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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 recertification survey was conducted by Healthcare Licensing and Surveys on 7/10/17 through 7/14/17. 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 LPN: Licensed Practical Nurse ARD: Assessment Reference Date BIMS: Brief Interview for Mental Status RAI: Resident Assessment Instrument Less commonly used abbreviations will be annotated in each deficiency.	F 000	**Submission of the plan of correction shall not be construed as a waiver of this provider's right to contest any and all deficiencies, nor is such submission an admission that the facts are as alleged, or that any regulatory violation occurred.** **The following is to be considered our Credible Allegation of Compliance.**	8/16/17
F 167 SS=B	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys,	F 167	F167 Right to Survey Results – Readily Available **Corrective action to resident(s):** The location of the survey binder was relocated to the corridor as you enter the building. Three years of surveys and complaint investigations were placed in the binder. A posting noting the availability of the survey binder was posted on 8/3/17. **How problem is identified for other residents and what corrective actions will be taken:** Residents will be notified of the survey binder location, availability of three years of	8/16/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natalie Kovell — TITLE: Administrator — (X6) DATE: 8/24/17

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
AUG 30 2017
Healthcare Licensing and Surveys

8/30/17 11:00 AM POC accepted via phone call with Natalie Kovell. Nurse Comp, RN

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

PRINTED: 07/28/2017
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 _____	07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	160 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 167	Continued From page 1 certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family and staff interview, the facility failed to post most recent survey results in a readily accessible place, and failed to post a notice of the availability of facility surveys and complaint investigations for the previous 3 years during 5 of 5 days of the survey. The findings were: 1. Observation from 7/10/17 to 7/14/17 showed there was a wall-mounted display with a binder labeled "survey" behind the receptionist desk across from the facility entrance which contained the 2016 Form CMS-2567 survey results and plan of correction. Accessing the survey binder required going behind the receptionist desk. There was no notice posted to indicate the availability of the facility surveys and complaint investigations for the preceding three years. 2. Interview on 7/11/17 at 2 PM with a group of residents revealed 7 of 8 residents could not state where the survey results were located. 3. Interview with a resident's family member on 7/14/17 at 10:30 AM revealed s/he was not aware	F 167	surveys and complaint investigations at the next three resident council meetings. Family members will be notified of the location and accessibility of the three years of survey and complaint investigations with a posted Notice of Availability, in the monthly newsletter and monthly billing statement and through the newsletter. **Measures/systemic changes to prevent recurrence:** After each survey or complaint investigation, the binder will be updated and three years will be kept in the binder. **Monitor permanent solution:** The survey binder will be updated by People Development Coordinator after each survey and the Administrator will audit that it is complete with the last three years of survey and complaint investigations and the presence of the posting of notice of availability of results. Results will be reported at QAPI meeting after the survey book has been updated and checked.	

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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 167	Continued From page 2 survey results were available to inspect and could not identify where the survey binder was located. Further, the resident had been living at the facility for two years. 4. Interview with the administrator on 7/14/17 at 10:54 AM confirmed the facility had failed to prominently post a notice regarding the availability of facility surveys and complaint investigations for the preceding three years. Further, she revealed the binder had been moved from its previous location, and confirmed it was not available to visitors or residents in its current location.	F 167		
F 225 SS=L	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of	F 225	**F225** **Corrective action to resident(s):** Resident #54 family was contacted on evening of 7/11/17 because the resident was discharged on 7/8/17. Administrator asked family member to ask resident about the abuse allegation and family notified administrator in the morning of 7/12/17 that the resident said, "no no no, no one ever did anything to me there, it was nothing but top-notch care. Resident's physician was notified by Administrator and Director of Nursing. A thorough investigation was initiated by the facility Administrator and Director of Nursing. **How problem is identified for other residents and what corrective actions will be taken:** Interviews with all residents or family members when resident was unable to be interviewed were conducted.	8/16/17

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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 225	Continued From page 3 actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	**Measures/systemic changes to prevent recurrence:** All team members were educated on the Abuse and Neglect Standard prior to returning to work. Education was provided at the All Team meeting on July 20th. Abuse and Neglect education will be provided quarterly for four quarters and then twice per year as outlined in the inservice schedule. **Monitor permanent solution:** The Director of Nursing or designee will conduct a random audit of (5) residents weekly for 4 consecutive weeks, then monthly for 12 months. These residents' records will be reviewed for allegations. Findings of the audit will be reported at QAPI. This plan of correction will be monitored/reviewed at the monthly Quality Assurance meeting for 12 months or until such time consistent substantial compliance has been met.	

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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 225	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, review of the facility incident log, and policy and procedure review, the facility failed to investigate and report allegations of abuse for 1 of 9 allegations (resident #54) reviewed. The failure resulted in an immediate jeopardy situation related to a possible perpetrator having further access to at-risk adults. The census was 53. The findings were: 1. Review of a social services note for resident #54 dated 6/20/17 and timed 2:22 PM showed "Given behaviors exhibited by [resident's name] during the day, including threatening staff, telling therapy that people were trying to rape [him/her] within the facility, and stating that people were stealing [his/her] money..." Further, the note indicated the facility contacted the regional ombudsman for "information about how to handle the situation" and "Project Out to discuss potential discharge plans." 2. Review of a social services note for resident #54 dated 6/20/17 and timed 5:14 PM showed the resident had a BIMS score of 12/15 (moderately impaired) and a depression score of 3/27 (minimal). Further, the note showed "....[s/he] spoke about the "people in the hallways" peaking in [his/her] room and gossiping about [him/her]...[s/he] said people out there keep trying to come in [his/her] room and touch [him/her] and do inappropriate things with [him/her]..." 3. Interview with the DON on 7/11/17 at 2:06 PM revealed all allegations of abuse or neglect should be reported to the charge nurse, and then the DON and administrator to ensure the resident	F 225		

PRINTED: 07/28/2017
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	160 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 225	Continued From page 5 is safe and to keep the alleged perpetrator away from the resident and the facility. The nurse would then investigate by assessing the resident for signs of injury and the facility cameras would be reviewed to attempt to identify the perpetrator. Further, it was revealed even if a resident had a cognitive deficit, the incident is still investigated and all theft, resident-to-resident altercations, and physical abuse should be reported to local law enforcement. The DON was not aware of any allegations during the previous 3 months. 4. Review of the facility's incident log between 7/10/16 and 7/10/17 showed no evidence the facility had identified, investigated, or reported an allegation of abuse for resident #54. 5. Interview with the DON and administrator on 7/11/17 at 3:53 PM revealed social services was part of the facility's abuse investigation protocol, and none of the allegations recorded in the 6/20/17 social service notes were investigated. Further, it was revealed the administrator became aware of the allegations on July "5th or 6th" and the DON became aware on July 10th; however, no investigation was initiated at that time. The resident discharged from the facility on 7/8/17. 6. Review of the policy and procedure titled "Abuse and Neglect Prevention Standard" last revised on 3/2017 showed "...IV. Identification: A, All team members will be observant for any resident or team members' conditions that might be indicative or predictive of potential abuse and/or neglect, such as suspicious bruising, withdrawn behaviors, stress, change in behaviors, etc. All observations of suspected abuse should be immediately reported to your supervisor or the facility administrator. If a crime	F 225		

