Reviewed & approved w changes on pages 2, 8 3, 19 & 21 after discussio. w John Nott on 8/16/06 @ 11:55 AM

DEPARTMENT OF HEALTH AND HU[illegible]N SERVICES
CENTERS FOR MEDICARE & MEDIC[illegible]D SERVICES

PRINTED: 08/04/2006
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 _____	07/27/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1900 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 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide care to residents in a manner which enhanced their dignity for three of 13 sample residents (#11, #33, #60) and 14 non-sample residents (#1, #4, #7, #10, #15, #20, #28, #30, #41, #48, #61, #68, #72, #77, and two unidentified residents). The findings were: 1. Observation on 7/24/06 from 6 PM until 6:35 PM in the secure locked unit revealed two certified nurse aides (CNA #2 and an unidentified CNA) were in the dining room with the following residents: #48, #10, #30, #11, #4, #68, #61, #15, #77, #28, #41, #33, #20, #7, #1, and #60. While the residents were eating, the radio was on. The radio was playing "Top 20" music (hip hop, rap, etc.). Review of the activity assessments for all of the residents revealed none of the residents were assessed as liking music from this decade ("Top 20" type music). The 7/6/06 activity assessment showed resident #10 liked country and western music. The 3/28/06 activity assessment revealed resident #33 liked hymns. During an interview on 7/26/06 at 1:35 PM, the life enhancement coordinator stated the residents enjoyed piano music, Johnny Cash music, and other soothing music. When asked if the residents would enjoy "Top 20" type of music, she replied "...oh absolutely not".	F 241	F241 Dignity The facility is committed to promoting care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1A. Activity assessments for residents (#11, #33, #60, #1, #4, #7, #10, #15, #20, #28, #30, #41, #48, #61, #68, #72, and #77) and all other residents that reside in the secure unit were reviewed with the nursing staff during an in-service on 8/7/06. Music is provided per resident's activity assessment and preferences such as country western, piano music, hymns and other soothing music. "Top 20" music is not played for the residents in the secure unit. *Completion date: 8/7/06* 1B. An in-service for nursing staff was provided on 8/7/06 regarding dignity. Resident music preferences and appropriateness was reviewed with the Life Enhancement Coordinator and discussed with the nursing staff during the in-service on 8/7/06. *Completion date: 8/7/06* 1C. A system of documentation has been developed and implemented to communicate to the nursing staff resident music preferences and preferences in general. This documentation/communication tool was reviewed with the nursing staff during the in-service on 8/7/06. *Completion date: 8/13/06*	

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

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 correction is requisite to continued program participation.

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F 241	Continued From page 1 2. Observation on 7/25/06 at 7:20 AM revealed CNAs #4 and #5 got resident #80 up for the day. When CNA #4 put the resident's shoes on, the CNA commented on the "sticky" shoe. Observation at that time showed the bottom of the resident's left shoe had a large accumulation of a sticky substance. Neither CNA attempted to clean the resident's shoe. Observation on 7/26/06 at 2:45 PM showed the shoe was in the same condition. During an interview on 7/26/06 at 3 PM, the director of nursing (DON) stated if a CNA noticed a shoe or clothing was soiled, the CNA should clean it or replace it. 3. Observation on 7/24/06 at 6:15 PM showed CNA #9 stood until 6:21 PM (six minutes) while assisting resident #72 with the evening meal. The CNA then left and returned at 6:22 PM. At that time the CNA assisted resident #72 and 2 other unidentified residents, one seated at another table. The CNA walked around and between tables as she assisted the residents until 6:32 PM (10 minutes). During the observation period, the CNA stood for a total of 16 minutes as she fed each resident a few bites at a time.	F 241	1C. The Life Enhancement Coordinator will monitor compliance with resident preferences during periodic random supervision of activities that are provided by the nursing staff. *Completion date: 8/13/06* 1D. Any concerns will be reported to the Quality Assurance Committee for review and recommendations for the next 90 days or until compliance is maintained for a period of 90 days. *Completion date: 8/13/06* including resident #72 3 2A. Nursing staff will continue to assist all residents during meals in a seated /eye level position. *Completion date: 8/7/06* added per request of John Vitt via phone on 8/18/06 at 11:55 AM JB 3 2B. Nursing staff received training on dignity issues regarding standing while assisting residents during meals during the nursing in-service on 8/7/06. *Completion date: 8/7/06* 3 2C. All Certified Nursing Assistants will continue to receive training regarding dignity during meal assistance during orientation and annually during competency evaluation. *Completion date: 8/7/06* 3 2C. The Staff Development Coordinator will monitor compliance during daily rounds. *Completion date: 8/7/06* 3 2D. Any concerns will be reported to the Quality Assurance Committee for review and a recommendation for the next 90 days or until compliance is maintained for a period of 90 days. *Completion date: 8/13/06*	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE 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 and staff interview, the facility failed to maintain a clean and orderly	F 253		

