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

PRINTED: 06/15/2012
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
	535034	A. BUILDING _____ B. WING _____	06/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	150 CARING WAY LANDER, WY 82520

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CAA - care area assessment CAT - care area trigger CNA - certified nursing assistant DON - director of nursing HIM - health information maintenance MAR(s) - medication administration record(s) MDS - Minimum Data Set mg - milligrams RN - registered nurse SSD - social services director UTI - urinary tract infection Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	**Submission of the plan of correction shall not be construed as a waiver of this provider's right to contest any and all deficiencies, nor is such submission an admission that the facts are as alleged, or that any regulatory violation occurred.** **The following is to be considered our Credible Allegation of Compliance.**	
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the results of the most recent survey was displayed in a location readily accessible to residents. In addition, the facility failed to post a notice of the survey results.	F 167	**F 167** **Correct deficiency to individual:** The binder with results of the most recent survey is labeled and placed in an accessible and designated area in our front lobby. There is a posted notice regarding survey result availability. **How others are identified and correction to others in similar situation:** A copy of the most recent survey results is labeled and placed in our front lobby with a posted notice regarding availability of these results. **Measures/systematic changes to prevent reoccur:** Administration will ensure the presence and availability of the survey results as well as the posting regarding the results. This will be monitored on a regular weekly basis. Staff have been informed of the expectation of maintaining the survey results and posting in the designated area. Location of these results will also be addressed at resident council for the next 3 months.	07/13/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deanna Schantz | TITLE: Administrator | (X6) DATE: 6-25-2012

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.

Changes made per phone on 6/28/12 @ 1:16pm with Deb Litter, acting Administrator. POC accepted. Janice Colin, OSLC

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F 167	Continued From page 1 availability. The findings were: Observation on 6/1/12 at 8:30 AM showed the survey results could not be found. Interview with the business office manager revealed the survey results were to be placed on the table located in the front lobby but she acknowledged they were not there. Further, she was not certain how long they had been missing. At 10 AM that day the office manager revealed the survey results were found in a drawer in the lobby area. The notebook the results were displayed in was not labeled indicating its contents; nor was there a posted notice to indicate the availability of the survey results.	F 167	**Monitor permanent solution:** Administration/designee will randomly audit presence of the survey results and posting on a weekly basis for the next 90 days. Concerns will be addressed immediately. Ongoing concerns with F 167 will be taken to our QA and A committee for resolution.	07/13/12
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social 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 staff interview, the facility failed to ensure 1 of 1 sample resident (#18) who required bilateral hearing aids received timely staff assistance to ensure both devices were available to maintain hearing. The findings were: Observation on 5/30/12 at 8:45 AM showed resident #18 wore a hearing aid in the left ear. At that time CNAs #7 and #8 stated the resident's right hearing aid was broken and they had to	F 250	**F 250** **Correct deficiency to individual:** Resident #18 has a SuperEar headphone and microphone set, as well as a headset at the bedside for all communication and activities. Additional SuperEar sets are available throughout the facility. Resident #18 frequently plays with his hearing aide taking them apart; the family has chosen not to have another hearing aide ordered. **How others are identified and correction to others in similar situation:** Social Services has a listing of all residents with hearing aids and they have all been evaluated to ensure they are functioning properly. **Measures/systematic changes to prevent reoccur:** Staff have been inserviced on the expectation that they report concerns with resident hearing aids to the charge nurse and Social Services. **Monitor permanent solution:** Social Services/designee will randomly audit several resident hearing aids each week for the next 90 days. Concerns will be addressed immediately. Ongoing concerns with F 250 will be taken to our QA and A committee for resolution.	

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F 250	Continued From page 2 speak very loudly in his/her left ear. This was demonstrated a few minutes later when the resident required loud speech and multiple repetitions before understanding the information being conveyed by the CNAs. According to the 3/9/12 annual MDS assessment, the resident had conductive hearing loss, wore bilateral hearing aids, and was dependent on staff for their care, cleaning, and placement. In addition to impaired hearing, the resident was also blind and required assistance with all ADLs, both of which were also documented as impacting communication. Review of nursing and social services notes showed no documentation that the resident's hearing aid was broken. On 5/31/12 at 10:20 AM the DON stated she was unaware the resident was not wearing both hearing aids; furthermore, she had no knowledge one had been broken. At 10:25 AM that day, the SSD also denied knowing the hearing aid had been broken. In an additional interview on 5/31/12 at 1 PM, the SSD stated the restorative aide reported telling an unidentified charge nurse approximately six weeks ago the resident's hearing aid was missing. The charge nurse did not report this to the DON or SSD, and the restorative aide did not follow up on her report that the hearing aid was missing.	F 250		
F 272 SS=E	483.20(b)(1) 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	F 272	Residents #8, #15, #16, #18, #20, #21 and #26 will have comprehensive assessments completed for all triggered areas 07/13/12 F 272 **Correct deficiency to individual:** The MDS cannot be completed retroactively. The Comprehensive MDS assessments will be completed, according to RAI guidelines; including CAA's and CAP's with resident specific assessment, cause and effect to resident, analysis of findings. Resident specific care planning has been completed for identified residents. **How others are identified and correction to others in similar situation**	

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F 272	Continued From page 3 assessment of a resident's needs, using the resident assessment instrument (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 on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide comprehensive assessments in a variety of areas for 7 of 12 sample residents (#6, #15, #16, #18,	F 272	All future comprehensive MDS assessments will include CAA & CAT assessment and analysis per RAI manual. **Measures/systematic changes to prevent reoccur:** Education of MDS nurses to include CAA & CAT assessment of analysis per RAI manual has been completed. **Monitor permanent solution:** DON or designee will ensure the presence of in-depth analysis of resident specific assessment weekly x 4 weeks and then monthly and PRN thereafter. Ongoing concerns with F272 will be taken to our QA and A committee for resolution	

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F 272	Continued From page 4 #28, #45, #56). The findings were: According to the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, April 2012, "Review a triggered CAA by doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions...This is also an opportunity to consider any issues and/or conditions that may contribute to the triggered condition, but are not necessarily captured in the MDS data...Use the information gathered thus far to make a clear issue or problem statement." Failure to complete comprehensive assessments of triggered areas was identified as follows: a. Review of the 3/26/12 annual MDS assessment for resident #8 showed the following areas triggered for comprehensive assessment: visual function, psychosocial well-being, falls, nutrition, psychotropic drug utilization, and pain. Review of the CATs showed the areas were not comprehensively assessed utilizing the causes and contributing factors to determine the rationale for care planning. b. Review of the 2/10/12 significant change MDS assessment showed resident #16 triggered for comprehensive assessments in the areas of ADLs, urinary and bowel incontinence, and psychotropic medications. Review of information identified by the MDS coordinator as the comprehensive assessment showed an analysis of the data in each of the specified areas was not performed to determine the cause and contributing factors. Instead, the data only repeated information already identified in the MDS assessment. c. Review of the 7/8/11 initial MDS	F 272		

