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 07/25/2024

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 7/22/24 through 7/25/24. Also reviewed in the course of the survey was complaint intakes WY00003926, WY00003900, WY00003770. The following common abbreviations are used throughout this document: ADL- Activities of Daily Living BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide LPN- Licensed Practical Nurse MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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; This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interview, and policy and procedure review, the facility failed to ensure residents received services to maintain good personal hygiene for 2 of 3 residents (#11, #24) reviewed for bathing. The findings were: 1. Review of the quarterly MDS assessment dated 4/26/24 showed resident #11 had a BIMS score of 3 out of 15 (severely cognitive impaired).	F 677	F677 Corrective action: DON and SSD followed up with residents #24 and #11 to ensure their bathing preferences were accurately reflected in their individual care plans. Identification of other residents: DON or designee will review the electronic health record on or before 8/30/2024 to ensure all resident's bathing preferences are listed in the EMR daily tasks.	8/8/24

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

Electronically Signed | 08/16/2024

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F 677	Continued From page 1 Review of section GG showed the resident had a range of motion (ROM) impairment of 1 side both upper and lower extremities. Review of the functional abilities showed s/he was dependent for oral hygiene, toileting, showers, upper body dress, lower body dress, personal hygiene, and putting on footwear. Review of the care plan last revised 6/5/24 showed "...for transfers mechanical lift (sit to stand) as needed with (2) staff assistance for toileting. Specifically, when transferring for baths or showers, please use full-lift as of 11/24/23 due to decreased ability to support own weight in sit-to-stand..." Further review showed the resident required extensive assistance with a hoyer lift for toileting, moderate assistance with a sit-to-stand lift for transfers, and limited to extensive assistance with personal hygiene/oral care. Further review showed the resident required extensive to total assistance, from 2 staff, with bathing/showering twice per week. The following concerns were identified: a. Review of the CNA task showed "ADL - Bathing Scheduled Thursday and Sunday;" however, the resident went 10 days between 5/12/24 and 5/23/24, 17 days between 6/2/24 and 6/19/24, 8 days between 6/28/24 and 7/7/24, and 9 days between 7/10/24 and 7/20/24 without bathing. Further review showed the missed dates were documented as "Not Applicable." b. Interview with the resident on 7/24/24 at 10:16 AM revealed s/he did not receive bathing like s/he would like. 3. Review of the admission MDS assessment dated 4/23/24 showed resident #24 had a BIMS score of 15 out of 15 (cognitively intact). Review of section GG showed the resident had no ROM impairment. Review of the functional abilities and goals showed the resident was dependent for	F 677	Systemic changes: The DON educated all CNAs and nurses on documenting resident baths and refusals in the EMR and notify charge nurse of refusals. A checklist was developed 8/9/24 and added to CNA and nurse's daily duties to improve communication. Monitoring: DON or designee will audit checklists as well as daily bathing schedules to ensure bathing tasks are completed. These audits will be completed for no less than three 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 DON or designee until compliance is achieved. Systems will be reviewed for quality assurance. The QAPI committee may modify this plan as needed to ensure that the facility remains in compliance.	

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F 677	Continued From page 2 toileting, showers, upper body dress, lower body dress, and putting on footwear. Review of the care plan initiated on 4/18/24 showed the resident had an ADL self-care performance deficit related to disease process multiple Sclerosis. Further review showed the resident was totally dependent on 2 staff for bathing. The following concerns were identified: a. Review of the CNA task showed "ADL - Bathing Wednesday and Saturday;" however, the resident went 5 days between 6/29/24 and 7/5/24, 5 days between 7/5/24 and 7/11/24, and 5 days between 7/11/24 and 7/17/24 without bathing. Further review showed the missed dates were documented as "Not Applicable" b. Interview with the resident on 7/22/24 at 4:03 PM revealed "sometimes I don't get my showers that I'm suppose to get. Sometimes it's once a week." 3. Interview with CNA #1 on 7/23/24 at 3:13 PM revealed "we normally have a CNA on duty for bathing. But there are days when there is not. The floor CNA's don't have time to give them. So, the resident will go without. 4 Interview with the administrator on 7/23/24 at 4:14 PM revealed staff should review resident care plans, and bath the residents based on their preferences. 5. Review of the policy "Bath, Shower/Tub" showed "...Documentation ...5. If the resident refused the shower/tub bath, the reason (s)."	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		8/14/24

