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

PRINTED: 10/21/2015
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 10/07/2015 |

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

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| F 000 | INITIAL COMMENTS<br><br>On 10/4/15 through 10/7/15 a complaint survey was conducted at Westview Healthcare Center. The survey was prompted by complaint intake WY00002113. | F 000 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, medical record review, and review of policies and procedures, the facility lacked evidence nursing staff provided the necessary assessments, monitoring, and nursing measures to ensure adequate pain management for 1 of 5 sample residents (#6) who had pain. The finding were:<br><br>Review of the medical record showed resident #6 was admitted to the facility in November 2014 with diagnosis that included Alzheimer's disease and discharged from the facility on 8/17/15. Review of the 7/6/15 quarterly MDS (Minimum Data Set) assessment showed the resident required extensive assistance with eating and total assistance with all other ADLs (activities of daily living). This review showed s/he had frequent bowel and bladder incontinence, severe cognitive impairment, usually understood others, | F 309 | F 309 Provide Care and Services for highest well being<br><br>A.<br>1. Resident #6 is no longer residing at this facility.<br>2. All residents MARS were assessed to ensure that post pain assessments were completed/documented for PRN pain medication administration according to policy.<br>3. All nurses will be in-serviced by DON or designee by 11/16/15 regarding completion of the post pain assessment evaluation and documentation of PRN pain medication administration.<br>4. Random audits of MARS will be reviewed for completion of post pain assessment evaluation and documentation of PRN pain medication administration weekly x4 weeks followed by monthly x2 months or until substantial compliance is achieved. | |

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

Executive Director 10-28-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
WY Dept of Health
OCT 30 2015
Healthcare Licensing and Surveys

Margo Made per phone with Tonya Mitchell, RN on 11/13/15 @ 1:15pm. POC accepted.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: G04211 Facility ID: WY0035 If continuation sheet Page 1 of 8

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| F 309 | Continued From page 1<br>and usually was understood by others. Further review showed verbal behavioral symptoms directed toward others occurred 1 to 3 days; and other behavioral symptoms (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) occurred daily. This review also revealed the resident exhibited additional behaviors that included wandering and rejecting care. Review of the pain assessment section of the MDS assessment showed the resident received non-pharmacological interventions and medication for pain, but the assessment could not be completed because the resident was unable to answer the pain assessment questions.<br><br>Review of the care plan, revised on 8/11/15, showed the resident had cognitive loss related to dementia with behavior disturbance, altered mental status, and Alzheimer's disease. This review also showed staff were directed to anticipate and meet needs per physical/nonverbal indicators of discomfort/distress and follow-up as indicated.<br><br>Review of the physician's order dated, 6/19/15, showed fentanyl patch was discontinued and Morphine 5 mg (milligrams) every four hours PRN (as needed) was ordered for pain in the limbs. According to the and physician's June 2015 to August 2015 orders the resident's pain medication regime included scheduled doses of Morphine in addition to the PRN doses, scheduled Tylenol Extra Strength 500 mg three times a daily, and Tylenol 650 mg PRN 1 to 6 times a day. | F 309 | 5. Results of these audits will be reviewed at the PI meeting monthly x3 months or until substantial compliance is achieved. 11-16-15<br><br>B.<br>1. Resident #6 is no longer residing at the facility.<br>2. All resident's current pain assessment scale will be evaluated for appropriateness<br>3. All nurses will be in-serviced by the DON or designee by 11/16/15 regarding the importance of utilizing the appropriate pain assessment scale when evaluating a resident's pain<br>4. Random audits of resident's pain assessment scale to ensure appropriateness of use will be conducted weekly x4 weeks followed by monthly x 2 or until substantial compliance has been achieved.<br>5. Results of these audits will be reviewed at the PI meeting monthly x3 months or until substantial compliance has been achieved. 11-16-15 | |

