DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

6/15/05

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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
	535039	A. BUILDING _____ B. WING _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

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F 176 SS=D	483.10(h) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by s483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of policies and procedures, the facility failed to assess and care plan 1 of 11 residents (#41) observed during medication passes for self-administration of medications. The findings were: Observation on 5/17/05 at 8 AM showed licensed practical nurse (LPN) #1 administered medications to resident #41. The medications included Miralax (a laxative) which was mixed in a cup of juice. The LPN observed the resident swallow some of the juice mixture, then left the remaining medication with the resident. Review of the medical record with registered nurse #1 confirmed the lack of an assessment or care plan for self-administration of medications. Interview with the resident on 5/18/05 at 7:54 AM revealed s/he was alert and oriented and wanted to take medications independently after they were prepared by the nurse. Review of the 5/9/05 quarterly Minimum Data Set assessment showed the resident was cognitively intact. According to the facility's 2004 "Self-Administration of Medication Policy," if a resident wanted to self-administer medications, the interdisciplinary team would assess the resident's ability to do so safely and care plan the process. However, interview with the director of nursing on 5/19/05 at 8:12 AM confirmed the facility was unable to produce an assessment and	F 176	F 176 Self Administration of Drugs The facility is committed to ensuring an individual resident may self-administer drugs if the interdisciplinary team has determined the this practice is safe. a. Resident #41 will be assessed for self-administration of drugs. Completion date: 6/24/05 b. All residents who wish to self administer medications will be assessed for self-administration of drugs. Completion date: 6/24/05 c. All new admissions who would like to do self administration of drugs will be assessed by the interdisciplinary team and reassessed quarterly. Completion date: 6/24/05 d. Social Service Director and MDS Coordinator will complete periodic audits for completion of self administration of drug assessments. Any concerns will be reviewed at the daily interdisciplinary meeting. Any trends identified will be addressed at the monthly Quality Assurance Meeting. Completion date: 6/24/05	7/3/05

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

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

8. 6/15/05

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F 176	Continued From page 1 care plan for the resident to self-administer medications.	F 176	F 253 Environment Westview is committed to providing a quality clean envioronment for the residents, families and staff at Westview Health Care Center	
F 253 SS=E	483.15(h)(2) ENVIRONMENT The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, review of the housekeeping schedule of duties, and a housekeeper job description, the facility failed to ensure a clean, orderly, and sanitary environment in two of three clean utility rooms, in two of four dining areas, and in the activity room. The findings were: 1. Observation on 6/17/05 at 9:45 AM revealed the following concerns in the clean utility room located on the short hallway: a. Observation of the refrigerator/freezer containing resident foods revealed it was unclean. There was a red colored unknown food substance and a yellow colored unknown food substance on the bottom of the freezer as well as a yellow colored unknown food substance on the inside of the freezer door. In the refrigerator was a tan colored, sticky unknown food substance on the bottom shelf of the door. b. Observation of the cabinet above the sink revealed a white powdery unknown substance on the bottom shelf used for storing crackers and plastic spoons. c. Observation revealed the floor was dusty and strewn with paper wrappers from straws. In addition, there were three brown spots of an	F 253	1a) corrective action for short hall utility room: 7/3/05 refrigerator freezer was cleaned, b) cabinet above the sink was cleaned. c).Floor in short hall utility room was cleaned. 2a)Corrective action for Medicare utility room: cabinet underneath microwave was cleaned and sorted correctly, b) unlabeled blue liquid was disposed of, cabinet was cleaned and sorted correctly. 4a) Dining room floor has been stripped and mopped. 6a) Care haven dining room floor, & baseboards cleaned thoroughly. 7a) Activity room floor cleaned thoroughly, 7/1/05 and will be stripped and waxed. B: Housekeeping supervisor to maintain check off sheets and daily walk through to assure that the deficient practice does not happen again. C: Measures to be put in place will include inservice for all staff on the importance of following their job descriptions and facility policies. The policy book will reflect that the refrigerator will be cleaned throughly once a week and checked daily. The cleaning schedule for the cabinets will be once a week thoroughly and checked daily. The floors are to be cleaned daily. The housekeepers will follow a cleaning list. All unmarked containers will be removed. Coffee filters will be placed in a container. Food and cleaning products will ~~not be placed on the same shelf.~~ Be stored Seperately Housekeeping staff will be retrained on the duties of side work and the cleaning list for each room in the facility. D: Monitoring will be done by the Housekeeping Supervisor. Audit list will be shared with administrator on a weekly basis and concerns will be brought to QA each month.	

