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

3/1/10

PRINTED: 02/11/2010
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
	535039	A. BUILDING _____ B. WING _____	01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure adequate housekeeping services to maintain cleanliness for 1 of 2 air vents in the main dining room. The findings were: Periodic observations from 1/25/10 through 1/28/10 revealed two return air vents located in the wall approximately 8 feet (ft.) above the floor in the main dining room. The vents were approximately 2 ft. by 3 ft. and located directly above resident dining tables. One of the vents and the visible duct work behind it were encrusted with dirt and dust. The concern was that in the event of a reverse air flow, at least six dining tables would likely be sprayed with the dirt and dust. Interview with the director of housekeeping on 1/28/10 at 9:48 AM confirmed the soiled condition of the vent. The director stated housekeeping attempted to keep the vent covers clean, but the maintenance manager would need to use a ladder to remove the air vent screws in order to clean the duct.	F 253	F253 The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1) The air vents in the main dining room have been cleaned. 2) The maintenance director will schedule a regular quarterly cleaning of the vents, and will clean more frequently if needed. 3) The Staff Development Coordinator will provide education to the maintenance director and housekeeping staff about the risk to residents if the air- flow were to reverse and spray dirt and dust in the dining room. The education will take place on or before March 10, 2010. 4) Members of the Performance Improvement Team will use a quality-monitoring tool to ensure regular cleaning of the vents. The vents will be checked randomly for dirt and dust; if noted, immediate in-servicing and/or corrective action will occur. The results of the audits will be reported monthly at the Performance Improvement Meeting for a period of three months or until substantial compliance is met.	3/10/10
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED 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	F 274	F274 The facility will 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.	3/10/10

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

Cynthia L. Rankin RN, CRRN, NHA | 2-21-10

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.

per phone call 3/1/10, Autumn DON Eddie Edy Holman accepted date of completion for all dates = 3/10/10

3/1/10

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F 274	Continued From page 1 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 record review and staff interview, the facility failed to identify conditions that necessitated significant change assessments for 2 of 7 sample residents (#3, #51) who required those assessments. The findings were: According to the "Centers for Medicare and Medicaid Services, Revised Long Term Care Facility Resident Assessment Instrument [RAI] User's Manual," revised December 2008, chapter 2 a significant change in resident status is a decline in two or more areas which include: "...Any decline in an ADL (activity of daily living) physical functioning area where a resident is newly coded as 3 (extensive assistance), 4 (total dependence), or 8 (activity did not occur),...Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days),...Emergence of a pressure ulcer at Stage II or higher, when no pressure ulcers were previously present at Stage II or higher..." 1. Review of the 7/23/09 quarterly Minimum Data Set (MDS) assessments for resident #51 showed the resident did not have pressure sores and required limited assistance with transfers and	F 274	1) Comprehensive assessments have been completed for residents' #s 51 and 3. 2) Changes in residents' conditions will be reported in the morning meeting, which is held Monday – Friday. The MDS coordinator is present at that meeting and will investigate reported changes. If the changes meet criteria for a significant change in status he or she will schedule the ARD for the comprehensive assessment. He or she will inform the team. 3) The Executive Director will educate the MDS team about the criteria for a significant change in status. The education will be conducted on or before March 10, 2010. 4) Members of the Performance Improvement Team will use a quality- monitoring tool to randomly audit to ensure that significant changes in status result in comprehensive assessments being completed. The results of the audits will be reported monthly at the Performance Improvement Meeting for a period of three months or until substantial compliance is met.	

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F 274	Continued From page 2 walking. Review of the 10/6/09 quarterly MDS assessment showed s/he developed a stage II pressure sore and had declined to requiring extensive assistance with walking. Review of the 12/22/09 quarterly MDS assessment showed the resident had significant weight loss, was unable to walk, and continued to have a stage II pressure sore. Interview with the MDS coordinator on 1/28/10 at 11:10 AM confirmed the MDS assessments were accurate, and a significant change assessment should have been completed. 2. Review of the 10/29/09 quarterly MDS assessment showed resident #3 required limited assistance with bed mobility, transfers, dressing, and ambulation in both the room and hallway. Comparison of that assessment with the subsequent MDS assessment dated 1/20/10 revealed the resident had declined requiring "extensive" assistance in those same areas. Interview with the MDS coordinator on 1/27/10 at 5:27 PM confirmed the resident's decline in the documented ADLs. The coordinator stated she misinterpreted instructions in the RAI manual and, therefore, did not complete a significant change assessment.	~~F 274~~	F276 The facility will assess residents using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every three months. 1) The quarterly assessment for resident # 5 has been completed. 2) The MDS coordinator will use a scheduling tool to ensure that all quarterly assessments are completed in accordance with CMS guidelines. 3) The Executive Director provided education to the MDS coordinator regarding the timely completion of quarterly resident assessments. 4) Members of the Performance Improvement Team will use a quality – monitoring tool to randomly audit to ensure that quarterly resident assessments are completed timely. The results of the audits will be reported monthly at the Performance Improvement Meeting for a period of three months or until substantial compliance is met.	3/10/10
F 276 SS=D	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a quarterly	F 276		

