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

PRINTED: 12/06/2013
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 _____	C 11/21/2013

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

12/24/13 ae

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: DON- Director of Nursing RN - Registered Nurse CNA- Certified Nurse Aide MDS- Minimum Data Set ADLs- Activities of daily living Less commonly used abbreviations will be annotated in each deficiency	F 000		
F 221 SS=F	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and medical record and facility policy review, the facility failed to ensure 5 of 5 sample residents (#8, #10, #33, #35, #52) with physical restraints were assessed and evaluated for the use of the restraints. The findings were: 1. Medical record review showed resident #35 was admitted to the facility on 6/12/13 with diagnoses including dementia. Review of the significant change MDS assessment dated 10/1/13 showed the resident was cognitively impaired, required assistance from staff for ADLs and was at risk for falls. The MDS did not assess the resident as having a physical restraint.	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 12/10/13

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.

POC accepted 12/24/13 @ 2:25PM a verbal corrections from Joann Farnsworth ADM — Connie Chapman RN

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F 221	Continued From page 1 Review of a physician's order dated 10/21/13 showed an order for a lap buddy (a thick cushion placed in a wheelchair below the armrests extending to the abdomen) when the resident was up in his/her wheelchair. Review of the nursing progress notes showed the resident sustained an unwitnessed fall on 10/20/13 and a lap buddy was utilized as an intervention for preventing falls. The following concerns were identified: a. Observation on 11/18/13 at 2:15 PM and periodically on 11/19/13 and 11/20/13 showed the resident was seated upright, had a lap buddy in his/her wheelchair and was able to self propel the wheelchair. The resident's movement was limited to sitting in the wheelchair and s/he was unable to stand. The resident also had a clip alarm on the back of the wheelchair attached to the back of his/her shirt. Observation on 11/19/13 at 11:37 AM showed CNAs walking with resident in the hall near the nursing station. Observation on 11/20/13 at 9:50 AM with DON revealed the resident was unable to removed the lap buddy upon request as the resident stated, "I can't take it off." The DON verified the resident had an unsteady gait but was able to stand and walk independently when the lap buddy was not in place. b. Review of the medical record further showed there was no assessment for the use of the lap buddy as a physical restraint. 2. Medical record review showed resident #10 was admitted to the facility on 1/23/12 with diagnoses including non-Alzheimer's dementia. Review of the quarterly MDS assessment dated 9/18/13 showed the resident was severely cognitively impaired, required assistance from staff for ADLs, and did not have a physical	F 221	F221 The facility will ensure that all residents will be free from physical restraints for purposes of discipline or staff convenience. This will be accomplished by: A) Resident #8, #10, #33, #35, and #52 and all residents will be assessed for the use of physical restraints. B) NHA and DON will educate all nursing staff about proper procedure for restraint use. This will be done at an inservice to be held in December, and through written handouts posted in the inservice manual. All nursing staff will be given a copy of the facility policy on restraints. C) Nursing Director and designated nurses will monitor compliance of the above procedures and address compliance issues immediately and report monthly to QI committee. Monitoring will be done randomly 1-2 times per week for 6 months.	1/10/14

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F 221	Continued From page 2 restraint. Review of the nursing progress notes showed on 11/3/12 the resident was trying to stand up from his/her wheelchair and to prevent falls a lap buddy was placed on the resident's wheelchair. Review of the medical record showed a physician's order dated 11/3/12 for the use of a lap buddy as needed. Review of the care plan updated on 9/19/13 identified the resident was at risk for falls. The interventions included staff assistance with transfers, assist of one when ambulating using a front wheeled walker, and use of a lap buddy when the resident was in his/her wheelchair. The following concerns were identified: a. Observation on 11/18/13 at 3 PM and periodically through 11/21/13 showed the resident was seated upright, and had a lap buddy in place when seated in his/her wheelchair. The resident was able to independently propel the wheelchair, however, the use of the lap buddy limited the resident to sitting in the wheelchair. Observation on 11/18/13 at 4:55 PM showed the resident's lap buddy was removed by staff in the dining room and placed next to the resident's wheelchair during dining. Observation with the DON on 11/21/13 at 10:25 AM revealed the resident was unable to remove the lap buddy from the wheelchair upon request. The DON verified the lap buddy was used because the resident attempted to stand and ambulate independently. b. Review of physical therapy notes dated 9/13/13 showed the resident ambulated with a forward rolling walker and had a, "bit of a shuffling gait." Review of the restorative charting dated 11/20/13 showed the resident used a front wheeled walker and ambulated 5 days a week with staff assistance. The restorative note further showed a review by the OT (occupational therapist) had been made on 11/20/13 and the	F 221		