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F 688	Continued From page 3 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on medical record review, and resident and staff interview, the facility failed to ensure residents received services to increase range of motion for 1 of 2 residents (#11) reviewed for restorative services. The findings were: 1. Review of the quarterly MDS assessment dated 4/26/24 showed resident #11 had a BIMS score of 3 out of 15 (severely cognitive impaired). Review of the resident's range of motion (ROM) showed impairment of 1 side both upper and lower extremities. Review of the functional abilities showed s/he was dependent for oral hygiene, toileting, showers, upper body dress, lower body dress, personal hygiene, and putting on footwear. Further review showed the resident had diagnoses which included stroke, hemiplegia, affecting right dominant side, seizure, and cerebrovascular accident (CVA) and the resident's therapy ended on 3/25/22. Review of	F 688	F688 Corrective action: On 8/14/24 the use of a splint was removed from resident #11's care plan as he/she chooses not to wear a splint. A physician's order was put into place for a range of motion (ROM) restorative plan for resident #11. Identification of other residents: The Restorative Aide and DON reviewed all residents for the need for ROM exercises. Residents were assigned to receive ROM based on physical function, the resident's limitations and risk for decreased mobility. Systemic changes: A procedure was written to identify and document resident's refusal of care and notify the physician of consistent refusals, to modify or discontinue the plan for restorative care. The Restorative Aide was provided education on documentation of resident	

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F 688	Continued From page 4 the care plan last initiated on 3/1/23 showed "[resident name] has limited physical mobility related to CVA. NURSING REHAB/RESTORATIVE: PASSIVE ROM Program #1 Stretches of contracted extremities." and "[Resident name] has hemiparesis to right side of body [related to] history of CVA in 1991. [S/he] has completed [his/her] therapy and is now transitioned to RNA [restorative nursing assistant] program." The following concerns were identified: a. Review of the physician orders failed to show orders for restorative care or splint placement. b. Interview with the resident on 7/24/24 at 11:55 AM stated s/he does wear a splint on his/her hand. Observation at that time showed the resident was not wearing a splint on his/her right hand for the contractures. 2. Interview with the restorative aide #1 revealed the resident was not receiving restorative care because s/he keeps refusing it. The aide further stated the staff was not documenting the refusals. 3. Interview with the administrator on 7/24/24 at 11:27 AM revealed staff were to follow the physician orders and the care plan. She confirmed if the staff were not documenting the splint and restorative refusal then it was not being done. Further she stated the restorative CNA recommended to discontinue restorative and the splint; however, the care plan revision was not made.	F 688	refusals in the EMR. Monitoring: The MDS Coordinator will perform three random audits per week of resident care plans to ensure restorative plans accurately reflect care provided. These audits will be completed for no less than three 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 DON or designee until compliance is achieved. Systems will be reviewed for quality assurance. The QAPI committee may modify this plan as needed to ensure that the facility remains in compliance.	
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	F 761		8/21/24

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F 761	Continued From page 5 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, policy and procedure review, and manufacturer's recommendation review, the facility failed to ensure medication was labeled with an open date for 1 of 2 medication carts (300 - 400 medication cart). The findings were: 1. Observation on 7/23/24 at 3:24 PM of the 300 - 400 medication cart with RN #1 showed one Novolog flex pen 100 unit/milliliter with no date, and one Lantus Solostar 100 unit/milliliter with no date. Interview at that time with RN #1 revealed the medication was for resident use, and confirmed the insulins were not dated. She	F 761	F761 Corrective action: On 7/23/24 the two insulin pens identified as having no open date were removed from the medication cart and discarded. Identification of other expired medications: On 8/9/24 Medication carts were audited for opened medications and expiration dates. Any medications without appropriate labeling were discarded. Systemic changes: Nursing staff will be provided education on the policy “Administering Medications” and the policy “Storage of Medication” on or before	

