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

PRINTED: 01/02/2015
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 ______	12/17/2014

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

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F 000	INITIAL COMMENTS The following Common abbreviations are used throughout this document: CNA Certified Nursing Aide DON Director of Nursing LPN Licensed Practical Nurse RN Registered Nurse	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and renovation plan review, the facility failed to ensure floors and walls were maintained in 1 of 2 dining areas (main dining room). The findings were: 1. Observation of the main dining room on 12/17/14 at 9:35 AM showed all 4 of the main walls had baseboards that were pulled away from the wall with accumulated dirt and debris behind them, which created uncleanable surfaces. Further observation showed three pilasters (outcropping of wall) located in the dining room had chips and cracks exposing metal and drywall. Pilaster 1, on the south wall near the dining room entrance, had chipped areas exposing metal at 4 feet in height that was 6 inches long, at 17 inches in height that was 3/4 inch long, at 31 1/2 inches in height that was 3/4 inch long, and at 32 1/2 inches in height that was 1/2 inch long. Pilaster 2, located on the north wall, had a chipped area at	F 253	F 253 Maintenance is responsible for the upkeep and repairs for the dining room. a) Maintenance will go through the entire dining room and patch and paint all chipped cracked all drywall areas that are damaged. Maintenance will also replace or epoxy seal all cracks in the dining room floor. b) Maintenance will monitor this dining room during monthly safety inspections and report this to our PI program.	1/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE NHA (X6) DATE 1/8/15

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.

RECEIVED
WY Dept of Health
JAN 12 2015
Healthcare Licensing and Surveys

POC accepted. message left for [illegible] NHA on 1/13/15 @ 2:26pm
[signature], OA[illegible]

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F 253	Continued From page 1 10 inches in height that was 3 inches long and another chipped area at 8 inches in height that was 4 inches long. Pilaster 3, located on the north wall, had a chipped area at 9 1/4 inches in height that was 3 inches long. All areas had exposed drywall, metal, or both which created uncleanable surfaces. Continued observation showed 4 areas of the floor with cracks and/or chips in the tile which created uncleanable surfaces. Area #1 outside of the activities office showed 1 tile with a crack 12 inches long and a missing piece of tile that was 3 inches x 1 3/4 inches. Area #2, near the dining room entrance, had seventeen 12 inch x 12 inch tiles that were broken, cracked, or chipped with a 3 inch x 2 1/2 inch area filled with some type of resin in the center of the tiles. Area #3, spanning from the pilaster on the south wall across the dining room to the first pilaster on the north wall, had 32 of 38 tiles (12 inch by 12 inch) which were broken, cracked, or chipped. Area #4, next to the south wall, had 8 broken, cracked, or chipped tiles. 2. Interview with the maintenance director on 12/17/14 at 10:46 AM revealed he was aware of the tiles, baseboard, and areas on the pilasters. The maintenance director also revealed there was a facility renovation planned that was expected to be completed by the end of 2016. However, the facility failed to ensure a specific time frame when the dining room would have the renovation completed.	F 253		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314	F314 a) WCHS will ensure that all measures are in place to maintain skin integrity for resident #51 and all residents. This will be accomplished by:	1/30/15

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F 314	Continued From page 2 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy and procedure review, and staff interview, the facility failed to ensure all measures were in place to maintain skin integrity for 1 of 9 sample residents (#51) at risk for pressure ulcers. The findings were: 1. Observation on 12/15/14 at 1:50 PM, 3:57 PM, and 4:30 PM showed resident #51 was lying in bed, on top of bedding, with a full body sling under the resident. Observation of a full body lift transfer on 12/15/14 at 4:30 PM showed after the resident was transferred from the bed to the wheelchair, the sling was left under the resident and the resident was taken to the dining room. The sling remained under the resident throughout the evening meal. Observation on 12/16/14 at 9:40 AM showed the resident in bed, on top of bedding, with the full body sling under the resident. Observation on 12/16/14 at 1:03 PM showed the resident was in his/her wheelchair with the sling under him/her. The resident was transferred with the mechanical lift from his/her wheelchair to the bed and the sling was left under the resident. Observation on 12/16/14 at 1:45 PM showed the resident was in bed, on top of bedding, with the sling under the resident. The resident was assisted to the wheelchair with a mechanical lift, and the sling was left under the	F 314	F314 A) Residents who require the use of sling for transfers will have the sling removed immediately after the transfer is complete, unless otherwise stated in the care plan. B) Wound Care Nurse will educate staff about pressure ulcer prevention and pressure points C) Random monitoring will be done by charge nurse to assure compliance and reported monthly to the QA Committee	1/30/15

