PRINTED: 08/10/2017
FORM APPROVED
OMB NO. 0938-0391

...TMENT 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
	535039	A. BUILDING _____ B. WING _____	C 07/27/2017

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

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 7/24/17 through 7/27/17 at Westview Healthcare Center located in Sheridan, WY. Also reviewed in the course of the survey were complaint intakes WY00002373 and WY00002415. The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual	
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, certifications, and complaint investigations made respecting the facility during the 3 preceding	F 167	F167 1. The survey book was updated with a statement reading "survey results are available for three years upon request" 2. Executive Director will audit the survey book monthly for three months to ensure statement is attached and visible to the public. 3. Resident council will be educated regarding the availability of the survey results. A posting will be placed at reception desk to notify families, residents, and visitors of the availability of survey results.	

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

Executive Director — 9-6-17

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.

SEP 06 2017
Healthcare Licensing and Surveys

Accepted 9.7.17

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F 167	Continued From page 1 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 and staff interview, the facility failed to ensure a notice indicating the availability of surveys for the preceding 3 years was posted as required. The resident census was 70. The findings were: Observation on 7/24/17 at 5:30 PM showed the results from surveys completed in 2015 and 2016 were available in a binder on an end table in the main entrance to the facility. Further observation showed there was no notice posted to let individuals know surveys from the preceding 3 years were available for review upon request. Interview on 7/27/17 at 8 AM with the administrator revealed she was unaware of this requirement.	F 167	4. Results of these audits completed by the Executive Director will be reviewed at the Performance Improvement meetings monthly for three months or until substantial compliance has been met. Performance improvement meetings consistent of at a minimum the Executive Director, Director of Nursing, and Medical Director, and additional staff as needed. The Performance Improvement committee identifies issues with respect to which quality assessment and assurance activities are necessary and develops and implements appropriate plans of action to correct identified quality deficiencies.	9-1-17
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,	F176 F 176	1. Inhaler was immediately removed from resident #56 walker until a medication self-administration assessment could be completed. A medication self-administration assessment was completed on August 14th 2017 for resident #56. 2. All residents who have medications at bedside are at risk of not having a medication self-administration assessment completed.	

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F 176	Continued From page 2 and resident and staff interview, the facility failed to ensure residents who self-administered medications were safe to do so for 1 of 1 sample residents (#56) who self-administered medications. The findings were: Medical record review showed resident #56 had diagnoses which included anxiety disorder, depression, and chronic obstructive pulmonary disease. The review showed the resident had a 4/11/14 physician order for a Combivent Respimat inhaler (Ipratroplum and Albuterol-bronchodilators) to be inhaled with 2 puffs 4 times a day as needed. The following concerns were identified: a. Observation of and interview with the resident on 7/25/17 at 2:05 PM revealed that s/he kept the inhaler at all times "In case I need it, which is not often." Further medical record review showed the resident had not been assessed to determine if s/he was safe to self-administer medications. b. Interview with the DON on 7/27/17 at 12 PM confirmed the facility failed to assess the resident for safety in regard to self-administration of medications, and also confirmed resident #56 possessed the inhaler at all times.	F 176	3. DON or designee will educate all nurses regarding the importance of completing a medication self-administration assessment for all residents that request to have medications at their bedside. Education will be provided to all residents and families as well as newly admitted residents and families regarding the need for the self-administration assessment if medications are requested at the bedside. 4. A 100% audit will be completed by DON or designee to ensure all residents who have medications kept at their bedside have the appropriate self-administration assessment complete and are educated. A random monthly audit, including those residents who have been newly admitted to the facility, will be implemented monthly for three months to determine if they have medication kept at the bedside and an appropriate self-administration assessment has been completed. 5. Results of these audits completed by the DON will be reviewed during the Performance Improvement meetings monthly for three months or until the committee is able to determine the process in place is effective.	9-1-17
F 225 SS=D	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;	F 225		

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F 225	Continued From page 3 (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 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.	F 225	F225 1. Resident #73 no longer resides in the facility 2. Any resident involved in allegations of staff to resident abuse/neglect or resident to resident altercations are at risk of staff and administration failing to report the incident to appropriate agencies within 2 hours per federal requirements. 3. Executive Director will educate all staff regarding timeliness for reporting any allegation of staff to resident abuse/ neglect as well as reporting any resident to resident altercations to Executive Director, Director of Nursing and/or Social Service Director. Report should be submitted no later than 2 hours upon knowledge of incident per Federal requirements. 4. Executive Director will implement check list for all allegations including resident to resident altercations which will be completed upon initiation of investigation. This will ensure proper notification to State and local agencies. 5. Investigations completed by the Executive Director will be discussed monthly at our Performance Improvement meetings for three months or until the committee is able to determine the process in place is effective.	9-1-17