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F 272	Continued From page 5 assessment for resident #16 showed the following areas triggered for comprehensive assessment: incontinence, psychosocial well-being, and mood state. Review of the CATs showed the areas were not comprehensively assessed utilizing the causes and contributing factors to determine the rationale for care planning. d. According to the 3/9/12 annual MDS assessment, resident #18 required comprehensive assessments for ADLs, urinary incontinence, falls, swallowing/nutritional status, and skin conditions. Review of information provided as the comprehensive assessments showed no evidence the data in each specified area was analyzed to determine the causes and impact on the resident. e. Review of the 2/3/12 annual MDS assessment for resident #28 showed the following areas triggered for a comprehensive assessment: psychotropic drug use and visual function. Review of the CATs showed the areas were not comprehensively assessed utilizing the causes and contributing factors to determine the rationale for care planning. f. Review of the 12/20/11 significant change MDS assessment showed resident #45 required comprehensive assessments in areas which included falls and nutrition. Review of the information designated as the comprehensive assessment for these areas showed the facility failed to document the impact on the resident, and they failed to analysis the data to form a plan for intervention. g. Review of the 3/1/12 significant change MDS assessment showed resident #66 required comprehensive assessments in areas which included falls and nutrition. Review of the	F 272		

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F 272	Continued From page 6 Information designated as the comprehensive assessment for these areas showed the facility failed to document the impact on the resident. Further, the assessments lacked an analysis of the data to develop an appropriate plan for intervention. Interview with the MDS coordinator on 5/31/12 at 10:05 AM revealed the information for the comprehensive assessments was taken from the CAT worksheets rather than the CAAs. She further acknowledged the data in each area should be analyzed to identify causes and contributing factors and to determine whether or not the area should be care planned.	F 272	F 278 **Correct deficiency to individual:** MDS Coordinator signed all MDS assessments in designated signature sections for all identified residents and assessments. **How others are identified and correction to others in similar situation:** MDS Coordinator or designee reviewed all MDS's within the window and ensured that all signatures are in place, as indicated by the RAI Manual. **Measures/systematic changes to prevent reoccurr:** MDS staff have been inserviced on the expectation that they sign all designated signature lines as indicated in the RAI Manual. AHT (software company) called on 6-15-12 and indicated that Section "X" can only be signed when a modification or correction occurs. **Monitor, permanent solution:** MDS or designee will audit MDS's weekly x 4 weeks to ensure signatures are in place; then monthly. Any concerns with F278 will be taken to the QA and committee for resolution.	07/13/12
F 278 SS=C	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED 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	F 278		

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F 278	Continued From page 7	F 278		

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 medical record review and staff interview, the facility failed to ensure the MDS assessments were signed appropriately for 13 of 19 sample residents (#2, #8, #15, #16, #18, #28, #31, #40, #42, #45, #46, #56, #57) who required those assessments. The findings were:

Review of all MDS assessments for residents #2, #8, #15, #16, #18, #28, #31, #40, #42, #45, #46, #56, and #57 showed signatures were looking for Sections V (CAA Summary, VB and VC) and Section Z (Assessment Administration, Z0500). On 5/31/12 at 10:05 AM the MDS coordinator stated she thought the signatures were computer generated, so she was not checking them. At 9:50 AM on 6/1/12 the coordinator reported there was a glitch in the computer software system, and the signatures were not being generated. The coordinator confirmed she had not physically signed the assessments to certify their completion.

Reference: Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, April 2012.
For Section V0200: Page V-5, "Coding

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F 278	Continued From page 8 Instructions for V0200B, Signature of RN Coordinator for CAA Process and Date Signed. V0200B1, Signature. Signature of the RN coordinating the CAA process. V0200B2, Date. Date that the RN coordinating the CAA process certifies that the CAAs have been completed..." For Section Z0600: Page Z-7, "Signature of RN Assessment Coordinator Verifying Assessment Completion. Item Rationale: Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete."	F 278	F 279 **Correct deficiency to individual:** Staff has been educated regarding the personal needs of Resident #16. The care plan for resident #16 has been reviewed and updated to reflect current functional status related to elimination. The weight order for Resident #45 has been changed by the physician to M-W-F, with physician notification of 3# or more weight gain. The care plan for resident #45 has been updated to reflect current orders. Resident #56 has been reviewed with current elopement risk assessment in place. The care plan has been updated to reflect Risk for Elopement, with Code Alert in place. **How others are identified and correction to others in similar situation:** Interdisciplinary team has reviewed care plans of residents who are at risk for elopement, daily weights and incontinence. Care plans have been updated for all residents with risk for elopement, daily weights, and incontinence. Care plans will be maintained as current by charge nurses and the interdisciplinary team. **Measures/systematic changes to prevent reoccur:** Charge nurses and the Interdisciplinary Team have been re-educated on the expectation that care plans are reflective of each resident's current status. Care plans will be developed as a result of resident assessments and they will be revised as needed to reflect current status. Direct care	07/13/12
F 279 tag=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279		

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F 279	Continued From page 9 by: Based on observation, staff interview, and medical record review, the facility failed to ensure a care plan was developed in a variety of areas for 3 of 12 sample residents (#16, #45, #66). The findings were: 1. Review of the 6/16/11 bladder assessment, the initial 6/29/11 MDS assessment, and the quarterly 12/13/11 and 3/13/12 MDS assessments for resident #16 showed s/he had mixed incontinence. Observation on 5/30/12 at 9:30 AM revealed the resident's incontinence brief was wet with urine. Review of the care plan, however, showed no evidence a care plan addressing the resident's toileting program for incontinence was developed. Interview with the DON on 6/1/12 at 8:30 AM verified no care plan was developed for toileting. 2. Review of the medical record showed resident #45 had diagnoses which included congestive heart failure, edema, and hypertension. Review of the physician's orders revealed a 3/7/12 order for daily weights, and to notify the physician for a weight gain of three pounds or more. Review of the care plan showed the facility failed to initiate a plan to address weight gain. During an interview with the MDS coordinator on 6/1/12 at 8:45 AM, she confirmed the facility failed to implement a care plan for the resident concerning weight gain and daily weight monitoring. 3. Review of the medical record for resident #56 showed s/he had diagnoses which included senile dementia. Review of the Unusual Occurrence Investigation Form dated 5/14/12 revealed the resident was marked for elopement and for a	F 279	staff have also been educated regarding personal care needs of Resident #16. Monitor permanent solution: The MDS nurse/designee will audit 2-3 resident care plans each week for the next 90 days to ensure that they are reflective of assessment results and current status of the resident. The care plan audit will target those residents who have been identified as At Risk for Elopement, have current physician orders for Daily Weights, or incontinence concerns. The audit will ensure that care plans are promptly updated when concerns are identified. Any problems will be corrected and ongoing concerns with F279 will be taken to our QA and A committee for resolution.	