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F 276	Continued From page 3 Minimum Data Set (MDS) assessment for 1 of 13 sample residents (#5) who required that assessment. The findings were: According to the medical record, an initial MDS assessment was completed for resident #5 on 10/9/09. Further review of the record showed the last Medicare assessment was completed on 12/17/09, but the quarterly MDS assessment, due by 1/9/10, was not available on 1/27/10. On 1/27/10 at 10:05 AM, the MDS coordinator confirmed the quarterly MDS assessment had not yet been completed and that neither of the previous Medicare assessments were coded as a quarterly. She stated she just "missed it."	~~F 276~~		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS 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, staff interview, and medical record review, the facility failed to implement care plans for 2 of 13 sample residents (#51, #75). The findings were: 1. Review of the care plan dated 1/20/10 showed staff were to assist resident #75 to the toilet before and after meals, or to check and change the resident's incontinence brief if s/he was too lethargic or weak to use the toilet. Review of the care guide available for the certified nursing assistants showed staff were to toilet the resident every three to four hours. Observation on 1/26/10	F 282	F282 The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. 1) The charge nurse on each shift will observe the CNAs to ensure that residents #s 75 and 33 are being assisted with toileting needs according to their individual care plans. 2) The charge nurses on each shift will randomly observe the CNAs to ensure that residents are being assisted with their toileting needs according to their individual care plans. If the charge nurses note that toileting assistance is not occurring according to a resident's care plan, immediate in-servicing and corrective action will occur with that CNA. 3) The Staff Development Coordinator will provide education to the nursing staff regarding following toileting plans as listed on each resident's care plan. The education will take place on or before March 10, 2010. 4) Members of the Performance Improvement Team will use a quality-monitoring tool to randomly observe CNAs to ensure that they are assisting residents to toilet according to their care plans. . The results of the audits will be reported monthly at the Performance Improvement Meeting for a period of three months or until substantial compliance is met.	3/10/10

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F 282	Continued From page 4 revealed the resident was not toileted, nor was his/her incontinence brief checked or changed from 7:55 AM until 1:15 PM, an elapsed time of 5 hours and 20 minutes. On 1/28/10 at 7:55 AM, the director of nursing confirmed the care plan was current. 2. Refer to F315 for details regarding the facility's failure to implement the toileting care plan for resident #33.	F 282		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING 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 and staff interview, the facility failed to ensure staff provided appropriate incontinence (perineal) care for 3 of 10 sample residents (#3, #19, #75) who required staff assistance with perineal care. The findings were: 1. Observation on 1/26/10 at 7:55 AM revealed resident #75 was incontinent of urine. Using a back and forth motion, certified nurse aide (CNA) #6 used the same area of a wipe to cleanse the resident's perineal area three different times. 2. On 1/26/10 at 9:35 AM observation showed resident #3 was incontinent of urine when toileted. While providing perineal care, CNA #6 first cleansed the resident's buttocks, then cleansed the perineal area with the same wipe. The CNA next obtained a new wipe and used the same	F 312	F312 A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1) The charge nurses on all shifts will observe CNAs as they provide perineal care to residents #s 3, 19, and 75 to ensure that appropriate technique is used. 2) The charge nurses on all shifts will randomly observe CNAs as they provide perineal care to residents to ensure that proper technique is used. If improper technique is observed, immediate in-servicing and/or corrective action will occur. 3) The Staff Development Coordinator will provide education to the nursing staff regarding using proper technique when performing perineal care for residents. The education will take place on or before March 10, 2010.	3/10/10

