PRINTED: 12/14/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUM... SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	12/01/2005

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 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS	F 279		

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 by:

Based on observation, medical record review and staff interview, the facility failed to develop a comprehensive care plan for one of fourteen sample residents (#5). The findings were:

Observation of resident #5 during mealtimes revealed the following:

a. On 11/28/05 from 5:45 PM until 6:35 PM the resident was seated in a wheelchair at a table with other residents, but had been positioned by staff with his/her back to the table (facing the wall). The resident remained positioned with his/her back to the table prior to the meal trays

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 violations occurred.

F279

The care plan for Resident #5 will be updated to reflect individualized dining needs. We have no other Residents with special positioning needs in the dining room.. 1-2-06

Staff will be inserviced regarding appropriate positioning at the dining table for Resident #5..

All Resident care plans will be reviewed and updated if necessary quarterly and as needed by the Interdisciplinary Care Team.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	NHA	12-30-05

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.

DOC = 1/2/06

Accepted 12/29/05; Received with Bess Litton, DON

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F 279	Continued From page 1 being served. b. Observation on 11/29/05 from 8 AM until 8:57 AM revealed the resident was positioned facing the table until his/her meal tray was delivered, then the resident was turned away from the table. c. On 11/29/05 at 1 PM the resident was assisted with dining, and was positioned facing the other residents at the table. Review of the current care plan dated 9/20/05 revealed positioning during meals was not addressed. During an interview on 11/30/05 at 4:35 PM, the director of nursing (DON) stated the resident should be positioned with his/her back to the table because the resident was less distracted and less agitated when positioned that way. However, the DON stated the resident should face the table until the meal tray was delivered. The DON further stated positioning during melas should have been addressed on the care plan.	F 279	F279 Cont'd: Random audits of Resident #5 positioning at the dining table will be completed by the DON, SDC or designee one meal per day for one week and randomly each week thereafter for two months. Audits will be taken to the quarterly QA Committee meeting. F318 A Physical Therapy screen will be completed for Resident #33. Documentation of the screen will be placed in the medical record.	1-27-06
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide services to maintain range of motion for one (#33)	F 318	All Residents will be screened by Physical Therapy or Occupational Therapy at least quarterly and as indicated to ensure appropriate assessment of range of motion and functioning levels. Reviews will be completed to determine the needs	

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F 318	Continued From page 2 nine sample residents with limited range of motion. The findings were: Review of the 6/2/05 annual and 11/10/05 quarterly Minimum Data Set (MDS) assessment showed resident #33 had range of motion limitations to one arm and both legs. Observation on 11/29/05 at 1:20 PM revealed certified nurse aide (CNA) #1 provided care for the resident while the resident was in bed. The resident was on his/her back with both knees bent. The CNA stated the resident was unable to straighten his/her legs, and had pain in the legs when staff provided care for the resident. The CNA stated the resident did not receive restorative services, but would probably benefit from those services. Review of the current medical record revealed no evidence the resident received restorative range of motion services. During interviews on 11/29/05 at 4:25 PM and 4:40 PM, the director of nursing (DON) stated she reviewed the thinned chart and the resident last received restorative services in July of 2002. The DON stated restorative was discontinued at the time because the resident refused. Review of the 11/10/05 quarterly MDS assessment showed the resident did not resist care. During an interview on 11/29/05 at 4:40 PM the DON stated there was no evidence the resident had been re-assessed since 2002 or that other alternatives had been attempted.	F 318	F318 Cont'd: for therapy services or restorative services. Documentation will be placed in the medical record related to the results of the screens/reviews. The IDT will audit the medical record quarterly to ascertain the completion of the screen. All audits will be brought to the quarterly QA Committee meeting. F324 All staff will be inserviced for the high-low bed safety. The Nursing staff will complete a review of all Residents, including Resident #49, identified as requiring the bed in the lowest position when not attended. Proper positioning of the bed height will be identified in the daily care	1-2-06
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 324		