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F 253	Continued From page 2 interior in two bathing rooms and in the secure unit dining room. The findings were: 1. Observation on 7/24/06 at 6:05 PM and 7/25/06 at 8 AM and 8:45 AM in the secure unit revealed the following concerns: a. The dining room walls contained numerous splatters and drips of dried liquid. Specifically, the splatters were located to the left of the pantry door, to the left of the activity closet, on the wall behind the horseshoe-shaped table, and on the rear wall underneath the table. b. The rear dining room wall had a large black smudge approximately 12 inches by 6 inches underneath the dry erase board. c. The window sills for both dining room windows contained an accumulation of dirt and debris. Observation on 7/26/06 at 10 AM with the housekeeping supervisor revealed the above findings were the same. The housekeeping supervisor stated the windows should be cleaned once a week, and staff should clean the walls when they notice drips. 2. Observation on 7/25/06 at 12:15 PM and 1 PM revealed the bathing rooms in the long hallway ("Beach" room) and in the secure unit contained ceiling vents which had a large accumulation of dust. During an interview on 7/26/06 at 10 AM, the housekeeping supervisor stated the vents should be cleaned by the maintenance department. However, on 7/26/06 at 1:12 PM, the maintenance director stated he was not aware he was supposed to clean the vents. 3. Observation on 7/26/06 at 12:15 PM in the long hall bathing room ("Beach" room) revealed three	F 253	2A. Residents' personal articles will continue to be monitored for cleanliness each shift by the nursing staff and changed or cleaned when soiled. Resident #60 had his/her shoes cleaned on 7/27/06 *Completion date: 8/7/06* 2B. Nursing staff received training regarding dignity issues related to cleanliness of personal articles during the nursing in-service on 8/7/06. added per request of John Lyman via phone on 8/10/06 @ 11:55 AM LB *Completion date: 8/7/06* 2C. Nursing staff will continue to receive training regarding dignity issues related to cleanliness of personal articles during initial orientation and during annual competency evaluations. *Completion: 8/7/06* 2C. Director of Nursing and Staff Development Coordinator will monitor compliance of cleanliness of personal articles during daily rounds. *Completion date: 8/13/06* 2D. Any concerns will be reported to the Quality Assurance Committee for review and a recommendation for the next 90 days or until compliance is maintained for a period of 90 days. *Completion date: 8/13/06* F 253 Housekeeping/Maintenance The facility is committed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	

LB

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F 253	Continued From page 3 tiles were missing from the front of the dividing wall next to the shower. In addition, the top of the dividing wall was missing caulk between the tiles for approximately five feet. During an interview on 7/26/06 at 9:10 AM, the maintenance director stated the caulk "shrank up" and disappeared. He confirmed the tiles were missing.	F 253	1a-c. Housekeeping department removed the splatters and drips in the secure unit dining room. The black smudge was also removed. The windowsills in the dining room were cleaned. *Completion date: 8/25/06* 2a. The housekeeping department cleaned the vents in the Beach bathing room and in the secure unit. *Completion date: 8/25/06* 3a. The tile and grout in the beach bathing room was repaired and replaced by the maintenance director. *Completion date: 9/1/06* 1-3b. an inspection of the facility was completed by the maintenance director and housekeeping supervisor. All areas with drips or spill or smudges were cleaned. All vents throughout the facility were cleaned. *Completion date: 9/1/06* 1-2c. The housekeeping supervisor completed an in-service regarding the cleaning schedules. All walls and windowsills will be cleaned weekly and as needed for drips or spills and accumulation of dust or dirt. The housekeeping department will clean all vents monthly. *Completion date: 9/1/06* 3c. The maintenance director will be responsible for completing all tile/grout repairs as needed and on a quarterly basis. *Completion date: 9/1/06* 1-3c. The housekeeping supervisor will monitor for compliance with the cleaning schedule, and the administrator and maintenance director will monitor for compliance with the quarterly repair schedule. *Completion date: 9/1/06* 1-3d. Concerns will be reported to the Quality Assurance Committee for review and recommendations for 90 days or until compliance is maintained for a period of 90 days.	