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F 312	Continued From page 5 area of that wipe twice to clean the perineum. 3. Observation on 1/26/10 at 10:45 AM showed non-sample resident #19 was incontinent of urine, and CNA #9 used the same wipe to cleanse the resident's buttock and perineal area. The CNA refolded the wipe prior to each front to back stroke; However, the wipe did not have a clean surface area after the first two strokes. The CNA continued to refold and use it, completing an additional five strokes with the unclean wipe. 4. On 1/27/10 at 10:55 AM, CNA #6, who was responsible for providing care for residents #3 and #75, stated she had been taught to cleanse the perineal area from front to back only. The CNA also stated a clean area of the wipe was to be used for only one cleansing stroke.	F 312	4) Members of the Performance Improvement Team will use a quality-monitoring tool to randomly observe CNAs as they perform perineal care for residents. . The results of the audits will be reported monthly at the Performance Improvement Meeting for a period of three months or until substantial compliance is met.	
F 315 SS=D	483.25(d) URINARY INCONTINENCE 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, staff interview, and review of medical records, the facility failed to ensure necessary care and services to address urinary incontinence were provided for 2 of 7 sample residents (#33, #75) who were incontinent of	F 315	F315 Based on the resident's comprehensive assessment, the facility will 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. 1) The charge nurse on each shift will observe the CNAs to ensure that residents #s 75 and 33 are being assisted with toileting needs according to their individual care plans.	3/10/10

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F 315	Continued From page 6 urine. The findings were: 1. Review of the admission Minimum Data Set assessment dated 11/23/09 revealed resident #33 was frequently incontinent. Review of the care guide showed staff were to check and change the resident every two to three hours and at night when needed. Continuous observation of the resident on 1/26/10 from 8:15 AM to 1:15 PM revealed staff did not check or change the resident during that five hour period. Observation at 1:15 PM showed the resident's wheelchair cushion and disposable brief were soiled with feces and urine when certified nurse aides (CNA) #9 and #8 provided perineal care. During an interview at that time, the CNAs verified that the resident had not received toileting assistance from 8:15 AM to 1:15 PM. The CNAs stated they assisted the resident to the bathroom before breakfast, and they offered toileting assistance at lunch time. According to the CNAs, the resident said s/he did not need to go to the bathroom. However, the surveyor had noticed a distinct odor of urine and feces around the resident at 9 AM that morning. 2. Review of the care plan dated 1/20/10 revealed staff were to assist resident #75 to the toilet before and after meals, or to check and change the resident's disposable brief if s/he was too lethargic or weak to use the toilet. Review of the care guide available for CNAs showed staff were to toilet the resident every three to four hours. Observation on 1/26/10 at 7:55 AM showed the resident was incontinent, and the brief was changed. Further observation showed the resident was not toileted after breakfast or before lunch that day. When questioned on 1/26/10 at 12:10 PM, CNA #6 stated the resident did not	F 315	2) The charge nurses on each shift will randomly observe the CNAs to ensure that residents are being assisted with their toileting needs according to their individual care plans. If the charge nurses note that toileting assistance is not occurring according to a resident's care plan, immediate in-servicing and corrective action will occur with that CNA. 3) The Staff Development Coordinator will provide education to the nursing staff regarding following toileting plans as listed on each resident's care plan. The education will take place on or before March 10, 2010. 4) Members of the Performance Improvement Team will use a quality-monitoring tool to randomly observe CNAs to ensure that they are assisting residents to toilet according to their care plans. . The results of the audits will be reported monthly at the Performance Improvement Meeting for a period of three months or until substantial compliance is met.	

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F 315	Continued From page 7 usually urinate a lot and would not be changed until after lunch. Observation continued until the resident's disposable brief was changed at 1:15 PM, an elapsed time of 5 hours and 20 minutes. At this time, the resident was noted to have been incontinent of urine.	F 315		
F 318 SS=E	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 medical record review and staff interview, the facility failed to provide treatment and services as planned by the restorative nursing program (RNP) for 4 of 6 sample residents (#3, #5, #32, #75) who required those services. The findings were: 1. According to the 11/13/09 plan for the RNP, resident #75 had decreased strength in the lower extremities and was to "sit to stand" in the parallel bars five to ten times with the resident standing as long as tolerated each time. The plan was for the resident to receive this service five days a week for four weeks and then be re-evaluated. Review of a restorative progress note dated 12/23/09 documented the resident "had been having decreased lower extremity strength et [and] having more difficulty with transfers...will continue intervention et reevaluate in 1 month." Review of the RNP flowsheet for December 2009	F 318	F318 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. 1) The new Restorative RN will observe the RNAs to ensure that programs written for residents #s 3, 5, 32, and 75 are offered to the residents as written. 2) The new Restorative RN will observe the RNAs to ensure that residents with restorative programs are offered services per the written plan for each of them. If the RNAs are not offering to perform the restorative programs for residents, immediate in-servicing and/or corrective action will occur. 3) The Executive Director will educate the Restorative Nurse and RNAs regarding compliance with restorative programs. The education will occur on or before March 10, 2010. 4) Members of the Performance Improvement Team will use a quality-monitoring tool to randomly observe RNAs to ensure that restorative programs are being offered to residents as written. The results of the audits will be reported monthly at the Performance Improvement Meeting for a period of three months or until substantial compliance is met.	3/10/10

