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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted at Westward Heights Care Center in Lander, Wyoming along with the annual recertification survey from 7/6/15 to 7/9/15. The complaint which was included in the survey was WY00001980. The following common abbreviations and acronyms are used throughout this document: ADON Assistant Director of Nursing CNA Certified Nurse Aide DON Director of Nursing MDS Minimum Data Set NHA Nursing Home Administrator RN Registered Nurse SDC Staff Development Coordinator Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natalie Kovell — TITLE: Administrator — (X6) DATE: 8/17/15

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.

WY Dept of Health
AUG 19 2015
Healthcare Licensing and Surveys

Over

S 8/19/15

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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 164	Continued From page 1 The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review the facility failed to provide privacy during 1 of 8 observations of resident care (#21). The findings were: Observation on 7/7/15 at 11:07 AM showed resident #21 turned on the bathroom call light for assistance. CNA #1 knocked on the door, entered the room, and failed to close the door. The CNA then knocked on the bathroom door and entered to assist the resident. The bathroom door was left open providing a gap between the bathroom door and the door frame where care could be observed from the hallway in the bathroom mirror. Further observation at that time showed that conversation between the staff member could be heard in the hallway explaining procedures to the resident. Review of the policy "Lippincott Procedures-Perineal care of the male patient" revised 10/3/14, provided by the facility, showed a section titled "Implementation" that included a directive to "provide privacy." Interview with the SDC on 7/915 at 11 AM revealed the staff	F 164	**F164 Privacy/Confidentiality of Records** Correct deficiency to individual: Resident #21 will receive privacy during ADL care. The nursing staff will close the door to his room and/or door the the bathroom during care. How others are identified and correction to others in similar situations: An audit will be completed to identify all dependent residents who require ADL/toileting care on or before 8/22/15. Identified residents will be reviewed for adherence to privacy practices during care. Measures/systemic changes to prevent recurrence: Staff will be educated on or before 8/22/15 regarding the need to provide privacy during ADL care to all dependent residents. Monitor permanent solution: The DON, ADON, or their designed will conduct random audits for the next 60 days on providing privacy during ADL care to dependent residents. Education will be given to all new staff members regarding providing privacy during resident care. Results of audits will be discussed at monthly QAPI meetings.	8/22/15

8/19/15 - This POC accepted between Natalie Karell, Administrator and Tony Madden, Surveyor with a DOC of 8/22/15 for all tags. cg 8/19/15

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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 164	Continued From page 2 member should have closed the doors to ensure privacy during care.	F 164		
F 253 SS=E	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 and staff interview, the facility failed to provide a sanitary and well-maintained environment in 2 of 2 resident bathing suites (A and B). The findings were: 1. Observation of the storage area in bathing suite A on 7/7/15 at 11:18 AM showed 2 walls had 5 areas with chips and cracks exposing metal and/or drywall. Wall 1 was connected to the area entrance door and wall 2 was adjacent to wall 1 dividing the room. a. Area 1 was on wall 1, 3" from the floor and measured 4" by 5" and had exposed drywall and metal. b. Area 2 was on wall 1, 29" from the floor and measured 1 1/2" by 8 1/2" and exposed drywall and metal. c. Area 3 was on wall 1, 32" from the floor and measured 1" by 9 1/2" and exposed drywall and metal. d. Area 4 was on wall 1, 34" from the floor and measured 2" by 9" and exposed drywall and metal. e. Area 5 was on wall 2, 5 1/2" from the floor and spanned the entire length of the wall and exposed drywall.	F 253	F253 Housekeeping and Maintenance Services Correct deficiency to individual: The facility will maintain a sanitary, orderly, and comfortable interior. This will be accomplished by repairing all cracks, holes, chips, and exposed drywall in the Bathing Suites A & B and the adjacent storage areas. How others are identified and correction to others in similar situations: The Administrator will educate the maintenance and housekeeping staff on maintaining a sanitary, orderly, and comfortable interior. Measures/systemic changes to prevent recurrence: A quality improvement monitoring tool will be implemented by the Maintenance Supervisor. Monitor permanent solution: An audit of the facility will be completed monthly. Any items identified as needed fixing will be scheduled immediately for repair. The results of the audits and repairs completed will be reported quarterly at a QAPI meeting.	8/22/15