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| F 309 | Continued From page 2<br>Review of the November 2015 through August 2015 pain assessment sections of the medication administration records showed the staff were directed to use the wong pain scale assessment tool and based on this assessment scale the resident ' s tolerable pain level was 3 or below. Review of the pain assesament flow sheet showed the following concerns:<br>a. On 7/31/15 at 12:21 AM, 8/10/15 at 12:47 AM, on 8/17 at 2:45 AM and 5 PM morphine was administered; however, the post pain assessment for effectiveness was not completed.<br>b. On 7/1/15, 7/2/15, 7/17/15, 7/18/15, 7/23/15, and 7/21/15 morphine was administered but the appropriate pain scale assessment was not used.<br>c. On 7/13/15 the morphine was administered when the pre-assessment showed an acceptable pain level.<br><br>During interviews on 10/8/15 with RN (registered nurse) #1 at 5:25 PM, RN #2 at 5:45 PM, and RN #3 at 6:15 PM, all verified the pain assessments were not done consistently, and further stated it was difficult to assess the resident's pain due to his/her advance dementia and efforts to address the family members' concerns.<br><br>Review of the policy and procedure titled "Pain Management - General Guidelines" showed guidelines for conducting quarterly pain reviews to evaluate and review current pain management regimens and effectiveness. This review showed guidelines for evaluating pain ratings that consistently exceed acceptable level of pain, and evaluating changes in pain occurrences or characteristics. | F 309 | C.<br>1. Resident #6 is no longer residing at this facility.<br>2. All residents MARS were reviewed for accuracy and consistency of pain assessments to determine if a resident is at or beyond an acceptable pain level prior to administering a pain medication according to policy and procedure.<br>3. All nurses will be in-serviced by the DON or designee by 11/16/15 regarding the accuracy and consistency of pain assessments to determine if a resident is at or beyond an acceptable pain level prior to administering a pain medication according to policy and procedure.<br>4. Random audits of pain assessments will be conducted to ensure pain medication has not been administered prior to assessment of the resident's acceptable pain level. Audits will be conducted weekly x4 weeks followed by monthly x2 months or until substantial compliance has been achieved. | |

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| F 329 | Continued From page 3 | F 329 | 5. Results of these audits will be reviewed at the PI meeting monthly x3 months or until substantial compliance has been achieved. | 11-16-15 |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS | F 329 | F 329 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.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, medical record review, and review of policies and procedures, the facility failed to adequately monitor 1 of 4 sample residents (#6) with antipsychotic drug use. The findings were:

Review of the medical record showed resident #6 was admitted to the facility in November 2014

A.

1. Resident #6 is no longer in the facility
2. The MARS of all residents receiving ~~Temazepam~~ Psychotropic medication will be audited for congruency with behaviors documented on the behavior tracking form and appropriate effectiveness further documented.
3. All nurses will be in-serviced by the DON or designee by 11/16/15 regarding the importance of properly documenting the use of ~~Temazepam~~ Psychotropic medication for behaviors and its effectiveness on the behavior tracking form.
4. Random audits of MARS and behavior tracking forms will

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| F 329 | Continued From page 4<br>with diagnosis that included Alzheimer's disease and discharged from the facility on 8/17/15. Review of the 4/7/15 quarterly MDS (Minimum Data Set) assessment showed the resident required total assistance with toileting and extensive assistance with all other ADLs (activities of daily living). This review showed s/he had frequent bowel and bladder incontinence, severe cognitive impairment, usually understood others, and usually was understood by others. Further review showed verbal behavioral symptoms directed toward others occurred 1 to 3 days; and other behavioral symptoms (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) occurred daily. According to this assessment wandering and rejecting care were behaviors that were not exhibited at this time.<br><br>Review of the 7/6/15 quarterly assessment showed s/he required extensive assistance with eating and total assistance with all other ADLs. This review revealed no changes were assessed regarding bowel and bladder incontinence; and cognitive impairment. Further review revealed s/he exhibited wandering and rejecting care behaviors in addition to the behaviors noted during the 4/7/15 MDS assessment.<br><br>Review of the care plan, revised on 8/11/15, showed the resident had cognitive loss related to dementia with behavior disturbance, altered mental status, and Alzheimer's disease. Review of the care plan also showed interventions included monitoring for effectiveness of psychotropic medication use. | F 329 | conducted for congruency related to behaviors and its effectiveness documented for those residents receiving ~~Temazepam~~ weekly x4 weeks followed by monthly x2 months or until substantial compliance has been achieved.<br>5. Results of these audits will be reviewed at the PI meeting monthly x3 months or until substantial compliance has been achieved.<br><br>B.<br>1. Resident #6 no longer resides in the facility<br>2. 100% audit of all the behavior tracking forms of residents on ~~Temazepam~~ will be conducted for the presence of non-pharmacological interventions prior to the administration of ~~Temazepam.~~<br>3. All nurses will be in-serviced by the DON or designee by 11/16/15 regarding the importance of implementing non-pharmacological interventions prior to the administration of ~~Temazepam~~ for behaviors. | 11-16-15 |