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F 253	Continued From page 2 unknown food substance on the floor approximately halfway between the door to the room and the refrigerator. Observation on 5/19/05 at 8:10 AM revealed the same concerns were present. 2. Observation of the clean utility room on the Medicare hall on 5/17/05 at 10 AM revealed the following concerns: a. The cabinet located underneath the microwave contained three vases which were unclean. Two vases were dusty and one had a dried dark brown substance in the bottom and on the sides. Located on this same shelf were resident clean supplies including one bottle of Perlwash, four packages of Perlwipe cloths, one of which had spots of an unknown dark brown substance splattered on it, and one box of denture tablets. b. Observation of a freestanding cabinet revealed there was an unlabeled blue liquid in a plastic bottle located on the second shelf from the top. Interview with certified nurse aide (CNA)#4 at this time revealed he thought the liquid was either dish soap or bath soap. Also located on the same shelf were the following food and kitchen supplies: coffee filters without any protective covering, an opened box of straws, an opened bag of plastic cups, an uncovered container of sugar and creamer packets, one jar of peanut butter with a lid, one can of thickening powder, one unopened bag of coffee and one opened box of coffee blend. Located on the shelf beneath the unidentified liquid were individually packaged crackers, coffee filters, and eight bananas. Observation on 5/19/05 at 8:10 AM revealed the same concerns were present. 3. Review of the housekeeper job description,	F 253		

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F 253	Continued From page 3 "Part Two: Responsibilities, Standards and Competencies," revealed housekeeping duties included cleaning the inside and outside of refrigerators exclusive of the medication areas. Review of the housekeeping schedule revealed the utility rooms were scheduled for cleaning between 6 AM and 9 AM daily. On 5/19/05 at 8:15 AM interview with housekeeper #2 and at 8:45 AM with housekeeper #3 revealed cleaning the refrigerators/freezers and clean utility rooms was part of housekeeping "side work" duties. Both housekeepers stated one housekeeper is assigned this duty on a daily basis. 4. Observation of the main dining room on 5/16/05 from 6:30 PM until 6:40 PM revealed six spots of an orange colored unknown food substance on the floor next to table eleven. In addition, an orange colored unknown food substance was located on the floor next to tables five, nine, and three. Also, a brownish unknown food substance was located on the floor by resident #64. Observation on 5/17/05 from 7:30 AM to 8:30 AM and again at 11:50 AM revealed the same spots were on the floor in the main dining room. Interview with housekeeper #1 on 5/18/05 at 9:55 AM revealed the practice was to sweep and spot mop before breakfast. She further stated sweeping and doing a total mop was completed after breakfast and after lunch daily. Review of the facility's housekeeping schedule and instructions revealed from 6 AM to 9 AM the "First thing you do when you get here is sweep and spot mop the dining room floors." Further review of the schedule revealed all dining rooms should be cleaned between 1 PM and 2 PM. 5. During a confidential interview with a cognitive	F 253		

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F 253	Continued From page 4 resident on 5/17/05 at 9:41 AM, he/she stated cleanliness in the facility is just "fair." The resident further stated his/her observations revealed housekeepers just cleaned down the middle of the rooms and hallways and never moved furniture or objects to clean thoroughly. He/she stated that a few weeks ago spots of cooked cereal remained on the floor in the main dining area for four days. During a confidential interview with a second cognitive resident at 9:50 AM on 5/17/05, the resident stated his/her feet often stuck to the dining room floor because it was not clean. 6. On 5/16/05 at 5:45 PM in the Care Haven dining room, observation showed numerous food particles behind two recliners. In addition, there was dark debris build-up around the baseboard of the dining area, and dried spills were on the base of a metal round stool. On 5/17/05 at 8 AM, observation revealed the food particles remained behind the recliners, and the status of the baseboards and the stool remained unchanged. 7. During an anonymous interview on 5/18/05 (Wednesday) at 10:05 AM, a staff member reported the popcorn on the floor of the activity room had been there since the previous Friday (5/13/05). The staff member also stated that lack of cleanliness was a problem throughout the facility. Observation of the floor of the activity room on 5/18/05 at 3 PM revealed popcorn and pieces of paper in corners and behind the furniture. In addition, the surveyor's shoes stuck to the floor while walking around the room. Observation on 5/19/05 at 8:40 AM revealed that the popcorn and pieces of paper were still in the same locations. Observation on 5/18/05 at 10:18 AM showed	F 253		