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F 279	Continued From page 10 prior history of elopement. Review of the corresponding nursing note dated 5/16/12 as a "late entry" showed the resident was found in the parking lot "going to see Dr." Review of the resident's care plan revealed elopement was not addressed. During an interview on 6/1/12 at 8:45 AM, the MDS coordinator confirmed the facility failed to implement a care plan for the resident concerning elopement.	F 279	**F 280** **Correct deficiency to individual:** Resident #31 was immediately assessed and identified as an ambulatory resident, who has a Code Alert bracelet on the residents wheelchair. The Code Alert system was analyzed by Maintenance, and deemed to be functioning properly. The care plan for Resident #31 was correct at the time of survey. Resident #31 may have been	07/13/12
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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, medical record review and staff interview, the facility failed to revise the	F 280	mis-identified by the former DON as the findings related to resident #31 in the 25676 were not correct. Findings for Resident #46 were not correct and were actually reflective of resident #42. Resident #46 has never attempted to leave the building. Resident #42 was assessed and information regarding resident #42 is current in the Risk for Elopement protocol book as well as current elopement risk assessment. The care plan was reviewed and updated to reflect the resident's risk for elopement. The care plan reflects that resident #42 will not allow the code alert bracelet to be placed on their person and it is therefore placed on their walker. Ongoing functioning assessment of Code Alert system is completed daily, per protocol. **How others are identified and correction to others in similar situation:** The Interdisciplinary Team completed a review of all residents identified as At Risk for Elopement. Care plans were reviewed and updated to indicate current risk factors for	

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	535034	A. BUILDING _____ B. WING _____	06/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	180 CARING WAY LANDER, WY 82520

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F 280	Continued From page 11 care plans for 2 of 12 sample residents (#31, #46) to reflect each resident's current status. The findings were: 1. Observation on 5/31/12 at 8:20 AM showed resident #31 in his/her wheelchair with an alarm attached to the chair. Review of the 5/10/11 care plan for falls showed the resident ambulated with assistance and s/he was to be encouraged to ask for assistance to ambulate. In addition, the 5/10/11 care plan for memory impairment showed the resident was to wear a wanderguard alarm at all times. Interview with the DON on 6/1/12 at 11 AM revealed the resident did not ambulate any longer. Further, the resident did not wear the wanderguard on his/her person because s/he no longer ambulated. The DON also stated the resident had followed visitors exiting the building without causing the alarm to sound. She acknowledged the care plan needed to be revised. 2. Observation on 5/31/12 at 8:20 AM showed resident #46 ambulated with a walker with an attached alarm. Review of the 4/27/12 care plan for wandering showed a monitoring device was to be placed on the resident to sound when s/he left the building. In addition, the exits the resident favored for elopement were to be noted. Interview with the DON on 6/1/12 at 11 AM revealed the resident refused to wear the monitoring device. The device was then placed on the walker. In addition, she stated the resident favored exiting through the front entrance door, but the information was not included on the care plan.	F 280	elopement. Charge Nurse is responsible for elopement risk assessments and ensuring that the residents care plan is updated and maintained. **Measures/systematic changes to prevent reoccur:** Charge nurses have been trained to care plan any elopement attempt, including, if a pattern is evident, the exit the resident tends to use. The Interdisciplinary team is also aware of their responsibility to reflect elopement risks on the resident's care plan. Ongoing functioning assessment of Code Alert system is completed daily. **Monitor permanent solution:** The DON/designee will audit residents who are at risk for elopement weekly for 90 days to ensure that the care plan is current. Problems will be corrected immediately. Any identified ongoing concerns related to F280 will be reported to the QA and A committee for resolution.	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	**F 281** **Correct deficiency to individual:** The Registered Dietician has completed all nutritional assessments for the identified residents (#8, #15, #16, #28, #42, #45, and #46). Resident #45 is now to be weighed M-W-F, with notification of physician for weight gain of 3# or more. The care plan has been updated to reflect current weight order of M-W-F as well as physician notification based on weight gain. Updates are completed by the charge nurse according to physician orders.	07/13/12

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F 281 Continued From page 12

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to ensure the registered dietitian (RD) completed MDS assessments and related comprehensive nutritional assessments for 8 of 8 sample residents (#8, #15, #16, #18, #28, #42, #45, #46) who were reviewed for nutrition. In addition, the facility failed to follow physician orders for 1 of 14 sample residents (#45). The findings were:

1. Review of the comprehensive nutritional assessments for residents #8, #15, #16, #18, #28, #42, #45, and #46 showed each was signed by the certified dietary manager (CDM) for the nutritional area and all related nutritional care area assessments. During an interview on 5/31/12 at 1:30 PM, the certified dietary manager confirmed she, not the RD, completed all comprehensive nutritional assessments and corresponding nutritional CAAs required for each resident.

According to the 2008 Standards of Practice for Registered Dietitians in Nutrition Care, published by the American Dietetic Association, Standard 1: Nutrition Assessment, The registered dietitian (RD) uses accurate and relevant data and information to identify nutrition-related problems. Rationale: Nutrition Assessment is the first of four steps of the Nutrition Care Process. Nutrition Assessment is a systematic process of obtaining, verifying, and interpreting data in order to make

F 281

How others are identified and correction to others in similar situation:
An audit was completed to identify all residents at nutritional risk. The Registered Dietician (RD) will complete nutritional assessments for these residents promptly to ensure that all interventions are in place. Other residents will have nutritional risk assessments completed by the RD with admission and in the conjunction with their care plan schedule The Registered Dietician (RD) will delegate appropriate tasks to Dietary Manager (CDM), with RD completing the Nutritional Assessments.
We currently have no other residents with orders for obtaining and reporting daily/frequent weights to the physician. Any similar orders in the future will be correctly completed by the charge nurse.

Measures/systematic changes to prevent reoccur:
Education has been completed identifying the Registered Dietician (RD) as the professional who must complete all resident nutritional assessments. The Certified Dietary Manager (CDM) is responsible for the task of gathering data for the RD, and inputting data into the MDS. Education was completed for CDM and RD, related to nutritional assessments.
Charge Nurses have been educated regarding the proper notification process of MDS's, as well as following physician orders related to Resident # 42.

Monitor permanent solution:
MDS Nurse or designee will audit

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F 281	Continued From page 13 decisions about the nature and cause of nutrition-related problems. It is initiated by referral and/or screening of individuals...for nutrition risk factors...It provides the foundation for Nutrition Diagnosis, the second step of the Nutrition Care Process. Further, the 2008 Standards of Practice specifically state: "The RD does not delegate the nutrition care process, but may assign certain tasks for the purpose of providing the RD with needed information (e.g., screens, gathering of data and other information) or communicating with and educating patients." 2. Review of the medical record for resident #45 showed s/he had a 3/7/12 physician order for daily weights. The order also required staff to notify the physician if the resident experienced a weight gain of three or more pounds. Review of the March, April, and May 2012 MARs, Vital Signs and Weight Records, and Weight Lists showed the resident's weight was not recorded on 3/11/12, 3/12/12, 3/13/12, 3/22/12, 4/25/12, 4/26/12, 5/9/12, 5/10/12, 5/12/12, and 5/29/12. Further review showed the facility failed to notify the physician concerning the resident's weight gain for the following: a 3.1 pound weight gain from 4/13/12 through 4/14/12, a 9 pound weight gain from 4/27/12 through 4/28/12, and a 6 pound weight gain from 5/6/12 through 5/7/12. During an interview with the DON on 6/30/12 at 11 AM, she confirmed the resident's weights were not always recorded, and the physician was not always notified of a weight gain of three or more pounds. According to the Wyoming Nurse Practice Act, revised July 2010, Section 3, pages 3-8 of the Wyoming State Board of Nursing's Administrative Rules and Regulations, nursing staff must function under the direction of a licensed	F 281	2-3 nutritional assessments weekly with the MDS cycle to ensure that they are being completed by the RD. Additionally, the DON/designee will audit Resident #42 weekly along with other residents who have future orders for frequent weights to ensure that physician orders are followed. These audits will continue for the next 90 days and corrections will be made immediately. Any ongoing concerns related to F281 will be reported to the QA and A committee for resolution	