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F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review the facility failed to ensure three (#45, #60, #78) of 16 sample residents received comprehensive assessments. The	F 272	F272 Comprehensive Assessments The facility is committed to conducting initial and periodic comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. The facility is committed to making a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment includes at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. 1A. The Restorative Nurse reviewed the RAP module for resident number 45 on 8/8/06 and updated the assessment information to include all comprehensive factors contributing to the resident's ADL functional status. *Completion date: 8/8/06*	

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F 272	Continued From page 6 findings were: 1. Review of the 6/5/06 annual Minimum Data Set (MDS) assessment showed resident #45 triggered for a comprehensive assessment in the area of activities of daily living (ADLs). According to Section V of that MDS, the information was located in the Resident Assessment Protocol (RAP) module. However, review of that RAP module showed the only information was the resident's diagnoses, medications, and "short term memory loss with periodic confusion (see care plans)." Interview with registered nurse (RN) #5, who completed the ADL assessment, confirmed a comprehensive assessment was lacking. 2. Review of the 4/14/06 annual MDS assessment for resident #60 showed psychotropic medications triggered (indicating further assessment). However, review of the RAP modules revealed a RAP module for psychotropic medications was lacking. On 7/26/06 at 12:30 PM, the MDS coordinator stated she could not find the psychotropic medication assessment. 3. Observation of resident #78 on 7/25/06 at 7:47 AM revealed the resident used a urinary catheter. Review of the resident's medical record revealed a face sheet (no date) which documented the resident entered the facility on 3/6/06 with diagnoses which included quadriplegia. Further review revealed a catheter justification worksheet dated 4/14/06 and documented the reason for continued use as "quadriplegia spinal stenosis." Review of the RAP module dated 3/10/06 revealed the resident used the catheter due to a diagnosis of "quadriplegia". Interview and record	F 272	2A. A comprehensive Psychotropic RAP assessment has been completed by the Social Service Director for resident number 60 on 8/3/06. *Completion date: 8/3/06* 3A. The catheter justification worksheet and comprehensive RAP module for Urinary Continence was updated on 8/3/06 for resident number 78 to include the diagnoses neurogenic bladder. *Completion date: 8/3/06* 1-3B. The MDS Coordinator, Social Service Director, and Restorative Nurse completed an audit for completion of comprehensive Rap assessments on 8/13/06. The Restorative Nurse completed an audit of diagnoses listed on all residents' Urinary Catheter Worksheets. All Rap assessments/Urinary Catheter Worksheets are comprehensive and complete for all residents. *Completion date: 8/13/06* 1-3C. The MDS Coordinator will perform periodic audits for completion of comprehensive Rap assessments using an MDS Scheduling tool. The Director of Nursing will complete periodic audits of diagnoses listed on Urinary Catheter Worksheets to ensure compliance. *Completion date: 8/13/06* 1-3D. Any concerns will be reported to the Quality Assurance Committee for review and recommendations for 90 days or until compliance maintained for a period of 90 days. *Completion date: 8/13/06*	

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F 272	Continued From page 6 review with the restorative nurse on 7/25/06 at 5:26 PM revealed the nurse was unable to find a comprehensive assessment that identified the reason for the urinary catheter other than quadriplegia.	F 272		

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F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure four (#2, #23, #44, #78) of 16 sample residents had accurately coded Minimum Data Set (MDS) assessments. The findings were: 1. Observation of resident #2 on 7/25/06 at 9:47	F 278	F278 Resident Assessment The facility is committed to completing accurate assessments that reflect the resident's status. A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals. A registered nurse signs and certifies that the assessment is completed. Each individual who completes a portion of the assessment signs and certifies the accuracy of that portion of the assessment. 1-3A. The MDS Coordinator reviewed each MDS assessment for resident number 2, 23,and 78 that were noted to have a coding error. The MDS Coordinator documented in each resident's interdisciplinary notes referencing each assessment that had coding errors and documenting the resident's current functional status. *Completion date: 8/13/06* 4A. The MDS Coordinator reviewed the MDS assessment coding error for resident number 44 and completed a note in resident number 44's interdisciplinary notes referring to the coding error and documenting that the resident does not currently use a chair prevents rising. *Completion date: 8/13/06* 1-4B. The MDS Coordinator and Restorative Nurse will continue to review functional status prior to completion of all resident's MDS assessments to ensure accuracy of coding of the MDS. *Completion date: 8/13/06*	

