11/2/10 POC accepted w/o revisions

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

PRINTED: 10/28/2010
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 _____	PP 10/15/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations and acronyms are used throughout this document: RN - Registered Nurse DNS - Director of Nursing Service CNA - Certified Nursing Assistant LPN - Licensed Practical Nurse MDS - Minimum Data Set ADL - Activities of Daily Living Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide maintenance to ensure the doors and walls in 10 of 30 resident rooms were in good repair. The findings were: 1. Observation during a tour of the facility from 8 AM through 9 AM on 10/15/10 showed the following doors and door frames had noticeable gashes: a. In room #2 the bathroom door had a gash on the inside that was 2 inches from the bottom of the door. The gash measured 4 inches by 2 inches. b. In room #5 the bathroom door frame had a gash on the room side that extended from the for a distance of 3 feet.	F 253	The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This will be accomplished by: 1. Doors and door frames in rooms #2, #5, #7, #21, #24 will be refinished by maintenance personnel to remove gashes. 2. Walls in rooms #1, #8, #10, #13, #14 will be repaired and all rooms will be inspected by maintenance personnel every month to ensure repairs are performed in a timely manner. 3. Compliance will be monitored randomly by maintenance manager and reported monthly to PI	11/29/10

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Wyoming Dept of Health

11/2/10 POC accepted with agreed revisions @ 2:15 pm per DON Irma Fouch—PP nurse

NOV 08 2010

Office of Healthcare Licensing and Surveys

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F 253	Continued From page 1 c. In room #7 the bathroom door frame had a gash on the room side that extended from the floor for a distance of 3 feet. d. In room #21 the left wall closet door had a gash all the way across (18 inches) and 3 feet from the floor. e. In room #24 the bathroom door was scraped 32 inches across on the inside and 2 feet from the floor. 2. Observation during a tour of the facility from 8 AM through 9 AM on 10/15/10 showed the following rooms had walls that were in need of repair: a. In room #1 s bathroom wall had a gash 5 feet across and three inches from the floor. Also, the bedroom had a 3 foot gash on the wall. . b. In room #8 a bathroom wall had a gash 18 inches across. c. In room #10 the bedroom wall had 6 scraped spots with noticeable missing paint. The largest spot measured 4 inches by 4 inches. d. In room #13 a wall had multiple paint chips in a corner. Also, a bathroom wall had a 3 foot gash. e. In room #14 the partial wall at the closet had a 6 inch by 24 inch gash on the corner. During an interview with the maintenance director on 10/15/10 at 9 AM, he presented a list of wall and door items that he intended to repair, which included the above items and several additional items. He further stated this list was prepared following a tour after the survey team entered the facility.	F 253		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		

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F 282	Continued From page 2 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 ensure care was provided in accordance with the written plan of care for 3 of 12 sample residents (#18, #22, #24). The findings were: Refer to F312 for details regarding the facility's failure to provide ADL assistance, specifically hand hygiene after toileting, according to the plan of care for two residents (#22, #24). Refer to F315 for details regarding the facility's failure to provide toileting assistance according to the plan of care for resident #18 .	F 282	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 will be accomplished by: 1. Residents #18, #22, #24 and all residents will receive hand hygiene after toileting and before meals. 2. DON will provide education to staff regarding hand hygiene for residents after toileting and before meals. 3. Compliance will be monitored randomly and reported monthly to QA by DON	11/29/10
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. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff monitored the fluid intake for 1 of 1 sample resident (#24) who had physician's orders for this monitoring	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: 1. Fluid intake will be monitored and recorded every shift for resident #24 and all residents with orders to monitor fluid intake. 2. DON will provide education to staff regarding intake and output monitoring and reporting.	11/29/10

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F 309	Continued From page 3 after the resident was treated for dehydration. The findings were: According to a physician's note dated 6/29/10, resident #24 received intravenous fluids that month for hypernatremia due to dehydration. The physician also documented the resident was trying to keep him-/herself hydrated, but it was difficult to get in enough nutrition and fluids. According to the 6/29/10 physician's orders, staff were to monitor the resident's fluid intake to ensure the resident received 48 ounces of fluid daily. Review of the care plan showed the resident had severely impaired cognitive skills and required verbal cues, assistance, or supervision with ADLs. Further review showed staff were to offer and encourage increased fluids; however, interventions for ensuring adequate hydration were lacking. Interview with the administrator on 10/15/10 at 8:40 AM, revealed she was unable to provide evidence that staff had been monitoring the resident's fluid intake. She also stated the only record of the resident's intake was the documentation in the July to October 2010 fluid intake with meals records. She stated she was unsure of the accuracy of these records. Review of the records showed the documented amount each day was less than 48 ounces.	F 309		
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	Residents who are unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. This will be accomplished by: 1. Residents #22 and #24 and all residents will receive hand hygiene after toileting and before meals.	11/29/10