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F 253	Continued From page 6 an unidentified housekeeper dust-mopped the room of resident #17. The housekeeper cleaned the floor in the center of the room but did not move any items to clean under or around them.	F 253	F 282 Resident Assessment The facility is committed to ensuring that the services are provided by qualified persons in accordance with each resident's written plan of care.	
F 282 SS=D	483.20(k)(3)(ii) RESIDENT ASSESSMENT The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure staff followed the care plan for one (#19) of nine sample residents who required assistance with ambulation. The findings were: On 5/16/05 at 5:35 PM, observation showed certified nurse aide (CNA) #1 transferred resident #19 from his/her bed to a wheelchair with the use of a gait belt. Interview with the CNA at this time revealed the resident had not ambulated for the past two weeks. The resident was then taken by wheelchair to the dining room for supper. At 6 PM the resident requested to go to the bathroom. The CNA transported the resident by wheelchair to his/her room. On 5/17/05 at 7:25 AM, the resident was again transported to the dining room for breakfast with the use of a wheelchair. Review of the resident's May 2005 care plan showed he/she was to ambulate with the use of a walker. Interview with the physical therapist on 5/18/05 at 9:50 AM revealed the resident was able to ambulate 60 to 70 feet with the assistance of a walker. On 5/18/05 at 5:10 PM, observation	F 282	a. Resident #19's care plan has been updated to reflect residents fluctuating mobility status and physical therapy orders dated 5/3/05 which state Patient may use w/c and also ambulate with assist. C.N.A. staff will continue to encourage resident to ambulate with FWW. Completion date: 6/24/05 b. Resident ADL care plans will be reviewed by the IDT to ensure physical therapy orders match care plan interventions and reflect interventions for residents with fluctuating mobility status and resistance to cares. Completion date: 6/24/05 c. Nursing staff received in-servicing regarding providing care according to the care plan on 6/7/05. Nursing staff received in-servicing on interventions for residents who are resistive to cares on 6/7/05. Therapy staff received in-servicing regarding updating care plans with order changes on 6/7/05. A copy of the therapy orders will given to the restorative nurse and MDS coordinator. Completion date: 6/24/05 d. Alzeimer Unit manager, restorative nurse and staff development coordinator will do random monitoring of ambulation programs to ensure compliance. Any concerns will be discussed at the daily interdisciplinary meeting. Any trends identified will be reviewed at the monthly Quality Assurance Meeting. Completion date: 6/24/05	7/3/05

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F 282	Continued From page 6 showed the resident was capable of ambulating with a walker from the bedroom to the dining room. Interview with CNA #2 at that time confirmed the resident could ambulate and the staff had not followed the resident's care plan.	F 282		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure that one (#55) of the 11 sample residents identified by the facility as experiencing pain was treated for breakthrough pain during transfers and range of motion (ROM) exercises resulting in avoidable pain. The findings were: During facility tour on 5/16/05 at 3:30 PM, observation revealed resident #55 wore a left leg brace. Interview with certified nurse aide (CNA) #1 at that time revealed the resident sustained a fracture to the left knee. Review of a 5/2/05 x-ray report confirmed the resident sustained a minimally displaced lateral condyle fracture. On 5/16/05 at 5:30 PM observation showed CNAs #1 and #3 transferred the resident from a	F 309	F 309 Quality of Care The facility is committed to ensuring each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. a. Resident #55 continues to receive Tylenol Extra Strength 500mg—2 tabs every 6 hours alternating with ibuprophen 800mg every six hours. Resident #55 receives lortab 5/500mg one to two tablets PO every 6 hours PRN. Physical Therapy was in-serviced on requesting pain medication approximately one hour before therapy treatment. Completion date: 6/24/05 b. Therapy will notify Licensed Nurse approximately one hour before treatment of residents who have pain so that the nurse can provide pain medication. Completion date: 6/24/05 b. Nurses and Rehab Service Manager received in-servicing regarding pain management and prevention of break through pain. Nurses will assess for pain every shift and document on the medication record a 1-10 pain assessment and intervention for pain as appropriate. Completion date: 6/24/05	7/3/05

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F 309	Continued From page 7 shower chair to a wheelchair. During the transfer, the resident's body became rigid, he/she exhibited facial grimacing, and the resident verbalized to the CNAs that he/she was experiencing pain in the left leg. Review of the May 2005 medication administration record (MAR) showed the resident received ibuprofen (Advil) 800mg at noon, but had received no other pain medication since that time. On 5/17/05 at 10:15 AM, observation showed a physical therapist provided ROM exercises to the resident's left leg. Each time the resident's left leg was flexed, the resident's body became stiff, he/she exhibited facial grimacing, and the resident verbalized to the physical therapist that he/she was experiencing pain. Review of the May 2005 MAR showed the resident received acetaminophen (Tylenol Extra Strength) 500 mg (2 tablets) at 6 AM, but had received no other pain medication since that time. On 5/18/05 at 11:30 AM, the physical therapist stated the resident had done much better with the ROM exercises that morning, and had not complained of pain or discomfort during the procedure. Review of the MAR for 5/18/05 showed the resident received acetaminophen 500 mg (2 tablets) at 6 AM. In addition, the resident had received Lortab 5/500 at 8 AM. Observation of the resident on 5/18/05 at 11:35 AM showed he/she was resting comfortably with no complaints of pain. Review of the resident's May 2005 care plan, and interview with the physical therapist on 5/17/05 at 3 PM, and the restorative nurse at 6:45 PM, confirmed the resident had not been evaluated or treated for breakthrough pain.	F 309	c. Director of Nursing, MDS Coordinator will conduct periodic audits for compliance. Completion date: 6/24/05 d. Any concerns will be discussed daily at the interdisciplinary team meeting for intervention. Any trends identified will be reviewed at the monthly Quality Assurance Meeting. Completion date: 6/24/05	
F 328 SS=D	483.25(k) QUALITY OF CARE The facility must ensure that residents receive	F 328		

