POC accepted 6/19/13

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536034	A. BUILDING _____ B. WING _____	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	150 CARING WAY LANDER, WY 82520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA Certified Nurse Aide DON Director of Nursing MAR medication administration record MDS Minimum Data Set PT Physical Therapist RN Registered Nurse Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	F241 Dignity and Respect of Individuality Correct deficiency to individual Resident #30 receives incontinence care while positioned in bed or on the toilet per care plan. Staff will be educated to provide all requested cares to residents to maintain their need for dignity and respect during care. The care plan for resident #30 has been reviewed and updated to reflect her need to be positioned in bed and/or on toilet to receive incontinence care. Protect resident from similar situations Audit completed to identify all residents who require the use of a mechanical lift for transfers and/or to receive ADL care. Identified residents have been reviewed for needed assistance and care plans have been updated. Staff will be educated on meeting the needs of residents to include their right to be treated with dignity and respect while encouraging personal independence during ADL care. Measures/Systematic Changes to prevent reoccur: The DON/Designee will conduct random weekly audits on residents who require toileting/incontinence care using a mechanical lift for 90 days. Staff	7/1/2013
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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure dignity during care for 1 of 12 sample residents (#30). The findings were: During an observation of resident #30 on 5/14/13 at 10:40 AM, CNAs #1 and #2 were using a sit-to-stand lift to transfer the resident to his/her bed. Also, RNs #1 and #2 were in the resident's room at the time. The resident was incontinent of urine and stool, and the aides began to provide incontinence care to the resident while s/he was in an upright position in the lift and holding onto the lift handles. Between 10:40 AM and 10:50 AM (5 minutes), the resident stated 4 times that s/he	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Kerell	Administrator	6/7/13

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.

Changes made per phone conversation with Natalie Kerell, Administrator, on 6/19/13 @ 3:55 pm. Janell Cole, DON/L

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F 241	Continued From page 1 could not hold on, and requested to be placed onto the bed. The aides did not act upon the resident's requests, but instead replied each time that they were trying to hurry. After the first request, the resident lowered his/her head and had a visible frown, appearing uncomfortable. Finally, the resident spoke up a fifth time and stated, "I'm going to turn loose any time." At that point at 10:50 AM the aides placed the resident in bed. During an interview with CNAs #1 and #2 immediately after the observation, each stated that they usually placed the resident in bed before administering personal care, but felt this time they could hurry and get done by leaving the resident upright. They both acknowledged the best procedure was not to leave the resident up in the lift, but to place him/her in bed before administering personal care.	F 241	education will be provided to maintain resident's rights for respect and individuality during care. Monitor permanent solution DON/designee will audit weekly for residents who require mechanical lifts for ADL assistance, to maintain resident's rights for dignity and respect during care, for 90 days and then following MDS scheduled cycle. Any concerns with F241 will be taken to the IDT for review. Audits will be reviewed in QA meetings monthly but 3 months often if stable for remainder of year.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279	F279 Development Comprehensive Care Plans Correct Deficiency to individual Staff will be educated regarding the personal needs of residents #28. The care plan for resident #28 has been reviewed and updated to reflect current functional status related to elimination. How other are identified and correction to others in similar situation. Interdisciplinary team has reviewed care plans of residents who are at risk for incontinence. Care plans have been updated for all residents with risk for incontinence. Care plans will be maintained as current by charge nurses and the interdisciplinary team. Measures/Systemic changes to prevent reoccur:	7/1/2013