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F 221	Continued From page 3 resident's level of functioning had not changed in the past 3 months. c. Review of the medical record showed there had been no initial assessment for the use of the lap buddy, and no periodic reviews had been done to determine the ongoing use of the lap buddy. 3. Review of the physician's orders for resident #33 showed on 6/25/12 an order for use of a "lap buddy" as needed. An observation on 11/19/13 at 11:55 AM showed the resident ambulated in the hallway with the assistance of two staff members. Review of the quarterly MDS nurse's note dated 11/7/13 showed the resident was a high risk for falls. Further, it showed the lap buddy was used while the resident was in the wheelchair for his/her safety. Review of the care plan dated 11/15/13 showed the lap buddy was used as a fall intervention. According to a social service summary note dated 11/11/13, the resident required help from staff with ADLs and walked with assistance. The note further showed a lap buddy was used in the wheelchair because the resident "leans forward or will stand up and try to walk and fall." Observation on 11/20/13 at 9:50 AM showed the resident had the lap buddy cushion in place on his/her wheelchair. When the resident was asked by CNA #3 at that time to remove the cushion, the resident was unable to do so. CNA #3 verified the cushion was used to keep the resident from rising. Review of the medical record showed there was not an evaluation or assessment completed related to the use of the lap buddy as a physical restraint. 4. Review of the 10/22/13 physician recapitulation orders for resident #52 showed on 12/21/11 an order was written for a lap buddy to be used when	F 221		

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F 221	Continued From page 4 the resident was up in the wheelchair. The order showed this was for "fall/safety." Observation on 11/18/13 at 2:20 PM showed the resident was seated in his/her room in a wheelchair with a lap buddy attached to the chair. Interview with the DON on 11/20/13 at 3:47 PM verified the resident was unable to remove the lap cushion and it was used to keep the resident from standing up without assistance and falling from his/her wheelchair. Review of the medical record failed to show any assessment or evaluation of the lap buddy being a physical restraint. 5. Review of the 10/23/13 recapitulation of physician orders for resident #8 showed an order dated 12/27/12 for the use of a lap buddy as needed. Observation on 11/18/13 at 4:05 PM showed the resident was in a wheelchair with a lap buddy and a tab alarm in place. The resident was independently propelling him/herself on the secure unit of the facility. Review of the fall risk assessment dated 10/16/13 for the resident showed the resident was a high risk for falls. Review of the social services summary dated 10/21/13 showed the resident had a lap buddy in the wheelchair for his/her safety "due to many previous falls." Review of the care plan for falls dated 3/28/13 showed the resident was to transfer with the assistance of 1 to 2 people and ambulate with a walker or with hand held assistance. On 11/20/13 at 3:53 PM the resident up in the wheelchair with the lap cushion in place. When the resident was asked by CNA #3 to remove the lap cushion, the resident was unable to release the restraint. At that time CNA #3 verified the lap cushion was in place to prevent the resident from standing up. Review of the medical record failed to show an assessment or evaluation for the use of the lap buddy as a	F 221		

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F 221	Continued From page 5 physical restraint. 6. Observation of a posted note at the nursing station on 11/18/13 at 4:20 PM showed a CNA reminder to, "please remember to remove all lap buddies at meal time and put them back on before the resident leaves the dining room." 7. Interview with the DON on 11/21/13 at 9:30 AM revealed she and the interdisciplinary team had not considered the lap buddies as restraints. The interview further revealed some of the residents who utilized lap buddies for safety were not able to remove them independently. Observations made with the DON on 11/21/13 revealed none of the resident's who utilized lap buddies were able to remove the lap buddy when asked. The DON verified these residents were able to stand and walk independently; however, they did not have a steady gait and were not safe in walking unassisted. 8. Review of facility policy titled, "A. Use of Physical Restraints", dated January 17, 2007 showed, "A. 3. Restraints include the use of such devices as...lap cushions and trays that the resident cannot remove...10. Restraints shall only be used after a pre-restraining assessment is completed and the interdisciplinary team has tried other alternatives unsuccessfully...There shall be no PRN [as needed] orders for restraints."	F 221		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

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F 241	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview the facility failed to ensure dignity was maintained for four residents (#7, #17, #29, #30) during 1 of 2 meal observations on the secured unit. The findings were: Observation on 11/18/13 at 4:55 PM showed the meal trays were delivered to the secure unit. Paid feeding assistant #1 assisted the residents seated in the dining area. Resident #30 wandered around the dining area with his/her food. At that time, CNA #1 was assisting resident #8 with his/her shower. Residents #7, #29, #17 remained in the common area unable to independently transfer to the dining room for the meal. Interview with the paid feeding assistant during the observation revealed she was not permitted to assist dependent residents to the dining room. The following concerns were identified: a. Observation of the evening meal on the secured unit on 11/18/13 at 5:50 PM revealed resident #17 was assisted to the dining table by CNA #1. Paid feeding assistant #1 retrieved the resident's meal tray from an uncovered cart where it had been sitting since 4:55 PM (55 minutes). The meal was covered with a loose lid and consisted of a cheeseburger and corn salad. Without checking the temperature or offering to re-heat the cheeseburger, paid feeding assistant #1 served it to the resident. Observation additionally revealed resident #29 and resident #7 were served the cheeseburger meal at 5:57 PM and at 6:01 PM respectfully (over 1 hour after trays were delivered to the unit). Paid feeding assistant #1 or CNA #1 did not offer to re-heat	F 241	F241 The facility will provide care for residents in an environment that promotes respect and dignity. This will be accomplished by: A) Resident #7, #17, #29, and #30 and all residents will be closely supervised at meals. Food will be served in a timely manner and at the appropriate temperatures. Staff will offer assistance to residents who are unable to feed themselves. CNA working in the Special Care Unit will call charge nurse to request additional assistance when needed. B) DON will educate nursing staff and nutrition support staff about proper procedure for meals. C) Nursing Director and designated nurses will monitor compliance of the above procedures and address compliance issues immediately and report monthly to QI committee. Monitoring will be done randomly 1-2 times per week for 6 months.	1/10/14