8/19/15

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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 253	Continued From page 3 2. Observation of the storage area in bathing suite B on 7/7/15 at 11:25 AM showed 1 wall had 3 areas with chips and cracks drywall. The areas were located just below the light switch in the area. a. Area 1 was 27" from the floor and measured 30" by 1/2" and exposed drywall. b. Area 2 was 32" from the floor and measured 28" by 2" and exposed drywall. c. Area 3 was 31" from the floor and measured 2" by 1 1/2" and exposed drywall. 3. Observation of the bathing area in bathing suite B on 7/7/15 at 11:15 AM showed 3 walls had 11 areas with chips and cracks drywall. Wall 1 was on the knob side of the entrance door, wall 2 was on the hinge side of the entrance door, and wall 3 was next to the tub. a. Area 1 was on wall 1, 31" from the floor and measured 2 1/2" by 1/2" and exposed drywall. b. Area 2 was on wall 1, 31" from the floor and measured 1" by 1" and exposed drywall. c. Area 3 was on wall 2, 5" from the floor and had 17 areas that were chipped away. The chips were located in an area that measured 10" by 23" and all exposed drywall. d. Area 4 was on wall 2, 20" from the floor and had 11 areas that were chipped away. The chips were located in an area that measured 15' by 10" and exposed drywall. e. Area 5 was on wall 2, 24" from the floor and measured 1" by 1" and exposed drywall. f. Area 6 was on wall 2, 24" from the floor and measured 1/2" by 1/2" and exposed drywall g. Area 7 was on wall 2, 24" from the floor and measured 1/2" by 1/2" and exposed drywall. h. Area 8 was on wall 2, 24" from the floor	F 253		

8/19/15

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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 253	Continued From page 4 and measured 1/2" by 1/4" and exposed drywall. i. Area 9 was on wall 2, 24" from the floor and measured 1/2" by 1/2" and exposed drywall. j. Area 10 was on wall 2, 24" from the floor and measured 1/2" by 1/2" and exposed drywall. k. Area 11 was on wall 3, 24" from the floor and measured 1/2" by 33" and exposed drywall. 4. Interview with NHA on 7/9/15 at 10:30 AM confirmed the areas observed and the facility was not able to sanitize the areas appropriately. Further interview with the NHA at that time revealed there was a plan to update the facility; however, correction of these areas was not identified as part of the plan.	F 253		8/22/15
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 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	**F279 Develop Comprehensive Care Plans** Correct deficiency to individual: Charge nurses/MDS nurses will be educated on the importance of updating the care plan as new interventions are developed. Resident #7's care plan has been updated to reflect that this resident needs assistance putting on and taking off her Ted Hose daily. Direct caregivers have been educated on the interventions in place. Resident #7's care plan was updated to include interventions for insomnia on 7/17/15. A sleep evaluation was completed for this resident on 7/17/15. Behavior monitoring for insomnia is in place. A three-day sleep/activity pattern record was implemented for resident #7 on 7/30/15. A gradual dose reduction of clonazepam was requested on 7/10/15; awaiting response from MD. How others are identified and correction to others in similar situations: A review will be completed on or before 8/22/15 to identify residents who have current physician orders for	