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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 225	Continued From page 6 is suspected, the Elder Justice Act requires all individuals to report...V. Investigation A. All allegations of abuse and/or neglect will be investigated and reported in accordance with the state and federal laws. B. In the situation of an allegation of abuse, the following people will be notified immediately: Administrator, DON, and Social Services...VII. Reporting/Response Reporting must be made to the Administrator or Designee and other officials (including State Survey Agency and/or APS where state law provides for jurisdiction in LTC facilities) in accordance with state law through established procedures. Follow the state's specific reporting guidelines and requirements. Any alleged physical, mental, verbal or sexual abuse; mistreatment, neglect, misappropriation of resident's property, ("Property" includes medications), exploitation, or involuntary seclusion of a resident by a team member is to be reported to the proper authorities..." 7. On 7/11/17 at 5:06 PM the administrator and DON were notified of the immediate jeopardy situation that had the potential to affect all residents because the facility had failed to investigate and report an allegation of abuse. The facility's action plan included the following corrective actions: a. An investigation of the allegations of abuse was initiated on 7/11/17. b. All interviewable residents, and family members of residents who were not interviewable were contacted to identify any other allegations of abuse. c. All allegations will be investigated and reported per the facility policy. d. All team members will be educated on the Abuse and Neglect Prevention Standard prior to	F 225		

PRINTED: 07/28/2017
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	07/14/2017

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 225	Continued From page 7 returning work. e. All newly hired team members are trained on hire and prior to contact with residents. 8. The facility action plan was accepted on 7/12/17 at 4:35 PM, and the Immediate Jeopardy was removed on 7/12/17 at 7:32 PM. However, deficient practice remained at a scope and severity of F (widespread potential for harm that is not immediate jeopardy).	F 225		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, policy and procedure review, and review of the CMS RAI (resident assessment instrument) version 3.0 manual, the facility failed to complete a significant change MDS assessment for 1 of 3 sample residents (#19) who required a significant change assessment. The findings were: 1. Review of the 11/8/16 quarterly MDS assessment revealed resident #19 had ADL	F 274	**F274** Comprehensive Assess after Significant Change **Corrective action to resident(s):** A significant change MDS was done on resident #19 on 4/13/17. **How problem is identified for other residents and what corrective actions will be taken:** An audit of all current residents was completed by the interdisciplinary team On 8/4/17. Any residents identified as having met significant change criteria will be scheduled and have a significant change assessment completed. **Measures/systemic changes to prevent recurrence:** Residents who may need to be considered for significant change assessments will be discussed weekly at IDT Risk meetings. The MDS Coordinator or their designee is responsible for monitoring changes in resident condition that may warrant a significant change MDS. The facility's	8/16/17

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

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 _____	07/14/2017

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 274	Continued From page 8 needs which included limited assistance with toilet use and bathing, and was independent with dressing. Further, the resident had frequent urinary incontinence, and occasional bowel incontinence. Review of the 2/7/17 quarterly MDS assessment showed the resident had declined in status, and required extensive assistance with dressing, toilet use and bathing, was always incontinent of urine, and had frequent bowel incontinence. 2. Interview with the MDS coordinator on 7/14/17 at 8:25 AM confirmed that a significant change assessment should have been completed due to the changes reflected in the 2/7/17 quarterly MDS assessment in the noted ADL areas as well as the change in bowel and bladder incontinence. 3. Review of the facility policy titled "MDS 3.0 Completion", dated 8/5/15, stated "A significant change is defined, according to the RAI Manual, MDS, as a decline or improvement in a resident's status that: 1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not self-limiting (for declines only); 2) impacts more than one area of the resident's health status; and 3) requires interdisciplinary review and/or revision of the care plan." 4. Review of the "CMS RAI version 3.0 manual, October 2016," showed "...04. Significant change in status assessment (SCSA) (A0310A=04)... other conditions may not be permanent but would have such an impact on the resident's overall status for more than two weeks that they would require a comprehensive assessment and care plan revision. For example, a hip fracture may be viewed as a transient condition but it would	F 274	new electronic medical records system, Point Click Care, (implemented 5/1/17) has a built-in tool to notify MDS Coordinators that a significant change has occurred when an MDS is being completed. Education provided to the Interdisciplinary Team on significant change criteria by MDS Coordinator. **Monitor permanent solution:** Residents who are showing decline or improvement in one or more areas of their health status will be discussed every week during Risk Meetings. If residents meet criteria for a significant change, this will be completed under direction of the MDS Coordinator or their designee. This will be monitored/reviewed by Director of Nursing or designee at the monthly Quality Assurance meetings for 3 months or until such time as substantial compliance has been met. An audit of 5 residents will be completed by the DON or their designee weekly for four weeks, monthly for three months, or until substantial compliance has been achieved	

PRINTED: 07/28/2017
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	160 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 274	Continued From page 9 generally have a major impact on the resident's functional status in more than one area (e.g., ambulation, toileting, elimination patterns, activity patterns)..." Continued review showed "...Decline in two or more of the following...any decline in an ADL (activities of daily living) physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment." Further, the RAI stated a significant change assessment is appropriate when " ...There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments..."	F 274		
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS (b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the CMS RAI Manual, the facility failed to complete a comprehensive assessment within 366 days after the most recent comprehensive assessment for 1 of 9 sample residents (#19) who required an annual assessment. The findings were:	F 275	**F275** Comprehensive Assess at least every 12 months **Corrective action to resident(s):** A quarterly assessment was completed on 2/7/17, but it should have been an annual assessment. When the error was discovered, an annual MDS was completed on resident #19 on 3/22/17. **How problem is identified for other residents and what corrective actions will be taken:** The MDS Coordinator completed an audit of all current residents on 8/2/17 to determine that they have had an annual assessment within 366 days of their previous annual assessment. **Measures/systemic changes to prevent recurrence:** MDS Coordinators will work together to schedule and verify dates and assessment types. A copy of the ARD calendar will be given to the Administrator and DON monthly, outlining which assessments (quarterly and annual) are due that month. A list of the last assessments that were	8/16/17

PRINTED: 07/28/2017
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	07/14/2017

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 275	Continued From page 10 1. Review of the MDS schedule showed resident #19 had an annual comprehensive MDS assessment with an assessment reference date (ARD) of 3/21/17. Further review showed the resident's prior comprehensive assessment had an ARD of 2/9/16, a difference of 406 days. 2. Interview with the MDS Coordinator on 7/14/17 at 8:25 AM confirmed there had not been a comprehensive assessment completed within 366 days of the prior comprehensive assessment with the ARD of 2/9/16. 3. Review of the "CMS RAI version 3.0 manual, October 2016," Chapter 2 revealed "...The ARD of an assessment drives the due date of the next assessment. The next comprehensive assessment is due within 366 days after the ARD of the most recent comprehensive assessment..."	F 275	completed on all residents in the previous electronic MDS record system will be made available to the MDS Coordinators to use to verify last annual assessment dates. MDS Coordinators are aware of the requirements for an annual MDS on every resident. **Monitor permanent solution:** Routine audits will be completed by the Director of Nursing or their designee to audit assessment type and date. These audits will be completed on 5 residents weekly for four weeks, monthly for three months, then quarterly and as needed. Audit records will be reviewed by the QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights	F 279	**F279** Develop Comprehensive Care Plans **Corrective action to resident(s):** The care plan for resident #22 was reviewed by the interdisciplinary team and updated as indicated. The care plan for resident #8 was reviewed by the interdisciplinary team and updated as indicated. **How problem is identified for other residents and what corrective actions will be taken:** An audit was completed by the IDT on 8/3/17 to ensure that all residents who have incontinence, significant weight loss or potential for weight loss have current care plans and interventions.	8/16/17

