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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 in conjunction with the recertification survey by Healthcare Licensing and Surveys on 7/20/15 through 7/23/15. The complaint survey was prompted by complaint intake WY00002038. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 240 SS=D	483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to provide an environment and daily routine to enhance the quality of life for 1 of 13 sample residents (#51). The findings were: Review of the 5/4/15 quarterly MDS assessment showed resident #51 was admitted to the facility	F 240	240—Care and environment promotes quality of life A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. 1. Resident #51's guardian and previous case manager will be contacted to discuss preferences and possible interests to promote quality of life and psychosocial well- being. Social Services will discuss with guardian options of making room more homelike.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Tonya M [illegible] | Executive Director | 8-14-15

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.

8/13/15 - This POC accepted between Tonya Mercer - Executive Director with a POC of 8/14/15 for all tags.

8/13/15

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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 240	Continued From page 1 on 10/17/14 and had diagnoses including severe intellectual disability, dual sensory impairment, epilepsy, pain in joints, and anxiety. Further review showed the staff assessment for mood and for daily activity preferences were not completed. The following concerns were identified: a. Review of the "Mood" care plan dated 5/18/15 showed the resident was at risk for "alteration in mood state" including "sad, apathetic, anxious appearance" and had a "lack of motivational interest." Interventions included "Promote homelike environment, when possible use familiar objects from home or objects with sentimental value, family pictures, etc.". Observation on 7/22/15 at 11:28 AM showed the resident laying in bed, on a bare mattress, awake facing the wall. There were no sheets or blankets on the bed. The resident was holding and manipulating a pillow with his/her hands. There was no pillow case on the pillow. The resident's side of the room was bare without any personal effects. b. Review of the initial activities evaluation dated 10/17/14 showed the "Activity Pursuit Patterns and Preferences" section was crossed out, with "resident unable to answer" written in. The evaluation failed to provide meaningful information to be used in providing an activity program or to determine the resident's likes and dislikes. c. Review of the 5/18/15 care plan for "Psychosocial Well-Being" showed interventions included "Invite, encourage, remind, escort to activity programs consistent with resident's interests." However, the care plan failed to identify what the resident's interests were, or what kinds of activities the resident may respond to. d. Review of the admission Social Service	F 240	2. Education provided to Activity and Social Services departments related to utilizing all available resources to gather specific and individualized information needed to provide and promote quality of life for each resident. 3. All staff continue to offer and explore interventions related to resident #51 including increased tactile stimulation. 4. A random audit will be conducted of resident #51's room by Social Services Director to ensure environment is comfortable and homelike. 5. Results of audit will be presented monthly in Performance Improvement meetings until substantial compliance has been met.	9-1-15

8/17/15

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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 240	Continued From page 2 Assessment dated 10/17/14 showed the resident was on comfort care, was "blind and mute. [S/he] can hear," and the areas related to the resident's family status and social activity patterns were left blank. e. Interview with the social services director on 7/23/15 at 11:06 AM revealed the resident loved lollipops, but she did not know much more about him/her. She verified more could be done to determine the resident's interests.	F 240		
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 ensure various rooms in 2 of 3 resident hallways (short hallway, long hallway) were clean and in good repair. The findings were: 1. Observation on 7/22/15 at 12:30 PM identified the following concerns with floor and wall damage, and cleanliness: a. The wall behind the entrance door above the baseboard in room #102 was gauged and scraped 32 inches across and 15 inches wide at 4 inches above the floor. b. The short hall shower room had linoleum missing from the floor that measured 13.5 inches long by 3.5 inches wide which was darkened with dirt and debris and created a surface that could not be adequately cleaned. In addition, a 1 inch by 1 inch area of baseboard at the start of the	F 253	253—Housekeeping and Maintenance Services The facility must provide housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior. 1. An inspection of the facility was completed by the Maintenance Director and ED to ensure all areas were cleaned/fixed/repaired. The walls in rooms #102 and #105 were repaired and repainted. Linoleum and baseboards in "short hall" shower room have been repaired and/or replaced. Bathroom doors in rooms #217 and #204 will be repaired and covered with protective sheet to ensure doors remain in good repair.	