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F 241	Continued From page 7 either resident's food. b. Observation of the evening meal on the secured unit on 11/18/13 at 5:45 PM revealed resident #30 was given ice cream. The resident had diagnoses of dementia and wandering behaviors. As the resident was walking around the dining area with the ice cream, s/he dropped the spoon being used on the floor. The resident picked up the spoon up off the floor and continued to use the soiled spoon to eat the ice cream. Staff did not provide clean utensils or attempt to re-direct the resident. Review of the annual MDS assessment dated 7/17/13 showed the resident was severely cognitively impaired and required assistance from staff for ADLs. In addition, review of the care plan updated on 10/9/13 showed staff were to provide supervision with eating.	F 241		
F 278 SS=F	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278	F278 The facility will accurately code the MDS assessments. This will be accomplished by: A) Resident #8, #10, #33, #35, and #52 and all residents will be accurately assessed and coded on the MDS for restraint use and all other modalities. B) NHA will educate nursing staff about proper procedure for assessment and coding of restraints. MDS coordinator will maintain her national certification to keep current on MDS regulatory guidelines.	1/10/14

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F 278	Continued From page 8 subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to accurately code the MDS assessment for 5 of 5 sample residents (#8, #10, #33, #35, #52) who utilized physical restraints. The findings were: 1. Review of the physician's orders for resident #33 revealed on 6/25/12 an order was started to use a "lap buddy" as needed. Observation on 11/20/13 at 9:50 AM showed the resident had the lap buddy cushion (a thick cushion placed in a wheelchair below the armrests extending to the abdomen) in place on his/her wheelchair. When the resident was asked by CNA #3 at that time to remove the cushion, the resident was unable to do so. CNA #3 verified the cushion was used to keep the resident from rising. Review of the medical record showed there was not an evaluation or assessment completed related to the use of the physical restraint. In addition, review of the 8/21/13 and the 11/13/13 quarterly MDS assessments failed to show the resident used a physical restraint. 2. Review of the 10/22/13 physician recapitulation	F 278	C) Nursing Director will monitor compliance of the above procedures weekly for 3 months and address compliance issues immediately and report monthly to QI committee	

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F 278	Continued From page 9 orders for resident #52 showed on 12/21/11 an order was started for a lap buddy to be used when the resident was up in the wheelchair. The order showed this was for "fall/safety." Observation on 11/18/13 at 2:20 PM showed the resident was seated in his/her room in a wheelchair with a lap buddy attached to the chair. Interview with the DON on 11/20/13 at 3:47 PM verified the resident was unable to remove the lap cushion and it was used to keep the resident from standing up without assistance and falling from his/her wheelchair. Review of the 9/11/13 quarterly MDS assessment showed the resident was not coded as using any physical restraint. Review of the medical record failed to show any assessment or evaluation of the physical restraint being used for the resident. 3. Review of the 10/23/13 recapitulation of physician orders for resident #8 showed an order dated 12/27/12 for the use of a lap buddy as needed. Observation on 11/20/13 at 3:53 PM revealed the resident was up in his/her wheelchair with the lap restraint in place. When the resident was asked by CNA #3 to remove the lap cushion, the resident was unable to release the restraint. At that time the CNA verified the lap cushion was in place to prevent the resident from standing up. Review of the medical record failed to show an assessment or evaluation for the use of the physical restraint. In addition, the 10/23/13 quarterly MDS assessment failed to code the resident as using any type of restraint. 4. Medical record review showed resident #35 was admitted to the facility on 6/12/13 with diagnoses including dementia. Review of the significant change MDS assessment dated 10/1/13 showed the resident was cognitively	F 278		