8/15/15

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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 279	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, observation and medical record review, the facility failed to ensure the care plan was updated to include current interventions for 1 of 12 residents (#7). The findings were: 1. Review of the Interdisciplinary Care Conference Worksheet dated 4/28/15, and review of the Treatment Orders for July 2015, showed Ted Hose/Knee Highs was an intervention for resident #7. Observation on 7/8/15 at 7 PM revealed the resident wore his/her Ted Hose knee highs and interview with the resident at that time revealed s/he wore them every day. Interview with CNA #3 on 7/8/15 at 7:08 PM verified the resident was supposed to wear the Ted Hose. However, review of the resident's care plan, last updated on 7/23/15, showed Ted Hose had not been identified as a resident need or approach. 2. Review of the May 2015 medication orders showed an order for Clonazepam (Brand name: Klonopin), "0.25 MG PO [by mouth] @ bedtime" for resident #7. Review of the medical record showed a physician's order, dated 7/1/15, prescribed an increase in Klonopin to 0.5 mg, 1 1/2 tablets at bedtime. Review of the care plan, updated on 7/23/15, showed insomnia was not identified as a problem/need and approaches that addressed insomnia were not developed. Interview with the DON on 7/9/15 at 1:28 PM verified insomnia had not been included in the care plan.	F 279	Ted Hose and those care plans will be reviewed to check that Ted Hose is identified as a resident approach. At this time, the MDS coordinator or their designee will be responsible for reviewing and updating the care plan to reflect new and current interventions. An audit will be completed to identify all residents on sedative/hypnotics in the facility on or before 8/22/15. These residents' care plans will be reviewed to ensure that insomnia has been identified and interventions are care planned. Measures/systemic changes to prevent recurrence: All new physician orders will be reviewed by the interdisciplinary team as part of the daily stand up meeting process. The MDS coordinator will update the care plans daily to reflect new and current interventions. All residents' care plans will be reviewed by the interdisciplinary team quarterly and annually according to the MDS cycle to make sure that current diagnoses have care planned interventions. Monitor permanent solution: The MDS coordinator or their designee will complete random chart audits for the next 60 days to ensure that residents' care plan interventions are all present and up to date. Results of these audits will be presented at the monthly QA meeting and corrections will be made to the care plans at the time of audit.	
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

8/19/15

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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 309 SS=D	Continued From page 6 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, medical record review, and review of policy and procedures, the facility failed to ensure staff used appropriate cleaning techniques for 1 of 7 residents (#26) with fecal incontinent care needs; and failed to ensure the necessary assessments and monitoring for pain management was implemented for 1 of 5 residents (#24) with pain. The findings were: 1. Review of the significant change MDS assessment dated 4/9/15 for resident #26 showed the resident was severely impaired with decision making, always incontinent of urine and bowel, and extensive assistance of 2 or more persons for toilet use and personal hygiene. Observation of care on 7/7/15 at 11:27 AM showed the resident was provided perineal care after being incontinent of urine and bowel. CNA #2 assisted resident to roll toward the door and CNA #1 began wiping the resident's buttock area. During perineal care, CNA #1 attempted to clean the bowel from the resident by wiping back and forth using the same wipe. CNA #1 then changed the wipe and again wiped back and forth with the wipe. The CNA then lifted the resident's scrotum	F 309	8/22/15 F309 Provide Care/Services for Highest Well Being Correct deficiency to individual: Staff will be educated on proper peri care procedure for resident #26, including wiping front to back, from clean to dirty, proper wiping, and using clean gloves to apply barrier cream. Nursing staff will be re-educated on the standard of reassing pain after pain medication is administered. For resident #24, nurses will be re-assessing after pain medication is administered for her pain. The non-pharmacological approaches attempted with resident #24 will be documented. How others are identified and correction to others in similar situations: An audit will be completed to identify all dependent residents who require ADL/toileting care on or before 8/22/15. Identified residents will be reviewed for adherence to privacy practices during care. Random audits of the MAR, and pain assessment flow sheets over the next 60 days. Nurses will be notified of need of re-assessment and education will be	