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F 318	Continued From page 8 and January 2010 showed the treatment plan was not provided five times a week. Review of the daily calendar showed the resident's treatment was scheduled three days per week. During an interview on 1/28/10 at 9:40 AM, restorative aide #7 stated the resident's program was changed to three days per week as the resident had improved. However, on 1/28/10 at 10:18 AM, the restorative nurse, registered nurse (RN) #5, stated the resident had never been re-evaluated. She confirmed the program was still to be completed five days a week. She verified there was no evidence the resident had improved, and she had no idea why the program was changed to three days per week. 2. The restorative nursing plan for resident #3 was reviewed on 1/28/10 with RN #5. According to that plan, the resident was to receive restorative services three times a week starting on 1/4/10. However, review of the restorative flowsheet for January 2010 showed the program was not provided three times each week, even though the resident's name was on the calender for that number of days per week. At 10:30 AM on 1/28/10 the RN confirmed the program was not provided as planned, and there was no evidence as to why it was not so provided. 3. Review of the medical record for resident #32 showed a physician's order for restorative therapy three times a week beginning 10/21/09. Review of the restorative nursing flowsheet for November 2009 showed a strength related to the resident's progress was his/her willingness to participate in the restorative program. Restorative staff documented the resident received restorative services six days in November (11/2/09, 11/11/09, 11/16/09,11/20/09,11/21/09, and	F 318		

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F 318	Continued From page 9 11/25/09). Furthermore, at no time during the month of November was there evidence the resident was offered therapy three times a week. The resident's restorative program was discontinued on 12/14/09 and attributed to his/her "...refusal to attend/participate..." 4. Review of the RNP plan showed the goal for resident #5 was to maintain and/or increase mobility, decrease the risk of falls, and improve the resident's strength and endurance. A strength documented for the resident was that s/he would participate with the program, which was to be provided three times per week. Although the resident's name was on the daily calendar four days per week, review of the January 2010 restorative flowsheet showed the program was actually only offered twice a week. There was no documentation as to why the third time was not provided as planned.	F 318		
F 329 SS=D	483.25(l) 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	F 329	F329 Each resident's drug regimen will be free from unnecessary drugs. Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. 1) Resident # 4 is deceased. 2) The Chemical Restraint Committee will review residents who have orders for any psychotropic medications, including anti-depressants; the committee will recommend reductions in medications appropriately and obtain orders from the physician. A risk benefit statement will be obtained from the physician to justify using the medication if necessary.	3/10/10

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	535039	A. BUILDING _____ B. WING _____	01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 329	Continued From page 10 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 assure the medication regimen for 1 of 13 sample residents (#4) was free of unnecessary medications. The findings were: According to physician's orders, resident #4 had received the antidepressant Elavil 10 milligrams since 7/1/06. Review of the medical record showed a dosage reduction had never been attempted, and the physician's rationale for continued use of the medication at that dosage was lacking. Further review failed to reveal a physician's statement delineating the risks versus the benefits of continued use of the antidepressant at the same dose. The administrator reviewed the record on 1/26/10, and at 5 PM, confirmed the lack of a medical rationale. At 7:18 AM on 1/27/10, the administrator stated she did not find an appropriate medical rationale in the resident's purged records.	F 329	3) The pharmacy consultant will educate the nurse managers regarding obtaining a risk benefit statement from a physician if the physician chooses not to reduce or discontinue a psychotropic medication. The education will occur on or before March 10, 2010. 4) Members of the Performance Improvement Committee will use a quality-monitoring tool to randomly audit the medical records of residents with orders for psychotropic medications. The audits will ensure that dose reductions have been attempted as appropriate, and ensure that there is a risk benefit statement in the record if the physician chooses not to reduce or discontinue the psychotropic medication. The results of the audits will be reported monthly at the Performance Improvement Meeting for a period of three months or until substantial compliance is met.	
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