8/17/15

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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 base of the shower was missing. The missing baseboard was darkened with dirt and created a surface that could not be adequately cleaned. 2. Observation on 7/22/15 at 4:40 PM identified the following concerns with door and wall damage: The bathroom door to room #105 was gauged and scraped entirely across which measured 34 inches long by 7.5 inches wide. In addition, the wall behind the entrance door was gauged and scraped in an area 56 inches long by 14 inches wide. 3. Observation on 7/23/15 at 11 AM identified the following concerns with door and wall damage: The bathroom door to room #217 was gauged and scraped entirely across which measured 33.5 inches across by 11 inches wide. In addition, the wall behind the entrance door was gauged and scraped which measured 34 inches long by 10 inches wide. 4. Observation on 7/23/15 at 11:30 AM identified the following concern with door damage: The bathroom door to room #204 was gauged and scraped entirely across which measured 39 inches long by 34 inches wide. 5. Interview with the maintenance director on 7/23/15 at 10:40 AM verified multiple areas of the facility were in need of repair. However, the facility failed to have a plan with a specific time frame to address these concerns.	F 253	2. The Maintenance Director will conduct random monthly audits for three months to ensure walls, flooring, and doors remain in good repair. 3. Results of these audits will be presented at the Performance Improvement meetings monthly for three months or until substantial compliance has been met.	9-1-15
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

8/17/15

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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 4 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). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop a comprehensive care plan 2 of 13 sample residents (#8 and #51). The findings were: 1. Medical record review showed resident #8 had diagnoses which included a cerebral-vascular accident (stroke). Review of the 6/24/15 annual MDS assessment showed the resident had functional limitation in range of motion to one side of his/her upper extremity. Review of the resident's July 2015 recapitulation of physician orders showed a 6/2/15 order for the resident to wear a right resting hand splint during the day and remove the splint at night. Periodic observations during the survey from 7/20/15	F 279	279 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 1. Resident # 8 and #51 care plans were updated to reflect specific individual interventions. All staff continue to offer and explore interventions related to resident #51. Resident #8 care plan was updated to reflect the splint use and the physician's orders. 2. All staff who are involved in developing care plans will be educated regarding the importance of individualizing each plan of care to meet specific needs of the resident. 3. A random performance improvement audit will be conducted weekly to ensure all residents care plans are specific and individualized according to each resident's needs. This audit will be conducted weekly for 4 weeks and monthly for two months.	

8/17/15

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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 through 7/21/15 showed the resident wore the splint. The following issue was identified: a. Review of the care plan showed the facility failed to develop a care plan concerning the splint. b. Interview with the DON on 7/23/15 at 10:10 AM confirmed the facility failed to develop a care plan to address the splint for this resident, and the physician's order should have been addressed in the care plan. 2. Review of the 5/4/15 quarterly MDS assessment showed resident #51 was admitted to the facility on 10/17/15 and had diagnoses including severe intellectual disability, dual sensory impairment, epilepsy, pain in joints, and anxiety. Further review showed the staff assessment for mood and for daily activity preferences were not completed. The following concerns were identified: a. Review of the 5/18/15 care plan for "Psychosocial Well-Being" showed interventions included "Invite, encourage, remind, escort to activity programs consistent with resident's interests." However, the care plan failed to identify what the resident's interests were, or what kinds of activities the resident may respond to. b. Review of the initial activities evaluation dated 10/17/14 showed the "Activity Pursuit Patterns and Preferences" section was crossed out, with "resident unable to answer" written in. The evaluation failed to provide meaningful information to be used in developing a care plan to provide an activity program based on the resident's likes and dislikes. c. Review of the admission Social Service Assessment dated 10/17/14 showed the resident was on comfort care, was "blind and mute. [S/he] can hear," and the areas related to the resident's	F 279	4. The results of these audits will be presented at the Performance Improvement meeting monthly for 3 months or until substantial compliance has been met.	9-1-15

