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Healthcare Licensing and Surveys

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

PRINTED: 11/13/2012
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
	535023	A. BUILDING _____ B. WING _____	10/30/2012

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

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA Certified Nurse Aide DON Director of Nursing MDS Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 170 SS=E	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on resident, staff and United States Postal Service (USPS) interviews, the facility failed to ensure mail was delivered to residents on Saturday. The findings were: Confidential interview with 12 residents on 10/28/12 at 1 PM revealed residents did not receive mail on Saturday. The majority also stated they were in favor of receiving Saturday mail. Interview with the activities director on 10/29/12 at 10:30 AM verified mail was not delivered to residents on Saturday. She also stated mail was delivered throughout the community including the hospital business office on Saturday; however, hospital staff was unable to sort and deliver the mail because the business office was closed on Saturday. Interview with	F 170	WCHS will provide unopened mail to the residents every day the mail is delivered from the US postal service, including Saturday. This will be accomplished by: A) Activities staff will go to the hospital daily to pick up all mail and deliver it to residents at the Manor. B) Activities Director will communicate to hospital staff and activities staff that each Saturday the mail will be delivered to the residents. C) Activities Director will monitor compliance and report to QI monthly.	12/15/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/23/12

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.

This POC accepted between Jo Ann Farnsworth, Administrator and Tony Madden - State Surveyor on 11/27/12 with a POC of 12/15/12 - State tag ongoing.

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F 170	Continued From page 1 USPS employee #1 on 10/29/12 at 1:05 PM confirmed the post office delivered mail to the hospital each Saturday.	F 170		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a significant change assessment following a decline in 2 or more areas for 1 of 2 sample residents (#30) who needed such an assessment. The findings were: Review of the 7/10/12 significant change MDS assessment and 10/10/12 quarterly MDS assessment for resident #30 showed the following concerns: a. Review of the 7/10/12 significant change MDS assessment showed the resident completed	F 274	WCHS will conduct a comprehensive assessment of resident #30 and all residents within 14 days after determining a significant change in a resident's condition that will not normally resolve itself without further intervention by staff. This will be accomplished by: A) MDS Coordinator and Social Worker will educate staff about what criteria must be present to warrant a significant change in condition MDS. B) Nurses will report residents with significant changes to the MDS Coordinator who will present the case to the IDT for further review. C) ITD will monitor for compliance and report to QI	12/15/12

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F 274	Continued From page 2 section C for cognitive patterns with a score of 5/15. Review of the 10/10/12 quarterly MDS assessment showed for cognitive patterns, the resident was not interviewable. Further, his/her cognitive skills were scored 2; moderately impaired with poor decisions and supervision required. b. Review of the 7/10/12 MDS assessment showed in section D for mood, the resident had mild depression with one area showing symptoms of feeling down, depressed or hopeless for at least half the days during the look-back period. Review of the 10/10/12 assessment for mood showed the resident had major depressive syndrome. Five items within the assessment were identified at a frequency of half or more days during the look-back period. The areas included little interest in doing things, feeling down, depressed or hopeless, sleeping too much or problems falling asleep, feeling tired and trouble concentrating. c. Review of the 7/10/12 assessment showed section E for behaviors was coded as "worse." The 10/10/12 assessment again showed his/her behavior was coded as "worse." d. Review of the 7/10/12 assessment, section G for functional status, showed the resident was coded 2; requiring limited assistance for eating. The 10/10/12 assessment showed s/he was coded 3 needing extensive assistance for eating. Interview with the MDS coordinator on 10/30/12 at 8:30 AM showed she had thought since there had been a significant change completed in July 2012, another significant change would not have to be accomplished.	F 274		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	Continued From page 3 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to follow the written plan of care for 1 of 12 sample residents (#36). The findings were: Observation on 10/28/12 at 8:55 AM showed resident #36 was sitting in his/her wheelchair (w/c) without a seat cushion. Review of the resident's care plan dated 7/3/12 showed s/he was at risk for skin breakdown and was to have a Roho Cushion (pressure relieving device) on the seat of the w/c. Continued random observations until 1:35 PM (4 hours 40 minutes) that same day showed the cushion was not in place while the resident remained sitting in the w/c. Interview with CNA #1 at that time verified the resident was to have a cushion, but it was unavailable because it had been taken to be cleaned sometime during the night shift.	F 282	WCHS will follow the written plan of care for each resident. This will be accomplished by: A) Resident #36 will have a ROHO seat cushion in her wheelchair when she is using the wheelchair. B) The charge nurse will observe that residents who have a need for wheelchair cushions are seated on the appropriate cushion. If not, charge nurse will educate staff and enforce compliance C) Director will educate staff of the reason for using wheelchair cushions and for following care plans. D) Director will monitor compliance and report to QI.	12/15/12
F 309 SS=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.	F 309		