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F 328	Continued From page 8 proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure that one (#19) of seven sample residents who required oxygen or small volume nebulizer (SVN) treatments received them as prescribed. The findings were: During a facility tour on 5/16/05 at 3:30 PM observation showed resident #19 had SVN and oxygen equipment at the bedside. Interview with certified nurse aide (CNA) #1 at that time revealed she had not seen the equipment in use for the resident for approximately 2 weeks. Observation of the resident on 5/16/05 at 4:45 PM, and from 5:35 PM until observations ceased at 7 PM revealed oxygen was not used. On 5/17/05 from 7:20 AM until observations ceased at 9:05 AM, the resident did not use oxygen. At	F 328	F 328 Quality of Care The facility is committed to ensuring that residents receive proper treatment and care for the following special services: injections; parenteral and enteral fluids; colostomy, ureterostomy, or ileostomy care; tracheostomy care; tracheal suctioning; respiratory care; foot care; prosthesis. a. Resident # 19 oxygen saturation results have been at 90% or above since 5/17/05. An order was received on 5/16/05 from physician to change duoneb treatments to prn. PRN oxygen order was discontinued on 6/7/05. Resident has not complained of chest pain. Nursing staff was in-serviced on therapeutic interventions when resident refuses care. Care plan was updated to reflect these interventions. Completion date: 6/24/05 b. Residents who have oxygen and nebulizer orders will be reviewed for treatment compliance and care plan interventions updated as needed. Physicians will be notified of residents who continue to refuse treatments despite interventions. Completion date: 6/24/05 c. Nursing staff were in-serviced on administration of PRN oxygen and nebulizer treatments and care plan interventions for residents who refuse treatment. Protocol for documentation of PRN oxygen orders on nursing treatment sheets will be revised to reflect PRN status. Completion date: 6/24/05	7/3/05

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F 328	Continued From page 9 11:10 AM, registered nurse (RN) #2 checked the resident's oxygen saturation (a method to determine a resident's gas exchange and oxygenation transport ability, and is normally over 90%,) while the resident was lying on his/her back in bed. The oxygen saturation was 88%. When the RN asked the resident to take a couple of deep breaths, the resident verbalized that it was painful with each breath. A Duoneb SVN treatment was then administered to the resident. Although the resident's oxygen saturation remained at 88% after the SVN treatment was completed at 11:45 AM, the resident remained without the use of oxygen. At 4:45 PM the resident was again observed without oxygen. On 5/18/05 the resident was observed at 9:50 AM with oxygen in place by nasal cannula. At 11 AM the resident was observed receiving an SVN treatment by mask. At noon the resident was in the dining room without his oxygen and at 5 PM his oxygen was again in place by nasal cannula. The following concerns were noted in regard to the oxygen and SVN use for this resident: a. Review of the resident's treatment record for May 2005 showed he/she was to receive oxygen at 2 liters by nasal cannula or mask in order to maintain oxygen saturation levels at greater than 90%. b. Review of a physician's order dated 3/29/05 showed that Duoneb SVN treatments were to be administered every four hours while the resident was awake. c. The resident was observed without oxygen on 5/16/05 at 2:30 PM, 4:45 PM and from 5:35 PM until observations ceased at 7 PM. On 6/17/05 the resident was observed without oxygen from 7:20 AM until observations ceased at 9:05 AM, and again at 11:45 AM and 4:45 PM. However, on 5/18/05 at 9:50 AM the resident was	F 328	Licensed nurses were in-serviced on interventions and documentation of interventions for decreased saturation, cough with complaints of pain with cough as well as documentation and physician notification of treatment refusal. ~~Completion date: 6/24/05~~ d. Staff development Coordinator and Director of Nursing will monitor oxygen and nebulizer treatment randomly for compliance as well as appropriateness of intervention and documentation periodically to ensure compliance. Any discussed at the daily interdisciplinary meeting. Trends identified will be reviewed monthly at the Quality Assurance Meeting. compliance issues will be Completion date: ~~6/24/05~~	

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F 328	Continued From page 10 observed with his oxygen in place by nasal cannula. At noon the resident was sitting in the dining room without oxygen. Review of nursing treatment sheets showed that from 5/1/05 until 5/18/05, the resident had refused to use oxygen only on 5/8/05 and 5/11/05 from 10 PM until 6 AM and on 5/17/05 from 6 AM to 2 PM. Review of nursing notes showed no documentation as to why the oxygen was not in use. d. Review of nursing flow sheets showed that on 5/9/05 the resident's oxygen saturation was 88% on room air. However, the nursing notes did not address what nursing interventions were provided to increase the resident's saturation level to above 90%. Review of nursing flow sheets revealed the resident's oxygen saturation on 5/14/05 at 4 AM, was 89% on room air. In addition, the nursing notes showed the resident complained of an occasional "hacky" cough and complained of pain in the chest area when he/she coughed. Nursing staff did not document what nursing interventions were provided to increase the resident's saturation level or to relieve the pain when the resident coughed. e. Review of the medication administration record (MAR) for the Duoneb SVN treatments showed that from 5/1/05 to 5/17/05 at 6 AM, 11 AM, 5 PM and 8 PM, the nursing staff initialed and circled to show the resident had refused all these treatments but one, which was taken on 5/17/05 at 11 AM. Review of nursing notes correlating with these refusals showed nursing staff did not provide supporting documentation to show interventions to attempt to ensure the resident received the prescribed treatments. f. Interview with RN #2 on 5/17/05 at 1:30 PM confirmed that professional nursing practice was lacking pertaining to appropriate assessment, interventions and documentation for this resident.	F 328		