8/17/15

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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 6 family status and social activity patterns were left blank. Interview with the social service director on 7/23/15 at 11:06 AM revealed the resident loved lollipops, but she did not know much more about him/her. She verified more could be done to determine the resident's interests.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to follow physician's orders regarding restorative services for 1 of 7 sample residents (#8) who required restorative services. The findings were: Medical record review showed resident #8 had diagnoses which included a cerebral-vascular accident (stroke). Review of the 6/24/15 annual MDS assessment showed the resident had functional limitation in range of motion to one side of his/her upper extremity. Review of the July 2015 recapitulation of physician's orders showed an 8/27/14 order for "Upper extremity strengthening 5 times a week [using a] 1 lb. barbell/yellow thera band exercises. Needs cueing." The following concerns were identified: a. Review of the April and May 2015 Restorative Records showed the program failed to incorporate the physician's orders for range of motion (ROM). The restorative goals were "Improve strength and endurance" and failed to incorporate measurable goals as per the	F 281	281-Services Provided Meet Professional Standards The services provided or arranged by the facility must meet professional standards of quality. 1. Therapy/Restorative Communication form will no longer be utilized. Any referral or clarification from therapy to the restorative program will be written on a telephone order in the medical record which will be reflected monthly on the Treatment Administration Record (TAR) to ensure compliance. 2. All therapy staff will be educated regarding the new process on writing telephone orders for a restorative program/clarification order for all residents participating in a restorative program. 3. The DON and or unit manager will conduct random weekly audits for residents participating in a restorative program to ensure compliance with physician orders. These weekly audits will include the treatment/physician orders for resident #8. Audits will be conducted weekly for 4 weeks and monthly for two months.	

8/17/15

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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 281	Continued From page 7 physician's order. The only specifics noted were "right hand stretches" without addressing whether the stretches were active or passive, how many stretches were to be accomplished, and how often stretches were to be done. b. Review of physician's orders showed the facility failed to clarify the 8/27/14 order for restorative services until 7/22/15 during the survey. At that time the facility had the ROM order changed to reflect a 6/10/15 Therapy/Restorative Communication Form. The form instructions, which restorative was utilizing for the resident instead of the physician's order, had restorative staff stretch the resident's right elbow and hand as tolerated three times a week. c. Interview with the corporate nurse on 7/22/15 at 12:20 PM confirmed physician's orders regarding restorative services should be carried out and clarified in a timely manner. d. According to the seventh edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, 2008, if an order is "questionable for any reason, the physician must be notified for clarification."	F 281	4. The results of these audits will be presented at the Performance Improvement meeting monthly for 3 months or until substantial compliance has been met.	9-1-15
F 282 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure care plans were implemented for 3 of 13 sample residents	F 282	282-Services By Qualified Persons/Care Plan The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. 1. Random weekly audits will be completed to ensure that care plans are being followed as written. The random weekly audits will include residents #13, #51, and #52.	