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F 309	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to monitor the bowel elimination pattern of 2 of 8 sample residents (#3, #36) to prevent constipation. 1. Review of the bowel elimination documentation showed resident #36 did not have a bowel movement from 10/2/12 through 10/9/12 (8 days) and 10/19/12 through 10/25/12 (7 days). Review of the quarterly MDS nurses' notes dated 10/1/12 showed the resident had a history of constipation and received Miralax and docusate daily. Further, the resident had severe cognitive impairment with a brief interview for mental status score of three. Review of the nurses' notes for 10/2/12 through 10/14/12 did not show the staff was aware the resident did not have a bowel movement or was assessed for constipation. 2. Review of the bowel elimination record for resident #3 showed s/he did not have a bowel movement from 9/30/12 through 10/5/12 (6 days). 3. Interview with the administrator on 10/28/12 at 5:10 PM acknowledged the resident's bowel movements needed to be recorded and monitored by the nursing staff.	F 309	Each resident will receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the plan of care. This will be accomplished by: A) Resident #3 and resident #36 and all residents will be monitored for bowel elimination. B) All bowel movements will be documented. C) Deviations from the resident's norm will be addressed by the charge nurse and documented in the medical record D) Director will educate staff of proper protocol for addressing elimination needs/variances. E) Director will monitor compliance of the above procedures and address compliance issues immediately and report monthly to QA committee	12/15/12
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.	F 312		

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F 312	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide appropriate incontinence care for 1 of 5 residents (#1) observed requiring such care. The findings were: Review of the 9/12/12 quarterly MDS assessment for resident #1showed s/he was totally dependent on staff for toilet use. Observation on 10/28/12 at 4:35 PM showed the resident was incontinent of urine and stool. CNA #2 cleansed the resident's posterior perineum at that time, but did not clean his/her anterior perineum. The CNA stated at that time she did not cleanse the resident's anterior perineum because the resident did not like to be cleaned in the front. Interview with the DON on 10/29/12 at 2:50 PM acknowledged the resident's entire perineum area needed to be cleansed.	F 312	WCHS will provide appropriate incontinence care for each incontinent resident. This will be accomplished by: A) Resident #1 and all incontinent residents will be cleansed both anterior and posterior after every toileting episode. B) DON will educate staff about proper procedure for perinea care. C) Director will monitor compliance of the above procedures and address compliance issues immediately and report monthly to QI committee	12/15/12
F 371 S6=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 6	F 371		

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to follow proper thawing procedures for 12 of 12 liquid nutritional supplements. In addition, the facility failed to follow the 2009 Food Code with respect to animals in 1 of 2 facility dining areas. The findings were:

1. Observation of the special care unit (SCU) on 10/29/12 from 1 PM to 3 PM revealed 12 nutritional supplemental milk shakes sitting on the counter next to the refrigerator. The shakes were only partially frozen. During an interview on 10/30/12 at 10:10 AM, CNA #4 stated nutritional shakes were routinely removed from the SCU freezer and allowed to thaw on the counter that same day. Review of the individual cartons revealed the following statement: "Store frozen. Thaw at or below 40 degrees. Use thawed product within 14 days. Keep refrigerated". During an interview with the dietary manager on 10/29/12 at 2:10 PM, she stated that staff were required to thaw Mighty Shakes completely in the refrigerator, and not thaw to room air. She further stated that the procedure used by staff in the secure unit to thaw Mighty Shakes outside of the refrigerator (on the counter to room air) was unacceptable.