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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 11 set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (I) 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 §483.24, §483.25 or §483.40; and (II) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (III) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 279	**Measures/systemic changes to prevent recurrence:** Residents who have had any changes are reviewed during our weekly risk meeting and care plans are reviewed by the interdisciplinary team to ensure that they are current. Additionally, resident care plans are updated with acute changes as they occur. Education has been provided to the IDT team expectation of maintaining current care plans. **Monitor permanent solution:** Weekly audits will be completed by the Director of Nursing or their designee to ensure that care plans for incontinence and weight loss are current. These audits will be completed on 5 residents weekly for four weeks, monthly for three months, then quarterly and as needed. Audit records will be reviewed by the QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee.	

PRINTED: 07/28/2017
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	07/14/2017

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 12 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to develop comprehensive and individualized care plans for 2 of 12 sample residents (#8, #22). The findings were: 1. Review of the 5/20/17 admission MDS assessment showed resident #22 had diagnoses which included diabetes mellitus, constipation, hyperlipidemia, and cognitive communication deficit. The resident's BIMS score was 3 (severely impaired). The resident required limited assistance of 1 person for eating, and had a weight of 137 pounds. The following concerns were identified: a. Review of a "Nutrition/Dietary" note dated 5/16/17 and timed 9:29 AM showed the resident's diet was regular and the registered dietician (RD) recommended a change to limited concentrated sweets (LCS) related to the diabetes diagnosis, and a multi-vitamin every day related to varied oral intake. Further, the documented weight at that time was 135 pounds. b. Review of a "Nutrition/Dietary" note dated 6/7/17 and timed 1:33 PM showed "IDT [interdisciplinary team] review of weight. Resident continues to have poor po [by mouth] intake. Resident may have acute illness. New order for UA obtained. Taking supplements. Will continue to observe weekly." c. Review of a "Nutrition/Dietary" note dated 6/21/17 and timed 1:52 PM showed "IDT review of continued weight loss. Resident continues to	F 279		

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

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 _____	07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	160 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 13 eat very small bites if at all. Resident is currently on a liquid diet until a [sic] esophegram is done. Weights will be updated as available. Continue weekly monitoring and progress from esophagram." d. Review of a "Nutrition/Dietary" note dated 6/28/17 and timed 4:20 PM showed "Weight review: Current weight is 100.5# [pounds] (6/26/17), 14.5% weight decline past 30 days, 25% weight decrease past 180 days. Current diet is LCS diet with Breeze supplement at meals. Overall decline reported...[resident name] is cued and limited assist at this time in the main dining room for meals...RD recommends change diet, offer meal fortification, offer chocolate healthshake at meals, Offer 60cc twocal [supplement] TID [three times per day]..." e. Review of a "Nutrition/Dietary" note dated 7/6/17 and timed 2:52 PM showed "60 Day Nutrition Review: Current weight is 99# (7/5/17)...15.7% weight decrease past 30 days, 26.8% weight decline past 180 days. Significant weight decline past 30-180 days. Current diet is Thin Liquids due to possible stricture. Resident is diabetic but not currently on diabetic diet while on thin liquid diet...Resident is assisted at meals in main dining room or in [his/her] room...No new nutritional recommendations at this time." f. Review of "Weights and Vitals Summary" showed a 5/17/17 weight of 137 pounds, a 5/21/17 weight of 124.5 pounds (10% weight loss), a 5/28/17 weight of 117.5 pounds (17% weight loss), a 6/11/17 weight of 106 pounds (29.2% weight loss), a 6/21/17 weight of 100 pounds (37% weight loss), and a 7/9/17 weight of 98 pounds (39.7% weight loss). g. Review of the care plan showed no evidence a nutritional care plan was developed or implemented.	F 279		

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

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 _____	07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	160 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 14 h. Interview with the DON and dietary manager on 7/13/17 at 5:05 PM confirmed the resident's nutrition care plan was not developed. Further, it was revealed a care plan should have been developed related to the resident's identified weight loss and need for interventions. 2. Review of the admission MDS assessment with an ARD of 5/22/17 showed resident #8 had triggered care areas which included falls, depression, urinary tract infection and incontinence of bowel and bladder. The resident was assessed as having problems with both short and long term memory. The assessment further showed the resident required extensive assistance with transfers, dressing, toilet use and personal hygiene, and s/he was charted as always incontinent of both bowel and bladder. The following concerns were identified: a. Review of the "Initial/Interdisciplinary Care Plan" dated 5/15/17 showed in the area of bowel/bladder continence, the resident was marked as incontinent of both bowel and bladder. There were check boxes for interventions which included toileting plan, bladder retraining, catheter, pads/briefs and ostomy, however, none of the interventions were checked. b. Review of the Care Area Assessment (CAA) worksheet, dated 5/27/17 showed: "Resident is currently always incontinent of bladder, Requires 1-2 person assist for her task of toileting." The contributing factors checked for the resident's incontinence included psychological or psychiatric problems, urinary tract infection, urinary urgency and need for assistance in toileting, Parkinson's disease, depression, and use of antidepressants. The CAA care plan considerations stated the overall objective for the care plan would be improvement, slow or	F 279		

PRINTED: 07/28/2017
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	160 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 15 minimize decline, avoid complications, and minimize risks. Further, the CAA noted "Requires 1-2 person assist for task of toileting. Receiving OT, PT and ST [occupational therapy, physical therapy, speech therapy] services currently. Decrease the number of bladder incontinent episodes. Decrease the amount of assistance for [his/her] task of toileting and promote independence as able." c. Review of the resident's care plan, initiated 5/27/17 and last updated 7/13/17, listed incontinence only as problem related to falls. Interventions to prevent falls included "Anticipate and meet resident's needs PRN [as needed]" and "Resident will be evaluated for bowel and bladder program." The care plan did not provide details on the assistance the resident needed for toileting, or interventions to decrease the number of bladder incontinent episodes as described in the CAA.	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the	F 280	**F280** Right to Participate in Planning Care **Corrective action to resident(s):** A three-day Hourly Elimination Diary is being completed on resident #8. **How problem is identified for other residents and what corrective actions will be taken:** An audit was completed on 8/2/17 to ensure that all residents have had a three-day Hourly Elimination Diary completed. If it was determined that a resident does not have a current three-day Hourly Elimination Diary, or it has not been completed correctly, a new three-day diary has now been initiated.	8/16/17