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F 761	Continued From page 6 stated they were considered expired. 2. Interview with the administrator on 7/23/24 at 4:13 PM revealed insulin should have a date on it when it is taken out of the refrigerator. Further interview revealed if the insulin was not dated, staff should dispose of it. 3. Review of the policy and procedure "Insulin Administration" showed "...Steps in the Procedure (Insulin Injections via Syringe)...4. Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening). 4. Review of "www.mynovoinsulin.com" accessed on 8/6/24 showed the NovoLog pen was to be disposed of after 28 days even if there was insulin left in the pen or vial. 5. Review of "www.lantus.com" accessed on 8/6/24 showed the insulin expired in room temperature in 28 days.	F 761	8/21/24. A checklist was developed 8/9/24 and added to nurse's daily duties to document review of medications for open/expiration dates. Monitoring: The DON or designee will conduct monthly audits of each medication cart for required open/expiration dates of medications. These audits will be completed for no less than three months to ensure compliance. Any concerns identified will result in immediate education and corrective action. Results of the audits will be reported at the QA&A meeting by the DON or designee until compliance is achieved. Systems will be reviewed for quality assurance. The QAPI committee may modify this plan as needed to ensure that the facility remains in compliance.	
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.	F 851		8/16/24

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F 851	Continued From page 7 §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.	F 851		

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F 851	Continued From page 8 §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on Payroll Base Journal (PBJ) review and staff interview, the facility failed to ensure the quarterly PBJ data was submitted timely for 1 of 4 quarters (4th quarter of 2023). The findings were: 1. Review of the four quarters showed the facility failed to submit the July 1, 2023 through September 30, 2023 (4th quarter of 2023) data. 2. Interview with the business office manager on 7/24/24 at 5:08 PM revealed she began submitting the PBJ in January and the facility had another staff member entering the data to PBJ prior to that. Further interview confirmed the 4th quarter of 2023 did not have data submitted.	F 851	F851 Corrective action: The facility failed to submit the PBJ for quarter July 1st through September 30th, 2023. The deadline has expired for submission. Identification of others: Review of documentation showed the required PBJ reports have been submitted as required beginning on 10/15/2023. Systemic changes: The new Business Office Manager received training upon hire on PBJ submissions and deadlines. The submission requirements were reviewed with the BOM to ensure understanding. Monitoring: The Administrator or designee will audit the timeliness of PBJ submissions. These audits will be completed for no less than three months to ensure compliance. Any concerns identified will result in immediate education and corrective action. Results of the audits will be reported at the QA&A meeting by the Administrator or designee until compliance is achieved. Systems will be reviewed for quality assurance. The QAPI committee may modify this plan as needed to ensure that the facility remains	

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F 851	Continued From page 9	F 851	in compliance. 10/15/2023	
F 880 SS=D	Infection Prevention & Control 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;	F 880		7/30/24

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F 880	Continued From page 10 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a 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, and policy review, the facility failed to ensure hand hygiene was done during wound care for 1 of 2 sample residents (#35) who received wound care. The findings were: 1. Observation of wound care on 7/23/24 at 9:28	F 880	F880 Corrective action: On 7/29/24 LPN #2 received education on the proper procedure for donning/doffing PPE and hand hygiene during wound care. Identification of others: All residents at the facility have the potential risk for wounds	

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F 880	Continued From page 11 AM for resident #35 showed LPN #2 changed the dressing on the right upper shoulder without concern. The LPN then doffed her gloves after dating the dressing, and donned gloves and dressed the left lower arm with out hand hygiene in between. 2. Interview with LPN #2 on 7/23/24 at 9:46 AM revealed this was how she always done the dressing changed. She stated she thought she did hand hygiene between doffing and donning. 3. Interview with administrator on 7/23/24 at 3:07 PM revealed staff were expected to perform hand hygiene before donning and when doffing their gloves. 4. Review of policy and procedure "Handwashing/Hand Hygiene" showed "...Applying and Removing Gloves. 1. Perform hand hygiene before applying non-sterile gloves. ..3. When removing gloves, [talks about how to removed the gloves included in to 4.] ... 5. Perform hand hygiene.	F 880	which would require wound care that meets standards of practice for infection control. Systemic changes: On 7/30/2024 the DON provided education to all nursing staff on hand washing, including technique and appropriate times to wash hands. Monitoring: DON or designee will conduct weekly hand hygiene and wound care audits for no less than three months to ensure standards of practice for infection control are met. 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 Administrator or designee until compliance is achieved. Systems will be reviewed for quality assurance. The QAPI committee may modify this plan as needed to ensure that the facility remains in compliance. 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.	

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 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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