STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING	C 11/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON COUNTY HEALTH SERVICES	1124 WASHINGTON BLVD NEWCASTLE, WY 82701

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing MAR-Medication administration record MDS- Minimum Data Set RD-Registered Dietitian RN-Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interviews, review of facility's policy and procedure, and review of the annual training program, the facility failed to effectively train staff on abuse for 2 of 5 staff members (housekeeping staff #1, housekeeping staff #2) interviewed concerning abuse. The findings were: 1.1nterviewwith the administrator on 11/3/11 at 9:30AM revealed all employees had annual training related to abuse and neglect and this was done through a computer module that also required a test. Review of the abuse prevention and reporting policy last reviewed in October 2010, showed it covered the need for training and	F 226	WCHS will effectively train staff on abuse for all staff members, including housekeeping staff. This will be accomplished by: 1. Human Resources will educate all new staff about abuse identification and reporting. 2. DON & Administrator will educate housekeepers #1 and #2, and all staff about abuse identification and reporting. 3. All staff will acknowledge comprehension of this policy via signed attendance of annual training and completion of follow-up test. 4. A quality monitoring tool will be implemented to ensure comprehension of abuse policies by all staff. Compliance will be reported to QA committee monthly.	12/17/11

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE	TITLE	(X6) DATE
	Administrator	11/23/11

Accepted w/changes made per agreement of Joann Farnsworth, 12.8.2011

NHA on 12/6/11 @ 2:34pm Louise Lukas

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F 226	Continued From page 1 the training would be held annually. Review of the abuse and neglect education materials showed the training included types of abuse and reporting procedures. However, when interviewed, two employees were unable to knowledgeably answer questions related to types of abuse and what they would do if they were to witness abuse. The following concerns were identified: a. Interview with housekeeping staff #1 on 11/3/11 at 7:40 AM revealed she had not received training related to abuse, because as housekeeping, there was no direct resident care. Further, she said there was some information about resident abuse on Learning Harbor, an annual computer training requirement. She could not give any details about what the training covered concerning abuse. b. Interview with housekeeping staff #2 on 11/3/11 at 8:10 AM revealed she had received training on abuse; however, she had to ask the activity director what training she had actually received. The housekeeper could not knowledgeably answer questions that were asked related to abuse.	F 226		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of the activity	F 248	WCHS will provide an ongoing program of activities designed to meet the interests and needs of each resident. This will be accomplished by: 1. Resident # 12, #24, #44, #9, #17 and all new residents will be assessed upon admission to identify an acitivity plan based on individual needs. 2. Quarterly reviews will be conducted and care plans updated as needed.	12/17/11

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F 248	Continued From page 2 calendars, the facility failed to meet the activity needs for 3 of 12 open sample residents (#12, #24, #44) and two non-sample residents (#9, #17). The findings were: 1. Review of the October and November 2011 secure unit activity calendar showed each morning "mind exercise"\ "current events", and "body exercise" were scheduled activities. There were eight residents who resided on the secure unit, and one CNA assigned to the unit during the day shift. The following concerns were identified: a. Observation on 11/1/11 at 9 AM showed the activity "mind exercise" was being provided by activity assistant #1 in the common area. The activity was a memory game, and there was one non-sample resident #9 who was participating. The other five residents in the area were asleep including sample residents #12, #44, #24. The activity assistant did not make any attempt to awaken or interest these sleeping residents. b. Observation of the "current events" activity on 11/1/11 following the memory game revealed there was no interest by the residents. While activity assistant #1 read the newspaper, resident #171ooked at a photo album, resident#9 occasionally looked up, and the three residents sleeping continued to sleep. At no time during the activity did the activity assistant or CNA try to raise the level of interest. c. Interview with the activity director on 11/3/11 at 8:20AM revealed there was a recent turnover in activity staff and the three part-time employees were still being trained. She stated she was responsible for the training and had not had the opportunity to spend much time with each of them. She acknowledged there was a need to wake the residents up to participate, and have the	F 248	3. Acitivities Director will establish a detailed acitivities program for the Special Care Unit. All staff will be educated on this program. Quiet time and resting time will be configured into this program to allow times for optimal alertness to enhance the meaningful activity facilitated. 4. Each resident's response will be documented daily to assure their needs and goals are addressed in their plan of care are being met with meaningful activity. 5. Activities aides and CNAs will work together in accordance with the Special Care Unit activity schedule and each residents' activity assessment to assure residents have opportunity to participate in acitivty offered and activities of individual interests. All residents will be included and invited to each group activity. Sleeping residents will be encouraged to waken and participate. Resident refusals will be honored and documented.	