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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 280	Continued From page 16 plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 280	**Measures/systemic changes to prevent recurrence:** The ADON/Restorative nurse will be responsible for initiating and ensuring completion of the three-day elimination diary per the facility's operating standard. Nursing staff will be reeducated on completion of the three-day Hourly Elimination Diary. The ADON or their designee will be responsible for review and evaluation of the elimination diary and the bowel and bladder assessments to determine individualized care planning. **Monitor permanent solution:** Weekly audits will be completed by the DON or their designee on the completion of three- day elimination diaries. These audits will be completed on five residents weekly for four weeks, monthly for three months, then quarterly and as needed. Audit records will be reviewed by the QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 280	Continued From page 17 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of facility policy and procedure, the facility failed to follow care plan interventions for 1 of 8 sample residents (#8) with developed care plans. The findings were: 1. Review of the admission MDS assessment with an ARD of 5/22/17 showed resident #8 had triggered care areas which included falls, depression, urinary tract infection and incontinence of bowel and bladder. The resident was assessed as having problems with both short and long term memory. The assessment further showed the resident required extensive assistance with transfers, dressing, toilet use and	F 280		

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

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 _____	07/14/2017

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 280	Continued From page 18 personal hygiene, and s/he was charted as always incontinent of both bowel and bladder. The following concerns were identified: a. Review of the care plan created on 6/16/17 showed an intervention "Resident will be evaluated for bowel and bladder program." This intervention was dated 6/27/17. b. Review of the resident's medical record showed an "hourly elimination diary" had been filled out on 7/1/17 and 7/2/17. The directions on the form stated "Keep a Daily Bladder Diary for a minimum of three (3) days to establish an incontinent resident's voiding and elimination pattern. Check the resident every hour and complete this chart...Every effort should be made to record elimination information every hour x [times] 72 hours to determine if there is a pattern." 2. Interview on 7/14/17 at 10:18 AM with the DON revealed the ADON was responsible for the facility's bowel and bladder program, but the ADON was no longer employed with the facility. She stated after looking at the ADON's records that "some projects were not finished." She was unable to provide evidence that a full evaluation had been completed on the resident as care planned on 6/27/17, and further was unable to provide evidence a bowel and bladder evaluation was performed on admission. 3. Review of the facility policy titled "Bowel and Bladder Management Standard" showed the following: a. "A resident who has a catheter or is incontinent of bladder (either on admission or during their stay) will be identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal urinary	F 280		

PRINTED: 07/28/2017
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	160 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 280	Continued From page 19 function as possible, this includes the prevention of urinary tract infections...." b. "Residents with fecal incontinence must receive the appropriate treatment and services to restore as much normal bowel function as possible." c. "Assessment Tools: Hourly Elimination Diary - started 3 days after admission and to be completed by day 7 of resident stay Bowel Assessment - Done on admission, quarterly, annually, and with significant change... This assessment is complete after 3 days of Hourly Admission Diary is completed by not later than day 8 of admission. Bladder Assessment - Done on admission, quarterly, annually, and with significant change...This assessment is complete after 3 days of Hourly Admission Diary is completed by not later than day 8 of admission. Incontinence Summary Guide - A tool to assist in formulating comprehensive summary to assist in formulation of Bowel and Bladder Program."	F 280		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 315	**F315** No Catheter, Prevent UTI, Restore Bladder **Corrective action to resident(s):** Resident #43's physician was faxed on 7/14/17 by the DON requesting orders for use of urinary catheter. When it was not returned promptly, the DON re-faxed the MD on 7/17/17 requesting orders for catheter. The physician responded on 7/19/17 that the resident could have the catheter	8/16/17

PRINTED: 07/28/2017
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	160 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 315	Continued From page 20 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review the facility failed to ensure residents admitted with indwelling catheters were assessed for removal of the catheter for urinary catheters 1 of 1 sample resident (#43) with indwelling catheters. The findings were: 1. Review of the medical record for resident #43 showed s/he was admitted on 7/3/17 with diagnoses that included a peri-rectal abscess. Observation on 7/11/17 at 8:35 AM showed the resident had a Foley catheter. Interview with the	F 315	discontinued unless there was a contraindication. Per progress note by charge nurse on 7/19/17, "Received return fax with order to remove catheter unless contraindication. Resident has peri-gluteal abscess and states understanding that catheter is in place to facilitate wound healing." Resident's catheter was removed on 7/27/17 after wound VAC therapy was discontinued. Resident discharged to home on 7/28/17. Diagnosis for use of catheter on this resident was rectal abscess (requiring wound VAC therapy). **How problem is identified for other residents and what corrective actions will be taken:** An audit will be completed by the Staff Development Coordinator/Infection Control Nurse or their designee to ensure all residents in the facility with catheters have orders for use with appropriate diagnosis. If orders are not present for catheters, these will be obtained by the physician. **Measures/systemic changes to prevent recurrence:** Licensed nurses will be educated by the DON and SDC/ICN on the necessity of obtaining orders and diagnoses on	

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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 APPRORRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 21 resident at that time revealed s/he had the catheter placed while in the hospital related to his/her wound. 2. Review of the admission orders dated 7/3/17 showed no evidence of a physician's order for the Foley catheter. Review of the post-operative note dated 6/19/17 showed the Foley catheter was placed intra-operatively. 3. Interview with the DON on 7/13/17 at 5:30 PM confirmed the resident did not have an order for the Foley catheter and a physician's order was required.	F 315	residents with catheters. Education will be provided on the bowel and bladder standard to licensed nurse and order verification within PCC. The SDC/ICN will identify at the weekly Risk meeting residents with catheters, ensure orders and diagnosis are obtained and assessment/care planning have been completed. **Monitor permanent solution:** Routine audits will be completed by the ADON or their designee on all residents with catheters, to ensure that orders for use are in place. These audits will be completed weekly for four weeks, monthly for three months, then quarterly and as needed. Audit records will be reviewed by the QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee.	
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323	**F323** Free of Accident Hazards/Supervision/Devices **Corrective action to resident(s):** The art supplies from resident #24's desk were removed and placed in a locked office. They are now stored in the resident's room in a storage box. Resident # 19 was assessed by a	8/16/17

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

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 _____	07/14/2017

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 22 Informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure items that could cause injury were secured or attended in 1 of 2 resident hallways (100 hall). Further, the facility failed to assess 1 of 5 sample residents (#19) for safety with enabler bar use. The findings were: 1. Observation on 7/12/17 at 1:13 PM showed art supplies were located in the hallway outside the rooms of residents #9 and #12. The art supplies included scissors, markers, watercolor paints, a pencil sharpener, glue, and some other items. At the time of the observation, no one was present with the art supplies, and the supplies were not safely secured. 2. Review of the 5/9/17 admission MDS assessment showed resident #9 had BIMS score of 4 (severely impaired), had a depression score of 2, and had exhibited no behaviors at the time of the assessment. The following concerns were identified: a. Review of a progress note dated 6/2/17 and timed 4:46 AM showed "Resident having a hard time adjusting to roommate. Feels the room is [his/hers]. Resident found sitting on roommate by CNA prior to 2200 [10 PM]. Resident had to be coaxed back to [his/her] side of the room. No further incidents this shift." b. Review of a progress note date 6/2/17 and timed 11:06 PM showed the resident was "very agitated" and wanted to "break a window or	F 323	nurse using a pre-restraining evaluation and the enabler bar was removed by maintenance department. **How problem is identified for other residents and what corrective actions will be taken:** The leadership team did room searches and removed nail clippers, scissors, nail files from resident rooms. These items were also kept in the med room, in bags with resident identification written on them. They are available to be checked out by the nurse when needed, and are to be returned to the nurse when they are done being used, to be locked in the med room. An audit was completed on 7/28/17 by Social Services to identify all residents who currently have enabler bars. Per IDT review, residents who have enabler bars that do not need them for bed mobility or assistance with transfers had these bars removed by the maintenance department. All residents with current enabler bars will be checked to make sure that a pre-restraining evaluation is completed, measurements have been documented, care plans state that enabler bars are in place, and a therapy screen has been requested for use of enabler bars. These will be reviewed quarterly as part of each resident's MDS assessment process.	

