e. Interview on 7/20/22 at 2:06 PM with the DON revealed the facility could have tried heat, massage, or repositioning to alleviate pain. She confirmed the care plan and the weekly pain	F 697	Assessment and Management will be reviewed and updated by August 19, 2022 to ensure pain management is provided to residents who require such services. Residents with acute pain will be assessed for pain every shift and within 1 hour after administration of an intervention, to evaluate effectiveness. All residents will have a comprehensive pain management assessment with review of their individual plan of care, completed by DON or designee, to ensure pain management interventions including non-pharmacological interventions are in place to meet each resident□s individual pain control goals and preferences by September 2, 2022 Nursing staff will receive education regarding the pain management policy by August 26, 2022 The DON or designee will conduct weekly audits of pain management including non-pharmacological interventions for one month then monthly thereafter 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.	

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F 697	Continued From page 7 assessment did not include non-pharmacological interventions.	F 697		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review the facility failed to ensure medications were labeled in accordance with professional standards in 1 of 4 medication storage units (100-200 hall medication cart). In addition, the facility failed to ensure medication storage was	F 761	F 761- The facility will ensure medications are labeled in accordance with professional standards. The Levemir 100unit/ml flex pen with no	9/2/22

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F 761	Continued From page 8 secure and safe for 1 of 2 (100 - 200 medication room) medication storage rooms. The findings were: 1. Observation on 7/20/22 at 8:50 AM of the 100 - 200 hall medication cart showed one Levemir 100 unit/milliliter flex pen with no date to indicate when it was opened or when it would expire. Interview at that time with RN #1 revealed the medication was for resident use and she confirmed she was unsure when it was placed in the cart or when the medication expired. 2. Observation on 7/20/22 at 9:20 AM showed the 100 - 200 medication room had a box of multiple medications on the floor, to the right side of the room, and a duffle bag of multiple medications on the floor in the center of the room. Interview at that time with RN #1 revealed any nurse can access the medication room, and CNA #1 had access to the medication room to stock supplies. 3. Interview with the DON on 7/20/22 at 10:27 AM confirmed CNA #1 had access to the medication rooms to restock supplies. Further, she stated the nurses should let the CNA in the room. 4. Review of policy titled "Administering Medications" revised 12/2012, showed "... 9. When opening a multi-dose container, the date opened shall be recorded on the container." 5. Review of policy titled "Storage of Medications" revised April 2007, showed "...10. Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys."	F 761	open or expiration date was discarded on July 20th, 2022. The entry/access code to the medication rooms on both south and north hall were changed on July 20, 2022. Only persons authorized to prepare and administer medications have access to the entry code. Medication carts were audited for opened and expiration dates on July 22, 2022. All medications without appropriate labeling were discarded. The policy Administering Medications and the policy Storage of medications, will be reviewed by August 19, 2022. Nursing staff will receive education regarding proper labeling and storage of medications, and which employees are authorized to have unsupervised access to the medication rooms by August 26, 2022 The DON or designee will conduct monthly audits of each medication cart 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 880 SS=E	Infection Prevention & Control	F 880		9/2/22

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F 880	Continued From page 9 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 10 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, and review of the CDC guidelines, the facility failed to ensure infection control procedures were followed related to PPE use and/or hand hygiene during 3 random observations and during 1 of 3 observations of wound care (resident #8). The census was 40. The findings were: 1. Observation of room 202 showed an isolation	F 880	F 880- CNA #1, PTA #1, COTA #1, and SSD received education and have demonstrated competency on the proper procedure for donning/doffing of PPE on or before July 29, 2022. RN #1 was educated and demonstrated competency on July 22, 2022.	