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F 278	Continued From page 8 AM revealed s/he required the assistance of two staff members for dressing and transfer. The observation revealed the resident had no voluntary movement of his/her right side. Medical record review revealed the face sheet, undated, documented the resident was admitted on 3/27/06 after a cerebral venous accident affecting one side. Review of a physical therapy (dated 3/27/06) and an occupational therapy (dated 3/28/06) evaluation revealed the resident had right sided weakness and had no strength or range of motion (ROM) to the right side. Review of the most recent quarterly MDS assesment dated 6/22/06 documented the resident had full ROM and voluntary movement to both sides. Interview with the MDS coordinator on 7/26/06 at 9:40 AM revealed the quarterly MDS assessment was inaccurately coded. 2. Observation of resident #23 on 7/25/06 at 9:02 AM revealed the resident was dependent for transfers and activity of daily living (ADL) care. Review of the resident's medical record revealed the most recent MDS assessment was a significant change assessment dated 5/22/06. Further review showed the resident was coded as having no impairment in ROM or voluntary movement. Interview with the restorative nurse on 7/26/06 at 2:20 PM revealed the resident was unable to lift his/her legs and the coding in the MDS assessment was not accurate. 3. Observation of resident #78 on 7/25/06 at 7:47 AM revealed the resident was totally dependent on staff for transfer and ADL care. Review of the undated face sheet revealed the resident was admitted on 3/6/06 with diagnoses which included quadriplegia. Review of the resident's admission	F 278	1-4C. The Restorative Nurse and Director of Nursing will complete periodic audits of MDS assessments to ensure accuracy of coding. *Completion date: 8/13/06* 1-4D. Concerns that are identified will be reported to the Quality Assurance Committee for review and recommendations for the next 90 days or until compliance maintained for a period of 90 days. *Completion date: 8/13/06*	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 278	Continued From page 9 Resident Assessment Instrument (RAI) showed the resident was coded as having full ROM and voluntary movement. Review of the most recent quarterly assessment dated 6/2/06, revealed the resident was coded as having limitation on one side to having limitation on both sides for ROM and partial to full loss of voluntary movement. Interview with the MDS coordinator on 7/26/06 at 9:40 AM revealed the admission RAI was inaccurately coded. 4. According to the 7/17/06 quarterly MDS assessment, resident #44 was restrained by a chair which prevented rising. Observation on 7/25/06 at 1:30 PM showed certified nurse aides (CNAs) #1 and #3 lifted the resident, who did not stand or bear weight, during a transfer from the wheelchair to a recliner. CNA #1 elevated the resident's feet after the transfer. During an interview on 7/25/06 at 2:05 PM, the resident stated s/he was unable to stand or get out of the recliner independently. Interview with the MDS coordinator on 7/26/06 at 12:56 PM confirmed documenting the chair as a restraint was a coding error.	F 278		

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and medical record review, the facility failed to assure care plans for three (#31, #44, #60) of 13 sample residents were updated to reflect the current status of each resident. The findings were: 1. Observation on 7/24/06 at 6:25 PM revealed resident #31 ate independently. Further observations on 7/25/06 at 7:15 AM and 8:02 AM showed the resident got out of bed and up from chairs without assistance. In addition, the resident ambulated independently with a front wheeled walker. Interview with the resident on 7/25/06 at 9:10 AM revealed s/he dressed independently.	F 280	F280 Care Plans The facility is committed to ensuring that the resident has the right, unless adjudged incompetent or other wise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan is developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. 1-3A. The interdisciplinary team reviewed and updated the care plans for resident number 31, 44, and 60 to reflect the resident's improvement in functional status. *Completion date: 8/13/06* 1-3B. All resident care plans have been reviewed by the interdisciplinary team to ensure that the care plan reflects all resident's current status. *Completion date: 8/13/06* 1-3C. The MDS Coordinator will complete periodic audits of resident care plans to ensure care plans reflect all resident's current status. *Completion date: 8/13/06*	

DEPARTMENT OF HEALTH AND HUM[illegible] SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/04/2006
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 _____	07/27/2006

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F 280	Continued From page 11 However, review of the care plan showed the resident required extensive assistance with bed mobility, transfers, locomotion, dressing, and eating. Interview with the director of nursing on 7/26/06 at 9:30 AM verified the care plan had not been updated to reflect the resident's current status. 2. According to the care plan, resident #44 ate in the limited assistance dining room and required a built-up spoon and blue Dycem (piece of thin rubber to keep items from slipping) under his/her plate. Observations on 7/24/06 at 6:10 PM and 7/25/06 at 8:15 AM showed the resident ate independently in the main dining room. The resident used regular silverware and had no assistive devices. On 7/26/06 at 9:40 AM, registered nurse (RN) #6 stated the care plan had not been updated to reflect the resident's current status. 3. Review of the care plan dated 4/18/06 showed resident #60 utilized a seat belt in the wheelchair. However, observation of the resident on 7/24/06 at 6 PM and again on 7/25/06 from 7:01 AM until 9:36 AM revealed the resident did not have a seat belt in the wheelchair. Review of physician orders showed on 7/10/06 there was an order to discontinue the seat belt. During an interview on 7/25/06 at 2:10 PM, the Minimum Data Set (MDS) coordinator stated the care plan was reviewed by the team in early July. The MDS coordinator stated when the seat belt was discontinued on 7/10/06, staff should have updated the care plan.	F 280	1-3D. Concerns will be reported to the Quality Assurance Committee for review and recommendations for 90 days or until compliance is maintained for a period of 90 days.	