8/19/15

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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 309	Continued From page 7 up from the back side by pulling on the tissue and spreading it up to the thigh causing the resident to yell "ow!" The CNA finished wiping the bowel and changed gloves. After applying new gloves, the CNA noticed more bowel and wiped it away using her right hand. The CNA then used the same hand and picked up a tube of skin barrier cream. The CNA did not change gloves before handling the tube of cream. The resident was then positioned on a clean brief and the CNA provided perineal care to resident's penis and pubic area. Review of policy and procedure, "Lippincott Procedures-Perineal care of the male patient", reviewed on 10/3/2014, showed during implementation the staff member is to provide care to the perineal area before cleaning the anal area. Further review showed staff is to clean the top and sides of the scrotum prior to the bottom of the scrotum and anal area and should "handle the scrotum gently to avoid causing discomfort." Continued review showed that under the special considerations sections the staff should "avoid excessive friction and scrubbing, which can further traumatize the skin." Interview with the SDC on 7/9/15 at 11:00 AM revealed the CNA should have changed the side of the wipe after each stroke, avoided wiping back and forth, cleaned the resident front to back and cleanest to dirtiest, and the gloves should have been changed prior to touching the tube of skin barrier cream to prevent contamination. 2. Review of the medical record showed resident #24 was admitted to the facility on 3/30/15 after receiving hospital care for a pelvic fracture. Review of the 4/30/15 significant change MDS assessment showed the resident had frequent pain daily. Review of the 3/30/15 physician's	F 309	provided on the spot for any missing assessments. <u>Measures/systemic changes to prevent recurrence:</u> The DON has contacted the TENA representative for the facility's incontinence products to request an in-service for nursing staff on proper product use. Staff will be in-serviced on proper peri care procedure per facility policy on or before 8/22/15. Re-education on peri care will be provided to nursing staff on a yearly and PRN basis. Annual and PRN education will be provided to nursing staff on pain standards and documentation of pain medication administration. <u>Monitor permanent solution:</u> Random audits will be performed by the SDC/ICN or their designee on peri care performance on for the next 60 days. Results of audits will be discussed at monthly QAPI meetings. Random audits will be performed by the DON/ADON or designee on the MARS and pain flow assessments. The results will be discussed at the monthly QA meeting.	

8/19/15

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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 309	Continued From page 8 orders showed Lidoderm patch 5% for 12 hours was ordered for generalized pain. Review of the 4/23/15 physician's orders showed Tylenol 650 milligrams (mg) three times daily, Fentanyl 50 micrograms patch (a transdermal pain medication) every 72 hours, and Oxycodone10 mg every two hours as needed were also ordered for pain. The following concerns identified: a. Review of the June and July 2015 nursing notes, pain flow sheet, and medication administration record showed the resident received Oxycodone as needed for pain; but re-assessment for effective pain management was not completed consistently. This review showed the resident was not re-assessed after Oxycodone was administered 3 times on 6/8/15 and once on 6/9/15, 6/15/15, 7/1/15, 7/3/15, and 7/6/15. Further review revealed no documentation regarding non-pharmacological approaches for relieving the resident's pain. b. Interview with the resident on 7/8/15 at 11:40 AM revealed s/he had severe back and "tailbone" pain and sometimes the pain medication helped and sometimes it didn't. c. Interview on 7/9/15 at 12:46 PM with RN #1 revealed the nurses were required to document a before and after pain assessment when administering as needed pain medications. At that time she acknowledge the documentation had not been done on 6/8/15, 6/9/15, 6/15/15, 7/1/15, 7/3/15 and 7/6/15.	F 309		
F 314 SS=G	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 does not develop pressure sores unless the	F 314	**F314 Treatment/Services to Prevent /Heal Pressure Sores.** **Correct deficiency to the individual:** Resident #28 continues monthly appointments to the wound care clinic monthly and PRN. A certified wound nurse assesses resident's pressure ulcer on a weekly basis. Wound vac therapy continues per MD orders. CNAs were educated on 7/13/15 on the importance of frequent repositioning on all residents who have or are at high risk for development of pressure ulcers. They will reposition every two hours while in bed and every hour while in a wheelchair.	8/22/15