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F 278	Continued From page 10 impaired, required assistance from staff for ADL's and was at risk for falls. The MDS did not assess the resident as having a physical restraint. Review of a physician's order dated 10/21/13 showed an order for a lap buddy when the resident was up in his/her wheelchair. Review of the nursing progress notes showed the resident sustained an unwitnessed fall on 10/20/13 and a lap buddy was utilized as an intervention for preventing falls. Review of the medical record further showed there was no assessment for the use of the lap buddy. 5. Medical record reviewed showed resident #10 was admitted to the facility on 1/23/12 with diagnoses including non-Alzheimer's dementia. Review of the quarterly MDS assessment dated 9/18/13 showed the resident was severely cognitively impaired, required assistance from staff for ADL's, and did not have a physical restraint. Review of the care plans updated on 9/19/13 identified the resident was at risk for falls. Interventions included assisting with transfers, one person assisting resident with ambulating using a front wheeled walker and using a lap buddy when the resident was in his/her wheelchair for safety. Review of the nursing progress notes showed on 11/3/12 the resident was trying to stand up from his/her wheelchair and a lap buddy was placed on the resident's wheelchair. Review of the medical record also showed a physician's order dated 11/3/12 for the use of a lap buddy as needed. Review of the nursing progress notes dated 11/7/13 showed the interdisciplinary team discussed the lap buddy ..and were, "all in agreement to continue with lap buddy due to [his/her] increased restlessness and risk for falls." Additional review of the medical record showed there had been no initial	F 278		

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	535023	A. BUILDING _____ B. WING _____	C 11/21/2013

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WESTON COUNTY HEALTH SERVICES	1124 WASHINGTON BLVD NEWCASTLE, WY 82701

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F 278	Continued From page 11 assessment for the use of the lap buddy, and no periodic reviews had been done to determine its ongoing use. 6. Interview with the DON on 11/21/13 at 9:30 AM revealed she and the interdisciplinary team had not considered the lap buddies as restraints. Observations made with the DON on 11/21/13 revealed none of the residents who utilized lap buddies were able to remove the lap buddy when asked. The DON verified these resident's were able to stand and walk independently; however, they did not have a steady gait and were not safe in walking unassisted.	F 278		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. *This REQUIREMENT* is not met as evidenced by: Based on observation, medical record review, staff interview and review of the facility's policy and procedures, the facility failed to provide 3 of 11 sample residents (#8, #30, #33) and 1 non-sample resident (#17), who were dependent on the staff for assistance with ADLs. The findings were: 1. Observation on 11/19/13 at 11:40 AM showed resident #8 was taken to the bathroom by CNA #3. The resident's incontinence pad was removed and it was wet with urine. The CNA cleansed the	F 312		

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F 312	Continued From page 12 resident's posterior perineum and did not cleanse the anterior perineum where urine would have come in contact with the skin. Review of the 10/23/13 quarterly MDS assessment showed the resident was totally dependent on the staff for personal hygiene. 2. Medical record review showed resident #30 was admitted to the facility on 8/17/12 with diagnoses including non-Alzheimer's dementia. Review of the quarterly MDS assessment dated 9/29/13 revealed the resident was severely cognitively impaired and was dependent on staff for bathing and hygiene. Review of the care plan updated on 10/9/13 identified the resident had a functional deficit for performing ADLs. Interventions included the resident being totally dependent on staff for bathing and hygiene. The following concerns were identified: a. Observation on 11/19/13 at 9:10 AM showed the resident was taken to the bathroom by CNA #3. The CNA removed the resident's incontinence pad. The resident was incontinent of stool. The CNA cleansed the resident's posterior perineum and did not clearise the anterior perineum. b. Observation of dining on the secured unit on 11/18/13 at 5:30 PM revealed the resident had long, jagged fingernails and the nailbeds were encrusted with thick brown matter. The resident was using his/her hands to eat pieces of tomato. Subsequent observations on 11/20/13 and 11/21/13 revealed the resident continued to have long, jagged fingernails with thick brown matter encrusted in the nailbeds. Interview with CNA #2 on 11/21/13 at 11:20 AM revealed the resident was resistive to care and nail care was performed if the resident allowed.	F 312	F312 The facility will ensure that all residents who are unable to carry out ADLs will receive the necessary services to maintain good personal hygiene. This will be accomplished by: A) Resident #8, #30, #33, #17, and all incontinent residents' perineum will be cleansed both interiorly and posterior after every toileting episode. B) Resident #30, #33, and all residents' fingernails will be trimmed and kept clean. C) DON will educate nursing staff about proper procedure for peri care and fingernail care and all personal hygiene. D) DON and designated nurses will randomly monitor compliance of the above procedures weekly for 6 months and address compliance issues immediately and report monthly to QI committee	1/10/14