8/18/15

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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 282	Continued From page 8 (#13, #51, #52). The findings were: 1. Review of the 5/11/15 care plan related to ADLs showed resident #13 was at risk for developing pressure ulcers related to decreased mobility, incontinence, Alzheimer's disease, and Diabetes. The care plan approaches specified the resident was to have his/her heels floated or to wear protective boots when in bed. Observation on 7/21/15 at 10:10 AM showed the resident was in bed asleep. At that time CNAs #1 and #2 pulled back the blankets upon surveyor request. This observation revealed the resident was not wearing the protective boots, and the resident's heels were not floated. The CNAs verified the heels should be floated; and as far as they were aware the boots were only used at night. Interview with the DON on 7/23/15 at 9:50 AM verified the plan should be followed to protect the resident's heels when in bed. 2. Review of the 7/10/15 quarterly MDS assessment showed resident #52 had diagnoses including dementia. Further review showed s/he required total assistance of two people for bed mobility and had bilateral lower extremity range of motion limitations. Review of the Braden Scale for predicting pressure ulcer risk dated 7/8/15 showed the resident was at moderate risk for developing pressure ulcers. The physician order recap for July 2015 showed "float heels at all times with blue boots when in bed." Review of the "Risk for Pressure Ulcers" care plan dated 5/18/15 showed interventions including "float heels when in bed." The following concerns were identified: a. Observation on 7/21/15 at 9:58 AM, RN #1 and CNA #3 assisted the resident to bed, took off the resident's shoes and metal braces, and	F 282	2. Re-education of all nursing staff will be completed regarding following care plans for all residents. The education will be conducted by the SDC and nurse managers 3. A performance improvement audit tool will be used to randomly audit content of the care plan compared to the actual care provided to the resident to ensure consistency. Audits will be conducted weekly for 4 weeks, monthly for 2 months and quarterly thereafter. 4. Results of the audits will be presented at the Performance Improvement meeting for three months or until substantial compliance has been met	9-1-15

8/19/15

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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 282	Continued From page 9 covered the resident with a blanket. Soft blue booties were observed at the foot of the bed, but were not placed on the resident's feet. b. Observation on 7/22/15 at 4:47 PM showed the resident laying in bed. CNA #1 and CNA #4 arrived at that time to assist the resident up from bed. When they pulled back the blankets, the resident was observed wearing sneakers and metal leg braces on both legs. Interview at that time with CNAs #1 and #4 revealed they put the blue boots on the resident at night only. c. Interview with the DON on 7/23/15 at 9:45 AM confirmed the resident should wear booties at any time while in bed. 3. Review of the 5/4/15 quarterly MDS assessment showed resident #51 was admitted to the facility on 10/17/14 and had diagnoses including severe intellectual disability, dual sensory impairment, epilepsy, pain in joints, and anxiety. Further review showed the staff assessment mood score was not completed. Review of the "Mood" care plan dated 5/18/15 showed the resident was at risk for "alteration in mood state" including "sad, apathetic, anxious appearance" and had a "lack of motivational interest." Interventions included "Promote homelike environment, when possible use familiar objects from home or objects with sentimental value, family pictures, etc." The following concerns were identified: a. Observation on 7/22/15 at 11:28 AM showed the resident laying in bed, on a bare mattress, on the right side facing the wall. There were no sheets or blankets on the bed. The resident was holding and manipulating a pillow with his/her hands. There was no pillow case on the pillow. The resident's side of the room was bare without any personal effects.	F 282		

8/17/15

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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 282	Continued From page 10 b. Interview on 7/23/15 at 11:05 AM with the social service director revealed that she "hasn't tried much" to determine the resident's interests and possible objects that could create a homelike environment for the resident.	F 282		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure restorative services were provided as planned for 4 of 8 sample residents (#8, #13, #36, #51) with a need for range of motion (ROM) services. The findings were: 1. Medical record review showed resident #8 had diagnoses which included a cerebral-vascular accident (stroke). Review of the 6/24/15 annual MDS assessment showed resident had functional limitation in ROM to one side of his/her upper extremity. Review of the July 2015 recapitulation of physician's orders showed an 8/27/14 order for "Upper extremity strengthening 5 times a week [using a] 1 lb. barbell/yellow thera band exercises. Needs cueing." The following concerns were identified: a. Review of the April and May 2015	F 318	318 Increase/Prevent Decrease in Range of Motion Based on the comprehensive assessment of a resident, the facility must ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. 1. A 100% audit will be completed for all residents participating in the Restorative Nursing program or receiving range of motion services including #8, #13, #36 and #51 to ensure the physician order is concurrent with the treatment/program being provided. 2. DON/Restorative manager will educate the nursing staff regarding documentation compliance for all residents in any restorative nursing program, including range of motion services	