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F 279	Continued From page 2 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a care plan for all needed areas for 1 of 12 sample residents (#28). The findings were: Review of the 2/5/13 annual and 4/23/13 quarterly MDS assessments revealed resident #28 was frequently incontinent of bladder. The care area assessment for incontinence for the 2/5/13 annual MDS assessment showed the resident required extensive assistance with toileting. Review of the January through May 16, 2013 CNA flow sheets revealed the resident was incontinent of bladder almost every shift, every day. Review of the current care plan dated 4/24/13 revealed it addressed combative behaviors during peri-care, but failed to include a toileting plan or other interventions to address the resident's incontinence. An interview on 5/16/13 at 9:10 AM with the DON revealed the resident's incontinence should have been addressed on the care plan.	F 279	Charge nurses and the Interdisciplinary team will be re-educated on the expectation that care plans are reflective of each resident's current status. Care plans will be developed as a result of resident assessments and they will be revised as needed to reflect current status. Direct care staff also will be educated regarding personal care needs of resident #28. Monitor permanent solution: The MDS nurse/designee will audit 2-3 residents care plans each week for the next 90 days to ensure that they are reflective of assessment results and current status of the resident. The care plan audit will target those residents who have been identified as at risk for incontinence. The audit will ensure that care plans are promptly updated when concerns are identified. Any problems will be corrected and ongoing concerns with F279 will be taken to the interdisciplinary team for review. Audits will be reviewed in QA meeting monthly for 3 months and then quarterly for the remainder of the year.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	F282 Services by Qualified Persons/Per Care Plan Correct Deficiency to individual Nursing staff will be in-serviced on the posted Physical Therapy Transfer Instructions for resident #6. Protect Resident in Similar Situations	7/1/2013

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F 282	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of posted instructions, the facility failed to ensure care was provided in accordance with the written plan of care for 1 of 12 sample residents (#6). The findings were: Review of the current care plan for resident #6 revealed an intervention dated 3/15/13 for staff to "Follow w/c [wheelchair] placement beside bed" and "Therapy posted in room for w/c positioning." Review of the posted instructions revealed "Transfer Instructions. Position wheelchair to patient's LEFT side flush with the bed and raise the armrest..." Observation on 5/14/13 at 10:46 AM revealed CNA #3 assisted the resident to transfer from the wheelchair to bed. The resident positioned himself/herself with his/her left side next to the bed. However, the CNA told the resident to switch, and position himself/herself with the right side next to the bed. The CNA then transferred the resident towards the right side. Interviews on 5/14/13 at 1:26 PM and on 5/15/13 at 3 PM with PT #1 and PT #2 revealed staff had been instructed to transfer the patient towards his/her left side.	F 282	Audit completed to identify all residents who require specific Physical Therapy Instructions for transfers. Measures/systemic changes to prevent reoccur: Nursing staff will be in-serviced on following the interventions as listed on the care plan. The DON/designee will conduct random weekly audits (3xwk) to assure proper transfer instructions are utilized. Issues identified will be corrected immediately. Monitor permanent solution Results of observations for following the care plan interventions provided by Physical Therapy for transfer instructions will be reviewed by the Interdisciplinary Team for continued compliance and direct further corrective action as needed. Any concerns with F282 will be reviewed for three months and re-evaluated. Audits will be reviewed at QA meetings monthly for 3 months and then quarterly for the remainder of the year. dc	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F309 The facility will implement the facilities elimination protocol for all residents.	7/1/13

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F 309	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility's elimination protocol, and staff interview, the facility failed to implement the facility bowel protocol for 2 of 5 sample residents (#6, #27) who were monitored to prevent constipation. The findings were: Review of the facility documentation titled "Elimination Protocol" showed the following: "Each night, after midnight, the night nurse will review elimination records for their nurses' station. From this review, they will generate a list of residents who are in need of interventions for bowel management. This list will be documented below. 1st Day (24-hour period without a BM[bowel movement])-Offer 4 oz. prune juice or natural laxative and document in interview column. 2nd Day (48-hour period without a BM)-Give 30 ccs MOM [milk of magnesia] p.o. [by mouth] (or whatever PRN [as needed] is ordered by their physician) on the 6-2 shift. Document on MAR [medication administration record] and intervention column. 3rd Day-(72 hours without a BM)-Charge nurse to assess bowel sounds, palpate and document assessment results. The bowel assessment should be done by day charge nurse (in event there are absent bowel sounds that indicate physician notification) and again by the evening charge nurse prior to suppository administration. You will also determine if resident is uncomfortable and document. Then give Dulcolax or glycerin suppository as ordered to be given PR at a time that is agreeable to resident (generally	F 309	Correct deficiency to individual: Resident #6 will receive the facilities elimination protocol interventions as outlined in the bowel protocol. Resident #27 will receive the facilities elimination protocol interventions as outlined in the bowel protocol. Licensed nurses will be educated on the facilities elimination protocol including generating a list of residents in need of interventions for bowel management, documenting interventions and bowel assessments of residents, along with resident's comfort being noted in the medical record. How others are identified and correction to others in similar situations: An audit was completed and identified residents who have constipation as a diagnosis. CNA's will be educated on residents need for accurate documentation of bowel movements daily. Measures/systemic changes to prevent reoccur: The DON/Designee will perform audits 3xweek to elimination protocol and 4-5 residents, resident care flow sheets for 90 days, and then monthly x 3 months. Audits will focus on residents needing	