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

PRINTED: 07/28/2017
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 _____	07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	180 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 23 something so I can get out of here and go home." c. Review of a progress note dated 6/18/17 and timed 7:36 AM showed the resident became "very agitated" at approximately 11 PM because another resident was in his/her bathroom. Resident #9 called the other resident an inappropriate name and slammed the door. The resident continued to escalate as evidenced by "speaking loudly that nobody else should be in [his/her] bathroom and verbalizing anger/frustration." Further, the note indicated the facility implemented a "plan for safety" which included moving the resident into a private room with a "non-shared restroom." 3. Review of the 6/21/17 admission MDS assessment showed resident #12 was usually understood and understands, had a BIMS score of 3 (severely impaired), had a depression score of 3, and had exhibited no behaviors. 4. Observation on 7/12/17 at 2:03 PM showed the art supplies continued to be unsecured and 4 staff members were in the hall near them. The staff members left the area where the supplies were located and did not secure them. 5. Observation on 7/12/17 at 2:18 PM showed an unidentified staff member assisted resident #12 into his/her room. The art supplies remained unattended and unsecured. 6. Observation on 7/12/17 at 3:03 PM showed resident #12 left his or her room and stopped at the desk where the art supplies were located. The resident handled items on the desk, shuffled papers, laid them down again, and then returned to his/her room.	F 323	**Measures/systemic changes to prevent recurrence:** Residents who wish to have a scissors and who have the cognitive ability to be safe, they will be provided a bandage or safety scissors. Any other resident need for scissors will be handled with assistance from facility staff. On admission, residents and families will be informed about not bringing scissors or other potentially unsafe items into the building. Staff will be educated on the expectation that they are aware of potentially unsafe items and that they secure and report these items to their supervisor. Upon discharge from the facility, enabler bars will be removed from resident beds by maintenance. The IDT has developed a checklist to be used to verify rooms have been cleaned, equipment has been removed, and that if enabler bars were present, they have been removed. This checklist will be given to maintenance and housekeeping by social services when residents discharge. If an enabler bar needs to	

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 _____	07/14/2017

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 24 7. Observation on 7/12/17 at 3:10 PM showed resident #12 left his/her room and grabbed a box of facial tissues off the desk where the art supplies were located and threw the box on the floor. An unidentified staff member approached the resident and assisted him/her back into the room. The art supplies remained on the desk unattended and unsecured. 8. Observation on 7/12/17 at 3:14 PM showed resident #12 left his/her room and was standing by the desk with the art supplies. An unidentified CNA approached the resident and then convinced him/her to return to his/her room. 9. Observation on 7/12/17 at 3:26 PM showed resident #12 wandered down the hall and stopped at the desk where the supplies were located. Two unidentified staff members approached the resident and communicated with him/her and then both staff members walked away from the resident. At that time, the resident went back to desk and stood near it. An unidentified staff member returned to the resident and assisted him/her back into his/her room. 10. Observation on 7/12/17 at 3:41 PM showed resident #12 left his/her room and went to the desk where the art supplies were located. The resident handled papers and items on the desk, then set the items down again. At no time during observation did resident #12 handle the scissors even though they remained accessible. 11. Observation on 7/12/17 at 3:43 PM showed resident #12 attempted to leave the facility through the exit door near the desk. Staff approached the resident and assisted him/her back to his/her room.	F 323	be initiated on a resident, when maintenance applies the bar, measurements will be taken by maintenance and provided to MDS, who will complete a Pre-Restraining Evaluation and list the enabler bar measurements. The MDS Coordinators will review the pre-restraining evaluation quarterly, determine if enabler bar(s) are still appropriate to be used, ensure that measurements of the bar is documented, and send a therapy screen for evaluation of enabler bar use. **Monitor permanent solution:** The Director of Nursing or their designee will complete weekly audits of five resident rooms for scissors and other potentially hazardous items and enabler bar use on residents. These audits will be completed weekly for four weeks, and monthly for three months. Audit records will be reviewed by the QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 25 12. Observation on 7/12/17 at 4:57 PM showed the art supplies remained on the desk unattended and unsecured. 13. Interview with the administrator on 7/12/17 at 6:58 PM confirmed that scissors would be a safety risk for residents with cognitive impairment. Further, it was revealed that the facility did not allow residents to keep scissors or any other item that could present a risk to health and safety of the residents. In regards to enabler bars: Review of a quarterly MDS assessment dated 2/7/17 showed resident #19 had a BIMS score of 8 (moderately impaired) and had diagnoses which included unspecified lack of coordination and non Alzheimer's dementia. Observation on 7/10/17 at 4:59 PM showed the resident was not in bed. The bed had an enabler device in place on the outside of the bed and the other side of the bed was against the wall. The device was designed to have 5 gaps between the bars which were large enough for the resident to place his/her limb through. The gaps measured 3 1/2 inches by 4 inches, 4 1/2 inches by 6 1/2 inches, and 2 inches by 6 inches. Review of the resident's medical record showed no evidence that a safety assessment was completed. Interview with the administrator on 7/14/17 at 1:34 PM revealed an assessment for safety of the device had not been completed.	F 323		
F 325 SS=G	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration.	F 325	**F325** Maintain Nutrition Status Unless Avoidable SS= G	8/16/17

PRINTED: 07/28/2017
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	07/14/2017

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 325	Continued From page 26 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on medical record review, and family and staff interview, the facility failed to identify and implement nutritional interventions to prevent weight loss for 1 of 3 sample residents (#22) with significant weight loss. This failure resulted in a 24% weight loss in 29 days for resident #22. The findings were: 1. Review of the 5/20/17 admission MDS assessment showed resident #22 had diagnoses which included diabetes mellitus, constipation, hyperlipidemia, and cognitive communication deficit. The resident's BIMS score was 3 (severely impaired), and s/he required limited assistance of 1 person for eating. The resident had a weight of 137 pounds. Review of "Weights and Vitals Summary" showed a 5/14/17 weight of 136.2 pounds. The following concerns were identified: a. Review of the care plan showed no evidence a nutritional care plan was developed or	F 325	**Corrective action to resident(s):** Resident #22's nutrition care plan was corrected to include current interventions, dietary preferences, and diagnostic test completed 7/27/17. Records were obtained from assisted living center where resident lived prior to admission and from the local hospital to see what resident's baseline weight was before admission. The attending Physician was notified that the resident's baseline weight prior to admission was 118-120 pounds. This was recorded in IDT progress notes as well. Resident's weight has steadily increased and resident is now #105 as of 8/2/17. **How problem is identified for other residents and what corrective actions will be taken:** An audit has been completed on all residents who have significant weight loss or are at risk for weight loss, to make sure that they have current care plans and interventions, that physicians and the dietician have been notified, and that the IDT has discussed nutritional interventions.	

