PRINTED: 07/23/2015
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0036	A. BUILDING: _____ B. WING _____	07/09/2016

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) COMPLETE DATE
S2928	Ch 11 Sec 6 (b)(iii) Physical Environment (b) Sanitary Environment. The Nursing Care Facility shall establish policies and procedures for investigating, controlling and preventing infections. (iii) The facility shall report the required diseases/conditions to the Wyoming Department of Health, Epidemiology Unit as per W.S. §35-4-107. In addition, those conditions classified as nosocomial where two (2) or more persons, either residents or employees, are affected shall be reported immediately to the State Health Officers, the County Health Officer, and the Licensing Division. The Nursing Care Facility Administrator or his/her designated representative shall furnish all available pertinent information related to such disease or condition to the Licensing Division . This State Rule and Regulation is not met as evidenced by: Based on review of Licensing Division records and staff interview, the facility failed to notify the Licensing Division of an outbreak of infectious disease in the facility. The findings were: Review of Licensing Division records failed to show any report to that agency of an outbreak of infectious disease at the facility in the month of January, 2015. Interview with the Infection Control Nurse on 7/9/15 at 11:00 AM revealed the facility had identified an outbreak of influenza in the facility, with residents testing positive for influenza where notification was done to the state epidemiologist, but confirmed the facility failed to notify the Licensing Division.	S2928	**S2928 Physical Environment 8/22/15** **Measures taken to correct deficiency:** This facility has established a procedure to ensure all necessary parties, including the State Department of Health, the Fremont County Health Officer, and the State Licensing and Surveillance Division be notified when an infectious outbreak occurs within the facility to residents and/or staff affecting two or more people. **How problem is identified and correction to similar situations:** In the future, all three departments will be notified of any infectious outbreak within the facility affecting two or more people. **Measures/systemic changes to prevent recurrence:** This procedure is kept by the Infection Control Nurse in the APIC manual with the outbreak prevention and investigation policy. **Monitor permanent solution:** Illness patterns are monitored by the Infection Control Nurse and discussed with the Interdisciplinary Team weekly and any trends will be reported as identified. Infection patterns are also reviewed in monthly QAPI meetings.	

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natalie Forrell — TITLE: Administrator — (X6) DATE: 7/31/15

STATE FORM EYP211 If continuation sheet 1 of 3

RECEIVED
WY Dept of Health
JUL 31 2015
Healthcare Licensing and Surveys

8/19/15 Signature c Natalie Forrell - PIC accepted agreed to changes

8/19/15
1

PRINTED: 07/23/2015
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0036	A. BUILDING: _____ B. WING _____	07/09/2015

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) COMPLETE DATE
S3001	Ch 11 Sec 11 (a)(i) Dietetic Services The facility shall provide dietetic services that meet the nutritional needs of residents according to the science of nutrition. The dietetic service shall operate with safe food handling practices from receipt through service in accordance with the most current edition of the FOOD CODE from the U.S. Department of Health and Human Services, Public Health Service, Food and Drug Administration. (a) Dietary Supervision. Overall supervisory responsibility for the dietetic service shall be assigned to a full-time qualified dietetic supervisor. (i) If the qualified supervisor is not a Registered Dietitian, she/he shall be a graduate of a dietetic technician program approved by the American Dietetic Association or a dietary managers' educational program approved by the Certifying Board of Dietary Managers. Training and experience in food service supervision and nutrition equivalent in content to the approved educational programs are acceptable. This State Rule and Regulation is not met as evidenced by: Based on staff interview and review of kitchen staff schedules, the facility failed to ensure qualified management for dietary services. The facility census was 53. The findings were: Interview with the administrator on 7/6/15 at 3:15 PM revealed the previous dietary manager terminated her employment with the facility	S3001	S3001 Dietetic Services **Measures taken to correct deficiency:** A new Dietary Manager has been hired and will begin on July 29, 2015. The new manager will enroll in the CDM class to begin the formal certification process required of this position. **How problem is identified and correction to similar situations:** In the future if the CDM leaves their position, the facility will appoint a full-time interim CDM or contract with a dietitian for interim coverage. **Measures/systemic changes to prevent recurrence:** Ensure that the facility has a full-time CDM in the dietary department and if there is an opening, the facility will contract with a dietitian to oversee the dietary department. **Monitor permanent solution:** The NHA will be responsible for securing proper oversight of the dietary department in the absence of a CDM employed by the facility. A monthly QA report will be submitted to CMS for certification of DM until certification received. - Amy	~~8/22/15~~ 8/1/16

8/19/15

PRINTED: 07/23/2015
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0036	A. BUILDING: _____ B. WING _____	07/09/2015

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) COMPLETE DATE
S3001	Continued From page 2 approximately two weeks ago and the new dietary manager was scheduled to began employment the last week in July 2015. The administrator further stated the new employee's enrollment in the Certified Dietary Manager (CDM) classes would not begin until after she was hired. Interview with cook #1 on 7/6/15 at 3:35 PM and cook #2 on 7/8/15 at 4:25 PM revealed the administrator was the interim CDM until a new CDM was hired to replace the one that resigned two weeks ago. Review of the July 2015 kitchen staff schedule confirmed the lack of a current CDM.	S3001		

8/19/15