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F 312	Continued From page 13 3. During an observation on 11/18/13 at 5:20 PM showed resident #17 was taken to the bathroom by CNA #1. The resident was transferred to the bathroom with the use of a sit-to-stand lift. The resident's outer clothing and incontinence pad were wet with urine. The CNA removed the wet items and cleansed the resident's posterior perineum. She did not cleanse the anterior perineum, the lower abdomen or the upper thighs where urine would have come in contact with the skin. 4. Review of the undated policy and procedure for Perineal Care showed: ..."Continue to wash the perineum moving outward to and including thighs, alternating from side to side..." An interview with the DON on 11/21/13 at 11 AM confirmed the anterior and posterior perineum needed to be cleansed. 5. Review of the medical record for resident #33 showed the resident was admitted to the facility on 6/22/12 with diagnoses including non-Alzheimer's dementia. Review of the quarterly MDS dated 11/13/13 showed the resident was severely cognitively impaired and was totally dependent on staff for assistance with bathing and hygiene. Review of the care plan updated 11/15/13 identified the resident as having a functional deficit for performing ADLs. Interventions included the resident being totally dependent on staff for bathing and hygiene and receiving showers twice a week. Observation on 11/20/13 at 12:25 PM revealed the resident had long, jagged fingernails and the nailbeds were encrusted with thick brown matter. Observation on 11/21/13 at 11:20 AM with CNA #2 revealed the resident had just received a shower. The resident's fingernails remained long and jagged	F 312		

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F 312	Continued From page 14 and the nailbeds continued to be encrusted with thick, brown matter.	F 312		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview and review of manufacturer instructions, the facility failed to ensure safety devices were applied appropriately for 6 of 16 residents (#1, #14, #30, #33, #35, #51) who used the wander guard system. In addition, the facility failed to ensure a mechanical lift assessment was completed for 1 non-sample resident (#17) who required a mechanical lift for transfers. Finally, the facility failed to ensure a housekeeping closet on the secured unit that stored chemicals was kept locked during 1 of 2 observations. The findings were: 1. Periodic observations made 11/18/13 through 11/21/13 revealed resident's #1, #14, #33, #35, and #51 wander guard signaling devices (electronic devices used to decrease and/or prevent unsafe episodic wandering) attached to the metal frames on their wheelchairs. Additionally, resident #30 had the signaling device attached to his/her clothing, and not to his/her	F 323	F323 The facility will ensure that all residents will be free from any accidents or hazards and each resident receives adequate supervision and assistive devices to prevent accidents. This will be accomplished by: A) Resident #1, #14, #33, #35, and #51 will have safety devices properly applied B) All chemicals will be locked in an area not accessible to residents. C) NHA contacted manufacturer about proper placement of wanderguards for residents in wheelchairs. It was recommended to NOT place wanderguard on the metal part of the wheelchair and also NOT on the wrist, because of interference from the metal on the wheelchair. Facility will place the wanderguard on the wheelchair back.	1/10/14

A'd 12/24/13 2:25PM Placed per manufacturers guidelines per Joann Farnsworth ADM/DO

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F 323	Continued From page 15 person. Review of the "FirstQ Wander Guard Departure Alert System Users Instructions" showed the signaling devices "...are designed to be worn on a wrist, but can be placed on an ankle..." In addition, a black bold print warning box in the instruction manual showed, "Do not place the signaling device on or next to metal, such as wheelchair frames...metal could interfere with the signal sent to the door modules." The following concerns were identified: a. Observation of resident #1 on 11/19/13 at 9:50 AM revealed the wander guard signaling device was attached to the resident's wheelchair frame. The resident stood up and walked away from the wheelchair unassisted in the hall near exit doors. b. Observation of residents #35 and #51 on 11/19/13 at 7:45 PM revealed the residents were in their beds and the wander guard signaling devices remained attached to the residents' wheelchairs. c. Observations made 11/18/13 at 5:20 PM and periodically through 11/21/13 revealed resident #30 had the wander guard signaling device secured to the back of his/her shirt with a safety pin. d. Interview with the DON on 11/20/13 at 3:30 PM revealed she was unaware of the warnings in the instructions for the wander guard device. Also, she was unable to find an assessment on these residents' records to show they were at risk for elopement or had wandering behaviors that included use of the wander guard device. She stated the wander guard devices were initiated due to wandering behaviors at some point since the resident's admission. 2. Review of the history and physical dated 6/28/13 for resident #17 showed s/he had	F 323	D) Resident #17, and all residents will be assessed by the Therapy Department to determine the best transfer equipment to use for each individual. E) Resident Care Coordinator will develop a tracking tool to assure transfer assessments are completed and care plans are updated. F) NHA & DON will educate nursing staff about proper procedure for wanderguards. G) DON & Residents Coordinator will educate nursing staff about new procedures for evaluation of lift use. H) DON will educate nursing staff and housekeeping staff about proper procedure for keeping hazardous chemicals inaccessible to residents. I) Nursing Director and designated staff will monitor compliance of the above procedures and address compliance issues immediately and report monthly to QI committee. Monitoring will be done randomly 1-2 times per week for 6 months.	