2. Observation of the evening meal in the SCU on 10/30/12 at 5:48 PM revealed a cat sitting under a resident's chair while the resident was eating. Further observation revealed another resident at a different table threw a small piece of food onto the floor. The cat immediately walked over to the discarded food and began to eat it. CNA #4

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F 371	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to follow proper thawing procedures for 12 of 12 liquid nutritional supplements. In addition, the facility failed to follow the 2009 Food Code with respect to animals in 1 of 2 facility dining areas. The findings were: 1. Observation of the special care unit (SCU) on 10/29/12 from 1 PM to 3 PM revealed 12 nutritional supplemental milk shakes sitting on the counter next to the refrigerator. The shakes were only partially frozen. During an interview on 10/30/12 at 10:10 AM, CNA #4 stated nutritional shakes were routinely removed from the SCU freezer and allowed to thaw on the counter that same day. Review of the individual cartons revealed the following statement: "Store frozen. Thaw at or below 40 degrees. Use thawed product within 14 days. Keep refrigerated". During an interview with the dietary manager on 10/29/12 at 2:10 PM, she stated that staff were required to thaw Mighty Shakes completely in the refrigerator, and not thaw to room air. She further stated that the procedure used by staff in the secure unit to thaw Mighty Shakes outside of the refrigerator (on the counter to room air) was unacceptable. 2. Observation of the evening meal in the SCU on 10/30/12 at 5:48 PM revealed a cat sitting under a resident's chair while the resident was eating. Further observation revealed another resident at a different table threw a small piece of food onto the floor. The cat immediately walked over to the discarded food and began to eat it. CNA #4	F 371	The facility will store, prepare, distribute and serve food under sanitary conditions. This will be accomplished by: A) Liquid nutritional supplements and all frozen foods will be thawed in the refrigerator. B) The cat that lives in the SCU will be kept away from the dining area. C) Dietary manager will educate dietary and nursing staff about proper thawing processes D) DON will educate nursing staff about keeping pets out of dining and food prep areas. E) Dietary staff will monitor thawing procedures and address compliance issues immediate and report monthly to QI committee F) DON will monitor compliance and report monthly to QI.	

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F 371	Continued From page 7 noticed the cat eating the food and immediately removed the cat from the dining area and placed it in a secured location. Interview with the CNA at the time revealed the cat usually stays out of the dining area when residents eat. According to Food Code 2009 U.S. Public Health Service 6-501.115 (B) Live animals may be allowed in the following situations if the contamination of food can not result: (4) pets in the common dining areas of institutional care facilities such as nursing homes, assisted living facilities, group homes at times other than during meals.	F 371		
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 observation, medical record review and staff interview, the facility failed to report a medication irregularity for 1 of 14 residents (#15) observed during random medication passes. The findings were: Observation on 10/28/12 at 3 PM showed	F 428	The pharmacist will report any irregularities in the drug regimen to the attending physician, and DON. Appropriate person will act upon any reported irregularities. This will be accomplished by: A) Resident #15 and all residents who use albuterol nebulizer treatments will have a specific dose written with the albuterol order. B) Pharmacist will monitor albuterol and all medication for specified doses and report any absence of dosage to the attending physician for further dosage information. C) Nurses will monitor for compliance and report to director. D) DON will monitor compliance of the above procedures and address compliance issues immediately and report monthly to QA committee	12/15/12