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F 281	Continued From page 14 physician.	F 281	F 309	07/13/12
F 309 69=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of facility policies and procedures, the facility failed to ensure all necessary assessments, monitoring, and nursing measures were implemented for pain management for 1 of 6 sample residents (#16) who experienced pain. In addition, the facility failed to ensure staff consistently monitored and evaluated weight fluctuations for 1 of 1 sample residents (#45) who were being monitored for weight gain. The findings were: 1. Review of the 3/13/12 quarterly MDS assessment for resident #16 showed s/he had almost constant pain that interfered with day to day activities. Review of the medical record showed a physician's order dated 2/29/12 for the pain medication, Hydrocodone/APAP 5/325 mg, three times daily as needed. Continued review of the orders showed the physician ordered Tylenol 500 mg one to two tablets every six hours as needed for pain on 4/4/12. Review of the MAR and the pain flow sheet for May 2012 revealed	F 309	**Correct deficiency to individual:** Charge Nurses have been educated on the Pain Management Protocol, including PRN medication, non-pharmacological interventions prior to PRN administration, pain assessment, and required follow-up for efficacy. Resident #16 has been placed on alert charting for pain management, and is assessed for pain every shift. The care plan for Resident #16 has been updated to reflect this change. Resident #45's physician was notified, and the resident is no longer on daily weights; now being weighed on M-W-F, with notification of physician for weight gain of 3# or more. The care plan for resident #45 has been updated to reflect this change. **How others are identified and correction to others in similar situations:** An audit was completed on residents identified requiring pain management interventions. Any resident considered to be at risk for the identified practice was referred to the QA and A committee for resolution. Care plans have been reviewed and updated. Charge nurses have been educated on the expectation that non-pharmacological interventions pain management practices are attempted and documented prior to administering a PRN narcotic for pain management. Education also included the pain management protocol with required documentation for pre-assessment and follow up efficacy assessment, and physician notification when ordered.	

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F 309	Continued From page 15 the following concerns with pain management: a. Review of the MAR showed the resident received Tylenol 500 mg (number of tablets not documented) for pain on 5/2/12 at 8 PM. Review of the medical record showed no evidence the resident's pain was assessed as to type, intensity or description at the time of the administration of Tylenol. In addition, there was no evidence the resident's pain was re-assessed to determine the effectiveness of the Tylenol in relieving the resident's pain. Finally, there was no evidence non-pharmacological interventions were attempted to address the resident's pain. This same scenario occurred on the following dates and times as well: 5/3/12 at 8 PM, 5/4/12 at 8 PM, 5/8/12 at 9 PM, 5/9/12 at 9:20 PM, 5/10/12 at 9:30 PM, 5/11/12 at 8:15 PM, 5/14/12 at 9:30 PM, 5/15/12, 5/16/12 and 5/17/12 (all had no time documented), and 5/20/12 at 8:30 PM. In addition to the administration of Tylenol, the resident also received Hydrocodone/APAP 5/325 mg for pain without evidence of assessment or re-assessment on 5/2/12 at 9:45 PM, 5/5/12 at 10:15 PM, and on 5/21/12 at 11:30 PM. b. Review of the facility policy on pain assessment and management, revised October 2010, showed the nurse should gather the following information when assessing pain: "....(1) Intensity of pain (as measured on a standardized pain scale); (2) Descriptors of pain; (3) Pattern of pain (e.g., constant or intermittent); (4) Location and radiation of pain; (5) Frequency, timing and duration of pain." c. Interview with the DON on 5/31/12 at 5:15 PM verified the expectation of pain management was to re-assess the resident's level of pain one to two hours after administration of a pain medication to determine the effectiveness.	F 309	**Measures/systematic changes to prevent reoccur:** The DON/designee will conduct weekly audits on 4-5 residents who receive PRN pain medications, for the next 90 days. Audits will focus on residents who have PRN pain medications to ensure appropriate pain management steps are being completed (pain assessment, non-pharmacological interventions, PRN administration, follow-up efficacy assessment, and documentation.) **Monitor permanent solution:** The DON/designee will audit weekly for residents who have alternate weigh orders (other than weekly) or physician notification orders for 90 days. Any resident identified to have an alternate weight order or physician notification directives will be audited for compliance to schedule and physician notification. Any concerns related to F309 will be reported to the Q A and A committee for resolution.	

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F 309	Continued From page 16	F 309		

2. Review of the medical record showed resident #45 had diagnoses which included congestive heart failure, edema, and hypertension. Review of a 3/1/12 fax to the physician showed the resident had 3+ edema to the left lower extremity, 2+ edema to the right lower extremity, slight edema of the perineal area, and expiratory wheezes all throughout the lung fields; the physician responded with a Lasix (diuretic) order. Review of the physician's orders revealed a 3/7/12 order for daily weights and to notify the physician for a weight gain of three pounds or more. Review of the May 2012 MAR showed the resident had an order for Lasix 60 mg twice a day. Review of the physician's orders for 5/31/12 showed the physician increased the Lasix to 80 mg twice a day after receiving a communication from RN #9 that the resident had a weight gain of over three pounds. The following concerns were noted:

a. Review of the March, April, and May 2012 MARs, Vital Signs and Weight Records, and Weight Lists showed the resident's weight was not recorded on 3/11/12, 3/12/12, 3/13/12, 3/22/12, 4/26/12, 4/26/12, 5/9/12, 5/10/12, 5/12/12, and 5/29/12.

b. Further review showed the facility failed to notify the physician concerning the resident's weight gain for the following: a 3.1 pound weight gain from 4/13/12 through 4/14/12, a 9 pound weight gain from 4/27/12 through 4/28/12, and a 6 pound weight gain from 5/6/12 through 5/7/12.

c. During an interview with the DON on 5/30/12 at 11 AM, she confirmed the resident's weights were not always recorded, and she could not be certain the weights were taken. She also confirmed the physician was not always notified concerning a weight gain of three or more

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F 309	Continued From page 17 pounds.	F 309	F 312 **Correct deficiency to individual:** Resident #16 receives grooming and hygiene assistance per care plan. Staff has been educated on the need to provide all requested cares to dependent residents.	07/13/12
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of facility policies and procedures, the facility failed to ensure personal grooming was performed for 1 of 4 dependent sample residents (#16). The findings were: Review of the 3/13/12 quarterly MDS assessment for resident #16 showed s/he required extensive staff assistance for personal hygiene, grooming and dressing. Observation on 5/30/12 at 9:30 AM showed the resident received morning care by CNAs #10 and #7. During the observation, the resident stated s/he needed his/her hair combed because it "must look pretty bad" and s/he "didn't want to scare people." Continued observation showed neither CNA combed, nor assisted the resident to comb, his/her hair. Review of the facility policy on brushing and combing hair, revised April 2007, showed "The resident's hair should be brushed and combed every morning before breakfast and whenever necessary throughout the day." In addition, observation showed neither CNA provided oral hygiene or assisted the resident to brush his/her teeth. Interview with the DON on 5/31/12 at 5:15	F 312	**How others are identified and correction to others in similar situation:** Audit completed to identify all dependent residents, who require ADL care. Identified residents have been reviewed for needed assistance, and care plans have been updated. Staff has been educated on meeting the needs of residents who are dependent **Measures/systematic changes to prevent reoccur:** The DON/designee will conduct raudom resident daily audits on grooming and hygiene for the next 90 days. Staff education for all new hires will be provided for resident needs, grooming and hygiene, with follow up competencies at the quarterly timeline. **Monitor permanent solution:** DON/designee will audit weekly for dependent residents who require ADL assistance, for 90 days and then following MDS scheduled cycle. Any concerns with F312 will be taken to our Q A and A committee for resolution.	