8/17/15

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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 318	Continued From page 11 Restorative Records showed the program failed to incorporate the physician's orders for ROM. The restorative goals were "improve strength and endurance" and failed to incorporate measurable goals. The only specifics noted were "right hand stretches" without addressing whether the stretches were active or passive, how many stretches were to be accomplished, and how often stretches were to be done. b. Review of a 6/10/15 Therapy/Restorative Communication Form showed occupational therapy referral for restorative to stretch the resident's right elbow and hand as tolerated three times a week. However, the facility failed to obtain a discontinuance of the 8/27/14 physician's order. c. Review of the April 2015 Restorative Record showed the facility failed to document any ROM services for the resident from 4/24/15 through 4/30/15 (7 days). Review of the May 2015 Restorative Record showed the facility failed to document any ROM services for the resident from 5/14/15 through 5/28/15 (15 days). 2. Review of the 9/29/14 significant change, and 3/18/15 quarterly MDS assessments showed resident #13 had ROM limitations bilaterally of both the upper and lower extremities. Review of the 6/19/15 quarterly MDS assessment showed the resident had no ROM limitations. According to the restorative records for June and July 2015 the document showed the resident had goals to maintain ROM and strength and mobility. The approach was 5 times per week for lower and upper extremity exercise. The following concerns were identified: a. Review of the June 2015 record showed during the first 16 days of the month the resident received these exercises on 6/6/15. There were no refusals or other reasons documented to show	F 318	3. Therapy/Restorative Communication form will no longer be utilized. Any referral or clarification from therapy to the restorative program will be written on a telephone order in the medical record which will be reflected monthly on the Treatment Administration Record (TAR) to ensure compliance. 4. Results of the audits will be presented monthly at the Performance Improvement meeting for three months or until substantial compliance has been met.	9-1-15

8/18/15

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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 318	Continued From page 12 why the exercise services were not completed on the other days of the month. b. Review of the July 2015 restorative record showed the resident received services on 11 days from 7/1/15 to 7/21/15. There were no documented refusals for the 4 days when restorative services were not completed as planned. 3. Review of the 5/23/15 quarterly MDS assessment showed resident #36 had ROM limitations on one side of both the upper and lower extremities. Review of the 6/12/15 significant change MDS assessment showed the resident had no ROM limitations. Review of the June and July 2015 restorative records showed a plan was in place for the resident to exercise on the "nu-step-bike" 3 times per week for strengthening and endurance. Review of the June 2015 record showed the resident received the services 1 day (6/4/15) from 6/1/15 to 6/14/15 with no refusals documented. 4. Review of the 5/4/15 quarterly MDS assessment showed resident #51 was admitted to the facility on 10/17/14 and had diagnoses including severe intellectual disability, dual sensory impairment, epilepsy, pain in joints, and anxiety. Further review showed the resident had bilateral upper and lower extremity range of motion limitations. The following concerns were identified: a. Observation on 7/21/15 at 9:05 AM showed resident #51 was seated in a wheelchair in the activity room. The resident's feet did not touch the floor and were hanging down without any supports available. b. Interview on 7/22/15 at 3 PM with occupational therapist (OT) #1 revealed the	F 318		