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F 312	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure staff provided hand hygiene for 2 of 9 sample residents (#22, #24) who required assistance with activities of daily living. The findings were: Review of the 7/26/10 significant change MDS assessment showed resident #22 required extensive assistance with personal hygiene and toileting. Review of the plan of care showed staff were to assist the resident with washing his/her face and hands. Observation on 10/13/10 from 4:25 PM to 4:37 PM showed CNA #2 assisted the resident to and from the toilet, then the resident self-propelled to the dining room and began to eat his/her supper. During the observation, the CNA did not assist the resident with hand hygiene. Review of the 8/10/20 quarterly MDS assessment for resident #24 showed the resident required extensive assistance with toileting and personal hygiene care. Review of the corresponding plan of care showed staff were to assist the resident with washing his/her face and hands. Observation on 10/14/10 from 7:50 AM to 8:10 AM showed CNA #3 did not help the resident with hand hygiene after toileting, or before and after assisting the resident to brush his/her teeth. Further observation showed after the oral care was completed, the CNA propelled the resident to the dining room, and the resident ate breakfast without receiving hand hygiene prior to eating. Interview with the CNA at that time revealed the facility required staff to perform hand hygiene for themselves, but she had "never thought about" doing it for the residents. Interview with the administrator on 10/15/10 at 9:05 AM revealed	F 312	2. DON will provide education to staff regarding hand hygiene for residents 3. Compliance will be monitored randomly and reported monthly to QA by DON	

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F 312	Continued From page 6 staff were expected to wash residents' hands after toileting and before meals.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide care to promote continence for 1 of 9 sample residents (#18) who was incontinent of bladder. The findings were: Review of the 10/11/10 annual MDS assessment revealed resident #18 was frequently incontinent of bladder and totally dependent on staff for all ADLs. According to the corresponding care plan the resident required assistance with toileting upon rising, before and after meals, and as needed. Review of the care plan showed additional interventions included "check and change" every two hours. Observation on 10/13/10 from 9 AM until after lunch at 1:50 PM (elapsed time: four hours and fifty minutes) showed the resident was not toileted, checked or changed. Further observation at 1:50 AM showed CNA #1 removed the resident's urine-soiled,	F 315	Residents who are incontinent of bladder will receive appropriate treatment and services to prevent UTI's and to restore as much normal bladder function as possible. This will be accomplished by: 1. Resident #18 and all residents will be toileted as indicated in their personalized plan of care. 2. DON will provide education to staff regarding resident toileting schedules. 3. Compliance will be monitored randomly and reported monthly to QA by DON.	11/29/10

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F 315	Continued From page 6 disposable brief prior to assisting the resident to the bathroom. At that time the CNA stated other duties prevented her from providing the incontinence care and toileting in a timely manner that day. The CNA also stated the resident had fewer episodes of bladder incontinence when staff provided toileting assistance every two to three hours.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN 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 ensure 1 of 3 sample residents (# 24) with contractures received appropriate care to prevent further decrease in range of motion. The findings were: Periodic observations of resident #24 from 10/12/10 through 10/15/10 revealed the resident's right hand was contracted in a fist. Review of the 6/23/10 occupational therapist's assessment for the resident revealed the therapist recommended a right hand splint to decrease flexion contractures and ulnar deviation due to arthritis. Review of the 7/8/10 physician's orders showed a right hand splint was ordered to be worn at night. Review of the 7/10, 8/10, 9/10 and 10/10 MARs showed the resident refused to wear the splint.	F 318	Residents with limited range of motion will receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This will be accomplished by: 1. Resident #24 and all residents with contractures will receive appropriate care to prevent further contracture. 2. Therapists will provide follow-up when residents are not compliant with plan of care. 3. DON will provide education to staff regarding contractures and treatments. 4. Compliance will be monitored monthly by resident care coordinator and reported monthly to QA	11/29/10

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F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN 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 ensure 1 of 3 sample residents (#24) with contractures received appropriate care to prevent further decrease in range of motion. The findings were: Periodic observations of resident #24 from 10/12/10 through 10/15/10 revealed the resident's right hand was contracted in a fist. Review of the 8/23/10 occupational therapist's assessment for the resident revealed the therapist recommended a right hand splint to decrease flexion contractures and ulnar deviation due to arthritis. Review of the 7/8/10 physician's orders showed a right hand splint was ordered to be worn at night. Review of the 7/10, 8/10, 9/10 and 10/10 MARs showed the resident refused to wear the splint.	F 318	Residents with limited range of motion will receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This will be accomplished by: 1. Resident #24 and all residents with contractures will receive appropriate care to prevent further contracture. 2. Therapists will provide follow-up when residents are not compliant with plan of care. 3. DON will provide education to staff regarding contractures and treatments. 4. Compliance will be monitored monthly by resident care coordinator and reported monthly to QA	11/29/10 PP