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F 323	Continued From page 16 diagnoses to include chronic left hip pain with severe degenerative arthritis and severe vascular necrosis (little to no blood supply with dead cells/tissue). Review of the 10/16/13 annual MDS assessment showed the resident was totally dependent on staff for transfers. Further, it showed s/he had limited range of motion of the lower extremities on one side. The following concerns were identified: a. Observation on 11/18/13 at 5:20 PM showed resident #17 was transferred to the bathroom with a sit-to-stand lift by CNA #1. During the transfer, the resident leaned back and away from the lift with the sling placed under the arms supporting his/her weight. The resident complained of pain with facial expressions indicating pain throughout the transfer and during perineum care. The CNA stated the resident had pain in his/her hip. b. During an observation on 11/19/13 at 10:40 AM the resident was again transferred to the bathroom with the sit-to-stand lift from his/her wheelchair by CNA #3. The resident complained of pain throughout the transfer. The CNA stated the resident had left hip pain. c. During an interview with the DON on 11/20/13 at 12:30 PM, she acknowledged the resident had not been evaluated for the use of the sit-to-stand lift. 3. Observation on 11/18/13 at 5:45 PM revealed a closet door labeled housekeeping was left open on the secured unit. The closet contained several chemical items including a spray bottle labeled, "disinfectant please keep locked up." In addition, a spray can of air freshener, and a spray can of disinfectant were visible and easily accessible to passersby. During the observation resident #30 was observed wandering past the closet, pausing	F 323		

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F 323	Continued From page 17 and peering into the open closet. RN #1 and CNA #1 walked past the open closet; however, they did not close and/or secure the door. Interview with the DON on 11/21/13 at 9:15 AM revealed she expected staff to store disinfectants/chemicals in a locked closet.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 329	F329 The facility will ensure that all residents will be free from unnecessary drugs. This will be accomplished by: A) Dose reductions will be attempted for resident # 8, #30 and all residents who are using antipsychotic medicaitons. B) NHA will educate nursing staff, pharmacist, and physicians about proper procedure for antipsychotic use. C) DON will educate nursing staff on behavioral interventions, and reporting/documentation procedures. D). DON and designated nursing staff will monitor compliance of the above procedures and address compliance issues immediately and report monthly to QI committee. Monitoring will be done randomly 1-2 times per week for 6 months	1/10/14

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F 329	Continued From page 18 interview, the facility failed to ensure residents were evaluated and gradual dose reductions attempted for the continued use of psychopharmacological medications for 2 of 12 sample residents (#8, #30). The findings were: 1. Review of the 2/26/13 significant change MDS assessment showed resident #8 had diagnoses to include dementia, anxiety disorder and depression. Review of the progress and order sheet dated 10/28/13 showed the resident was prescribed the medications Haldol 0.5 mg (antipsychotic) twice daily and Prozac 20 mg (milligrams) daily (antidepressant). The following concerns were identified: a. Review of the psychotropic drug history showed the medication Haldol was started on 7/19/12 and then increased on 8/18/12 from once daily to 2 times daily. In addition, the document showed the medication Prozac was started on 6/4/12 with no changes made to the dose since it was started. b. Review of the psychotropic medication reviews dated 8/7/13 and 10/23/13 showed the primary behaviors displayed by the resident were wandering and yelling. The document further showed the CNAs reported the resident was not eating well and sleeping much more then in the past. The resident was ambulating less frequently and required more assistance. Recommendations included a pain medication evaluation. There were no recommendations made related to the use of Haldol or Prozac. c. Review of the monthly drug regimen reviews for 2012 and 2013 showed the pharmacist did not recommend any changes for the medications Haldol or Prozac. d. Review of the social services summary dated 10/21/13 showed the staff reported the	F 329		

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F 329	Continued From page 19 resident slept too much and had little energy which were observed daily. Behaviors included yelling and wandering on the unit. e. Review of the psychoactive medication quarterly evaluations dated 9/9/12 through 10/24/13 showed the medications Haldol and Prozac were not evaluated for effectiveness, there were no comments or recommendations made or documentation to show the care plan had been updated. Further, the behaviors warranting the use of the medication only showed; "see behavior sheets." 2. Review of the informed consent for psychoactive medications dated 10/9/13 showed resident #30 received the medication Ativan 0.5 (mg) daily and as needed every 6 hours for agitation. Further, the resident was initially prescribed the medication on 6/17/12 for vascular dementia and combative behaviors. The following concerns were identified: a. Review of the psychoactive medication quarterly evaluations dated 11/21/12 through 10/9/13 failed to reveal an evaluation was completed related to the effectiveness of the Ativan. In addition, there was no evidence that the care plan was updated related to the use of the medication or the resident's behaviors. Further, there were no recommendations made related to the resident's behaviors. b. Review of the psychotropic medication review dated 10/9/13 showed the resident received Zyprexia, an antipsychotic that had been discontinued on 2/13/13. Further, the document showed the discontinued medication was the last dose reduction. The document noted the resident was more combative, screaming, yelling, hollering and the behaviors were observed more during his/her showers. In addition, the resident was	F 329		