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F 225	Continued From page 4 (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. This REQUIREMENT is not met as evidenced by: Based on review of facility investigation documentation, staff interview, and review of policies and procedures, the facility failed to report an allegation of abuse to the State Survey Agency no later than 2 hours for 1 of 3 allegations (involving resident #73) reviewed. The findings were: 1. Review of facility investigation documentation revealed an allegation of verbal/mental abuse involving resident #73 occurred on 3/8/17 but was not reported to a facility supervisor until 3/13/17 at 6 PM, and was not reported to the State Survey Agency until 3/14/17 at 11 AM (6 days). 2. During an interview on 7/27/17 11:08 AM, the DON revealed she was not aware of the 2 hour reporting timeframe for allegations involving abuse, and confirmed the facility failed to report the allegation of abuse to the State Survey Agency no later than the 2 hours. 3. Review of the facility's policy "Reporting	F 225		

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F 225	Continued From page 6 Alleged Abuse" (Revised 2/7/17) showed "...Facilities must 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..."	F 225		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or	F 278	F278 1. The MDS for resident #68 and #70 have been modified and resubmitted to reflect the updated diagnoses 2. The MDS Coordinator will be educated regarding the importance of accuracy when coding the MDS by the Executive Director and DON. The education will include importance of the MDS Coordinator reviewing and updating diagnoses on assessments.	

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F 278	Continued From page 6 (II) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the CMS RAI version 3.0 manual, and staff interview, the facility failed to ensure MDS assessments were accurately completed for 2 of 13 sample residents (#68, #70). The findings were: 1. Review of the June 2017 medication administration record for resident #68 showed Latuda (an antipsychotic) 20 milligrams daily was ordered on 5/31/17 for schizophrenia. Review of the 6/21/17 annual MDS assessment failed to show the resident had a diagnosis of schizophrenia. 2. Review of the 10/7/16 annual, 4/5/17 quarterly, and 7/6/17 significant change MDS assessments for resident #70 showed inaccuracies in the following area: Review of section I5800 showed the resident did not have an active diagnosis of depression, however, section N0410 showed the resident received an antidepressant daily. Review of a physician order dated 6/10/17 showed the resident was started on Mirtazapine (anti-depressant) 7.5 mg daily. Review of the resident's current face sheet showed s/he had a diagnosis of depression. Review of the care plan updated 7/12/17 revealed the resident had a diagnosis of depression and had been medicated with an anti-depressant since 10/10/14.	F 278	3. The Health Information Manager will review all telephone orders daily and update any new diagnoses in the electronic health record to ensure the MDS Coordinator has current diagnoses to place on the assessments. HIMD will also work with local physicians to update and resolve diagnoses on each resident as needed. 4. A random monthly audit by the DON or MDS Coordinator will be conducted monthly for three months on all residents requiring an annual and quarterly assessment for coding accuracy of diagnoses on the MDS. 5. Results of these audits completed by the DON or MDS Coordinator will be reported to the Performance Improvement committee monthly for three months or until the committee is able to determine the process in place is effective.	9-1-17

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F 278	Continued From page 7 3. Interview with the MDS coordinator on 7/27/17 at 10:55 AM revealed it was her expectation active diagnoses be documented on the MDS assessments and she stated she did not review Section I before signing the MDS assessment as complete. Review of the "CMS RAI version 3.0 manual, October 2016" showed under section I "...Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period..."	F 278		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by; Based on medical record review, observation, and staff interview, the facility failed to provide timely incontinence care for 1 of 5 sample residents (#18) who required that care. The findings were: Medical record review for resident #18 showed s/he had diagnoses which included non-Alzheimer's dementia, psychotic disorder, stage III kidney disease, and altered mental status. Review of the 7/24/17 significant change MDS assessment showed the resident required extensive assistance of one staff member for	F312 F 312	1. Resident #18 had no negative outcomes due to untimely incontinence care. 2. All residents are at risk of not receiving incontinence care in a timely manner. 3. All nursing staff will be in-serviced by the DON or designee regarding the importance of providing timely incontinence care for all residents including resident #18. 4. The DON or designee will conduct random weekly observations for one month and monthly for three months thereafter, of the timeliness of residents receiving incontinence care. The observations will include resident #18. If any problems occur during observation, immediate re-education and/or corrective action will take place. 5. Results of these audits completed by the DON or designee will be reported to the Performance Improvement committee monthly for three months or until the committee is able to determine the process in place is effective.	9-1-17