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F 312	Continued From page 18 PM revealed all residents should have their hair combed and teeth brushed as part of the routine morning care.	F 312	F 323 **Correct deficiency to individual:** Resident #31 has been assessed for the risk of elopement, following elopement protocol. The care plan has been updated to reflect that Resident #31 has no pattern or preferred exit, for attempting to leave the building and the presence of a code alert bracelet on the resident's wheelchair. The Code Alert Alarm system has been tested by maintenance, and deemed to be fully functional. Resident #31 does ambulate with assist of staff. Resident identified as #46, is actually Resident #42. Audit revealed that further attempts to place a Code Alert bracelet on Resident #42 were unsuccessful. The Code Alert Alarm was then placed on the resident's walker. The resident's care plan has been updated to reflect Code Alert alarm placement, as well as the front door preference by the resident for attempted elopement. Care Plans for residents #31 and #42 are current and reflective of elopement prevention measures that are in place for each resident. **How others are identified and correction to others in similar situation:** An audit on all residents at risk for elopement was completed. Care plans were updated to reflect placement of alarm bracelet, and preferred exit door, if applicable. The elopement prevention policy is followed to include proper procedure for de-activating door alarms. **Measures/systematic changes to prevent reoccur:**	07/13/12
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure residents received adequate supervision and monitoring for 2 of 4 sample residents (#31, #46) who had a history of elopement. The findings were: 1. Review of the medical record for resident #31 showed s/he had diagnoses including dementia. Observation on 5/31/12 at 8:20 AM showed the resident was able to self-propel in his/her wheelchair. Review of the incident log showed the resident had eloped, or had attempted to elope, seven times from 2/5/12 through 5/15/12 from various exits of the facility to include the lobby near the location of the parking lot. The following concerns with safety management in regard to elopement were identified: a. Observation on 5/31/12 at 8:30 AM showed a wanderguard was placed on the resident's wheelchair. However, review of the incident logs	F 323		

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F 323	Continued From page 19 with the DON on 6/1/12 at 11AM showed the resident had been able to elope without the alarm sounding to alert staff of his/her exit. The DON said there were instances in which the resident left when the alarm was de-activated when other residents were leaving the building with visitors. b. Review of the 5/10/11 care plan for falls showed the resident ambulated with assistance and s/he was to be encouraged to ask for assistance to ambulate. In addition, the 5/10/11 care plan for memory impairment showed the resident was to wear a wanderguard alarm at all times. Interview with the DON at that time revealed the resident no longer ambulated and, furthermore, did not wear the wanderguard on his/her person. The DON also stated the resident had followed visitors exiting the building and that this action did not sound the alarm. She acknowledged the care plan did not address precautionary measures required to ensure this resident's safety. 2. Review of the medical record for resident #46 showed s/he had diagnoses including dementia. Review of the nurse's notes showed the resident had eloped three times from 1/31/12 through 4/25/12. The following concerns with safety management regarding elopement were identified: a. Review of the incident report dated 3/28/12 showed the resident was found beside the facility garage at 7:20 PM when s/he was headed to a nearby apartment complex to visit a friend. Review of the nurse's note dated 3/28/12 at 9:30 PM showed the facility attempted to place a wanderguard on the resident but the resident refused. Further review showed that following this incident the facility made no other attempts to	F 323	All staff has been educated to the Code Alert alarm, as well as the appropriate procedure for door alarm de-activation. Maintenance will test the function of the Code Alert alarm system daily. Resident with Code Alert bracelets will have their bracelet checked daily by nursing staff to ensure placement and proper functioning. **Monitor permanent solution:** The DON/designee will audit elopement prevention practices weekly for the next 90 days to ensure that Code Alert bracelets are checked daily and that door alarms and the Code Alert system is checked daily for proper function. Corrections will be made immediately. Any ongoing concerns with F323 will be reported to our Q A and A committee for resolution.	

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	530034	A. BUILDING _____ B. WING _____	06/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	160 CARING WAY LANDER, WY 82520

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F 323	Continued From page 20 place a wanderguard on the resident. b. Observation on 5/31/12 at 8:20 AM showed the resident ambulated with a walker with an attached alarm. Review of the 4/27/12 care plan for wandering showed a monitoring device was to be placed on the resident to sound when s/he left the building. In addition, the exits the resident favored for elopement were to be noted. Interview with the DON on 6/1/12 at 11 AM revealed the resident refused to wear the monitoring device; therefore the device was then placed on the walker. In addition, she stated the resident favored exiting through the front entrance door and she was concerned the resident could leave the facility when the alarm was de-activated for other residents and their visitors. She acknowledged the care plan did not address precautionary measures to ensure the safety of the resident.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329	F 329 **Correct deficiency to individual:** Residents identified (#15 and #8) have been reviewed for Psychotropic medication use and associated indication. Attending Physician's have been contacted with a request to attempt a gradual dose reduction. In the event the physician declines a gradual dose reduction, clinical rationale is to be provided by the physician to support their actions. **How others are identified and correction to others in similar situation:** An audit was completed to identify all residents receiving psychoactive medications, including initiation dates, dose, frequency, gradual dose reduction date, and efficacy. Any resident identified as a similar risk was assessed by the IDT for continued use and a GDR request was sent to physician. All care plans have been updated to reflect the current classification of psychoactive medication, indicated use, and targeted behaviors. **Measures/systematic changes to prevent reoccur:** Licensed nurses have been educated on the protocol for initiation of psychoactive medications, including assessment, obtaining physician's order, consent, care plan, and requirements for GDR. Consulting Pharmacist was contacted, standard was reviewed, and is being followed. **Monitor permanent solution:**	07/13/12

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	535034	A. BUILDING _____ B. WING _____	06/01/2012

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WESTWARD HEIGHTS CARE CENTER	150 CARING WAY LANDER, WY 82520

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F 329	Continued From page 21 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen for 2 of 12 sample residents (#8, #15) was free of unnecessary medications. The findings were: 1. Review of the orders showed the physician ordered Trazadone (an antidepressant but ordered for insomnia) 50 mg at bedtime on 4/15/11 for resident #15. Review of the MARs showed the resident had received it nightly since that date. According to a fax sent to the physician on 9/26/11, the resident's "mood is stable and is without insomnia. Discussed [with] IDT team: Consensus is that [name's] mood and behaviors are stable @ this dose and it is recommended that [s/he] continue [his/her] trazadone @ HS. May we have a continuing order For: Trazadone 50 mg po (orally) at H.S.?" Detailed review of the medical record provided no evidence the physician evaluated the resident to determine if the benefits of the medication at that dose outweighed the risks or if the dose could be decreased. Furthermore, evidence was lacking that the facility conducted an assessment to determine if the cause of the resident's insomnia	F 329	Weekly auditing of [illegible]-5 residents on psychoactive medications will be completed by the DON/designee for 90 days to ensure appropriate requests and follow up for gradual dose reductions from the physician are completed. Any concerns with F329 will be reported to the QA and A committee for resolution.	