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F 329 SS=D	483.25(l)(1) QUALITY OF CARE Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of facility policy, the facility failed to assure the drug regimen was free of unnecessary drugs for one (#26) of two sample residents who received hypnotic medication. The findings were: Review of the April 2005 physician's orders revealed resident #26 was prescribed Ambien (a sleep aid) 10 milligrams (mg) every evening beginning 2/5/05 for a diagnosis of insomnia. Review of the February, March, April and May 2005 medication administration records (MARs) showed Ambien 10 mg was given nightly from 2/5/05 to 5/17/05 with the exception of five nights (4/8, 4/9, 4/10, 4/11 and 5/13). Interview with the Minimum Data Set (MDS) assessment coordinator on 5/19/05 at 9:10 AM revealed she was not aware of any assessment done to determine the cause of the insomnia. In addition she confirmed there was no evidence a dose reduction was attempted or planned, or that the physician had documented the benefits of the excessive duration of Ambien. Review of the facility's psychotropic drug use policy, "sleepers" (page 4-11), confirmed "Drugs	F 329	F 329 Quality of Care The facility is committed to ensuring each resident is free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. a. An evaluation form for psychotropic medication was completed on 3/21/05 listing non-medicinal sleep inducing interventions that were ineffective. Resident #26 order for ambien was discontinued on 5/31/05. Resident is receiving lunesta 2mg po at HS as needed. Completion date: 6/24/05 b. Residents whose medications require periodic evaluation for possible dosage reduction will be reviewed by the Restraint Interdisciplinary Team and those residents' primary care physician will be contacted regarding evaluation for dosage reduction if the medications have not been evaluated according to the psychotropic drug use policy. Completion date: 6/24/05 c. Nursing staff and the Restraint Interdisciplinary Team were in-serviced regarding medications which require periodic evaluation for possible dosage reduction. Completion date: 6/24/05 d. The Social Service Director will complete quarterly audits to ensure compliance. Concerns will be addressed at the daily interdisciplinary team meeting. Trends will be reviewed at the monthly Quality Assurance meeting. Completion date: 6/24/05	7/3/05

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F 329	Continued From page 12 for sleep induction will be used only if other causes for insomnia (depression, pain, noise, light, caffeine, incontinence) have been ruled out... The daily use of sleepers/hypnotics will not exceed 10 days unless the attempts for gradual dose reduction is unsuccessful. A gradual dose reduction will be attempted at least three times within six months..."	F 329	F363 Dietary Service ~~A. Westview is committed to meet the nutritional needs of residents in accordance with the recommended~~ dietary allowances of the Food and ~~Nutrition Board of the National~~ Research Council by following the calorie controlled diets and pureed menus exactly as listed on the dietary flowsheets, approved by the facility's RD. B) In an ongoing, screening/assessment process, the facility's RD is currently implementing positive changes in medical nutrition therapy through the liberalization of most of the calorie controlled diets. These changes are being implemented to enhance the quality of life and nutritional status of older residents in our facility,as suggest in the American Dietetic Association's position statement of 2002 titled: Liberalized Diets for Older Adults in Long Term Care. C) The facility's RD and DM inserviced all dietary employees regarding nutritional needs, menus, diets, and texture modifications on 6/6/05 ~~a,d,e,~~ Dietary cooks were instructed to provide every item listed on the pureed diet menus flowsheet, including the service of pureed bread. Staff has been instructed by the RD to use broth, juice, (or milk or creamer- for those not lactose intolerant) in the preparation of bread slurry, rather than water.	7/3/05 -6/6/05-
F 363 SS=E	483.35(c)(1)-(3) DIETARY SERVICES Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the planned menus, the facility failed to follow the planned menus during two of two meal service observations for residents who were to receive calorie controlled and pureed diets. Review of the physician ordered diets revealed 17 residents had orders for calorie controlled diets, and 12 residents were to receive pureed diets including one lactose-free, pureed diet. The resident census was 73. The findings were: The pureed and calorie controlled menus planned for the noon and evening meals on 5/18/05 were not followed; for example: a. Review of the noon menu showed residents with pureed diets were to receive a slurry (a mixture of powdered thickener and	F 363		