8/19/15

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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 314	Continued From page 9 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, staff and resident interview, and policy and procedure review, the facility failed to implement interventions to promote healing and prevent avoidable worsening of pressure ulcers for 1 of 5 sample residents (#28) with pressure ulcers. This failure resulted in actual harm for resident #28 whose pressure ulcer worsened. The findings were: 1. Review of the 6/22/15 quarterly MDS assessment showed the resident required extensive assistance of two or more persons for ADL's (activities of daily living) including transfers, dressing, and toilet use, and was totally dependent on assistance from two or more persons for bed mobility. Further, the assessment showed the resident had a stage 4 pressure ulcer that measured 2 cm by 1.8 cm by 2.7 cm. Review of weekly pressure ulcer records showed a stage 4 pressure ulcer, located on the right gluteal fold, was identified on 1/28/15. On 6/26/15 the ulcer measured 1.5 cm by 0.6 cm by 1.5 cm and had tunneling at the one o'clock positioning that measured 2.8 cm. Further review showed there was also undermining noted at the eleven to twelve o'clock position that measured 1.3 cm. Review of the resident's care plan for pressure ulcer, initiated on 3/2/15, showed the resident had a wound vacuum applied on 5/6/15 and was to be	F 314	How others are identified and correction to others in similar situations: The interdisciplinary team and has reviewed the skin and wound management standard. An audit will be completed by a wound certified RN to identify those residents at highest risk for pressure ulcers on or before 8/22/15. These resident's care plans will be evaluated for prevention measures. Nurses at the facility will be educated on the skin and wound standard on or before 8/22/15. Measures/systemic changes to prevent recurrence: A repositioning documentation schedule will be developed for this resident on or before 8/22/15, and can be used for any future resident who frequently refuses to change position. Monitor permanent solution: The DON, ADON, or their designee will complete random audits on repositioning of residents at high risk for pressure ulcers for the next 60 days. Results of audits will be discussed at monthly QAPI meetings.	

8/19/15

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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 314	Continued From page 10 repositioned every 2 hours. Review of the indwelling catheter care plan, reviewed on 6/24/15, indicated the reason for use was a stage 4 pressure ulcer to the right ischial tuberosity. a. Observation of the resident on 7/7/15 at 9 AM showed the resident was sitting in his/her wheelchair eating breakfast. Continued observation on that date showed the resident remained sitting in the wheelchair reading a book at 11:04 AM. Further observation showed the resident sat in the wheelchair eating lunch at 12:30 PM. b. Observation of wound care on 7/8/15 at 3:30 PM revealed the resident had a stage IV pressure sore with tunneling on the right gluteal fold. c. Interview with the resident on 7/7/15 at 11:04 AM revealed the resident required staff to reposition him/her in the wheelchair and reading helps to distract him/her from being uncomfortable. Further interview at that time revealed staff had not repositioned or offloaded the resident. d. Review of 7/3/15 weekly pressure ulcer record showed the stage 4 to the right gluteal fold measured 1.4 cm by 1.0 cm by 2.0 cm with tunneling at the twelve o'clock position that measured 2.3 cm. Further review showed specialty interventions included specialty bed, wheelchair cushion, positioning devices, and to "reposition often." e. Review of the policy "Pressure Ulcer Risk Assessment" revised 6/2015 showed "...c) Repositioning...Note: Repositioning should occur during rounds which are expected approximately every two hours. Note: Residents in a wheelchair should be repositioned or weight shifted approximately every hour...." f. Interview with the SCD on 7/9/15 at 11 AM	F 314		