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F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy review, and staff interview, the facility failed to follow professional standards for one of 18 sample residents (#3) and one non-sample resident (#50) related to transcription of physician orders and restricted fluid intake. The findings were: 1. Observation on 7/26/06 at 7:20 AM showed licensed practical nurse (LPN) #7 prepared and administered medications, including three tablets of Senna (a laxative), each 8.6 milligrams (mg), to resident #50. Reconciliation of the medication pass with the physician's recapitulation (Recap) of orders form showed the July 2006 orders were for Senna 187 mg, three tablets daily. Further review of the May and June 2006 Recaps also showed the order was for Senna 187 mg, three tablets daily. Each of the Recap of orders forms was signed by a registered nurse as correct before the physician signed the order, and each order sheet was noted and transcribed to the medication administration records (MARs). Review of the MARs for April, May, June, and July 2006 revealed the orders were for Senna 187 mg, three tablets daily. When questioned on 7/26/06 at 9:50 AM, LPN #7 called the pharmacist who reported Senna came in 8.6 mg, not 187 mg. The LPN confirmed the transcription error and stated, "I wonder how we missed that!" Although the Recap of orders were signed as correct, the transcription error was not caught for at least four months.	F 281	F281 Professional Standards The facility is committed to providing or arranging services that meet professional standards of quality. 1A. The Senna order for resident number 50 was clarified on 7/25/06. The resident has been receiving the correct dosage. The order was changed to reflect the dosage given to the resident (8.6mg). *Completion date: 7/25/06* 1B. All Senna orders were reviewed for every resident to ensure accuracy of transcription. *Completion date: 7/25/06* 2A. Resident number 3 discharged to home on 7/25/06. 2B. An audit was completed for residents with orders for fluid restrictions. No current residents have orders for fluid restrictions. *Completion date: 8/7/06* 1-2C. Nurses received training regarding transcription of orders and fluid restriction policy during the nursing in-service held on 8/7/06. *Completion date: 8/7/06* 1-2C. Director of Nursing will complete periodic audits of medication orders and compliance with fluid restriction policy. *Completion date: 8/13/06*	

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F 281	Continued From page 13 According to the 2004 sixth edition of "Clinical Nursing Skills Basic to Advanced Skills," by Smith, Duell, and Martin; "If a written order...is questionable for any reason, the physician must be notified for clarification." 2. Review of the 5/26/06 hospital discharge summary revealed resident #3 had hyponatremia [decreased sodium in the blood] and was treated with a free water restriction. Review of the 5/26/06 admission orders showed the resident was on a 1200 cubic centimeters (cc) per day fluid restriction. On 6/15/06 the physician changed the order to 1000 cc/day (250 cc with each meal, and a total of 250 cc between meals). Review of the 7/21/06 laboratory report showed sodium was still decreased at 135 (normal range is 136-145). Review of the facility's policy "Restricted Fluids" (undated) showed staff should "...record the amount of fluids consumed by the resident in cc's....follow established intake and output procedures..." On 7/26/06 at 1:30 PM, registered nurse (RN) #10 stated staff should document fluid intake on an I & O (intake and output) sheet for residents on fluid restrictions. During an interview on 7/26/06 at 1:36 PM, certified nurse aide (CNA) #6 stated the resident was on a fluid restriction, and staff were to document on an I & O form. Review of the June and July 2006 meal intake record showed fluids consumed was not documented in cc's. Staff only documented the percentage of fluids consumed. Review of the medical record (including medication administration records and certified nursing flow sheets) revealed no documentation of fluids consumed between meals. The only documentation on an I & O sheet in the medical	F 281	1-2D. Concerns will be reported to the Quality Assurance Committee for review and recommendations for 90 days or until compliance is maintained for a period of 90 days. *Completion date: 8/13/06*	