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F 428	Continued From page 8 registered nurse #1 administered albuterol 0.083 percent nebulizer treatment to non-sample resident #15. Review of the 9/25/12 physician orders and October 2012 MAR for the resident showed a dose for the medication was not indicated. Further, the physician orders showed the medication was initially ordered on 3/14/12. Review of the Nursing 2012 Drug Handbook showed the albuterol solution for inhalation was available in four different doses; 0.083 percent, 0.5 percent, 0.042 percent and 0.021 percent. Interview with pharmacist #1 on 10/30/12 at 10:20 AM acknowledged the dose for the albuterol needed to be clarified. Further, if there were any irregularities noted in the medication orders, the pharmacy should notify the physician.	F 428		
F 441 SS=D	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 determines that a resident needs isolation to	F 441	The facility will maintain an infection control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. This will accomplished by: A) Resident # 30 and all residents will be given complete perineum care per facility procedure to include the CNAs washing hands after removing gloves. B) The Infection Control Nurse will educate all staff on facility policy and procedure for hand washing after removing gloves C) DON will provide a monthly QI tool to the charge nurses. D) Charge nurse will randomly observe incontinence care and record on the quality monitoring tool. E) Results will be reported to QI monthly by DON	12/15/12

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F 441	Continued From page 9 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 the facility's policy and procedures, the facility failed to ensure staff followed appropriate infection control practices during 2 random observations. The findings were: 1. Observation on 10/28/12 at 8:45 AM showed sample resident #30 was transferred from his/her chair to the bathroom toilet. CNA #1 removed the resident's incontinence pad with gloved hands and completed perineum care. The CNA then removed her gloves and donned a second pair of gloves without first washing her hands. She continued to assist the resident with oral care. 2. Observation on 10/29/12 at 2:30 PM showed CNA #3 passed water to residents in rooms #1, #2 and #16 with gloved hands. After taking the	F 441	2. When passing ice water, CNAs will cleanse their hands after filling each water pitcher. This will be accomplished by: A) Hand sanitizer will be placed on the ice cooler cart for CNAs to use. B) Infection control nurse will educate staff about facility policy and procedure for hand washing/infection control. C) DON will provide a monitoring tool and monitor randomly. D) monitoring results will be reported monthly to QI.	12/15/12

11/27/12

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	10/30/2012

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

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F 441	Continued From page 10 water pitcher from the resident's room she filled the pitcher with ice, took the pitcher back into the resident's room and went to the next room. She did not change her gloves between resident rooms or cleanse her hands. An interview with the CNA at the time acknowledged gloves should be changed between residents and hands cleansed. 3. Review of the facility's policy and procedure for hand hygiene dated 8/2009 stated; "Decontaminate hands after contact with inanimate objects (including medical equipment) in the vicinity of the patient." Further; "Decontaminate hands after removing gloves." 4. Interview with the infection control nurse on 10/30/12 at 8:20 AM revealed staff should wash their hands after removing their gloves and between residents.	F 441		
F 505 SS=D	483.75(j)(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 notify the physician of 1 of 1 contaminated urine specimen for sample resident #14. The findings were: Review of the nurses' notes dated 6/5/12 at 6:45 PM showed resident #14 stated s/he was not feeling well. The physician was notified and he ordered a urinalysis and chest x-ray. Review of	F 505	The facility will promptly notify the attending physician of abnormal lab results. This will be accomplished by: A) Lab results of resident #14 and all residents will be reviewed by charge nurse B) Charge nurse will contact attending physician to report abnormal lab results and request further instruction. C) Infection control nurse will educate nursing staff of policies and procedures related to abnormal lab results. D) Infection Control Nurse will monitor for compliance and report to QI	

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F 505	Continued From page 11 the notes dated 6/6/12 showed the urine was collected and the facility sent the lab results to the physician. The resident was then started on antibiotics. Review of the urinalysis showed a urine culture was also completed and results were to follow. The following concerns were noted: a. Review of the urine culture, received on 6/8/12 by the facility, showed the urine specimen was contaminated. b. Further review of the nurses' notes and physician orders did not show the physician was notified of the contaminated specimen or that another urine specimen was obtained. c. Interview with the infection control nurse on 10/30/12 at 8:20 AM revealed another urine specimen should have been collected after the facility was notified the initial specimen was contaminated.	F 505		

11/27/12