8/18/15

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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 318	Continued From page 13 resident was receiving occupational therapy targeting stretching, wheelchair positioning, muscle tone, and sensory issues until s/he was discharged from skilled therapy on 3/31/15. Additionally, at the time of discharge, the OT recommended a restorative nursing program for the resident, in which she believed the resident was still participating. Further, the OT stated she also recommended a weighted blanket for the resident to wear while in the wheelchair to encourage proper positioning; however, the blanket that arrived was not the correct size and was sent back. OT #1 further stated the correct sized blanket was supposed to be ordered, but she was unsure if that ever got done. c. Interview with restorative CNA #1 on 7/22/15 at 3:20 PM revealed the resident was not currently, nor had ever been, on a restorative program. d. Interview with OT #1 on 7/23/15 at 10:20 AM revealed the restorative program was written, but she was not sure what happened after giving the program to the restorative nurse. She further stated that she did not have any paperwork to show that the program was ordered and what it entailed. Additionally, she stated that the weighted blanket was ordered that morning. 5. Interview with restorative CNA #1 on 7/22/15 at 3:20 PM verified resident refusals were to be documented on the record. 6. Interview with the DON on 7/23/15 at 9:45 AM verified the documentation failed to show the services were provided as planned. She stated there were two restorative CNAs to complete the restorative programs, and they were managed by a nurse who was on leave during the first part of June. The DON verified she expected the	F 318		

8/17/15

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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 318	Continued From page 14 programs to be completed as planned to maintain or improve the ROM for these residents.	F 318		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure equipment was clean and food was properly labeled and dated in the facility kitchen. The findings were: 1. Observation on 7/20/15 at 3:20 PM showed the range top and two ovens were in need of cleaning. The equipment surfaces had an accumulation of cooked on grease and food. The equipment remained in need of cleaning when observed on 7/22/15 at 11:20 AM. Interview with the certified dietary manager (CDM) on 7/22/15 at 5 PM verified there were 2 full time vacancies for dietary staff, and this made it more challenging to ensure the cleaning was completed as scheduled. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and	F 371	371- Food Secure, Store/Prepare/Serve-Sanitary The facility must (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions 1. The range top and both ovens are being cleaned on a daily basis. CDM has ordered a stronger cleaning solution for the stove surfaces and ovens which will remove the cooked on grease and food from these surfaces. The plastic piece above the ice bin in the ice machine on Saddle ridge was cleaned immediately. The sour cream, cooked turkey and sliced turkey were discarded immediately upon discovery of inaccurate "used by" dates. 2. CDM will educate all dietary staff on the importance of cleanliness and writing a "used by" date accurately upon food items opened or removed from the freezer.	

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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 371	Continued From page 15 touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 2. Observation on 7/22/15 at 4:15 PM showed the interior of the ice machine located off the back nurses' station was in need of cleaning. The interior white plastic piece above the ice bin was soiled with a brownish colored substance. Interview with the CDM on 7/22/15 at 5 PM verified the maintenance department was responsible for the cleaning and sanitizing of the ice machines. Interview with the maintenance director on 7/23/15 at 10:35 AM verified the ice machine was on a 6 month schedule for sanitation; however, general cleaning was to be done as needed. According to Food Code 2013, U.S. Public Health Service: 3-305.11 "(A) Except as specified in ¶¶ (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination;" 3. Observation on 7/20/15 at 3:20 PM showed a container of sour cream which was available in the walk-in refrigerator labeled "best by 7/11/15." The reach-in refrigerator contained a cooked turkey breast wrapped in plastic labeled "use by 6/20" additionally there was a container of sliced turkey with the same label, "use by 6/20." Interview with the CDM on 7/22/15 at 5 PM revealed food products were required to have use by dates, and when past the date the items were to be discarded. She further stated the labels on the turkey must not have been replaced when the food was removed from the freezer.	F 371	3. A new and updated cleaning schedule will be implemented by the CDM to ensure daily cleaning of the stove surfaces, ovens and ice machines to ensure all federal requirements and specifications are met. 4. CDM will conduct a weekly audit to ensure the dietary staff are compliant with the cleaning schedules and completion of cleaning including the stove, ovens and ice machines. Audits will also include the "used by" dates are accurate on all food items in the kitchen. 5. The results of these audits will be presented monthly at the Performance Improvement meeting for a period of three months and until substantial compliance has been met.	9-1-15

8/12/15

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

PRINTED: 08/06/2015
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
	535039	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 371	Continued From page 16 According to Food Code 2013, U.S. Public Health Service: 3-501.17 "(A)...refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days.	F 371		

8/17/15