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| F 329 | Continued From page 5<br><br>Review of the February 2015 to August 2015 medications orders showed: On 2/23/15 Mirtazapine (antidepressant) 30 mg (milligrams) at bedtime was ordered. On 2/23/15 Citalopram (antidepressant) was decreased from 20 mg daily to 10 mg daily. On 5/13/15 Ativan (an anxiolytic) one mg 3 times a day was discontinued. On 7/9/15 Temazepam (a Benzodiazepine and hypnotic used for anxiety and insomnia) 7.5 mg PRN (as needed) four times a day was changed to every 6 hours PRN.<br><br>Review of the behavior monitoring form for July 2015 through August 2015 showed staff were monitoring the resident's behavior for the effectiveness of Citalopram, Mirtazapine and Temazepam. The targeted behavior for the medications were disruptive behavior to others, verbal aggression, and "restlessness, fidgety". The form included an area to document the date, location where the behavior occurred, interventions that were tried, and the resident's response to the interventions. Further review of the form showed nothing was documented for the month of July 2015. Review of the July 2015 through August 2015 nursing notes and medication administration records showed Temazepam was administered one time on 7/2, 7/3, 7/8, 7/12, 7/16, 7/17, 7/18, and 7/19 with no documented rationale for administering the medication. In addition the following concerns were identified during review of the July 2015 through August 2015 nursing notes:<br>a. On 7/4/15 Tamazepam was administered for agitation. Additional documentation regarding non-pharmacological interventions was lacking.<br>b. On 7/5/15 Tamazepam was | F 329 | 4. Random audits of behavioral tracking forms will be conducted to ensure nurses are implementing non-pharmacological interventions prior to the administration of psychotropic medication ~~Temazepam~~ weekly x4 weeks followed by monthly x2 months or until substantial compliance has been achieved.<br>5. Results of these audits will be reviewed at the PI meeting monthly x3 months or until substantial compliance has been achieved. | jc<br><br>11-16-15 |

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| F 329 | Continued From page 6<br>administered for yelling and combative behavior. Additional documentation regarding non-pharmacological interventions was lacking.<br>c. On 7/6/15, 7/7/15, and 7/9/15 Tamazepam was administered per family request with no documented behaviors.<br>d. On 7/20/15 Tamazepam was administered for combative, agitated, and verbally abusive behavior. However, efforts to use non-pharmacological interventions were not documented.<br>e. On 7/21/15 "cussing and hitting staff "... physician unable to trim resident's nails due to "extremely verbally and physically aggressive". Additional documentation regarding interventions that were implemented to address this behavior was lacking.<br>f. On 7/24/15 "appears if we cover" his/her head s/he will go to sleep without medication. Attempts to repeat this intervention as a non-pharmacological measure were not documented.<br>g. Tamazepine was not administered when the following behaviors were exhibited: On 7/31/15 was verbally aggressive and cussing during shower, reassurance and redirection were given but not effective. On 8/11/15 refused to be shaved and was "hitting" staff. On 8/13/15 was "combative and agitated", and on 8/15/15 was hitting, kicking, screaming and slapping.<br><br>During interviews on 10/6/15 with RN (registered nurse) #1 at 5:25 PM, RN #2 at 5:45 PM, and RN #3 at 6:15 PM, all verified the lack of identified non-pharmacological interventions that effectively addressed the resident's behaviors, and further stated it was difficult to determine the effectiveness of the PRN medication. | F 329 | | |

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| F 329 | Continued From page 7<br>Review of the Behavioral Health Program Policy and Procedure revealed "All staff is expected to document symptoms, interventions and outcomes on the Behavior Monitoring Form. The facility will evaluate the effectiveness of pharmacological and non-pharmacological interventions in accordance with state and federal regulations." | F 329 | | |