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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 325	Continued From page 27 implemented. b. Review of a nursing note dated 6/15/17 and timed 1:56 AM showed "...Remained in room this evening for dinner by request due to being tired from the move. Able to take medications whole without difficulty..." c. Review of a "Nutrition/Dietary" note dated 5/16/17 and timed 9:29 AM showed the resident's diet was "regular" and the registered dietician (RD) recommended a change to limited concentrated sweets (LCS) related to the diabetes diagnosis and a multi-vitamin every day related to varied oral intake. Further, the documented weight at that time was 135 pounds. d. Review of "Weights and Vitals Summary" showed a 5/17/17 weight of 137 pounds and a 5/21/17 weight of 124.5 pounds (12.5 pounds or 9.1% weight loss in 4 days). e. Interview with the registered dietician on 7/14/17 at 11:26 AM revealed she did not believe she was notified of a significant weight loss in the week after the resident was admitted. Further, she stated she would have been concerned about a 12.5 pound weight loss in 4 days. f. Review of "Weights and Vitals Summary" showed a 5/24/17 weight of 121 pounds, a 5/28/17 weight of 117.5 pounds, and a 5/31/17 weight of 116 pounds (21 pounds or 15.3% weight loss in 14 days). There was no evidence the facility implemented interventions to prevent further weight loss. g. Review of the nursing note dated 6/2/17 and timed 6:23 PM showed "...Family also wanted to know how much resident had been eating; this RN reported that intake had been between 25-75 percent for most meals, though [s/he] occasionally refuse [sic] a meal." h. Review of a "Nutrition/Dietary" note dated 6/7/17 and timed 1:33 PM showed "IDT	F 325	**Measures/systemic changes to prevent recurrence:** Residents with significant weight loss or at risk for significant weight loss are reviewed weekly by the IDT during Risk meetings. The IDT determines new nutritional interventions and updates the resident's plan of care at this time. Significant weight loss will be communicated to the resident, family, and physician, as well as the facility's consultant dietician. The dietician will document recommendations for interventions for individual residents. Education will be provided to the IDT and nurses on expectations of interventions related to significant weight loss. **Monitor permanent solution:** Routine audits of five random residents will be completed by the Director of Nursing or their designee to ensure that residents who have weight loss have current care plans, dietician reviews, and nutritional interventions have been implemented. These audits will be completed weekly for four weeks, monthly for three months, then quarterly and as needed. Audit records will be reviewed by the QAPI committee until such time consistent substantial	

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

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 _____	07/14/2017

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 325	Continued From page 28 [interdisciplinary team] review of weight. Resident continues to have poor po [by mouth] intake. Resident may have acute illness. New order for UA obtained. taking supplements. Will continue to observe weekly." I. Review of the June 2017 MAR showed the resident was ordered a multi-vitamin on 5/18/17; however, a caloric supplement was not ordered until the resident received an order for "Boost Breeze" on 6/16/17. J. Review of "Weights and Vitals Summary" showed a 6/7/17 weight of 117.5 pounds, a 6/11/17 weight of 106 pounds (11.5 pound or 9.7% weight loss from previous weight 4 days prior), and 6/14/17 weight of 104 pounds (33 pound or 24% weight loss in 29 days). k. Review of a nursing note dated 6/16/17 and timed 10:53 AM showed "...Spoke with ST [speech therapist] r/t [related to] resident having possible stricture, will fax MD again for response/orders." l. Interview with the DON and dietary manager on 7/13/17 at 5:05 PM confirmed the resident's nutrition care plan was not developed. It was revealed a care plan should have been developed related to the resident's identified weight loss and need for interventions. The DON further revealed the resident had nausea, vomiting, and other acute illness they believed to contribute to the weight loss. m. Review of the medication administration record for May 2017 showed the resident received an order for Zofran (an anti-nausea medication) 4 milligrams by mouth every 8 hours as needed on 5/22/17 for nausea and vomiting. n. Review of the medication administration record for May 2017 and June 2017 showed the resident only received Zofran on 7 out of the 25 days between 5/22/17 and 6/16/17.	F 325	compliance has been achieved as determined by the committee.	

PRINTED: 07/28/2017
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536034	A. BUILDING _____ B. WING _____	07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	160 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 325	Continued From page 29 c. Interview with the resident's family members on 7/13/17 at 8:20 PM revealed the family felt the resident's stay wasn't going well because the resident continued to decline. The family stated the resident did not have issues with eating prior to admitting to the facility. The family revealed the resident never ate "healthy," has always eaten small portions, and ate better when s/he was offered sweets. Further, the family felt pressured to have the esophagram performed; however, they felt the resident would not want the procedure completed and they declined to have it performed.	F 325		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329	**F329** Drug Regimen is Free From Unnecessary Drugs **Corrective action to resident(s):** A request for gradual dose reduction has been faxed to resident's new primary physician (resident's prior primary physician moved in July of 2017). The primary physician did not want a gradual dose reduction on resident's trazodone, and provided rationale for its use. In the future, gradual dose reductions will be requested from the resident's neurologist.	8/16/17

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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 30 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic 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 medical record review and staff interview, the facility failed to ensure medications were used at lowest effective dose and appropriately for 1 of 10 sampled residents (#16) with psychotropic medications. The findings were: 1. Review of the medical record for resident #16 showed the resident was admitted on 12/13/16 with diagnoses that included insomnia. Review of the Medication Administration Record (MAR) showed an order for Trazodone 50 milligram (mg), give 1-3 tablets by mouth as needed for insomnia. Review of the physician office note dated 7/12/16 showed resident had chronic insomnia and "will try a higher dose of Trazodone to see it this helps with her neuropathic symptoms." Further review of the physician office note showed resident took Trazodone 50 (mg) 2-3 tablets by mouth at bedtime. Review of the physician office note dated 09/27/16 revealed the resident had chronic insomnia and Trazodone helped. Further review of physician office note	F 329	**Measures/systemic changes to prevent recurrence:** After the IDT Psychotropics Review committee has determined that a gradual dose reduction needs to be requested from a physician, a request for gradual dose reduction will be signed by the IDT and sent to the resident's physician. This fax will then be kept in the Psychotropics binder until the next weekly IDT meeting, when the resident's records will be checked to see if the fax has been returned from the physician, signed, with either orders to decrease the dose of the medication or rationale as to why dose reduction was not ordered. If the physician has been faxed twice and an answer has not been received, the DON will contact the physician	