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F 880	Continued From page 11 cart in the hallway by the door. Interview on 7/18/22 at 11:33 AM with CNA # 1 revealed the resident in the room was a new admission and was on isolation precautions for COVID-19. The following concerns were identified: a. Observation on 7/18/22 at 11:33 AM showed CNA #1 wearing a surgical mask. The CNA donned a gown, gloves, and a face shield then entered the room. Upon exiting the room the CNA removed the PPE, except for the surgical mask, then walked down the hall. b. Observation on 7/18/22 at 3:43 PM showed 2 therapy assistants (PTA #1, OTA #1) wore surgical masks and donned gowns and gloves, however; neither donned a face shield. Further observation showed the PTA and OTA donned an N95 respirator mask over their surgical masks. When they exited the room, both staff members removed the gown, gloves, and the N95 respirator masks; however, neither removed the surgical mask. c. Observation on 7/20/22 showed the social services director and CNA #1 exited the room. They removed their gown, gloves, and face shield; however, neither staff member removed the N95 respirator mask. Continued observation showed the social services director held the face shield in her hand and walked down the hall without sanitizing or bagging the face shield. d. Interview on 7/21/22 at 1:50 PM with the infection control nurse #1 revealed the PPE expectations for droplet precautions were for staff to don a gown, gloves, either a face shield or goggles, and an N95 respirator mask. She stated when staff leave the room they were to doff all PPE, including the N95 mask, and perform hand hygiene. She further stated if there was a shortage of supplies, the staff would disinfect the face shields using a disinfecting wipe or discard	F 880	The Standard Precaution policy and the policy Dressings, Dry/Clean will be reviewed and updated as needed by August 19, 2022. All staff will be re-educated on the Standard Precautions Policy including proper use of PPE and hand hygiene and all nursing staff will be re-educated on the Dressings, Dry/Clean policy August 26, 2022 The infection control nurse or designee will conduct weekly audits of PPE use and proper infection control during dressing changes for no less than 12 weeks and monthly thereafter for 3 months, to ensure compliance. Any concerns identified during these audits will result in immediate education and corrective action. Results of the audits will be reported at the QA&A meeting by the IC nurse or designee until compliance is achieved. F 880- DPOC In accordance with Federal regulations at 42 CFR ¿488.424 Platte County Legacy Home will implement the F-880 Directed Plan of Correction. See attached DPOC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535053	A. BUILDING _____ B. WING _____	C 07/21/2022

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F 880	Continued From page 12	F 880		

the face shield when supplies were not limited.

e. Review of the "Personal Protective Equipment-Using Protective Eyewear" policy revised 9/10, showed..."Miscellaneous 1. Masks and eye protection devices, such as goggles or glasses with solid side shields or chin-length face shields, shall be worn together whenever splashes, sprays, spatter or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be expected. 2. Personal eyeglasses should not be considered as adequate protective eyewear....Procedure Guidelines...3. Dispose of, or clean, eyewear as applicable..."

f. Review of the CDC Guidance titled "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" last revised on 2/2/22 showed health care providers who enter a patient's room with suspected or confirmed SARS-COV-2 should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown gloves and eye protection (i.e. goggles or a face shield that covers the front and sides of the face)..." Further the CDC recommends "... the N95 mask should be discarded after the patient care encounter and a new one should be donned..." The CDC also recommends "..appropriate cleaning and disinfection after each use if reusable face shields or goggles are used..."

2. Observation on 7/20/22 at 11:08 AM showed RN #1 perform wound care on resident #8. The RN donned gloves, removed the dressing, and cleansed the wound. The RN doffed her gloves, donned cleaned gloves, and applied the new dressing on the wound. No hand hygiene was

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F 880	Continued From page 13 performed. Interview with the nurse at that time confirmed she did not perform hand hygiene when going from a dirty procedure to a clean procedure. a. Interview with the DON on 7/21/22 at 1:49 PM revealed hand hygiene and clean gloves were expected between dirty and clean dressing changes. b. Review of policy "Dressings, Dry/Clean" last revised 9/2013 showed ..."5. Wash and dry your hands thoroughly. 6. Put on clean gloves. Loosen tape and remove soiled dressing ...8. Perform hand hygiene. Open dry, clean dressing (s)... 11. Using clean technique, open other products... 12 Perform hand hygiene. Put on clean gloves..."	F 880		