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F 371	Continued From page 11 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to clean and maintain sanitary conditions for 1 of 3 ice machines used for residents. The findings were: While touring the facility on 1/26/10 at 2:10 PM, an ice machine was observed in a clean supply room adjacent to the central nurses' station. Closer observation of the machine showed the upper metal door frame and rubberized door gasket were covered with a grayish/black, slightly raised, and fuzzy material that appeared to be mold. The material covered about 20% of the total surface area of the upper frame. A paper towel rubbed over part of the affected area dislodged the material from the door frame. Registered nurse (RN) #1 stated in an interview on 1/27/10 at 9:15 AM that the ice machine in the clean supply room was used to make ice water for residents on the 100 and 200 hallways. The maintenance supervisor was shown the ice machine frame/seal on 1/27/10 at 4:35 PM; he acknowledged the grayish/black substance appeared to be mold. He stated housekeeping personnel was responsible for general cleaning of the ice machine on a daily basis, and he sanitized the machine annually. The supervisor did not remember when the unit was last sanitized or checked for cleanliness.	F 371	F371 The facility will store, prepare, distribute and serve food under sanitary conditions. 1) The ice machine was emptied and cleaned prior to the end of the survey. 2) The environmental services director will develop a regular cleaning schedule for the frames and seals on all ice machines. She will observe the housekeeping assistants to ensure that the ice machines are cleaned according to schedule. If ice machines are not cleaned according to schedule, immediate in-servicing and/or corrective action will occur. 3) The Staff Development Coordinator will educate the housekeeping staff regarding the importance of cleaning the ice machines to prevent the growth of mold and/or the potential spread of harmful organisms to residents. The education will occur on or before March 10, 2010. 4) Members of the Performance Improvement Committee will use a quality-monitoring tool to ensure that frames and seals of ice machines are cleaned according to the established schedule. The results of the audits will be reported monthly at the Performance Improvement Meeting for a period of three months or until substantial compliance is met.	3/10/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

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F 371	Continued From page 12 4-602.11 Equipment Food-Contact Surfaces and Utensils. · (E) Except when dry cleaning methods are used as specified under § 4-603.11, surfaces of utensils and equipment contacting food that is not potentially hazardous (time/temperature control for safety food) shall be cleaned: (1) At any time when contamination may have occurred; (2) At least every 24 hours for iced tea dispensers and consumer self-service utensils such as tongs, scoops, or ladles; (3) Before restocking consumer self-service equipment and utensils such as condiment dispensers and display containers; and (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: § (a) At a frequency specified by the manufacturer, or § (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.	F 371		
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.	F 441	F441 The facility will establish and maintain an infection- control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility will establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.	3/10/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 441	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of infection control logsheets and related infection control policies, the facility failed to implement and maintain an effective infection control program. The cumulative effects of this failure were evident in 3 critical areas: A. The facility failed to develop an effective process for monitoring compliance with hand hygiene practices among staff. Breaches in appropriate hand hygiene were observed during 1 of 2 meal observations, during 1 of 1 observations of an application of ointment for a non-sample resident #93, and during 1 of 1 routine phlebotomy rounds. B. The facility failed to maintain an accurate, data-driven infection surveillance program. This failure resulted in inaccurate antibiotic therapy tracking for 1 of 13 sample residents (#4). In addition, the facility's surveillance techniques failed to recognize the need for precautions related to drug-resistant microorganisms for 1 of 3 sample residents (#52). C. The facility failed to clean and maintain 1 of 3 ice machines used for residents. The findings were: A. Regarding hand hygiene: 1. Observation of the breakfast meal on 1/26/10, from 7:45 AM to 8:50 AM, showed certified nurse aide (CNA) #8 repeatedly rubbed her nose, left eye, and, on one occasion, covered a sneeze with her left hand. The CNA was not wearing gloves, nor did she perform hand hygiene during the 65 minute observation, even after touching her nose, face, and covering her sneeze. Intermingled with	F 441	1) The Staff Development Coordinator (SDC) will observe the CNAs as they serve residents #s 28, 18, and 17 their meals to ensure that proper hand sanitation techniques are used. The SDC will observe CNAs as they provide personal care to resident #63 to ensure that proper hand hygiene technique is used. The SDC will observe the phlebotomist as he or she collects blood samples from residents #s 20, 38, and 58 to ensure that she uses proper hand hygiene technique and uses standard precautions. Furthermore the phlebotomist will be observed to ensure that the collection tray is not placed on the floor or anywhere where it will be contaminated; and the SDC will also ensure that the sharps container used by the phlebotomist is not over-filled. Resident #52 is no longer culture-positive for methicillin resistant Staphylococcus aureus (MRSA). The Director of Nursing (DON) will ensure that the surveillance system for tracking infections will be used properly by entering all antibiotics as "antibiotics" and not as "medications". The ice machine was cleaned prior to the end of the survey.	