7/15/05

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F 363	Continued From page 13 water) of garlic bread. Observation at 12 PM of the meal preparation revealed the slurry was not prepared, nor was any type of bread pureed and served. b. Review of the pureed diet orders revealed resident #61 was to receive a lactose-free pureed diet. Observations at 11:15 on 5/18/05 showed cook #1 added half-and-half to the pureed parsley carrots. Interview with the dietary manager on 5/19/05 at 10 AM revealed half-and-half should not have been served to the resident. c. Review of the 1200 Calorie diabetic menu revealed smaller portions were to be served including: 2 ounce portion of chicken, no garlic bread, and 1/3 cup of spaghetti. Observation at 12:20 PM revealed resident #43, who was on a 1200 calorie diabetic diet, received a 3 ounce portion of chicken, garlic bread, and 1/2 cup of spaghetti. d. Review of the evening pureed menu revealed a barbecue pork with a bun was to be pureed. Observation at 5 PM revealed cook #2 did not puree any buns or any other type of bread. e. Review of the restricted concentrate sweets (RCS), 1800 Calorie diabetic and 2000 Calorie diabetic evening menus revealed a serving of graham crackers was to be provided. Observations of the entire tray line between 5 PM to 6:20 PM showed no graham crackers were served. f. Review of the evening diabetic diet menus (1200,1500,1800 and 2000 Calories) revealed diet coleslaw was to be served. Observations of the entire tray line between 5 PM to 6:20 PM showed regular coleslaw was provided for all diets with the exception of the lactose-free pureed diet. g. Observation of the noon and evening tray line on 5/18/05 (Wednesday) between 12:15 PM	F 363	b. All dietary employees were instructed to use acceptable forms of non-dairy creamer, or broth, or juice in the preparation of all lactose-free pureed or low lactose pureed diets. RD will change terminology of diet order to Low Lactose to account for insignificant amounts of hidden lactose in some medications. c,f,g,h. All employees were instructed to follow any calorie controlled diets which have not yet been liberalized, exactly as listed on the flowsheets in regard to food content, dietary substitutions, alternative recipes, and portion sizes. Staff was reminded to use appropriate scoops and ladles for portion control. Flowsheets above the steam table will be changed daily to reflect current menus. D) The DM will review any specialty foods, recipes, or substitutions needed for calorie controlled or pureed diets and will ensure that these foods are purchased for the cooks to use. The DM will also observe trayline on a weekly basis to monitor compliance to the dietary flowsheets. The RD will begin a Quality Assurance program on July 1, to monitor dietary compliance to calorie controlled, pureed diets or RCS diets on a monthly basis through observation of preparation, trayline service or random test tray.	7/1/05

YBR 6/15/05

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F 363	Continued From page 14 and 1 PM, and between 5 PM and 6:20 PM, revealed the 5/16/05 (Monday) menu flow sheet was posted at the serving line. Interview with the dietary manager on 5/19/05 at 10 AM revealed the 5/18/05 (Wednesday) menu flow sheet should have been posted for the staff to follow. h. Interview with the dietary manager on 5/19/05 at 10 AM confirmed the dietary staff should have followed the planned pureed and calorie controlled menus.	F 363	F371 Dietary Service 1. a. The RD prepared a new milk product policy during state survey and it has been placed in the P & P manual. The policy will be given to all newly hired employees as of July 1, 2005, and they will sign that they have read and understand the information. Dietary employees were inserviced by DM and RD on 6/6/05 regarding Westview's milk expiration and discard policy. All employees were given a copy of the new policy. b. Dietary staff will check milk expiration /sell-by-dates, on a routine basis to ensure that the milk product is safe to serve. Nourishment refrigerators will be stocked three times a week and any expired products will be discarded at that time. the DM will monitor milk products and RD will review milk products and expiration dates on a regular basis. 2. a RD prepared Food Storage, Cooling of Potentially Hazardous Foods Policy & inserviced staff on safe methods of cooling food 6/6/05. The policy has been place din the P&P manual, and will be given to all new hires, who will sign that they have read and understand the information, and a copy was given to each dietary employee at the inservice.	7/3/05 7/1/05
F 371 SS=F	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of facility policy, and review of the kitchen cleaning schedule, the facility failed to assure dietary staff discarded expired milk, properly cooled leftovers, and followed acceptable hand washing procedures. In addition, food service equipment was not maintained in a clean and sanitary manner. The findings were: 1. The following concerns were noted with the storage of expired milk: a. Observation on 5/17/05 at 7:20 AM revealed one gallon of skim milk in the walk-in refrigerator dated 5/9/05. The expired milk was observed again on 5/18/05 at 6:20 PM (9 days past the sell by date). b. Interview with the dietary manager on 5/19/05 at 10 AM revealed milk with a date past the date marked on the container should be thrown away.	F 371	The policy states: foods must be cooled to 70°F within 2 hrs, and 40°F or less within 4 hours....	