8/19/15

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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 314	Continued From page 11 confirmed that residents should be repositioned every two hours while in bed, every 45 minutes while in a wheelchair, and resident #28 should be assisted by staff to reposition.	F 314	F323 Free of Accident/Hazards/Supervision/Devices Correct deficiency to individual: No adverse effects or harm have been experienced by residents #8, #28, and #49. The physical therapist and occupational therapist will assess the assist bars for safety and resident need for residents #8, #28, and #49. How others are identified and correction to others in similar situations: A review of all facility beds has been conducted by the Maintenance Supervisor (7/28/15) to identify all assist bars currently in use. Identified residents with assist bars will be assessed by a physical therapist for resident need and safety. Measures/systemic changes to prevent recurrence: Residents will be evaluated on an individual basis to determine a need for assist bars. The need for assist bars will be assessed by therapy screen and documented by the DON/ADON or their designee at least quarterly in conjunction with the resident's care planning/MDS schedule. The maintenance staff will be responsible for removing assist bars when no longer needed or after a resident is discharged. Monitor permanent solution: Random audits will completed over the next 60 days to ensure that residents will be	8/22/15
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, staff interview, medical record review, and policy and procedure review, the facility failed to ensure assist bars were assessed for safety for 3 of 3 sample residents (#8, #28, #49) who utilized those devices. The findings were: 1. Review of the 6/8/15 quarterly MDS assessment showed resident #8 was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 10/15, and diagnoses that included cerebral vascular accident, late effect hemiplegia, muscle weakness, and osteoarthritis. Observation on 7/7/15 at 9:07 AM showed an assist bar was attached to the open side of the resident's bed and the other side was against the wall. The device was designed to have 4 gaps between the bars; however only 2 gaps were accessible. One gap measured 6" by 4" and the second gap	F 323		

8/19/15

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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 323	Continued From page 12 measured 4" by 4" in size. Review of the resident's medical record revealed that a safety assessment was not completed. The facility failed to address the safety of the assist bar use or potential for limb entrapment. 2. Review of the 6/22/15 quarterly MDS assessment showed resident #28 was moderately cognitively impaired with a BIMS score of 12/15, and diagnoses that included debility malaise and muscle weakness. Observation on 7/7/15 at 9 AM showed an assist bar was attached to the open side of the resident's bed and the other side was against the wall. The device was designed to have 4 gaps between the bars; however only 2 gaps were accessible. One gap measured 6" by 4" and the second gap measured 4" by 4" in size. Review of the resident's medical record revealed that a safety assessment was not completed. The facility failed to address the safety of the assist bar use or potential for limb entrapment. 3. Review of the 3/31/15 quarterly MDS assessment showed resident #49 was cognitively intact with a BIMS score of 15/15, and diagnoses that included debility not otherwise specified and arthritis. Observation on 7/7/15 at 9:18 AM showed an assist bar was attached to the open side of the resident's bed and the other side was against the wall. The device was designed to have 4 gaps between the bars; however only 2 gaps were accessible. One gap measured 6" by 4" and the second gap measured 4" by 4" in size. Review of the resident's medical record revealed that a safety assessment was not completed. The facility failed to address the safety of the assist bar use or potential for limb entrapment.	F 323	evaluated for the need of assist bars. The therapy department will provide a written statement for those residents in need of an assist bar. Going forward, the therapists will perform a safety assessment regarding assist bars quarterly in conjunction with the residents care plan/MDS schedule. Results of audits will be discussed at monthly QAPI meetings.	

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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 323	Continued From page 13 4. Review of the facility policy "Assist Bar Assessment and Use" revised on 9/2014 showed "the need for assist bars should be assessed and documented at least quarterly in conjunction with the resident's care planning/MDS cycle." Further review showed the policy did not address resident safety or potential for limb entrapment. 5. Interview with the DON on 7/9/15 at 9:33 AM revealed the facility did not conduct safety evaluations for assist bars.	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.	F 329	**F329 Drug Regimen is Free From Unnecessary Drugs** **Correct deficiency to individual:** Residents #24 and #7 did not suffer any adverse effects from their medication regimens. Behavior monitoring for anxiety for resident #24 was initiated on 7/10/15 and will continue for the duration of her care. Resident #7's care plan was updated to include interventions for insomnia on 7/17/15. A sleep evaluation was completed for this resident on 7/17/15. Behavior monitoring for insomnia is in place. A three-day sleep/activity pattern record was implemented for resident #7 on 7/30/15. A gradual dose reduction of clonazepam was requested on 7/10/15; awaiting response from MD. **How others are identified and correction to others in similar situations:** An audit will be completed to identify all residents on	8/22/15