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F 281	Continued From page 14 record (which documented fluids consumed in a 24 hour period) was for 6/26/06 and 6/27/06. During an interview on 7/26/06 at 2:35 PM, the director of nursing (DON) stated staff should document on an I & O sheet if the resident was on restricted fluids. The DON stated there was no way to know how much fluid the resident consumed during the day if staff were not documenting intake in cc's. According to "Nursing Interventions and Clinical Skills," second edition, copyright 2000, the measuring and recording of intake and output is appropriate if a client has a fever, has edema, is receiving IV or diuretic therapy, or is placed on restricted fluids. The collection of data indicates the specific treatment alterations needed.	F 281	F323 Accidents The facility is committed to ensuring that the resident environment remains as free of accident hazards as is possible. 1A. The smoking assessment for resident number 45 was reviewed by the Social Service Director and updated to reflect resident's current status on 7/27/06. Care plan was updated on 7/27/06 to reflect the following changes. Resident number 45 is supervised by staff while smoking. Resident number 45's cigarettes and lighter are kept at the nursing station. *Completion date: 7/27/06*	
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to assure the environment was free of accident hazards for four of 13 sample residents (#11, #33, #45, #66). In addition, the facility failed to assure a safe environment while floors were mopped in the secure unit. The findings were: 1. According to the 9/14/05 smoking assessment, resident #45 was assessed as not safe to smoke independently or keep his/her cigarettes and	F 323	1B. All smoking assessments have been reviewed by the Social Service Director and care plan team on 7/27/06 to ensure safety of residents who smoke. *Completion date: 7/27/06* 1C. Smoking assessments will continue to be completed by the Social Service Director and care plan team on admission, quarterly, and as needed for changes in cognition and decline in physical function. *Completion date: 7/27/06* 1C. The Social Service Director and Director of Nursing will continue to monitor compliance with safety smoking measures and appropriateness of smoking care plans to ensure resident safety. *Completion date: 8/13/06* 1D. Concerns will be reported to the Quality Assurance Committee for review and a recommendation for 90days or until compliance is maintained for 90 days. *Completion date: 8/13/06*	

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F 323	Continued From page 15 lighter. The facility documented, "Family to supervise smoking. Resident with cognitive defects which would impair judgment. Would give smoking supplies to another regardless of orientation or cognition. Resident may become disoriented." Another smoking assesament, dated 11/22/05, documented the resident remained unsafe to smoke independently and the supplies were to remain at the nurses' station. Review of the 5/1/06 care plan showed the resident's cigarettes and lighter were to remain at the nurses' station. The following concerns were identified: a. Review of nursing notes from 5/2/06 through 7/25/06 showed staff documented the resident was confused and had multiple hallucinations, including one related to fire on 7/11/06. On 7/18/06, staff documented removing the resident's cigarettes "as it was reported [s/he] was smoking in room." On 7/24/06 at 9 AM staff documented the resident was "confused, unable to re-orient. Paranoid - thinks staff is plotting against [him/her]." Further review of later documentation on 7/24/06 showed "Cigs [cigarettes] given to Rt [resident] per c/o [complaints] staff being against [him/her], informed Rt [s/he] could keep cigs but can't not smoke in bldg [building] - if [s/he] does, cigs will be placed in med [medication] room. Rt. stated understanding." b. On 7/26/06 at 9:58 AM, interview with registered nurse (RN) #10 revealed the resident had given smoking supplies to another resident when the initial smoking assessment was completed on 9/14/05. The RN stated staff intermittently gave the resident's cigarettes and lighter back to him/her, and she confirmed they were removed on 7/18/06 due to the resident	F 323	2A. Safety assessments for wheel chair seatbelts have been completed by the interdisciplinary team on 7/27/06 for resident number 11, 33, and 65. Seatbelts for these residents have been adjusted for an individualized snug fit at the upper thigh/hip area on 7/27/06. Seat belts were fastened by closures to maintain individualized fit. *Completion date: 7/27/06* 2B. An audit was completed by the interdisciplinary team to ensure safety assessments have been completed for all residents with seatbelts. All seatbelts were assessed by the Restorative Nurse and Maintanence Director to ensure an individualized snug fit at the upper thigh/hip area. *Completion date: 7/27/06* 2C. The nursing staff received training on positioning and fit of seatbelts on 8/7/06. *Completion date: 8/7/06* 2C. The interdisciplinary team received training regarding safety assessments on 8/7/06. *Completion date: 8/7/06* 2C. The Director of Nursing and Staff Development Coordinator will monitor seatbelt fit daily during rounds. *Completion date: 8/13/06* 2C. The Social Service Director and Director of Nursing will complete periodic audits to ensure safety assessments are complete for seatbelts. *Completion date: 8/13/06*	