SR 6/15/05

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F 371	Continued From page 15 According to the 1999 ServSafe Coursebook, Appendix C, Refrigerated Storage of Foods; the maximum storage period for fluid milk is 5 to 7 days after the date on the container. 2. The following concerns were noted regarding the cooling of leftovers: a. Interview with cook #2 at the end of the evening meal service on 5/18/05 at 6:20 PM revealed he planned to save the remaining barbecue pork to be used as a leftover. b. Observation on 5/19/05 at 8:15 AM showed leftover pork from the previous evening meal in a four quart plastic container, in a reach-in cooler. At the request of the surveyors, cook #1 took the temperature of the pork with a result of 60 degrees Fahrenheit (F). c. Interview with cook #1 at this time revealed the temperature was not acceptable as the pork should be cooled down to 40 degrees F within 6 hours. Cook #1 further stated, the pork should be thrown away. According to Food Code 2001, U.S. Public Health Service, 3-501.14: (A) Cooked potentially hazardous food shall be cooled: (1) Within 2 hours from 135 degrees Fahrenheit to 70 degrees Fahrenheit; and (2) Within 6 hours from 135 degrees Fahrenheit to 41 degrees Fahrenheit or less... 3. The following problems were noted with proper hand washing in the dish room: a. Observation on 5/18/05 between 12:47 PM and 12:56 PM revealed four instances when the dietary aide placed dirty utensils in the dish machine, then, without washing her hands, handled clean utensils.	F 371	3. Dietary employees were inserviced by RD and DM regarding sanitation and handwashing following the handling of dirty dishes. Employees have been instructed to wash their hands each time they handle dirty or contaminated equipment or utensils. DM and RD will observe handwashing practices on an ongoing basis to ensure proper sanitation practices are understood and followed. 4. The RD presented and asked for input on a new cleaning schedule at the facility's dietary inservice The new schedule will be finalized and put into practice before July 1, 2005. the new cleaning schedule requests that the DM contact maintenance each month to remove hood vents for cleaning and replace after they have been sanitized by dietary staff. the ceiling vent, door frame, range top, inside of ovens, back side of ice machine, floors/grouting and the range top will be cleaned prior to July 1st and on a regular basis. thereafter as part of routine cleaning schedules, among dietary, housekeeping and maintenance.	

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F 371	Continued From page 16 b. Interview with the dietary manager on 5/19/05 at 10 AM confirmed the dietary aide should have washed her hands. Review of facility policy titled, "Hygiene for Dietary Personnel" confirmed "All employees shall wash their hands, forearms and fingernails in an approved hand washing basin ...before starting work and as often as may be needed to remove soil and prevent contamination." According to Food Code 2001, U.S. Public Health Service, 2-301.14; Food employees shall clean their hands and exposed portions of their arms ... (E) After handling soiled equipment or utensils. 4. The following concerns were noted with proper cleanliness of food service equipment: a. Observations on 5/16/05 between 3:45 PM and 4:10 PM, and 5/18/05 between 10:10 AM and 12:20 PM, revealed the hood above the stove had excessive dust and grease accumulation, and the door and door frame on the clean side of the dish room had excessive accumulation of dust coming from a ceiling vent. The range top and inside of both ovens had excessive accumulation of cooked on food. The floor and plumbing behind the ice machine had excessive dust and grease build up. b. Interview with cook #1 on 5/16/05 at 3:45 PM revealed the cleaning was not done as scheduled due to short staffing. Review of the kitchen cleaning schedule and the facility policy titled: "Dietary Equipment Cleaning" showed the vent hood filters, walls, floors/grouting, and the range top (burners) were to be cleaned weekly.	F 371		

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F 371	Continued From page 17 According to Food Code 2001, U.S. Public Health Service, 4-60.11: ...(B) The food-contact surfaces of cooking equipment and pans shall be free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.	F 371		
F 429 SS=D	483.60(c)(2) PHARMACY SERVICES The pharmacist must report any irregularities to the attending physician and the director of nursing. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of facility policy, the facility failed to ensure that drug irregularities were reported by the pharmacist for one (#26) of two sample residents who received hypnotic medications. The findings were: Review of the 2/25/05, 3/31/05 and 4/28/05 monthly pharmacy review revealed no reported irregularities for Ambien 10 milligrams ordered nightly for resident #26 beginning on 2/05/05. Review of the February, March, April and May 2005 medication administration records (MARs) showed Ambien 10 mg was given nightly from 2/5/05 to 5/17/05 with the exception of five nights (4/8, 4/9, 4/10, 4/11 and 5/13). Interview with the Minimum Data Set (MDS) assessment coordinator on 5/19/05 at 9:10 AM confirmed there was no evidence that the pharmacist reported the irregularity. Review of the facility's psychotropic drug use policy, "sleepers" (page 4-11) confirmed "... the daily use of	F 429	F-429 Pharmacy Services The facility pharmacist is committed to reporting any irregularities to the attending physician and the director of nursing. a. Resident # 26 ambien order was discontinued on 5/31/05 and an order was received for lunesta 2mg po qhs prn. Resident # 26 will be reviewed monthly for drug irregularities. Any irregularities will be reported to the Director of Nursing and the physician. Completion date: 6/24/05 b. Residents whose medications require periodic evaluation for possible dosage reduction will be reviewed by the pharmacist. Any drug irregularities will be reported to the Director of Nursing and physician. Completion date: 6/24/05 c. Nursing staff and the Restraint Interdisciplinary Team will be in-serviced regarding medications which require periodic evaluation for possible dosage reduction on 6/7/05. Completion date: 6/24/05 d. Pharmacist will complete monthly audits for compliance. Concerns will be addressed at the daily interdisciplinary team meeting. Any trends will be reviewed at the monthly Quality Assurance Meeting. Completion: 6/24/05	7/3/05