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F 314	Continued From page 3 resident after transfer 2. Interview with CNA #1 on 12/16/14 at 4 50 PM revealed they leave the sling under the resident "because it is easier." 3. Review of a 12/15/14 nursing note showed the resident's "left and right side of buttocks remains red in color, no drainage noted, has skin breakdown periodically." Review of the 12/8/14 Braden assessment showed the resident had a score of 15, which indicated that the resident was at risk for skin breakdown. Review of the care plan showed the resident had "potential for pressure ulcer development related to score of 15 on Braden scale, bed mobility/dependence, bowel incontinence, and history of skin breakdown." 4. Review of the facility's policy on Identification, Treatment, and Prevention of Pressure Ulcers, 100.629 revised on 10/2003, showed the facility would "allow for" removal of or lessening of causative factors." 5. Interview with the DON on 12/17/14 at 11:45 AM revealed slings should be removed when the resident was in bed or the wheelchair, and the sling being left under the resident increased the risk for pressure ulcers.	F 314		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and	F 356	F356 WCHS will post the following information on a daily basis: Facility name The current date total number and actual hours worked by RNs, LPNs, LV CNAs Resident Census	1/30/15

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F 356	Continued From page 4 unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law) - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater This REQUIREMENT is not met as evidenced by. Based on observation, review of facility posted staffing, and staff interview, the facility failed to post all required information on their daily staff postings for 3 of 3 days observed. The findings were: Random observations during the period from 12/15/14 through 12/17/14 showed the facility posted daily staffing detailing only the number of hours staff were scheduled to work. Review of 3 months of staffing revealed the facility failed to post actual numbers of employees in the	F 356	F356 This will be accomplished by: A) The night nurse will complete the date and current census on the staffing form and give to the day charge nurse to complete for her shift. The evening and night nurses will complete the staffing information for their respective shifts at the beginning of the shift. B) DON will monitor for compliance and accuracy and report results to QA Committee monthly	1/30/15

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F 356	Continued From page 6 categories of RN, LPN and CNA that worked; only listing hours in each category. Interview with the administrator on 12/17/14 at 2:55 PM confirmed that the facility only posted the staff hours, and not the actual number of staff in each category.	F 356		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection (a) Infection Control Program The facility must establish an infection control program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F441 1/30/15 WCHS will establish an infection control program which will ensure that staff perform hand hygiene after each direct resident contact for which hand washing is indicated by acceptable professional practice. This will be accomplished by: A) Infection control nurse will educate staff on infection control, and the protocol for hand hygiene. B) Staff will demonstrate proper hand hygiene at all times when assisting with meals. C) Staff will demonstrate proper hand hygiene during catheter care of resident #51 and all residents with foley catheters. D) Infection Control Nurse will monitor randomly for compliance and report monthly to QA Committee.	

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F 441	Continued From page 6 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policies, the facility failed to ensure staff performed hand hygiene during 1 of 3 dining observations (evening meal) and 1 of 3 observations (#51) of catheter care during transfers. The findings were: 1. Observation in the dining room on 12/15/14 at 4:55 PM showed CNA #2 was sitting with the residents waiting for meal trays to be delivered. The CNA rubbed her own face and hands, held a neighboring resident's hand, and touched the resident's wheelchair. When one of the residents at the table had a meal tray delivered, the CNA picked up a piece of bread in an ungloved hand and applied butter to it. The CNA then picked up a second piece of bread and buttered it as well. The CNA did not wash her hands or use sanitizer prior to buttering the bread. 2. Observation on 12/16/14 at 1:45 PM of the transfer for resident #51 showed CNA #1 removed her gloves and held the resident's catheter bag with her bare hands during the transfer. The CNA then placed the catheter bag on the wheelchair, and without washing her hands or applying gloves, unhooked the lift sling, straightened the resident's clothing, ran her hand through the resident's hair, fastened the wheelchair seat belt, then picked up a hairbrush,	F 441		

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F 441	Continued From page 7	F 441		

and brushed the resident's hair.

3. Review of the facility's policy for hand hygiene revised on 01/2014, and entitled "Hand Hygiene, D1," showed "Hand Hygiene is generally considered the most important single procedure for preventing healthcare-associated infections...Indications for handwashing and hand antisepsis- C. Decontaminate hands before having direct contact with patients...E. Decontaminate hands after contact with a patient's intact skin... H. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. I. Decontaminate hands after removing gloves."

4. Interview with the administrator on 12/17/14 at 3:20 PM revealed "hand washing is always a QA [quality assurance] item because of it being an ongoing problem."

5. Interview with the infection control nurse on 12/17/14 at 10 AM revealed staff should wash or use foam sanitizer prior to entrance into the resident rooms, after glove changes, before exit of resident rooms, after handling catheter bags, and prior to handling food.