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F 324	Continued From page 3 by: Based on observation, staff interview, and medical record review, the facility failed to ensure one (#49) of six sample residents who were at risk for falls, had the bed positioned to reduce the risk of fall when staff was not in the room. The findings were: Observation of care for resident #49 on 11/29/05 at 8:57 AM revealed the resident required assistance from certified nurse aide (CNA) #10. The CNA used a mechanical sling lift and transferred the resident to the bed, which was equipped with a bolster mattress (a mattress with a raised edge to assist a resident with identifying the boundary of the mattress). As the CNA provided personal care, she ran out of incontinence care wipes and left the room to retrieve more wipes. The observation revealed the resident was left lying in bed; the CNA did not lower the bed height before leaving the room. Observation and measurement of the flat portion of the mattress surface to the floor was 30 inches. Interview with the CNA on 11/29/05 at 9:25 AM revealed the bed was adjustable to a lower position. The CNA stated she did not lower the bed when she left the room to get wipes because she knew she would be right back. The CNA demonstrated the bed's lowest position which measured 15 inches from mattress surface to the floor. Review of the resident's medical record revealed a fall risk assessment dated 9/30/05 which assessed the resident as a high risk for falls. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated 9/30/05 revealed the resident was severely impaired for cognition and required extensive assistance with bed mobility. (As defined by the MDS: with extensive assistance, the resident might perform	F 324	F324 cont'd: plan for each identified Resident. Daily care plans will be updated as necessary by the MDS Coordinator on an ongoing basis. Audits will be completed for individualized appropriate bed height position by DON, SDC and/or designee on a random basis one time per week for four weeks and randomly thereafter for two months. Audits will be taken to the quarterly QA Committee for review. F331 The Physician caring for Resident #5 has been notified of the required documentation for a request for dose reduction. Appropriate documentation was received 12/5/05 and orders followed.	1-2-06

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F 324	Continued From page 4 part of the activity over the 7-day assessment period, but full staff performance was required during part of the assessment period). Interview with the director of nursing (DON) on 11/30/05 at 9:45 AM revealed the resident had some bed mobility and the DON stated her expectation was for staff to place the bed in a low position anytime the staff member had to leave the room. According to "Nursing Assistant: A Nursing Process Approach," 9th edition, copyright 2004, the authors teach CNAs to to make the environment as safe and user-friendly as possible. One of the interventions taught is to keep the bed in the lowest possible position with the wheels locked.	F 324	F331 cont'd: The DON, Social Services Director, MDS Coordinator, Pharmacy Consultant and NHA will review all Residents receiving antipsychotic medications for appropriate attempts at dose reductions. The DON, Social Services Director, MDS Coordinator, Pharmacy Consultant and NHA will audit monthly the medical records for all Residents receiving antipsychotic medications for appropriate dose reduction attempts and appropriate documentation. Results of the audit will be taken to the quarterly QA meeting.	
F 331 SS=D	483.25(l)(2)(ii) ANTIPSYCHOTIC DRUGS Based on a comprehensive assessment of a resident, the facility must ensure that 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, policy review, and staff interview, the facility failed to assure a dose reduction was attempted for one (#5) of two sample residents who received antipsychotic medication. The findings were: Review of physician orders revealed resident #5 had received Risperdal (antipsychotic) 0.5 milligrams (mg) twice per day since 10/19/04.	F 331		

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F 331	Continued From page 5 Review of the medical record showed no evidence a dose reduction was attempted. Review of the medical record with the director of nursing (DON) on 11/30/05 at 11 AM revealed on 5/9/05 the pharmacist requested a dose reduction of the Risperdal. The physician marked a box "No." There was no rationale as to why a dose reduction would be contraindicated. The DON stated the resident had actually received that dose of Risperdal since July 2003, and a dose reduction had not been attempted. The DON further stated there was no documentation showing a dose reduction was contraindicated. Review of the October and November 2005, behavior monitoring sheets for Risperdal showed the resident was monitored for "danger to self" and "danger to others." The documentation showed the resident did not exhibit those behaviors. Review of the facility's "Chemical Restraint Policy" (7/2003, page 8-1) showed residents who receive antipsychotic drugs should have gradual dose reductions unless contraindicated.	F 331		