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F 323	Continued From page 16 smoking in the room. In addition, the RN stated she was not aware of the resident's current care plan. Furthermore, the RN stated she returned the cigarettes and lighter to the resident on 7/24/06 without consulting with the interdisciplinary team. Finally, the RN stated the resident remained confused and still had hallucinations. c. On 7/26/06 at 1:22 PM observation showed the resident ambulated with a front wheeled walker (FWW) to the smoking area, removed a pack of cigarettes and a lighter from a bag attached to the FWW, lit a cigarette, and started smoking. The resident was unaccompanied by family, and staff were not at the nurses' station. 2. Observation on 7/24/06 of residents who had seatbelts in their wheelchairs revealed the following concerns: a. Observation on 7/24/06 at 6 PM and again on 7/25/06 at 7:05 AM revealed resident #11 was in a wheelchair with a seatbelt on. The seatbelt was not snug at the hips, but rather was loose and hung at the level of the mid thighs. Review of the 10/17/05 physical restraint assessment showed there was no positioning evaluation or assessment for the safety of the seat belt. Review of the medical record revealed no evidence a safety assessment was performed. b. Observation on 7/24/06 at 6 PM and again on 7/25/06 at 7 AM revealed resident #33 was in a wheelchair with a seat belt on. The seatbelt was not snug at the hips, but rather was loose, and hung at the level of the mid thighs. Review of the 2/24/06 physical restraint assessment showed positioning and safety of the seatbelt was not addressed. Review of the medical record revealed no safety assessment was performed.	F 323	2D. Concerns will be reported to the Quality Assurance Committee for review and recommendations for 90 days or until compliance has been maintained for 90days. *Completion date: 8/13/06* 3A. The housekeeping department received training regarding safety of residents, staff, families during mopping on 7/27/06. *Completion date: 7/27/06* 3B. Yellow Caution Wet Floor signs are placed in the area where the floor is being mopped before the start of mopping process and the Caution sign remains in place until the floor is dry. All residents, staff and visitors that are in the area are cautioned also not to walk in the wet floor area and assisted away from the area as needed. *Completion date: 7/27/06* 3C. The House Keeping Supervisor will monitor compliance. *Completion date: 8/13/06* 3D. Concerns will be reported to the Quality Assurance Committee for review and a recommendation for 90 days or until compliance is maintained for a period of 90 days. *Completion date: 8/13/06*	

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F 323	Continued From page 17 c. Observation on 7/24/06 at 6:35 PM and on 7/25/06 at 7:05 AM showed resident #65 was in a wheelchair with a seatbelt on. The seatbelt was loose, and hung at the level of the mid thighs. Review of the 10/27/05 physical restraint assessment showed no positioning or safety assessment was completed. d. During an interview on 7/26/06 at 12:50 PM, the social service director (who is a member of the restraint committee) stated there was not an assessment for the safety of the seatbelts. On 7/26/06 2:35 PM, the director of nursing (DON) also confirmed the lack of a safety assessment. The DON further stated the seat belts should be fitted to the residents, and should not be loose. 3. Observation on 7/25/06 at 10:30 AM revealed housekeeper #1 mopped the dining room floor in the secure unit. The life enhancement coordinator and some residents in wheelchairs were still in the dining room. No caution signs were placed while the housekeeper mopped the floor. The entire floor was mopped from wall to wall. When the housekeeper was finishing up, resident #10 walked in the dining room from the hallway, and walked across the wet floor. Neither staff member said anything to the resident. On 7/26/06 at 10 AM, the housekeeping supervisor stated staff should only mop half of the dining room floor at a time, to leave a dry area to walk on.	F 323		