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	535039	A. BUILDING _____ B. WING _____	01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

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F 441	Continued From page 14 the observed behaviors the CNA assisted residents with their breakfast meal. a. The CNA assisted resident #28 by spreading jelly on the resident's toast, a process that required the CNA to handle the resident's food with her hands. After spreading jelly on the toast, the CNA wiped her hands on the front of her scrub pants and then proceeded to lift the resident's glass with her fingers on the rim, which is the part of the glass that contacts the resident's mouth. After feeding the resident two bites of food, the CNA wiped her hands on the resident's napkin; Twelve minutes later she wiped the resident's face and mouth with the same napkin. The CNA twice repositioned the resident's wheelchair during breakfast, once by rotating the tire with her hand and once by pulling on a foot rest. b. The CNA placed her fingers on the mouth contact area of resident #18's water glass and then held the glass for the resident to drink; the CNA later added a straw to the glass, handling the mouth contact area of the straw with her unwashed hands. The CNA repositioned the resident's cereal bowl with her thumb inside the bowl and in contact with the cereal; she wiped her hand on the front of her scrub pants after placing the bowl in front of the resident. She also spread jelly on this resident's toast, handling the bread with her hands. c. At 8:35 AM the CNA took a cart with four meal trays to the Pioneer Hallway where she removed a cover and carried a plate to resident #17's room. The CNA carried the plate with her thumbs over the top edge, making contact with the resident's food. The CNA again wiped her hands on the front of her pants; no hand hygiene was observed prior to ending the observation at 8:50 AM.	F 441	2) The SDC will randomly observe the CNAs as they serve meals to ensure that proper hand sanitation techniques are used. If improper technique is observed, immediate in-servicing and or corrective action will occur. The SDC will randomly observe the CNAs as they provide personal care to residents to ensure that proper technique is used. If improper technique is observed, immediate in-servicing and or corrective action will occur. The SDC will randomly observe the phlebotomist to ensure that proper hand sanitation technique is used; to ensure that standard precautions are used; to ensure that the collection tray is not contaminated and then moved to a clean surface; and to ensure that the sharps container is not over-filled. If there are any observations to the contrary, immediate in-servicing and or corrective action will occur and the lab manager will be notified. The DON will ensure that the facility's policy is followed for any resident that requires contact or droplet precautions, or isolation. If it is noted that policy is not followed regarding infection control precautions or isolation, immediate in-servicing and or corrective action will occur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

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F 441	Continued From page 15 2. On 1/26/10 at 11:33 AM, observation showed non-sample resident # 63 was incontinent of urine and feces. After donning gloves, CNA #4 completed incontinence care appropriately. However, the CNA failed to remove the gloves and perform hand hygiene before obtaining a tube of A & D ointment and squeezing some of the ointment onto her gloved hand. The CNA then applied the ointment over the resident's perineum and replaced the tube for future use. Immediately after the observation, the surveyor asked the CNA about changing gloves and performing hand hygiene. The CNA confirmed she had not performed either task and stated, "I didn't even think about it." 3. Observation on 1/27/10, from 7:15 AM to 7:30 AM, of a phlebotomist collecting blood samples for a local laboratory revealed a breach in appropriate hand hygiene practices. The phlebotomist was observed to enter three separate resident rooms and do the following: a. In the first room, the phlebotomist placed her blood collection tray on the over-bed table, donned a single glove, and then used both hands to perform a venipuncture and collect blood from non-sample resident #20. She removed the single glove upon exiting the resident's room. b. The phlebotomist proceeded to the second room to collect a blood sample from non-sample resident #38. The resident was sitting in his/her wheelchair in the bathroom. The phlebotomist placed her blood collection tray directly on the bathroom floor adjacent to the resident's wheelchair, and performed the venipuncture and blood collection in the resident's bathroom. The procedure involved the repeated activity of removing and placing items in the tray sitting on	F 441	The DON will follow the instructions for using the infection tracking surveillance system. Physician's orders will be checked daily to ensure that all antibiotics are entered into the system. If it is noted that the antibiotic orders are not entered into the system, immediate in-servicing and or corrective action will occur. The environmental services director will develop a regular cleaning schedule for the frames and seals on all ice machines. She will observe the housekeeping assistants to ensure that the ice machines are cleaned according to schedule. If ice machines are not cleaned according to schedule, immediate in-servicing and/or corrective action will occur. 3) The DON or ED will educate the entire staff regarding using proper hand hygiene technique at all times; the entire staff will also be educated regarding the use of infection control precautions and isolation. This education will occur on or before March 10, 2010. The SDC will provide an in-service to the phlebotomist regarding proper hand sanitation technique, how to handle the blood collection tray without cross contaminating surfaces, the use of standard precautions, and the proper use and filling of a sharp's container. This education will occur on or before March 10, 2010.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