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F 429	Continued From page 18 sleepers/hypnotics will not exceed 10 days unless the attempts for gradual dose reduction is unsuccessful. A gradual dose reduction will be attempted at least three times within six months..."	F 429		
F 445 SS=F	483.65(a) INFECTION CONTROL Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of infection control policies and procedures, the facility failed to ensure linen was handled in a manner that prevented the spread of infection. The findings were: During a tour of the laundry area on 6/18/05 at 11:55 AM, the following concerns were identified: a. Interview with the laundry manager revealed the same staff who sorted the dirty linen also handled the clean linen. The manager further stated staff wore gloves but did not wear gowns or any kind of clothing protection when sorting the dirty linen prior to handling the clean linen. b. Review of the facility's infection control policies and procedures, chapter 7: Departmental Policies "A Guide to Infection Control", revealed "Gloves and gowns must be used while sorting soiled linen." Interview with the infection control coordinator on 6/19/05 at 9:15 AM revealed infection control policies should be followed. Interview with the laundry manager on 6/19/05 at 9:25 AM revealed she was unaware of an infection control policy other than for isolation.	F 445	F445 Infection Control A. Laundry staff will use gowns and gloves to sort linens as per P & P. Blankets will be removed from soiled linen room, + stored elsewhere B. Laundry supervisor will inservice all staff on the proper sorting of soiled linen. Supervisor will monitor staff for proper following of P & P for infection control and handling laundry. She will identify any concerns. C. P & P will be inserviced and open for review for the laundry staff. D. Laundry supervisor will monitor and enforce these policies.	7/3/05 7/1/05

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 446	Continued From page 19 c. Observation revealed a linen cart with clean blankets located in the soiled side of the laundry area. Interview with the laundry manager at the time revealed blankets were washed then stored in this area for back-up when extra blankets were needed. She further stated these blankets were "rinsed" but not rewashed prior to being given to residents.	F 445		
F 454 SS=B	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure waste was contained in covered dumpsters. The findings were: Observation of the dumpsters on 5/18/05 at 12:30 PM while accompanied by the maintenance director, revealed three of the four dumpsters had lids left opened with trash and garbage bags located inside. One sack of trash was not secured. Interview with the maintenance director at 12:35 PM revealed he had an ongoing problem with staff leaving the dumpster lids off.	F 454	F454 Physical Environment a)Corrective action was to replace heavy dumpster lids with lighter weight rubber lids to provide for easier closure. b) Any time the lids are left in an open position it will be identified as a deficient practice. c) Staff inserviced on the regulation that lids must be closed at all times. d) Maintenance supervisor will be the charge person for monitoring the practice of closing the garbage lids. All supervisors that go by the dumpsters are to check and report if a violation has occurred. F465 Physical environment A. The ice was removed immediately upon notification by maintenance and the DM B. Staff was inserviced to immediately report to the DM or maintenance any safety issue including ice in the freezer. It needs to be reported so that safety concern can be handled timely. C. This is a brand new freezer. Maintenance determined that the ice build up was caused by the door not fitting properly. A new door will be ordered. D. DM, RD and maintenance will monitor freezer. When the new door arrives, ice build up should not be a problem	7/3/05 5/6/05 7/3/05 order date Door ordered on 6/13/05
F 465 SS=D	483.70(h) PHYSICAL ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:			

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	536039	A. BUILDING _____ B. WING _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 466	Continued From page 20 Based on observation on three of three days of survey, and staff interview, the facility failed to assure the floor in one of two walk-in freezers was maintained in a safe manner. The findings were: Observation on 5/16/05 at 3:50 PM revealed an excessive accumulation of ice build-up on the floor and wall of the outside walk-in freezer. Two patches of ice were on the floor located by the door in the main walk area. The patch closest to the door measured 42 inches by 22 inches, and the second patch measured seven inches by four and one half inches. In addition, ice on the wall under the condenser unit measured 39 inches long and three inches wide. Observation on 5/17/05 at 4:10 PM, and again on 5/18/05 at 10:06 AM showed the ice was still present. During each of the three observations, no physical precautions were present to alert dietary staff of the safety hazard. Interview with the dietary manager on 5/19/05 at 10:15 AM revealed she was unaware of the ice build up and did not know how long it had been there.	F 465		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 535039	DATE SURVEY COMPLETE: 5/19/2005
NAME OF PROVIDER OR SUPPLIER: WESTVIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 1990 WEST LOUCKS STREET SHERIDAN, WY	

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 372	483.35(h)(3) DIETARY SERVICES The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure waste was contained in covered dumpsters. The findings were: Observation of the dumpsters on 5/18/05 at 12:30 PM while accompanied by the maintenance director, revealed three of the four dumpsters had lids left opened with trash and garbage bags located inside. One sack of trash was not secured. Interview with the maintenance director at 12:35 PM revealed he had an ongoing problem with staff leaving the dumpster lids off.

Preparation and execution of this response and plan of correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusions set forward in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and State law. This response and plan of correction constitutes the Facility's allegation of compliance.

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

The above isolated deficiencies pose no actual harm to the residents