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F 329	Continued From page 22 was still present. After reviewing the medical record, the DON stated on 6/1/12 at 8:10 AM she was unable to find a clinical rationale from the physician for continuing Trazadone at that dose. 2. Review of physician orders for resident #8 showed s/he was started on Prozac 20 mg every morning for a diagnosis of depression. The order was dated 4/23/11. On 3/28/12, a gradual dose reduction was requested of the physician; however, the physician denied the request without providing a clinical rationale for doing so. Interview with the DON on 6/1/12 at 8:30 AM verified no clinical rationale was provided for not attempting a gradual dose reduction of the antidepressant medication.	F 329		
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure physician visits occurred as required for 7 of 12 sample residents (#8, #15, #16, #18, #28, #40, #46). The findings were: 1. Review of the medical record showed no	F 387	**Correct deficiency to individual:** All identified residents (#8, #15, #16, #18, #28, #40, and #46) are current on their physician's visits. Future physician visit needs are be tracked by our Health Information Manager and they will be scheduled in accordance with regulatory requirements. **How others are identified and correction to others in similar situation:** An audit has been completed on all residents for physician visit compliance. Any resident identified as needing a physician visit has been scheduled. Physicians have been notified in writing of the timeline requirement for resident visits. Required physician visits will be tracked and scheduled. **Measures/systematic changes to prevent reoccur:** Staff have been educated regarding the physician visit requirement (once every 30 days for the first 90 days after admission, and at least once ever 60 days thereafter.) Scheduling and transportation aides have been educated on the 10-day physician visit window. **Monitor permanent solution:** Bi-weekly audits will be completed by the DON/designee regarding scheduled visits for residents. These audits will occur for 90 days	07/13/12

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F 387	Continued From page 23 evidence resident #16 was seen by a physician during the six month period from 4/15/11 through 10/12/11. The resident was next seen by the physician three months later on 1/12/12. On 6/1/12 at 8:20 AM, the manager of HIM stated she was looking for evidence of physician visits and would fax it, if found. No faxed information was received. 2. Review of the physician progress notes for resident #40 showed the physician visited on 11/30/11 and 2/9/12. Interview with the HIM manager on 6/1/12 at 11:30 AM revealed there was no other information to show the physician visited between 11/30/11 and 2/9/12 (71 days). Further, there were no progress notes available after 2/9/12 to show the resident was seen by his/her physician (111 days). 3. According to the medical record, resident #16 was admitted on 2/2/11. Review of the progress notes showed no evidence the physician saw the resident between 6/16/11 and 9/19/11 (94 days). The DON and HIM manager were requested to obtain evidence of any other physician visits, but none was provided. 4. Review of the physician progress notes for resident #8 showed the physician examined the resident on 10/12/11 and then not again until 1/12/12, 92 days later. According to the HIM manager on 6/1/12 at 11:50 AM, she was unable to find evidence the resident was seen by the physician between the above noted dates. 5. Review of the physician progress notes for resident #16 showed the physician examined the resident on 10/12/11 and then not again until	F 387	to ensure that required visits are tracked, scheduled and completed. Any concerns identified with F387 will be reported to the QA and A committee for resolution.	

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F 387	Continued From page 24 1/12/12, 92 days between visits. According to the HIM manager on 6/1/12 at 11:50 AM, she was unable to find evidence the resident was seen by the physician between the above noted dates. 6. Review of the physician's documentation for resident #28 showed there were no notes to indicate the resident was seen between 11/30/11 and 2/9/12 (71 days) and from 2/9/12 to 5/4/12 (86 days). Interview with the HIM manager on 6/1/12 at 11:30 AM revealed there was no additional information to show the physician saw the resident between the itemized dates. 7. Review of the medical record showed resident #46 was admitted on 11/29/11. Review of the physician progress notes indicated the resident was not seen between 12/22/11 and 3/8/12 (46 days). The resident was not seen every 30 days for the first 90 days after his/her admission.	F 387		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on review of medical records, staff	F 428	**F 428** **Correct deficiency to individual:** Resident #15 has been reviewed and their attending physician has been contacted related to the Trazadone. The physician and pharmacist have been advised of the cited concerns and new medication orders have been received. **How others are identified and correction to others in similar situation:** An audit of similar residents revealed no other concerns related to F428. If other residents are identified with similar concerns, they will be referred to the consulting pharmacist and attending physician for resolution. Consulting Pharmacist indicated that all potential residents affected will be reviewed during future monthly reviews. **Measures/systematic changes to prevent reoccur:** Review of the F428 citation was reviewed with Consultant Pharmacist and expectations were expressed. The consulting pharmacist will review and identify antidepressants that are due for gradual dose reductions and recommendations will be made to the respective attending physician. The DON/designee will review all new admissions	07/13/12

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F 428	Continued From page 25 interview, and interview with the consultant pharmacist, the facility failed to identify irregularities for 1 of 12 sample residents (#15). The findings were: . According to the physician's orders and review of the MARs, resident #15 had received 60 mg of the antidepressant, Trazadone, daily since 4/15/11. Review of the monthly medication regime reviews showed no indication the pharmacist identified use of the antidepressant at the same dose for over a year as an irregularity. Review, with the DON on 6/1/12 at 8:10 AM, of the pharmacist's report of irregularities confirmed the medication was not identified. During an interview on 6/1/12 at 9:30 AM, the pharmacist verified he did not identify continued use of Trazadone at the same dose as an irregularity.	F 428	and readmissions for potential medication concerns and the attending physician will be contacted accordingly. **Monitor permanent solutions:** DON/designee will audit all resident pharmacy reviews monthly for the next 90 day to ensure proper follow-up related to F428. Any identified concerns related to F428 will be reported to the QA and A committee for resolution.	
F 431	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	**Correct deficiency to individual:** The identified vials have been destroyed. Staff education has been provided to ensure that vials are dated when opened, and destroyed no later than the expiration date. **How others are identified and correction to others in similar situation:**	07/13/12

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F 431	Continued From page 26 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and interview with the consultant pharmacist, the	F 431	An audit has been completed on all medications to ensure that there are no open and expired vials of medication available for use. There were no identified expired medication vials in use. **Measures/systematic changes to prevent reoccur:** Charge Nurse education has been provided to ensure that vials are dated when opened, and destroyed no later than the expiration date. Charge Nurses will complete ongoing monitoring of med room and medication carts for expired meds and this will be completed prior to administration of medications and weekly with infrequently used medications. Expired Meds will be properly discarded. **Monitor permanent solution:** DON/designee will perform random weekly audits on medications for expired meds for 90 days. Any identified concerns related to F431 will be reported to the QA and A committee for resolution.	