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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 31 showed the resident was on Trazodone 50 mg 2-3 tablets by mouth at bedtime. Review of admission documentation to facility failed to show evidence of physician documentation of rationale for taking Trazodone. 2. Review of the 4/6/17 "Request for Psychopharmicological Medication Change" showed the resident was receiving Trazadone 50mg 1-2 tabs every bedtime. The form was signed by the physician, but made no recommendation to reduce the dosage and did not provide a rationale for continuing the listed dosage. 3. Review of the "Antidepressant Medication Review" form dated 6/19/17 showed a gradual dose reduction as having been attempted on 4/6/17. However, review of the MARs for April, May and June 2017 showed no change in the Trazadone dosage. Review of the GDR dated 6/29/17 showed the physician signed the form but the section for the physician documentation was left blank. 4. Review of the 6/29/17 "Request for Psychopharmacological Medication Change" showed the resident was receiving Trazadone but did not indicate a dosage and did not recommend a dose reduction. 5. Interview with the consultant pharmacist on 7/14/17 at 8:30 AM revealed when a resident is on a home medication and is admitted to the facility it is difficult to get the dosage changed and he was not comfortable with the resident's current Trazodone dose. Further, it was revealed the resident's Trazodone dosage was "normally not what I would recommend. I would recommend a	F 329	and request a telephone order for gradual dose reduction or rationale as to why it is not ordered. **Monitor permanent solution:** Routine audits will be completed by the Director of Nursing or their designee on 5 random residents to evaluate if GDRs are being returned from physicians with rationale or requests for dose reduction. These audits will be completed weekly for four weeks, monthly for three months, then quarterly and as needed. Audit records will be reviewed by the QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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

PRINTED: 07/28/2017
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
	536034	A. BUILDING _____ B. WING _____	07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	160 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 32 low dose, which would be 12.5 mg - 25 mg."	F 329		
F 367 SS=D	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure an appropriate therapeutic diet was served per physician orders for 1 of 12 sample residents (#10) during meal time. The findings were: Review of the "At risk for potential impaired nutritional status" care plan last revised on 5/22/17 showed resident #10 had interventions which included "Offer finger foods, soup in mugs and hot cereal in mugs for better meal consumption." Review of the medication administration record for July 2017 showed the diet order for resident #10 was "Regular diet Mechanical soft texture, Regular Liquids consistency, Extra egg at breakfast." The following concerns were identified: a. Observation on 7/12/17 beginning at 5:36 PM showed the cook preparing meal trays to be served to residents during the dinner meal time. At the serving window was a pile of laminated diet cards printed with each resident's name, food	F 367	**F367** Therapeutic Diet Prescribed by Physician **Corrective action to resident(s):** The team member who served resident #10 a diet that was not the appropriate texture was re-educated on therapeutic diets and double-checking resident diet orders. The team member who prepared the incorrect diet texture for the resident was re-educated on preparing therapeutic diets and following resident diet orders. Resident #10 is served the correct diet as ordered by the attending physician. **How problem is identified for other residents and what corrective actions will be taken:** All residents who have mechanically altered diets have been identified. Residents are served the correct diet per their physician's order. The dietary manager will do random audits during mealtimes to see that residents are all being served their diets as ordered, in the appropriate texture. Any problems with diets will be corrected immediately and education will be given 1:1 to team members. **Measures/systemic changes to prevent recurrence:** An in-service will be provided to dietary team members on the preparation and	8/16/17

PRINTED: 07/28/2017
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	160 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 367	Continued From page 33 preferences, allergies, and dietary orders. Review of the diet card for resident #10 showed s/he had a mechanical soft diet ordered; however; the cook placed a regular serving of prime rib, mashed potatoes, gravy, a vegetable medley and a roll on the tray. The cook then placed the diet card on the tray with the plate. When the tray was picked up by the dietary manager, the card was placed in a pile for meals that had already been served. The dietary manager delivered the tray to the resident, placed it on the table, and assisted the resident by cutting the meat with a fork and knife. The kitchen manager was asked to verify the identity of the resident and his/her diet order. She confirmed the identity of the resident, and upon checking the diet card, verified the resident was given an incorrect meal. The tray was removed from the table, and the correct diet ordered meal was provided to the resident.	F 367	serving of correct therapeutic diets for residents. Education was provided at the July all-team meeting on making sure that residents receive their correct diet texture. Education will again be provided at the August all-team meeting on the importance of following therapeutic diets. **Monitor permanent solution:** The dietary manager will do random audits on five residents in the dining room to ensure that residents with therapeutic diets are served the correct diet. These audits will be completed weekly for four weeks, monthly for three months, then quarterly and as needed. Audit records will be reviewed by the QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee.	
F 371 SS=D	483.60(l)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (l)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (l) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371	**F371** Food Procedure, Store/Prepare/Serve, Sanitary **Corrective action to resident(s):** Resident #1 did not have any adverse outcomes related to improper food handling. The team member who performed improper food handling was educated by the Dietary Manager on using proper hand hygiene and gloves when preparing food.	8/16/17

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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 371	Continued From page 34 (l)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (l)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and food code review, the facility failed to ensure food was appropriately handled to prevent contamination during 1 of 1 meal preparation (evening meal). The findings were. Observation on 7/12/17 at 5:13 PM showed cook #1 prepared meals to serve to residents. The cook opened the door to an unheated wall oven unit, obtained a piece of fried chicken with his bare hand, placed it on a plate, and put it into a microwave. Interview with the dietary manager on 7/12/17 at 5:40 PM revealed the expectation was for staff to wear gloves when directly handling ready-to-eat food items. Review of the Food Code, U.S. Public Health Service, FDA, 2013, section 3-301.11 Preventing Contamination from Hands showed: "(B) Except when washing fruits and vegetables as specified under...food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. (C) Food employees shall minimize bare hand and arm contact with exposed food that is not in a ready-to-eat form."	F 371	**How problem is identified for other residents and what corrective actions will be taken:** All residents who are served a meal from the kitchen have been identified. The dietary manager has completed a food preparation and dining service audit. The dietary manager will complete audits during mealtimes to see that all dietary team members are handling food correctly. Any problems with team members not handling food properly or wearing gloves will be immediately corrected and 1:1 education will be provided. **Measures/systemic changes to prevent recurrence:** All dietary team members were in-serviced on hand hygiene and glove use on 7/25/17. All team members were educated 7/20/17 on using gloves when handling residents' food. Education will be provided again at the August all-team meeting on hand hygiene and glove use in the dining room. **Monitor permanent solution:** The dietary manager or their designee will complete random audits on five residents in the dining room and kitchen to ensure that residents' food is handled properly. These audits will be completed weekly for four weeks, monthly for three months, then quarterly and as needed. Audit records will be reviewed by the QAPI	

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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements; (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 441	committee until such time consistent substantial compliance has been achieved as determined by the committee. **F441** Infection Control, prevent spread **Corrective action to the resident:** The team members that were identified as not using appropriate infection prevention procedures were educated on hand hygiene and nebulizer cleaning. The nebulizer mask for the affected resident was replaced. **How problem is identified for other residents and what corrective actions will be taken:** The Infection Control Nurse, or their designee will complete random audits of hand hygiene in the dining room, during wound care, and during personal care. They will also perform random audits of nebulizer use to ensure that masks are cleaned after nebulizer administration. If any problems are identified during these audits, the ICN will provide 1:1 education to team members on correct infection prevention procedures. Team members will be educated on hand hygiene and nebulizer cleaning.	8/16/17

