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 _____	05/04/2023

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 form 5/1/23 to 5/4/23. The following common abbreviations are used throughout this document: DON: Director of Nursing CDC: Centers for Disease Control and Prevention CMS: Centers for Medicare & Medicaid Services LPN: Licensed Practical Nurse NHA: Nursing Home Administrator RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 574 SS=E	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and	F 574		6/13/23

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

Electronically Signed | 05/24/2023

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F 574	Continued From page 1	F 574		

email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)

(iii) Information regarding Medicare and Medicaid eligibility and coverage;

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;

(v) Contact information for the Medicaid Fraud

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F 574	Continued From page 2 Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and review of the admission packet, the facility failed to ensure residents were given the required notices. The census was 41. The findings were: 1. Interview with 8 residents of the resident council on 5/2/23 at 10:30 AM revealed the facility had not made them aware of the contact information for, or their right to file a complaint with, the State Survey Agency. 2. Review of the admission packet showed it failed to include the address (email and mailing) and telephone number of the State Survey Agency. In addition, the admission packet failed to include a statement that a resident could file a complaint with the State Survey Agency. 3. Interview with the social worker on 5/2/23 at 10:54 AM confirmed the information in the admission packet did not include all of the required notices.	F 574	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied. F574 - The facility will ensure that all residents are aware of the Information and contact information for filing grievances or complaints to the appropriate entities. This will be achieved by updating the Long Term Care Ombudsman's contact information and adding the Name, phone number, fax number, address and email address of the State Survey Agency; on page 13 of the admission agreement. This was completed on May 2nd, 2023. All current residents or their representative will be given an updated page 13 of the	

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F 574	Continued From page 3	F 574	admission agreement. The Social Service Director (SSD) or designee will conduct monthly audits on each new admission to ensure the information is present. SSD or designee will report the findings to each QA&A meeting for no less than three months or until compliance is achieved. The Activity Director or designee will educate current residents as to how to file a grievance, contact the State Survey Agency as well as the Long term Care Ombudsman at each monthly resident council meeting beginning on June 13th, 2023. This education will be documented in each meeting's minutes. These minutes will be audited by Activity Director or designee and brought to each QA&A meeting.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609		6/13/23

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F 609	Continued From page 4 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility investigation review, State Survey Agency incident report log review, policy review, and staff interview, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with Section 1150B of the Act for 1 of 4 allegations of abuse reviewed (involving resident #145). The findings were: 1. Review of the facility's policy "Abuse Prevention", last reviewed 8/6/20, showed "PROCEDURE: 1. If abuse or suspicious injuries of unknown origin is suspected: The facility staff will immediately (including nights, weekends, and holidays) report all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of property, to the Administrator or his or her designee. a. The Administrator/designee will make notification of reported allegation within 2 hours if the events that cause the suspicion result in serious injury 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury of the alleged occurrence (sic) the Office of Health Licensing	F 609	F609 □ The facility will ensure that all abuse allegations are reported to the appropriate state agencies as required by law and that all staff is educated on the abuse reporting requirements. All staff will be educated on the abuse reporting requirements and the facility policy and procedure by no later than June 13th, 2023. SSD or designee will interview each interview able resident currently residing in the facility regarding the care they receive to ascertain if there have been any other potential incidents of abuse by June 13th, 2023. SSD or designee will conduct audits of documentation at a minimum of five times per week for 4 weeks and weekly thereafter to ensure any concerning incidents have been investigated properly and reported to the proper agencies as required by law. All findings will be brought to QA&A for further review and analysis. The report will include any identified problems. Any problems identified will result in immediate education and corrective action. The	

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F 609	Continued From page 5 and Survey..." The following concerns were identified: a. Review of a nurse's note dated 1/17/23 showed resident #145 had "unbearable pain with facial grimacing and calling out" upon movement. Review of the facility's investigation showed on 1/19/23, RN #1 asked the former DON to speak with the resident related to an allegation LPN #1 had been verbally abusive and withheld pain medication the evening of 1/17/23. However, review of State Survey Agency incident report logs showed this allegation was not reported to the agency until 1/20/23 at 2:56 PM. 2. Interview with the NHA and interim DON on 5/4/23 at 10:21 AM revealed staff were expected to notify the interim DON or NHA of an allegation of abuse by either a phone call or a text and must wait for a response or it was considered a non-report. The NHA was unable to speak to the delay in reporting to the State Survey Agency because the individual who was the DON at the time the incident occurred was no longer employed at the facility.	F 609	reports will continue for no less than three months or until ongoing compliance has been achieved.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		6/13/23

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F 812	Continued From page 6 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on review of the dishwasher temperature log sheet, policy and procedure, the 2017 U.S. Public Health Service Food Code, and staff interview, the facility failed to ensure the water temperature of the dishwasher was at the proper temperature for sanitization to occur on 22 of 61 days reviewed. The census was 41. The findings were: 1. Review of the dishwasher temperature log sheet showed the temperature of the dishwasher was to be recorded in the morning and in the evening on each day of use. The following concerns were identified: a. Review of the March 2023 dishwasher temperature log sheet showed no temperature was recorded on 3/1, 3/2, 3/3, 3/4, 3/18, 3/26, 3/27, and 3/28. b. Review of the April 2023 dishwasher temperature log sheet showed no temperature was recorded on 4/2, 4/11, 4/14, 4/15, 4/16, 4/17, 4/18, 4/21, 4/22, 4/26, 4/27, 4/28, 4/29, and 4/30. 2. Interview with the certified dietary manager (CDM) on 5/4/23 at 8:42 AM revealed the facility used a dishwasher which required a high temperature of water to ensure the sanitizer was properly dissolved. The CDM stated the temperature of the water should be maintained between 175 and 180 degrees Fahrenheit. In	F 812	F812 □ All Dietary staff will be reeducated on using the dishwasher temperature log by June 13th, 2023. The facility will ensure that the dishwasher temperature will be recorded in the morning and in the evening each day of use. This will be achieved by auditing the current dishwasher temperature log weekly for the next three months. These audit results will be brought to each QA&A meeting. Reporting will occur no less than three months or until ongoing compliance has been achieved.	

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F 812	Continued From page 7	F 812		

addition, the CDM confirmed the temperature of the water had not been documented on the log sheets as required.

3. Review of the 2017 U.S. Public Health Service Food Code showed "4-302.13... Water temperature is critical to sanitization in warewashing operations. This is particularly true if the sanitizer being used is hot water. The effectiveness of cleaners and chemical sanitizers is also determined by the temperature of the water. Effective mechanical hot water sanitization occurs when the surface temperatures of utensils passing through the warewashing machine meet or exceed the required 71°C (160°F). Parameters such as water temperature, rinse pressure, and time determine whether the appropriate surface temperature is achieved. Although the Food Code requires integral temperature measuring devices and a pressure gauge for hot water mechanical warewashers, the measurements displayed by these devices may not always be sufficient to determine that the surface temperatures of utensils are reaching 71°C (160°F). The regular use of irreversible registering temperature indicators provides a simple method to verify that the hot water mechanical sanitizing operation is effective in achieving a utensil surface temperature of 71ºC (160ºF).

4. Review of the "Dishwashing Machine Use" policy, last revised March 2010, showed "...3. Dishwashing machine hot water sanitation rinse temperatures may not be more than 194 [degrees Fahrenheit], or less than: a. 165 [degrees Fahrenheit], for stationary rack, single temperature machines. b. 180 [degrees Fahrenheit] for all other machines."