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F 371 SS=E	483.35(l)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE 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, and review of the cleaning schedule, the facility failed to ensure cleaning of food preparation equipment and food spillage. The findings were: Observation of the kitchen area during the initial tour on 7/24/06 from 4:35 PM to 5:17 PM revealed the following concerns: a. Observation of the "Univex" blender revealed a dried white foamy substance. Interview with cook #1 on 7/24/06 at 4:56 PM revealed she was unable to remove the substance easily and had to scrub it away. The cook stated she had not used the mixer that day and she described the substance as "cheesecake" from the previous day. Interview with the registered dietitian on 7/25/06 at 5:10 PM revealed the blender should be cleaned after every use and the staff used a cleaning schedule. Review of the facility cleaning schedule revealed the blender should be cleaned after each use. b. Observation of a dry storage room revealed mustard colored spots on the floor and four packages of crackers spilled on the floor. A second observation of the dry storage room on 7/25/06 at 7 AM revealed the dry storage area was unchanged. Interview with the registered dietitian on 7/25/06 at 5:10 PM revealed spills in all areas should be cleaned at the time of the	F 371	F371 Sanitary Conditions – Food Prep & Service The facility is committed to store, prepare, and serve food under sanitary conditions. A. All kitchen appliances will be cleaned after each use. The dietary staff will clean all spills at the time of the spill. B. The dietary stuff will be required to follow the cleaning schedule. An in-service regarding the cleaning schedule was held on 8/1/06. C. An inspection of all storage units and kitchen appliances will be conducted daily using the sanitary checklist. C. The dietary manager will be responsible for monitoring compliance. D. Concerns will be reported to the Quality Assurance Committee for review and a recommendation for 90 days or until compliance is maintained for 90 days. *Completion date: 8/30/06* A. (cont. from above) The Univex blender, microwave, walk-in refrigerator, and storage room were all cleaned on 7/25/06. added per request by John w HHA via phone on 8/1/06 @ 11:55 AM KB	

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F 371	Continued From page 19 spill. c. Observation of the microwave revealed reddish colored food splatters on the interior surfaces. A second observation on 7/25/06 at 7 AM revealed the splatters remained in the microwave. Interview with cook #2 at that time revealed she had used the microwave to melt margarine but did not know what food substance caused the other splatters. Interview with the registered dietitian on 7/25/06 at 5:10 PM revealed the microwave should be cleaned after every use and the staff used a cleaning schedule. Review of the facility cleaning schedule revealed the microwave should be cleaned after each use. d. Observation of the walk-in refrigerator revealed wilted shredded lettuce spilled onto a lower shelf holding a wrapped ham, and onto the floor. A second observation on 7/25/06 at 7 AM revealed the spill remained unchanged. Interview with the registered dietitian on 7/25/06 at 5:10 PM revealed spills in all areas should be cleaned at the time of the spill. Review of the facility cleaning schedule revealed sweeping and mopping of floors was scheduled daily.	F 371		
F 465 SS=F	483.70(h) OTHER ENVIRONMENTAL CONDITIONS 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: Based on observation and staff interview, the facility failed to ensure a safe and sanitary	F 465		

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F 465	Continued From page 20 environment for residents and staff. Three of three showers lacked back flow prevention devices to protect the water system. In addition, environmental concerns were identified in the kitchen and in one staff bathroom. The findings were: 1. Observation on 7/25/06 at 12:15 PM of the bathing room in the long hallway (the "Beach" bathing room) revealed it had a shower. Observation on 7/25/06 at 1 PM of the bathing room in the secure locked unit revealed it had two showers. The observations revealed all three showers contained hoses with hand held shower attachments. The hoses were long enough to enable the shower heads to access the floor. None of the showers had a back flow prevention device. On 7/26/06 at 9:10 AM, the maintenance director confirmed the showers did not have a back flow prevention device or vacuum breaker. 2. Observation on 7/26/06 at 9:30 AM in the staff bathroom at the central nursing station revealed the rubber mopboards at the base of the walls were coming unglued and separating from the walls on three of the four walls. On 7/26/06 at 1:12 PM, the maintenance director confirmed the mopboards were coming unglued. 3. Observation of the kitchen area during the initial tour on 7/24/06 at 4:35 PM revealed a table top steamer was in use. The observation also revealed a steady drip of water from the steamer onto the counter top and then onto the floor, creating a puddle on the floor. A second observation on 7/26/06 at 10:54 AM revealed the steamer was in use and dripping onto the floor, but this time, a honeycomb rubber mat was in	F 466	F465 Other Environmental Conditions The facility is committed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1a. Back flow valves will be installed on the shower in the Beach bathing room, and on the two showers in the secure unit. *Completion date: 9/1/06* 2a. The mopboards in the Central bathroom will be replaced and/or glued to the walls by 9/1/06. *Completion date: 9/1/06* 3a. Replacement parts for the tabletop steamer have been ordered and repair will be completed by 9/1/06. *Completion date: 9/1/06* 1-3b-c. The maintenance director will be responsible for monitoring and completing routine repairs quarterly. *Completion date: 9/1/06* 1-3d. Concerns will be reported to the Quality Assurance Committee for review and recommendations for 90 days or until compliance has been maintained for 90 days. 1, (cont.) An overall facility inspection was done by the maintenance director and VHA to determine areas needing repair was done on 7/25/06. added per request of Kathleen Johnson, VHA on 8/15/06 @ 11:55AM	

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

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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 _____	07/27/2006

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 465	Continued From page 21 place.	F 465		