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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 441	Continued From page 36 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy and procedure review, and review of professional standards, the facility failed to ensure adequate hand hygiene was performed during 1 of 3 observations of wound care (resident #43), 1 of 3 observations of personal hygiene (resident #10), and during 2 of 2 meal observations. Further, the facility failed to ensure infection prevention techniques were followed for 1 non-sample resident (#48) who received nebulizer treatments. The findings were:	F 441	**Measures/systemic changes to prevent recurrence:** Nursing and dietary team m embers have completed a competency check for handwashing. Any problems identified during the competencies will be handled with 1:1 re-education. All nurses will complete a clean dressing competency. Any problems identified during the competencies will be handled with 1:1 re-education. Team members were educated on 7/20/17 on proper handwashing technique. A hand hygiene online learning module has also been assigned to all team members on MyNetLearning (the facility's online learning center). A module on wound care was also assigned to all licensed nursing staff on MyNetLearning. Nurses will be educated at the August nurse meetings on infection prevention in the dining room, during wound and personal care, and cleaning of nebulizer masks. CNAs will be educated at the August department meeting on infection prevention and hand hygiene. Dietary	

PRINTED: 07/28/2017
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	160 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 441	Continued From page 37 1. Observation on 7/10/17 at 6:09 PM showed CNA #4 was assisting 2 residents to eat. The CNA used her right hand to assist both residents and did not perform hand hygiene between interactions with the residents. Further, the CNA touched the first resident on the arm, then turned and provided the second resident a bite of food with the same hand. At 6:11 PM CNA #4 handled a napkin the second resident had in his/her lap. The CNA then turned and gave the first resident a bite without performing hand hygiene. 2. Observation on 7/10/17 at 6:20 PM showed CNA #5 entered the dining room without performing hand hygiene. The CNA obtained a paper towel and got it wet in the sink. The CNA took the paper towel and placed it on the table of a resident, touched another resident on the shoulder then returned to the first resident and used the paper towel to wipe the resident's face and hands. 3. Observation on 7/12/17 at 12:10 PM showed staff were passing meal trays to residents and providing set up help. The staff did not perform hand hygiene between meal trays. 4. Observation on 7/12/17 at 12:21 PM showed the dietary manager assisted residents during lunch. She touched a resident's shoulder and hands while the resident was coughing. She then went to the kitchen service window, retrieved a plate of food and a fruit cup, and brought them to a 2nd resident. She touched the 2nd resident's napkin, then touched the resident. She then touched the handle of a coffee cup for a 3rd resident with her right hand while rubbing the 3rd resident's back with her left hand. Next she touched her own clothing while pulling up her	F 441	team members were educated on hand hygiene/glove use and cross contamination by the registered dietician on 7/25/17. Pocket-sized hand sanitizers have been purchased and given to all team members so that these can be carried for use at any time. Extra hand sanitizers are available at the nurse's station and in the nurse supply room. All nursing and dietary team members will complete hand hygiene competencies quarterly. All CNAs will complete peri care competencies quarterly. Nurses will complete wound care competencies twice a year and as needed. Education will be given to nurses twice a year and as needed on cleaning nebulizer masks after use. If problems are identified during rounding or during completion of competencies, 1:1 education will be completed and PRN in-services will be held.	

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

PRINTED: 07/28/2017
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 _____	07/14/2017

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 441	Continued From page 38 apron. She visited another table and rubbed a 4th resident's back. At the same table she wrapped her right arm around the resident's back and gave him/her a hug. She then went to the coffee machine in the dining room, grabbed the coffee pot handle with her right hand, poured a cup of coffee, and replaced the pot. All tasks were performed without completing hand hygiene. 5. Observation on 7/12/17 at 12:32 PM showed CNA #6 was assisting a resident to eat. The CNA touched the resident's feet and wheel chair foot rests then entered the kitchen area. The CNA returned with a clothing protector and a glass of juice for the resident. The CNA moved to another resident and assisted the second resident with fluids. No hand hygiene was performed. 6. Observation on 7/12/17 at 11:29 AM showed CNA #3 and CNA #7 assisted resident #10 to the bathroom. When the resident was finished, CNA #3 applied gloves and provided perineal care to the resident. The CNA then applied a clean brief and pulled up the resident's pants without removing the contaminated gloves. 7. Observation of wound care for resident #43 on 7/11/17 at 10:25 AM showed the following concerns: a. RN #4 entered the resident's room, did not perform hand hygiene, put on gloves, and touched the dressing located on the resident's peri-rectal area. b. The RN removed the gloves, pulled open the drawers of the nightstand, and looked for dressing supplies. c. The RN left the room without performing hand hygiene. d. The RN returned to the room with dressing	F 441	**Monitor permanent solution:** Audits will be completed by Director of Nursing or their designee on five residents concerning infection prevention during wound care, personal care, in the dining room, and after nebulizer administration. These audits will be completed weekly for four weeks, monthly for three months, then quarterly and as needed. Audit records will be reviewed by the QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee.	

PRINTED: 07/28/2017
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	07/14/2017

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 441	Continued From page 39 supplies and did not perform hand hygiene. e. The RN put gloves on, touched the area surrounding the resident's wound, cleansed the area around the dressing, opened the dressing supplies, and reinforced the dressing on the wound. f. Review of the facility's policy titled Lippincott Procedures-Hand Hygiene, revised May 12, 2017 revealed "...using an alcohol-based hand rub is appropriate for decontaminating the hands before putting gloves on, after contact with a patient, when moving from a contaminated body site to a clean body site, after contact with wound dressings, after removing gloves..." 8. Interview with the infection prevention nurse on 7/14/17 at 10:05 AM revealed hand hygiene was expected to be performed between each resident contact in the dining room and upon entering a resident's room. Further, she revealed it was expected that glove changes would be performed anytime a nurse leaves the area when a dressing change was being performed and after perineal care before the staff member touched clean items such as a brief or the resident's clothing. 9 Observation on 7/11/17 at 9:20 showed resident #48 received a nebulizer breathing treatment. Upon completion of the treatment, RN #3 placed the mask and chamber on the bedside table. The following concerns were identified: a. Interview with the DON on 7/14/17 at 1 PM revealed the nebulizer masks and medicine chambers were not cleaned between uses. The DON stated, "When the nebulizer treatment is finished the nurse puts the mask and medicine chamber in either a baggy or pink basin. The mask and medicine chamber are changed weekly and the tubing is changed monthly. The domestic	F 441		

PRINTED: 07/28/2017
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	07/14/2017

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 441	Continued From page 40 aides have a log." b. Review of the PDR 2013 Edition Nurse's Drug Handbook showed nebulizers should be cleaned after use. c. Review of the National Asthma Education and Prevention Program patient education dated March 2013 showed, "after each treatment wash the medicine cup and mouthpiece or mask with warm water and mild soap. Rinse well and shake off excess water. Air dry parts on a paper towel..."	F 441		