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F 441	Continued From page 16 the bathroom floor. She again only used one glove to draw the blood, label the blood collection tubes, and discard used tubing and bloody gauze. c. The phlebotomist discarded the single glove, retrieved her blood collection tray from the bathroom floor, and walked to the central nurses' station. She placed the collection tray, contaminated from sitting on the floor, on the nurses' station desk and reviewed physician orders in the laboratory logbook. d. She then entered the third room to collect blood from sample resident #58. The phlebotomist placed her contaminated blood collection tray on the resident's over-bed table, collected blood by venipuncture, and labeled the tube of blood. She wore gloves on both hands during this procedure. e. In an interview with the phlebotomist at 7:30 AM, she stated she failed to use hand hygiene because the need to wash or sanitize her hands at long term care facilities had not occurred to her. f. Further observation on 1/27/10 at 7:35 AM showed a "sharps container" (rigid, puncture-resistant plastic biohazard container for disposal of needles and sharp-edged items) on the phlebotomist's tray was overfilled; two loops of a blood-filled plastic tubing and a plastic needle holder were protruding from the opening at the top of the container. The phlebotomist acknowledged in interview at 7:40 AM that the sharps container was "too full" and added that her intention was to replace the container once she arrived back at the location of her employment which was a 10-minute drive from the nursing home. g. During the 7:40 AM interview, the phlebotomist attempted to push the needle holder down into the sharps container, but the container	F 441	The Regional Director of Clinical Services will educate the DON regarding the proper use of the infection control surveillance system. This education will occur on or before March 10, 2010. The Staff Development Coordinator will educate the housekeeping staff regarding the importance of cleaning the ice machines to prevent the growth of mold and/or the potential spread of harmful organisms to residents. The education will occur on or before March 10, 2010. 4) Members of the Performance Improvement Team will use a quality-monitoring tool to ensure proper hand hygiene technique is used at all times; to ensure that the phlebotomist uses standard precautions, does not cross contaminate surfaces with the blood collection tray, and does not over-fill the sharp's container; to ensure that the facility follows its policy regarding infection control precautions and/or isolation; to ensure that the infection control surveillance system is used properly to correctly track and trend infections; and that the ice machines are cleaned regularly. The results of the audits will be reported monthly at the Performance Improvement Meeting for a period of three months or until substantial compliance is met.	

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	535039	A. BUILDING _____ B. WING _____	01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 17 was too full to accommodate any additional material. The phlebotomist stated she was employed by an outside laboratory and also collected blood specimens from other long term care facilities. h. The Centers for Disease Control & Prevention (CDC) Guideline for Hand Hygiene in Health-Care Settings, October 25, 2002, is a nationally-accepted standard for hand sanitation in healthcare facilities. The CDC recommends hand hygiene in the following relevant circumstances (pages 33-35 of the Guideline): 1. "Decontaminate hands before having direct contact with patients" 2. "Decontaminate hands before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure" 3. "Decontaminate hands after contact with a patient's [resident's] intact skin" 4. "Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient" 5. "Decontaminate hands after removing gloves" 6. "If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations [when hands are not otherwise visibly soiled with blood or body secretions]" i. The Occupational Safety & Health Administration (OSHA) regulation for Bloodborne Pathogens (29 Code of Federal Regulations, Part 1910) requires healthcare workers to properly contain and dispose of contaminated sharps. Designated sharps containers must 1. "be routinely replaced and not overfilled; 29 CFR, Part 1910.1030(d)(4)(iii)(A)(2)	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