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F 431	Continued From page 27 facility failed to ensure two vials of tuberculin skin testing solution were removed and disposed of appropriately after being opened. This failure potentially affected 7 of 7 residents admitted after 3/3/12. The findings were: Observation on 6/1/12 at 8:45 AM with LPN#12 showed two vials of tuberculin skin testing solution were labeled as opened on 2/3/12. An interview with the LPN at that time verified the date the vials were opened and confirmed they were available for use. Furthermore, the LPN was uncertain when the vials expired after they were opened. Interview with the pharmacist on 6/1/12 at 9:30 AM revealed the vials expired 30 days (3/3/12) after they were opened. Therefore, the medications had been expired for 89 days.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	**F 441** **Correct deficiency to individual:** Pericare for Resident #16 and wound care for Resident #18 are completed using proper infection control technique. The residents have not experienced any adverse effects from the cited practice. **How others are identified and correction to others in similar situation:** Hand hygiene, glove use, peri care and dressing change audits have been performed and any concern was immediately corrected and education of staff completed. Pericare and dressing changes will be completed on all residents using proper technique. **Measures/systematic changes to prevent reoccur:** Identified staff have been educated on the proper hand hygiene protocol and glove protocols. All staff education has been completed on proper peri care and dressing change technique including hand hygiene and glove protocols. This education will also be completed with new nursing staff. This education will also be include in quarterly inservicing by the SDC or designee **Monitor permanent solution:** SDC or designee will perform weekly peri care audits on 3-4 random staff members to	07/13/12

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F 441	Continued From page 28 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens 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 facility policies and procedures, the facility failed to ensure acceptable hand hygiene practice was performed. This failure affected 2 of 12 sample residents (#16, #19). The findings were: 1. Observation on 5/30/12 at 9:30 AM revealed resident #16 was incontinent of urine. Continued observation showed CNA #10 removed the wet incontinence brief, discarded it, rummaged through the resident's closet and found a garbage bag and placed it into a container for dirty laundry. She then assisted the resident to stand and move from the bedside commode to the recliner and straightened his/her clean clothing - all while wearing the same soiled gloves worn to remove the wet incontinence brief. Interview with	F 441	ensure proper hand hygiene techniques as well as proper glove techniques. Additionally, dressing change audits will be completed with 1-2 nurses each week for the next 90 days to ensure proper technique is used. Any concerns will be reported to the QA and A committee for resolution.	

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F 441	Continued From page 29 the infection control nurse on 5/31/12 at 4:30 PM revealed the CNA should have removed her soiled gloves after discarding the wet incontinence brief and prior to touching any clean surface. 2. Licensed practical nurse (LPN) #11 was observed while completing a dressing change for resident #18 on 5/31/12 at 7:05 AM. After setting up a clean field and opening needed supplies, the LPN removed her gloves, washed her hands, and then re-gloved. She next removed the boot from the resident's right foot, picking it up by the sole to set it aside. Without removing the gloves and performing hand hygiene, the LPN cut the old dressing free, established a clean field under the resident's right foot, and then removed the old dressing. While wearing the same gloves used to handle the boot, the LPN then cleansed the open wound with normal saline prior to removing the gloves, washing her hands, and regloving before appropriately completing the dressing change. During an interview at 7:30 AM that day, the LPN confirmed she cleansed the wound while wearing potentially contaminated gloves. She stated that a better technique would have been to reglove after performing appropriate hand hygiene. According to the facility's policy and procedure, "Dressings, Dry/Clean" 2001 MED-PASS, Inc. (Revised October 2010), after establishing a clean field for supplies, repositioning the resident, and adjusting his/her clothing, clean gloves should be donned after washing the hands. Then the old dressing is removed, the hands washed and dried, and the supplies opened. Clean gloves are donned prior to assessing and cleansing the wound and completing the dressing change."	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535034	A. BUILDING _____ B. WING _____	06/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	150 CARING WAY LANDER, WY 82520

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F 496 SS=D	483.75(e)(6)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on review of personnel files and staff interview, the facility failed to contact the Wyoming State Nurse Aide Registry for 1 of 1	F 496	F 496 **Correct deficiency to individual:** The identified staff (CNA #8) has received clearance from the Wyoming State Nurse Aide Registry for work. No concerns of abuse, neglect, or misappropriation of property was identified on this staff member. **How others are identified and correction to others in similar situation:** An audit was performed on all employees to ensure that required abuse, neglect, and misappropriation of personal property clearance has been received by the Wyoming State Nurse Aide Registry. No concerns were identified for any staff member. **Measures/systematic changes to prevent reocur:** All new employees will be checked against the Wyoming State Nurse Aide Registry for concerns related to abuse, neglect, and misappropriation of personal property, prior to beginning orientation. Any nurse aide concerns against an applicant will cause the applicant to be ineligible for employment. Human Resources/designee will be responsible for checking the appropriate registry status and Human Resources is aware of this responsibility. **Monitor permanent solution:** Human Resources/designee will audit on each new hire to ensure that appropriate abuse check has been completed prior to the new employee being allowed to work. Any concerns will be reported to the QA and A committee for resolution	07/13/12

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F 496	Continued From page 31 CNAs (#5) to determine if there were any findings of abuse, neglect, or misappropriation of property against her. The findings were: Review of personnel records on 5/31/12 at 2:30 PM showed CNA #5 was hired on 5/7/12. Further review failed to show evidence the facility checked with the Wyoming State Nurse Aide Registry to determine if findings of abuse, neglect, or misappropriation of property had been entered against her. During the review, the business office manager stated she had not submitted the required information to the nurse aide registry and, therefore, did not know if there were any findings against the CNA.	F 496	F 502 **Correct deficiency to individual:** The attending physician for Resident #15 was notified of the fact that the C&S was not completed with the recent UA. The physician had no new orders for Resident #15. The resident is not currently exhibiting any symptoms of a urinary tract infection. **How others are identified and correction to others in similar situation:** An audit was performed to ensure that any resident identified to have a Urinalysis with a C&S in the last 30 days has had the C&S performed in compliance with the physician's orders. There were no residents identified as not having the required lab work completed. All future UA specimens will be completed by the charge nurse with appropriate timing of ordered lab work, receipt of lab results, technique for obtaining a clean catch UA, and sterile technique for a straight cath collection for a urinalysis. All future physician ordered lab tests will be completed. **Measures/systematic changes to prevent reoccur:** Staff education has been completed with Charge Nurses related to lab work, receipt of lab work results, ordering lab work, techniques for obtaining a clean catch UA, and sterile technique for obtaining a straight cath collection of urine for urinalysis. HIM has been educated on obtaining lab work results on a timely basis. Weekly auditing will be performed on ordered lab work and receipt of lab work results by the Risk Team. **Monitor permanent solution:**	07/13/12
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory tests met the needs of 1 of 1 sample residents (#15) whose test results were documented as contaminated. The findings were: 1. According to laboratory results dated 5/16/12 for a urinalysis, resident #15 had a UTI and a culture was ordered. Review of the orders dated 5/16/12 showed the physician ordered the antibiotic, Macrobid. However, detailed review of the medical record revealed the ordered culture results were lacking. When obtained from the			