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F 318	Continued From page 7 Interview with the administrator on 10/15/10 at 9 AM revealed she was aware of the resident's contracted hand and arthritis pain. She stated staff had talked with the therapist about the resident's refusal to wear the splint; but they had not explored other options and had not tried alternative devices. She also added that staff should have tried to use a hand cone or similar device.	F 318		
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 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	F 329	Each resident's drug regimen will be free from unnecessary drugs. Adequate monitoring and indications for use of drugs will be documented. Antipsychotic drugs will not be given unless necessary to treat a specific condition as diagnosed and documented in the medical record. This will be accomplished by: 1. Residents #14 and #47 and all residents will be monitored for behaviors and have documentation supporting the use of antipsychotics. 2. DON will educate staff about regulatory guidelines for use of antipsychotic medications including when to use and how to monitor. 3. Compliance will be monitored monthly and reported monthly to QA by DON, including pharmacy monthly reviews pf	11/29/10

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 7 Interview with the administrator on 10/15/10 at 9 AM revealed she was aware of the resident's contracted hand and arthritis pain. She stated staff had talked with the therapist about the resident's refusal to wear the splint; but they had not explored other options and had not tried alternative devices. She also added that staff should have tried to use a hand cone or similar device.	F 318		
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 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	F 329	Each resident's drug regimen will be free from unnecessary drugs. Adequate monitoring and indications for use of drugs will be documented. Antipsychotic drugs will not be given unless necessary to treat a specific condition as diagnosed and documented in the medical record. This will be accomplished by: 1. Residents #14 and #47 and all residents will be monitored for behaviors and have documentation supporting the use of antipsychotics. 2. DON will educate staff about regulatory guidelines for use of antipsychotic medications including when to use and how to monitor. 3. Compliance will be monitored monthly and reported monthly to QA by DON, including pharmacy monthly reviews.	11/29/10

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 _____	pf 10/15/2010

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F 329	Continued From page 8 by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen for 2 of 14 sample residents (#14, #47) was free of unnecessary drugs. The findings were: 1. Review of the physician's orders for resident #14 showed Ativan was ordered for agitation and anxiety on 6/21/10, and Remeron was ordered as a replacement for Zoloft (an antidepressant) on 8/17/10. Further review showed Risperdal (an antipsychotic medication) 0.5 milligrams (mg) daily was ordered on 9/8/10. Review of the physician's documentation, dated before and after the Risperdal was initiated, showed no information to support the determination that the medication was indicated to treat, manage, maintain or cure a condition or symptom. Review of the September and October 2010 nurse's notes, medication administration records, and behavior monitoring records showed the Risperdal was not being monitored for effectiveness, complications, and adverse consequences. Review of the 9/20/10 pharmacy monthly drug review also showed no references to Risperdal. Interview with the DNS on 10/14/10 at 2:40 P.M. revealed she did not know the specific behavioral symptoms that the Risperdal was expected to address or the necessity of use. The DNS also stated the social worker was responsible for monitoring psychotropic medications but she was unable to find evidence that the social worker or other staff had done this. 2. Medical record review showed resident #47 had a 5/3/10 physician's order for Risperdal 0.5 mg by mouth each night. Further record review showed no evidence nursing staff had monitored	F 329		

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F 329	Continued From page 9 the medication for response, complications, or adverse consequences to support decisions for continuing, modifying, or discontinuing the medication. Review of the monthly pharmacy reviews also showed no references to Risperdal. Interview with the DNS on 10/14/10 at 2:40 PM, confirmed the facility nursing staff did not routinely document monitoring of psychotropic medications taken by residents.	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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	F 431	Drugs and biological used by this facility will be labeled in accordance with currently accepted professional principles and will include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This will be accomplished by: 1. All cassettes that contain medications for residents will be labeled with an expiration date. 2. DON will educate pharmacy staff and nursing staff about requirements for labeling medications and checking expiration dates. 3. Compliance will be monitored monthly by night shift nurses and reported monthly to QA	11/29/10

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F 431	Continued From page 10 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 and staff interview, the facility failed to ensure medications in cassettes stored in 2 of 2 medication carts were not expired and available for use. The findings were: During an observation on 10/14/10 at 3:30 PM, both facility medication carts had cassettes for oral medications for residents in the facility. None of the cassettes had expiration dates for the medications. Interview with the medication nurses (RN #1 and the DNS) immediately after the observation showed the cassettes did not have expiration dates, and nursing staff relied on the pharmacy to ensure the medications were not outdated. Interview with the facility's pharmacist on 10/15/10 at 4 PM revealed medications were dispensed to the cassettes from the pharmacy stock and another local pharmacy delivery, and no expiration date was added to the labels. He confirmed the nurses administering medications from the cassettes had no way to check when the medication would expire. According to "Nursing Interventions and Skills" by Elkin, Perry, & Potter, Fourth Edition, 2008, page 392: "Medications used past expiration date may be inactive or harmful to client."	F 431		