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F 329	Continued From page 20 more angry with his/her cares, hitting, and kicking staff then crying "bitterly." The same comments were made during the May 2013 review. There were no recommendations documented related to the behaviors to include nonpharmacologic interventions. Further, it did not show the effectiveness of the medication on the resident's behaviors. c. Review of the behavior monitoring form for July, August and September 2013 showed the resident displayed behaviors to include wandering in other resident rooms, resisting care, screening and yelling and combative behaviors on a daily basis. Review of the nurses' notes for October and November 2013 showed the resident continued to have combative behaviors, wandered on the unit and resisted care. There were no recommendations related to the resident's behaviors or changes in the medication noted. d. Review of the physician notes and orders failed to show there were any attempted dose reductions or consideration to change the medication Ativan. Further, there was no documentation to show there was a discussion of the resident's behaviors and what additional modifications may be considered. 3. An interview with the pharmacist on 11/21/13 at 12:15 PM revealed he was not involved in the discussions related to the psychotropic drug reviews and dose reductions and he was not notified of those meetings. The pharmacist acknowledged he needed to be more involved in the process of evaluating the use of psychotropic medications. 4. As of 12/6/13 there was no additional information provided related to medication dose	F 329		

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F 329	Continued From page 21 reductions for the residents.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure food was stored and prepared under sanitary conditions in two of two kitchens (main kitchen, manor kitchenette). The findings were: 1. The following hand washing issues were identified: a. Observation in the main kitchen on 11/20/13 at 11:18 AM showed cook #1 was wearing disposable gloves while pouring beverages. The cook used her gloved hand to open the refrigerator door, and without removing the gloves she proceeded to pour additional beverages and handle the cups by the rims. At 11:20 AM the cook left the kitchen continuing to wear the soiled disposable gloves, and then returned to the kitchen without changing the gloves or performing hand hygiene, and poured coffee into cups. b. Observation in the main kitchen on	F 371	F 371: It is the practice of the facility to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and Store, prepare, distribute and serve food under sanitary conditions. The Facility will assure food is stored, prepared, distributed and served under sanitary conditions. This will be accomplished by: A) The Dietary Manager met on 12/10/13 for a 1:1 visit on glove use and hand washing procedures with the staff identified. The Dietary Manager on 11/20/13 immediately moved the ready to eat meats to the appropriate shelf. Ceiling vents will be cleaned. B) The Dietary Manager will update the cleaning schedule and the food borne illness check list to include the review of proper food storage, glove use, and that the cleaning schedules include the ceiling vents.	1/10/14

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F 371	Continued From page 22 11/20/13 at 11:35 AM showed dietary aide #1 wore disposable gloves. The aide used her gloved hand to open the refrigerator door and without changing the gloves the aide proceeded to fill portion cups with salad dressing for resident meals. At 11:37 AM the aide again used her gloved hand to handle the refrigerator door and returned to meal preparation duties without changing the gloves or performing hand hygiene. c. Observation in the manor kitchenette on 11/20/13 at 11:50 AM showed dietary aide #2 was pouring thickened beverages for residents. The aide wore disposable gloves and twice she used her gloved hands to remove items from the refrigerator and without changing gloves or performing hand hygiene she continued to prepare the beverages. According to Food Code 2013, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands..." 2. Observation on 11/20/13 at 11:33 AM showed packaged ready-to-eat turkey and ham were being stored next to raw beef. The foods were stored on a bottom walk-in refrigerator shelf, and each food was on it's own tray. The tray containing the raw meat was pooled with liquid blood. Interview with the dietary manager on 11/20/13 at 11:45 AM verified the ready-to-eat foods needed to be stored away from the raw meat to prevent contamination issues. According to Food Code 2013, U.S. Public Health	F 371	C) A mandatory dietary in-service will be conducted by the Dietary manager with input from the consulting dietitian on the appropriate use of gloves, hand washing and food storage. The revised cleaning schedule will also be presented at the in-service D) The Dietary Manager will complete the food borne illness checklist at least 5/week and initial approval times weekly. E) Audit results and system components will be reviewed monthly by the Quality Assurance Committee for 6 months with subsequent plans of correction developed and implemented as deemed necessary. F) The consulting RD will note the compliance to food borne illness checklist monthly on the consulting dietitians report.	

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	535023	A. BUILDING _____ B. WING _____	C 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON COUNTY HEALTH SERVICES	1124 WASHINGTON BLVD NEWCASTLE, WY 82701 12/24/13 OC

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F 371	Continued From page 23 Service, 3-302.11 "(A) FOOD shall be protected from cross contamination by: (1) Separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables, and (b) Cooked READY-TO-EAT FOOD;..." 3. Observation on 11/18/13 at 2:20 PM and on 11/20/13 at 11:15 AM showed the ceiling vents located above two separate preparation tables in the main kitchen, and one ceiling vent located in the dry food storage area, had accumulations of dust and dirt on and around the vents. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371		
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).	F 373		