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F 248	Continued From page 3 person providing the activity show enthusiasm. 2. The following concerns were identified related to the activity assessments for residents #12, #24 and #44 who resided on the secure unit: a. Review of the 9/9/11 activity assessment for resident #24 showed it failed to include any specific activities the resident was interested in. The assessment was a form that included check marked boxes to show level of participation, psychosocial needs, mobility, vision, hearing, cognition, and socialization patterns. There were no notes or summary associated with the assessment to determine what would be a meaningful activity program for this resident. Review of the October 2011 activity tally record showed the resident was sleeping during 37 of 47 activities recorded. In addition, the resident received 9 one-to-one activities during the month of October 2011. Review of the one-to-one activity notes showed each activity was a conversation, and the average number of minutes spent for each activity was seven minutes. The notes failed to show how the resident responded to the activity. b. Review of the activity information for resident #12 showed an initial activity assessment was completed for the resident when admitted on 6/16/03. This initial assessment included the types of activities the resident enjoyed such as yard work and exercise, music, dancing shopping, helping others, and handi-work. On 9/28/11, almost eight years later, the resident was moved into the secure unit of the facility. Review of the quarterly/significant change activity assessment dated 10/18/11 showed it did not include specific activities the resident enjoyed. The assessment form was a data tool with boxes	F 248		

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F 248	Continued From page 4 that could be checked to show level of participation, psychosocial needs, mobility, vision, hearing, cognition, and socialization patterns. There were no notes or any summary to provide any information about the residents changing needs, or what may constitute a meaningful activity program for this resident. c. Medical record review for resident #44 showed s/he had diagnoses to include dementia, depression and anxiety. Review of the quarterly MDS assessment showed s/he had severe cognitive impairment. Review of the annual MDS assessment dated 5/3/11 showed the resident preferred, in part, the following activities: reading books, newspapers, keeping up with the news and participating in religious activities. Review of the care plan for activities last reviewed 10/19/11 showed the resident enjoyed religious activities, bingo and outings. Review of the October 2011 activity tally sheet showed no documented evidence for reading opportunities, one church, bible study activity and participated in bingo/aroma therapy one time. Further, documentation showed the resident was provided only two off unit activities/outings. d. Interview with the activity director on 11/3/11 at 8:30AM revealed she was aware the activity assessments for these residents were in need of updating to define what activities would be meaningful to the residents. She revealed many of the secure unit residents were on one-to-one visits; however, the visits and activities were not well planned or always documented.	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social	F 250		

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F 250	Continued From page 5 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to make arrangements to provide an adequate motorized wheelchair for 1 of 1 resident (#2) identified with this social service need. The findings were: During an observation on 11/2/11 at 2 PM in the resident's room, resident #2 was sitting in a motorized wheelchair. The resident was leaning to the right side and appeared uncomfortable. During an interview at that time, the resident stated that his/her low back was uncomfortable when in the wheelchair, and the wheelchair was too small. The resident further stated that the facility had evaluated the wheelchair and had found issues, but had not gotten back with the resident concerning any alternatives. Review of a 9/3/11 plan of treatment for outpatient rehabilitation, signed by the physician, showed the evaluation determined that the resident was unable to propel in a manual wheelchair secondary to leaning posture. The evaluation further determined that the current wheelchair had a seat that was too low and a back rest that was too short. The evaluation concluded that the resident could greatly benefit from a "Jazzy" or similar scooter with a higher seat, higher back, and wide armrests. During an interview with the social services director (SSD) on 11/3/11 at 8	F 250	WCHS will provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This will be accomplished by: 1. Social worker will assist resident #2 and all residents to attempt to locate a funding source to assist with purchase of equipment that would achieve the above. 2. Social worker will contact 4 different sources and request funding for motorized wheelchair. 3. Social worker will monitor and report to QA all requests and follow-up.	12/17/11