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F 309	Continued From page 5	F 309		

given 2-10 shift, after supper unless otherwise requested by resident). Document on MAR, 24-hour sheet, and intervention column.
4th Day-If above interventions have not been successful, advance to enema as ordered and continue with bowel assessments each shift until resolved. The attending physician should also be contacted as appropriate." The following concerns were noted:

1. Review of the medical record showed resident #6 had diagnoses including constipation. Review of the CNA care flow sheet showed the resident did not have a documented bowel movement (BM) on 5/11/13 through 5/14/13. Review of the "elimination protocol" documentation for 5/12/13, 5/13/13, and 5/14/13 showed nursing staff monitored the resident for not having a BM for 1, 2, and 3 days. However, further review of the documentation and the May 2013 MAR revealed no interventions were documented during that timeframe. There lacked evidence staff followed the facility's elimination protocol. During an interview on 5/15/13 at 2 PM, the DON and RN #3 stated they could find no documentation of interventions given, but they felt it was probably a "documentation issue."

2. Review of the March and April 2013 elimination protocol for bowel monitoring and intervention showed resident #27 did not have a bowel movement for the following extended time periods: 3/26/13 through 4/5/13 (10 days), 4/5/13 through 4/10/13 (5 days), 4/15/13 through 4/22/13 (7 days), and 4/22/13 through 4/28/13 (6 days). Further review showed the elimination protocol was not implemented. Review of the March and April 2013 MARs revealed no interventions were

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F 309	Continued From page 8 documented during those timeframes. In addition, review of the CNA documentation showed the aides did not document bowel movements for the resident during those timeframes. During an interview with the DON on 5/16/13 at 10:40 AM, she acknowledged that, other than the monitoring documentation showing extended periods without BMs, the facility failed to document interventions on the elimination protocol for the resident. 3. During an interview on 5/16/13 at 10:40 AM the DON stated the facility had a good system in place, but it was not effective if staff were not documenting appropriately to show the protocol was followed.	F 309	interventions for bowel management to ensure residents are receiving appropriate interventions per facilities bowel protocol. Monitor permanent solution: The DON/Designee will audit weekly residents receiving elimination protocol interventions for accurate documentation for 90 days and the monthly x3 months. Any concerns related to F309 will be taken to the IDT for resolution. Audits will be reviewed at QA meetings monthly for 3 months and then quarterly for the remainder of the year.	7/1/13
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of posted instructions, the facility failed to provide care to maintain or improve the ability to transfer for 1 of 9 sample residents (#6) who required staff assistance with transfers. The findings were: Review of the medical record revealed resident #6 had diagnoses including cerebral vascular accident and right-sided hemiparesis. Review of the current care plan showed an intervention dated 3/16/13 for staff to "Follow w/c [wheelchair] placement beside bed" and "Therapy posted in	F 311	F311 Correct deficiency to individual: Resident #6 receives transfer from wheel chair to bed as per care plan. Staff will be educated on the need to transfer residents as instructed by PT. How others are identified and correction to others in similar situations: Audit completed to identify all residents who receive instructions from PT on maintaining /improving ADLs. Measure/Systemic changes to prevent reoccur:	