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F 373	Continued From page 24 In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.	F 373	F373 The facility will use feeding assistants in accordance with State law. This will be accomplished by: A) Resident #8 and all residents on thickened liquids will be properly assessed for swallowing difficulties B) Nurses will complete the "Resident Assessment for NSA Program" form on all residents identified with swallowing difficulties. C) DON will educate nursing and nutrition support staff about the regulatory guidelines for paid feeding assistants D) Director and designated nurses will monitor compliance of the above procedures and address compliance issues immediately and report monthly to QI committee. Monitoring will be done randomly 1-2 times per week for 6 months	1/10/14

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F 373	Continued From page 25 A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of program information, the facility failed to ensure 1 of 3 residents (#8) the facility identified as having a complicated feeding problem, was provided the appropriate level of assistance. The findings were: Observation on 11/18/13 at 5:20 PM showed resident #8 was being provided bites of pureed foods, and drinks of thickened beverages by paid feeding assistant #1. Review of nutrition assistant program information provided by the facility on 11/19/13 showed resident #8 was to be fed by a CNA or a nurse due to the use of thickened liquids. Interview on 11/20/13 at 10 AM with the DON who also coordinated the feeding assistant program, revealed paid feeding assistant #1 was not a CNA. She further stated the resident's feeding complications needed to be re-assessed; however, until a new assessment was done the resident should not be fed by the feeding assistant.	F 373		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		

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F 428	Continued From page 26 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed ensure the pharmacist reported irregularities in the drug regimen review for 2 of 10 sample residents (#8, #30). The findings were: 1. Review of the 2/26/13 significant change MDS assessment showed resident #8 had diagnoses to include dementia, anxiety disorder and depression. Review of the progress and order sheet dated 10/28/13 showed the resident was prescribed the medications Haldol 0.5 mg (antipsychotic) twice daily and Prozac 20 mg (milligrams) daily (antidepressant). The following concerns were identified: a. Review of the psychotropic drug history showed the medication Haldol was started on 7/19/12 and then increased on 8/18/12 from once daily to 2 times daily. In addition, the document showed the medication Prozac was started on 6/4/12 with no changes made to the dose since it was started. b. Review of the monthly drug regimen reviews for 2012 and 2013 showed the pharmacist did not suggest any changes or recommend any actions to be taken related to the continued use of the medications Haldol or Prozac.	F 428	F428 The facility will ensure that the drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist who will report any irregularities to the attending physician, and the director of nursing; and the reports will be acted upon. This will be accomplished by: A) The pharmacist will receive the reviews of psychotropic drug history performed by nursing staff. During the monthly drug regimen review, the pharmacist will review the psychotropic drug history for completeness and accuracy. Any irregularities noted will be reported on the pharmacy review sheets. The pharmacist will report to the nursing staff if the psychotropic drug history was found to be incomplete or inaccurate. B) The pharmacist will keep a log of all changes made to any medications reviewed on the psychotropic drug history. After changes to any of these medications are made, the	1/17/14

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F 428	Continued From page 27 2. Review of the informed consent for psychoactive medications dated 10/9/13 showed resident #30 received the medication Ativan 0.5 mg daily and as needed every 6 hours for agitation. Further, the resident was initially prescribed the medication on 8/17/12 for vascular dementia and combative behaviors. The following concerns were identified: a. Review of the psychotropic medication review dated 10/9/13 showed the resident had received Zyprexia, an antipsychotic that was discontinued on 2/13/13. Further, the document showed the discontinued medication was the last dose reduction done for this resident. The document noted since the discontinuation, the resident was more combative, screaming, yelling, hollering and the behaviors were observed more during his/her showers. In addition, the resident was more angry with his/her cares, hitting, and kicking staff then crying "bitterly." The same comments were made during the May 2013 review. There were no recommendations documented related to the behaviors to include non-pharmacological interventions. Further, it did not show the effectiveness of the medication on the resident's behaviors. b. Review of the monthly drug regimen review from 8/30/12 through 10/28/13 showed the pharmacist did not suggest any changes or recommend any actions to be taken related to the continued use of the medication Ativan. He only noted the medication was being used. 3. Interview with the pharmacist on 11/21/13 at 12:15 PM revealed he was not involved in the discussions related to the psychotropic drug reviews and dose reductions and was not notified of those meetings. He acknowledged he needed to be more involved in the process of evaluating	F 428	pharmacist will review the chart for documentation on the effects of these changes. Any irregularities that occur as a result of these changes will be reported on the pharmacy review sheets. C) After the attending physician signs off on the pharmacy review sheet, the pharmacist will review the patient's chart to ensure that any irregularities have been properly addressed by the physician. If at that time the irregularities have not been addressed, the pharmacist will then contact the physician to request that the irregularity be addressed. D) The pharmacist will educate the physicians on the importance of the psychotropic drug history review and the physician's responsibility for acting upon any irregularities. This will be completed at the January Medical Staff meeting. E) Quality Assurance on this process will be performed by the Director and reported monthly to QA committee	

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F 428	Continued From page 28 the use of psychotropic medications.	F 428		