8/19/15

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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 329	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary medications for 2 of 13 sample residents (#7, #24). The findings were: 1. Review of the 4/30/15 significant change MDS assessment showed resident #24 was depressed, but did not have behaviors or impaired cognition. Review of the June and July 2015 medication administrations records showed a 4/23/15 physician's order for Ativan (an antianxiety medication) .5 milligrams (mg) every four hours as needed. Further review revealed the medication was administered on 6/21/15, 6/24/15, 6/25/15, 6/26/15, 6/27/15, 6/29/15, 7/4/15, 7/5/15, 7/6/15, and 7/7/15. Review of the 7/5/15 nurses notes showed "resident occasionally anxious, calls out for help." Review of nursing notes, dated 7/6/15, showed "increased anxiety and requested Ativan, administered per orders and effective." Review of nursing notes, dated 7/7/15, showed the resident "reports anxiety and medicated per orders." Review of nursing notes, dated 7/8/15, showed the physician added an additional medication, Zoloft 25 mg daily, for the resident's anxiety. Review of the behavior monitoring records for the resident showed the lack of monitoring for this anti-anxiety medication. During an interview on 7/9/15 at 1:28 PM, the DON stated the monitoring should have been implemented when the medication was started, and verified it was not done.	F 329	sedative/hypnotics in the facility on or before 8/22/15. A sleep evaluation will be completed by the DON, ADON, or their designee for all residents on sedative/hypnotics on or before 8/22/15. The DON/ADON or their designee will ensure that all residents on sedative/hypnotics have behavior monitoring in place on or before 8/22/15. Measures/systemic changes to prevent recurrence: Sleep/activity pattern records will be completed for all residents on sedative/hypnotics on admission and quarterly, following the MDS care plan schedule. New residents will have a sleep evaluation and three day sleep/activity pattern record completed on admission. Nurses will be educated on the sleep evaluation and sleep/activity pattern record on or before 8/22/15. Monitor permanent solution: Random audits of behavior monitoring sheets, sleep evaluations and sleep/activity pattern records will be completed by the DON or their designee for the next 60 days. Results of audits will be discussed at monthly QAPI meetings.	

8/13/15

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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 329	Continued From page 15 2. Review of the May 2015 medication orders showed an order for Clonazepam (Brand name: Klonopin), "0.25 MG PO [by mouth] @ bedtime" for resident #7. Review of the medical record showed a physician's order, dated 7/1/2015, prescribed an increase in Klonopin to 0.5 mg, 1 1/2 tablets at bedtime. Review of the medical record failed to show documented clinical rationale for the increase in Klonopin. Review of the care plan, updated on 7/23/2015, showed insomnia was not identified as a problem/need and approaches that addressed insomnia were not developed. Interview with the DON on 7/9/15 at 1:28 PM verified a sleep assessment had not been completed prior to determining the resident needed medication for sleep.	F 329		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to equip corridors with firmly secured handrails on each side for 1 of 2 hallways (A Hall) in the facility. The findings were: 1. Observation on 7/7/15 at 10:55 AM showed the handrail at the end of A hall near the exit door was very loose. 2. Observation on 7/7/15 at 11 AM showed the handrail outside of room 104 was very loose.	F 468	**F468 Corridors Have Firmly Secured Handrails** Correct deficiency to individual: The facility will ensure corridors are equipped with firmly secured handrails on each side. The handrail at the end of A Hall and handrail outside of Rm 104 have been repaired by the Maintenance Supervisor so they are firmly secured. How others are identified and correction to others in similar situations: Maintenance Supervisor will check all corridor hand rails each month to ensure they are firmly secured. Measures/systemic changes to prevent recurrence: If any handrails are in need of repair, the Maintenance Supervisor will ensure they are repaired immediately. Monitor permanent solution: The results of the corridor rails inspections will be reported at the monthly safety meeting.	8/22/15

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

PRINTED: 08/11/2015
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
	535034	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 468	Continued From page 16 3. Interview with the NHA on 7/9/15 at 10:30 AM confirmed the handrails were loose and and could result in injury if someone leaned on them.	F 468		