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F 311	Continued From page 7 room for w/c positioning." Review of the posted instructions revealed "Transfer Instructions. Position wheelchair to patient's LEFT side flush with the bed and raise the armrest..." Observation on 5/14/13 at 10:48 AM revealed CNA #3 assisted the resident to transfer from the wheelchair to bed. The resident positioned himself/herself with his/her left side next to the bed. However, the CNA told the resident to switch, and position himself/herself with the right side next to the bed. The CNA then transferred the resident towards the right side. Interviews on 5/14/13 at 1:26 PM and on 5/15/13 at 3 PM with PT #1 and PT #2 revealed staff had been instructed to transfer the patient towards his/her left side, which was his/her strong side.	F 311	The DON/Designee will conduct random audits (3xweek) on transfers from wheel chair to bed for the next 90 days. Staff education for all new hires, on PT recommendations for maintaining/improving ADLs will be provided with follow up audits on a quarterly basis. Monitor permanent solution: DON/Designee will audit weekly for residents who have PT recommendations for maintaining/improving ADLs for 90 days and then following MDS cycle. Any concerns with F311 will be taken to the IDT for resolution. Audits will be reviewed at QA meetings monthly for 3 months and then quarterly for the remainder of the year. F315 Correct deficiency to individual:	7/1/2013
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide services to promote continence for 1 of 4 sample residents (#28) with urinary incontinence. The findings were:	F 315	Resident #28 receives assist with toileting per care plan. Staff will be educated on the need to provide assist with toileting to dependent residents. How others are identified and correction to others in similar situations: Audit completed to identify all dependent residents who require assist with toileting. Identified residents have been reviewed.	

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F 315	Continued From page 8 Review of the 2/5/13 annual and 4/23/13 quarterly MDS assessments revealed resident #28 was frequently incontinent of bladder. The care area assessment for incontinence for the 2/5/13 annual MDS assessment showed the resident required extensive assistance with toileting. Review of the January through May 16, 2013 CNA flow sheets revealed the resident was incontinent of urine almost every shift, every day. The following concerns were identified: a. Review of the current care plan dated 4/24/13 revealed it addressed combative behaviors during peri-care, but failed to include a toileting plan or other interventions to address the resident's incontinence. The DON confirmed the lack of a toileting plan during an interview on 5/16/13 at 9:10 AM. b. Observation on 5/14/13 showed the resident went from 8:05 AM until 11:30 AM (3 hours 25 minutes) without staff assisting or encouraging the resident to use the bathroom. At 11:26 AM CNA #1 asked the resident if s/he wanted to use the bathroom. The resident replied "I don't need to." However, an interview with CNA #1 earlier at 11:20 AM revealed the resident did not always know when s/he needed to use the bathroom. At 11:47 AM CNA #3 assisted the resident with a transfer from the bed to the wheelchair. When asked, the resident told the CNA s/he did not need to use the bathroom. The CNA did not encourage the resident to use the toilet, or ask the resident if she could check to see if s/he was wet. During an interview at 11:52 AM, CNA #3 said the resident was usually incontinent and did not know when s/he needed to use the bathroom. At 1:30 PM (5 hours 25 minutes since the start of observation at 8:05 AM)	F 315	Measures/Systemic changes to prevent reoccur: The DON/Designee will conduct random resident audits (3xweek) on assist with toileting for the next 90 days. Staff education for new hires will be provided for residents toileting needs, with follow-up competencies at the quarterly basis. Monitor permanent solution: DON/Designee will audit weekly for dependent residents who require assist with toileting for 90 days and then following the MDS scheduled cycle. Any concerns with F315 will be taken to the IDT for resolution. Audits will be reviewed at QA meetings monthly for 3 months and then quarterly for the remainder of the plan. tc	

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F 315	Continued From page 9 CNA #1 took the resident to the bathroom. She stated the resident was incontinent and the brief was very wet. c. During an interview on 5/16/13 at 9:10 AM the DON stated the CNAs had been educated to assist residents to the bathroom "frequently", which meant during routine rounds approximately every two hours.	F 315		