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F 250	Continued From page 6 AM, she verified that the facility had not pursued other sources after it was determined that the resident did not qualify for motorized wheelchair assistance from medicaid. The resident had received medicaid assistance for a motorized wheelchair prior to admission to the facility, and that wheelchair was no longer available. The SSD also stated that the resident had no personal funds to purchase one. She further stated that the facility had contacted other agencies in the past concerning similar situations. However, the facility had failed to do so for the resident's current issue with the wheelchair.			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure the catheter for 1 of 4 sample residents (#48) with catheters was medically necessary. The findings were: Periodic observation on 10/31/11, 11/1/11, and 11/2/11 revealed resident #48 utilized a catheter.	F315	WCHS will ensure that resident #48 and all residents will not be catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infection and to restore as much normal bladder function as possible. This will be accomplished by: 1. Resident #48 and all residents who are admitted with a diagnosis of urinary retention and an indwelling catheter will be re-evaluated for urinary retention. 2. DON will educate nursing staff about guidelines for use of catheters. 3. Resident care coordinator will monitor catheter use (and necessity) and report to QA monthly all Residents with her appropriateness	12/17/11

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F 315	Continued From page 7 Review of nursing notes dated 5/3/10 at 2:20 PM and 3 PM showed the resident was transferred from the hospital with an indwelling catheter and the diagnoses for catheter placement was urinary retention. Review of the medical record showed no further evaluation related to the indwelling catheter or the urinary retention. Interview with the DON on 11/3/11 at 10:20 AM revealed after going through the medical record, there was nothing further found to show a medical necessity for continued use of the catheter.	F 315		
F 363 ss E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED 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 menu and diet cards, the facility failed to ensure the planned portion sizes were followed for 8 sample (#2, #3, #4 #10, #12, #32, #48, #53) and 23 non sample residents (#1, #6, #7, #8, #11, #13, #14, #20,#21,#22,#25, #26, #27,#30, #35, #37, #38, #41, #42, #43, #46, #49, #51) with regular diet orders during one meal service observation. The findings were: Review of the planned menu for the noon meal on 11/1/11 showed sallsbury steak, mashed potatoes, broccoli and bread were the main meal.	F 363	The facility will ensure that prepared menus will be followed to meet the needs of the residents in accordance with the recommended dietary allowances of the food and nutrition board. 1. The Dietary Manager (DM) will routinely observe the dietary staff during meal service to assure the proper portion sizes, according to the prepared menus, are served to all residents including sample residents #2, 3, 4, 10, 12, 32, 48, 53 and non sample residents #1, 6, 7, 8, 11, 13, 14, 20, 21, 22, 25, 26, 27, 30, 35, 37, 38, 41, 42, 43, 46, 49, 51.	12/17/11

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F 363	Continued From page 8 The regular diet portion sizes were 3 ounces of sallsbury steak, one half cup of mashed potatoes, and one half cup of broccoli. During the observation of meal service on 11/1/11 at 12:08 PM cook/server #1 used a number 12 scoop (equivalent to one third cup) to serve the potatoes and served the broccoli with a slotted spoon with no specific measure. Review of the diet cards showed there were 31 residents #1, #2, #3, #4, #6, #7,#8, #10, #11' #12, #13, #14, #20, #21' #22,#25, #26, #27, #30,#32,#35,#37,#38, #41, #42, #43, #46, #48, #49, #51, #53 who had regular diet orders with the regular planned portions. Interview with cook/server #1 on 11/2/11 at 11:24 AM revealed she did not follow the portion sizes on the menu, because the residents would think it was too much food. During an interview with the dietary manager and the consultant registered dietitian on 11/3/11 at 9 AM, they verified portions needed to be followed as written on the menu.	F 363	The consultant Registered Dietitian (RD) will also randomly observe meal services to assure the approved menus, including portion sizes, are followed. Corrective action and in-servicing will be immediate conducted as needed by the RD 2 An In-service was provided to all the dietary staff by the Registered Dietitian (RD) and Dietary Manager (DM) on November 11, 2011 on Menu preparation and compliance including the regular diet, portion sizes, and therapeutic menu extensions. 3 A quality monitoring tool will be implemented by the dietary manager to ensure proper portion sizes are used in accordance to the approved menus This monitor will be completed monthly and reported quarterly at the quality management meeting..	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE- SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 371	WCHS will ensure that food is stored, prepared, and distributed under sanitary conditions. This includes surfaces being effectively sanitized, hand washing performed as needed and food preparation areas and equipment will be kept clean. 1 The Dietary Manager (DM) will routinely observe the dietary staff during meal preparation and service to assure proper sanitary procedures are followed.	12/17/11