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F 441	Continued From page 18 (iii)" 2. "contain all contents and prevent leakage during handling, storage, transport, or shipping; 29 CFR, Part 1910.1030(d)(4)(iii)(A)(3)(ii)(B)" B. Regarding infection control surveillance techniques: 1. Medical record review on 1/27/10 at 12:55 PM revealed resident #52 was culture-positive for methicillin resistant Staphylococcus aureus (MRSA) on 1/8/10 while an inpatient at the local hospital where a tracheostomy was performed on 1/7/10. The source of the culture material was unclear, but was supposed by the director of nursing (DON), as stated in an interview on 1/27/10 at 3:40 PM, to have been either from the resident's nares or tracheostomy site. The record further showed the resident was placed on antibiotic therapy beginning 1/15/10 with a dosing regimen for 10 days of treatment. The resident was admitted to the long-term care facility on 1/18/10 for rehabilitation. The medication administration record showed the resident continued on antibiotic therapy for MRSA until 1/26/10. Observation of the resident's room on the initial tour of the facility on 1/25/10 at 7:15 PM failed to show any evidence of signage or other precautions noting the resident's potentially infectious condition with an epidemiologically-significant pathogen. Further, registered nurse (RN) #2 was observed to enter the resident's room on 1/25/10 at 7:20 PM and again at 7:55 PM without the use of any personnel protective equipment, such as a mask or gloves. Interview with the DON on 1/27/10 at 1:30 PM revealed she was aware resident #52 had a	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 441	Continued From page 19 MRSA-positive culture while at the hospital, but confirmed his/her current room had not been posted to indicate whether precautions where in place for staff and visitors. The DON did post a "STOP" sign on the resident's door on 1/27/10 at 2:30 PM; the sign directed visitors to check at the nurses' station before entering the room. Observation on 1/28/10 at 8:40 AM showed housekeeper #3 entered the resident's room and mopped the floor. The housekeeper continued down the hallway, mopping and removing trash in 2 adjacent rooms. The housekeeper did not wash her hands at any point during a twenty-seven minute observation that included her entering these three resident's rooms. When asked about the "STOP" sign on resident #52's door, the housekeeper stated she thought the sign meant the resident "...did not want a lot of visitors." The housekeeper further stated she did not remember receiving infection control training, although she admitted she was told to "wash my hands" when moving between rooms. 2. Review of resident #4's medical record on 1/26/10 showed the resident was placed on antibiotic therapy (ciprofloxacin) beginning 11/26/09 for a urinary tract infection (UTI). Notes in the record revealed the resident was often noncompliant with the antibiotic order, spitting the pill out of his/her mouth on 11 of 15 dosing events. The resident was then placed on a second antibiotic (levofloxacin) beginning 12/6/09. Infection control logs were reviewed on 1/27/10 at 1:45 PM. The logs for November and December 2009 showed resident #4 was tracked for a UTI, but "no" was recorded for antibiotic treatment. The DON stated in an interview at that time that she developed her surveillance log using data entered by nursing staff into a	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

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F 441	Continued From page 20 computer-based treatment record. The DON added she used data entered as "antibiotic" for updating her surveillance log, even though she was aware that antibiotics entered as "medication" (but not specifically as an "antibiotic") were not detected by the electronic record and, therefore, failed to appear on her infection tracking log. She acknowledged her current technique for tracking infections and antibiotic treatment based on computer data would not always produce accurate surveillance data. However, the flaw in the method of data entry had not been corrected. C. Regarding sanitation of ice machines: The facility failed to adequately clean and sanitize one ice machine. Refer to F371 for details related to this deficiency.	~~F 441~~		
F 465 SS=D	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the kitchen's dry storage room in a clean manner. The findings were: Observations on 1/25/10 at 7:30 PM, and then again on 1/27/10 at 4:48 PM, showed food stains, leaves, dry marshmallows, sugar packs, and bits of paper on the floor under the shelves in the dry storage room. Interview with the kitchen manager on 1/28/10 at 10:13 AM confirmed the observation. The manager stated the shelves	F 465	F465 The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. 1) The maintenance director will replace the shelves in the dry storage room. The new shelves will have wheels and the staff will be able to move them out to clean properly. 2) The certified dietary manager (CDM) will check the floor in the dry storage room weekly to ensure it is clean. 3) The CDM will educate the dietary staff about the importance of moving the shelves to clean the floor. The education will be conducted on or before March 10, 2010. 4) Members of the Performance Improvement Committee will use a quality-monitoring tool to ensure that the	3/10/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 465	Continued From page 21 could not be moved, and the floor underneath them was difficult to clean.	F 465	dry storage room floor remains clean. The results of the audits will be reported monthly at the Performance Improvement Meeting for a period of three months or until substantial compliance is met.	