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F 502	Continued From page 32 laboratory by the HIM manager on 5/31/12, the results showed the culture was not performed due to a "...contaminate pattern..." No further workup was completed to determine if the infection was appropriately treated with Macrobid. There was no way to determine if the laboratory services, as provided at this time for this resident, met his/her needs. 2. Interview with the DON on 5/31/12 at 4:30 PM revealed the facility had been experiencing problems with the laboratory testing for some time.	F 502	Lab orders and receipt of lab results will be audited weekly by the Risk team to ensure the timely completion of labs, the timely receipt of lab results and the timely follow-up with physician regard lab results. These audits will be done for the next 90 days. DON or designee will present audit to Risk team weekly. Any identified concerns for F502 will be reported to the QA and A committee for resolution.	07/13/12
F 505 SS=D	483.75(l)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the physician was notified of laboratory results for 2 of 12 sample residents (#15, #31). The findings were: 1. Review of laboratory results dated 5/16/12 for a urinalysis showed resident #15 had a UTI and a culture was ordered. However, detailed review of the medical record revealed culture results were lacking. Interview with the HIM manager on 5/31/12 at 11:10 AM revealed the results had not yet been obtained from the laboratory. When obtained by the HIM manager on 5/31/12, the results showed the culture had not been performed due to a "...contaminate pattern..." At 1:55 PM that day the HIM manager stated, that	F 505	**F 505** **Correct deficiency to individual:** The physicians for identified residents (#15 and #31) have been notified of cited lab concerns. Physician for resident #15 declined ordering an additional UA or C&S, as resident was not symptomatic. The lab results for resident #31 have been received for the 1/24/12 date; the physician has been notified of findings. **How others are identified and correction to others in similar situation:** An audit was performed to ensure that any resident identified to have a Urinalysis or C&S performed in compliance with the physician orders. There were no residents identified as not having the required lab work completed. Licensed nurse education has been completed to ensure appropriate physician notification of lab results. **Measures/systematic changes to prevent reoccur:** Staff education has been completed with Charges Nurses to ensure that there is physician notification related to lab results. HIM has been educated on obtaining lab work	

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F 505	Continued From page 33 since the results had not been received, the physician had not been notified by the facility that the culture was not completed. 2. Review of the medical record for resident #31 showed a urinalysis laboratory report dated 1/24/12 that showed the results met the criteria for a urine culture. Further review of the medical record showed there were no results of a urine culture following the urinalysis. Interview on 5/31/12 at 3:30 PM with the HIM manager revealed she contacted the laboratory and found the urine culture had been completed on 1/25/12. The laboratory had not sent the results to the facility until they were requested on 5/31/12. Review of the results of the urine culture showed, "probable contaminated specimen." The physician had not been notified of the results.	F 505	results on a timely basis. Weekly auditing will be performed on ordered lab work and receipt of lab work results and notification of the physician of lab results by the Risk Team. **Monitor permanent solution:** Lab orders and receipt of lab results and notification to the physician of lab results will be audited weekly by the Risk team to ensure the proper completion of labs including the timely follow-up with physician regarding lab results. This audit will continue for the next 90 days. DON or designee will present audit to Risk team weekly. Any identified concerns for F502 will be reported to the QA and A committee for resolution.	07/13/12
F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure the results of laboratory tests were filed in the medical record for 3 of 12 sample residents (#8, #15, #31). The findings were: 1. Review of the 3/7/12 physician's order for resident #8 revealed an order for a total CK (creatine kinase, a cardiac test). Review of the	F 507	F 507 **Correct deficiency to individual:** The Residents identified (#8, #15, and #31) have had their lab results requested from the laboratory and placed within the resident's medical record. Each individual physician of Resident #8, #15, and #31 have been notified of cited lab testing. **How others are identified and correction to others in similar situation:** An audit has been performed on resident laboratory tests and corresponding laboratory results. All residents have corresponding lab results filed within the medical record. No concerns were identified. **Measures/systematic changes to prevent reoccur:** Staff education was completed regarding receiving and filing of lab results in the medical records. Weekly audit on all labs	

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F 607	Continued From page 34 entire medical record revealed the results of the test were not in the medical record. Interview with the HIM manager on 5/31/12 at 3:34 PM revealed she had to call the laboratory to obtain a copy of the results. 2. Review of laboratory results dated 5/16/12 showed resident #15 had a UTI and a culture was ordered. Detailed review of the medical record failed to produce the culture results, and the HIM manager requested them from the laboratory. On 5/31/12 at 1:56 PM the manager confirmed the results were not filed in the resident's medical record. 3. Review of the medical record for resident #31 showed a laboratory report for a urinalysis dated 1/24/12 that indicated the results met the criteria for a urine culture. Further review of the medical record showed there were no results of a urine culture following the urinalysis. Interview on 5/31/12 at 3:30 PM with the HIM manager revealed she contacted the laboratory and found the urine culture had been completed on 1/25/12. However, the results were not filed in the resident's medical record.	F 607	orders and results will be completed for 90 days. **Monitor permanent solution:** Weekly audit will be conducted on all lab orders and corresponding results, ensuring the receipt of lab results and placement in the resident's medical record. Any identified concerns will be reported to the QA and A committee for resolution.	07/13/12
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514	**F 514** **Correct deficiency to individual:** The effectiveness of PRN (as needed) pain medications cannot be documented retroactively, and Resident #16's May 2012 MAR and pain flow sheet stand as cited. All future PRN pain medications for Resident #16 will be properly documented. **How others are identified and correction to others in similar situation:** An audit was performed identifying all residents receiving PRN pain medications. All PRN pain medications will be properly documented on the Medication Administration Record (MAR) and Pain Flow sheet. **Measures/systematic changes to prevent reoccur:** Licensed Nurses have been educated on the pain management protocol, which includes PRN medication administration and required documentation of medication administration. Charge nurses are responsible for accurate and complete documentation of all PRN pain med administrations. **Monitor permanent solution:** DON or designee will complete weekly audits of medication administration documentation	

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F 514	Continued From page 35 resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medical record notations were accurate in regard to medication administration for 1 of 12 sample residents (#16). The findings were: Review of the May 2012 MAR and the May 2012 pain flow sheet for resident #16 showed the following discrepancies and inaccuracies: a. According to the MAR, the resident was administered a pain medication 17 times which was not recorded on the pain flow sheet. b. According to the pain flow sheet, the resident was administered the pain medication Hydrocodone/APAP 5/325 mg on 5/3/12 at 11 PM and again on 5/22/12 at 11:30 PM. These medications were not recorded on the MAR. c. Interview with the DON on 5/31/12 at 5:15 PM revealed the MAR and pain flow sheet should not have discrepancies between them.	F 514	for 90 days and then random thereafter. Any identified concerns will be reported to the AQ and A committee for resolution	