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F 371	Continued From page 9 facility failed to minimize the potential for food-borne illness by ensuring surfaces were effectively sanitized, hand washing was performed when needed, and that food equipment was kept clean. The findings were: 1. Observation in the kitchen on 11/2/11 at 11 AM showed there was a five gallon bucket in a sink that contained water and wiping cloths. Cook/server #1 used one of the wet cloths to wipe down kitchen equipment including the steamer and the soup kettle. At 11:10 AM, interview with the dietary manager revealed they did not routinely test the sanitizer solution which contained quaternary ammonia. When tested at that time, there was no chemical detected by the testing strip. The dietary manager stated the automatic feed system that distributed the chemical sanitizer may not be working. She then mixed a new solution of water and chemical and tested it with a positive result. According to Food Code 2009, U.S. Public Health Service: 3-304.14, "...(B) Cloths in-use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under§ 4-501.114;" 2. Observation of meal service on 11/1/11 at 12:13 PM revealed cook/server#1 was wearing gloves while serving resident meals. When another staff member requested an item, the server used her gloved hand to open the refrigerator and get the item. The handle of the refrigerator was visibly soiled. Using the same gloved hands, the cook/server continued to serve resident meals. Interview with the dietary manager on 11/2/11 at 9 AM verified the server should have performed hand hygiene and	F 371	2 The sanitizer concentration will be taken and recorded at least three times a day to assure a proper concentration is maintained. A standard red sanitizing bucket has been initiated to store the solution and wiping cloths. A service call has been completed and the automatic feed system is now functioning and will continue to be checked as described above to assure the proper sanitizer concentration is met. 3 Dietary staff will perform proper hand hygiene, including changing gloves and washing hands after handling soiled equipment, before donning gloves for working with food, and engaging in other activities that contaminate the hand. A daily "Food Borne Illness" check list will be completed by the lead cook on a daily basis to assure proper hand hygiene is utilized. 4 Dietary staff will clean food production areas after each use and as soiled, including areas under the slicer to assure areas are kept free of dust, dirt, food residue and other debris. A daily "Food Borne Illness" check list will be completed by the lead cook on a daily basis to assure cleaning schedules are followed including the areas identified.	

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F 371	Continued From page 10 changed gloves prior to returning to the meal service. According to Food Code 2009, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS... (H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands 3. Observation in the kitchen on 10/31/11 at 1:17 PM and 1112111 at 11 AM revealed there were dried food particles underneath the mealslicer which was sitting on a food preparation table. Interview with the dietary manager on 1112111 at 11:12 AM verified the counter underneath the slicer needed cleaned and this should be done each time the slicer was used. According to Food Code 2009, U.S. Public Health Service 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. "...(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris."	F 371	5 The Dietary Manager (DM) will observe to assure sanitary conditions are maintained. If areas of concern are identified immediate in-servicing and corrective action will be taken. The consultant Registered Dietitian (RD) will also randomly observe meal preparation and service to assure sanitary conditions are followed. Corrective action and in-servicing will be immediately conducted as needed by the RD. 6 An in-service was provided to all the dietary staff by the Registered Dietitian (RD) on November 11, 2011 on Food Safety, specifically addressing Cleaning, Sanitizing and proper glove use. 7 A quality monitoring tool will be implemented by the Dietary Manager (DM) to ensure sanitary conditions and practices are maintained. This monitor will be completed monthly and reported quarterly at the quality management meeting. The consultant dietitian will also report any concerns, and review compliance on the sanitation and "Food Borne Illness" check logs on the monthly consultation report.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate	F 425		

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(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 425	Continued From page 11 acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to ensure medications were accurately dispensed for 1 random non-sample resident (#49). The findings were: Review of the medication orders for resident #49 showed an order for hydrocodone 10 mg on 8/23/11. During an observation on 11/2/11 at 12 PM, RN #1 *gave* non-sample resident #49 a pain medication labeled hydrocodone with acetaminophen 10/325 mg, one tablet. Review of the medication order and the MAR with the RN on 11/2/11 at 3 PM confirmed the medication order did not include acetaminophen with the hydrocodone. On 11/2/11 at 4 PM, the order was clarified by RN #1 with the physician, and the order was changed to include acetaminophen at that time. During an interview with pharmacist #1 on 11/3/11 at 8:40 AM, he confirmed the administered medication should not have included acetaminophen. He also confirmed the proper procedure was to verify the physician's order before dispensing the medication.	F 425	WCHS will ensure that medications are accurately dispensed for resident #49 and all residents. This will be accomplished by: 1. DON will educate nursing staff about the 5 R's of medication administration: right medication, dose, time, route, patient. 2. DON will conduct random audits to identify improper dispensing practices and report to QA monthly.	12/17/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING	C 11/03/2011

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