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F 312	Continued From page 8 toilet use and personal hygiene. Review of the "Care Directive" for the resident posted on the inside of the resident's closet door revealed the following requirements: "Frequently incontinent, check and change AC [before meals], PC [after meals], HS [at bedtime], and PRN [as needed]." The following concerns were identified: a. Continuous observation on 7/25/17 from 8:15 AM until 11:25 AM (3 hours and 10 minutes) showed staff failed to check the resident for incontinence or offer toileting assistance. b. On 7/25/17 at 10:50 AM (2 hours and 25 minutes into surveyor observation) the resident's pants had wet stains showing from the crotch to just above both knees on the inside of the pants. At that time the resident was observed to be in the activity room during an activity and in his/her wheelchair. c. Observation on 7/25/17 at 11:20 AM showed RN #1 propelled the resident via wheelchair to his/her room to obtain a blood sample. At 11:25 AM (3 hours and 10 minutes) the RN realized the resident had been incontinent of urine which included urine soaked through the resident's clothing and on the resident's wheelchair. At that time, CNA #1 took over incontinence care for the resident. d. Interview with CNA #1 on 7/25/17 at 11:50 AM confirmed that resident #18 should have been provided incontinence care in a more timely manner.	F 312		
F 323 SS=D	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	F 323	F323 1. The fan in resident #67's room was repositioned in an area of her room where the cord will not cross a pathway. 2. A 100% audit will be conducted by the Executive Director to ensure all resident rooms remain free of accidents/hazards.	

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F 323	Continued From page 9 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 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 and staff interview, the facility failed to ensure the environment remained free of accident hazards during 1 random observation (resident #67). The findings were: 1. Observation on 7/26/17 at 10:23 AM showed a fan was positioned near non-sample resident #67's bed with the electrical cord laying across the walkway and plugged into a power strip on the opposite side of the room. Staff were observed stepping over the cord to enter the room. 2. During an interview on 7/26/17 at 10:37 AM the DON confirmed the positioning of the fan was unsafe. At that time she repositioned the fan and	F 323	3. Executive Director will re-educate all staff on the importance of maintaining an environment free of accidents/hazards and repositioning items that may obstruct the pathway in a resident's room. 4. Executive Director will conduct a weekly audit for one month then monthly for three months to ensure the fan in resident #67's room has not been placed in a location that allows the cord to run across the pathway yet will still provide adequate air flow for this resident. 5. The results of this audit completed by the Executive Director will be discussed monthly at the Performance Improvement meetings for three months or until the committee is able to determine the process in place is effective.	9-1-17 CS

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F 323	Continued From page 10 plug to ensure safety.	F 323		
F 441 SS=D	483.60(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:	F 441	**F441** 1. Resident # 18 had no negative outcomes due to improper infection control practice after incontinence care. 2. All residents are at risk for improper infection control practices after incontinence care has been provided. 3. The Staff Development Coordinator will conduct education to all nursing staff regarding proper infection control techniques and procedures when providing incontinence care to residents. The Staff Development Coordinator or designee will conduct random weekly audits for one month then monthly for three months of all residents who are dependent upon staff to provide incontinence care, as well as utilize a wheel chair for mobility. These audits will include resident # 18. If problems are identified during these audits, immediate re-education and/or corrective action will take place. 4. A Performance Improvement Audit Tool will be used to conduct the audits. If problems are identified during the audits immediate re-education and/or corrective action will take place.	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 07/27/2017

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

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F 441	Continued From page 11 (A) The type and duration of the isolation, depending upon the infectious agent or organism 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 and staff interview, the facility failed to ensure adequate infection control practices during 1 random observation (involving resident #18). The findings were: Observation on 7/25/17 at 11:20 AM showed RN #1 propelled resident #18 via wheelchair to his/her room to obtain a blood sample. At 11:25 AM the RN realized the resident had been	F 441	5. The results of this audit completed by the Staff Development Coordinator will be discussed monthly at the Performance Improvement meetings for three months or until the committee is able to determine the process in place is effective.	9-1-17

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F 441	Continued From page 12 incontinent of urine which included urine soaked through the resident's clothing and on the resident's wheelchair. At that time, CNA #1 took over incontinence care for the resident and placed the resident in his/her bed for the care. The following concerns were identified: a. CNA #1 provided incontinence care for the resident. However, the CNA failed to clean the resident's wheelchair. b. On 7/25/17 at 11:45 AM the CNA placed the resident back into the wheelchair in his/her clean clothing without cleaning the urine-stained wheelchair. d. Interview with CNA #1 on 7/25/17 at 11:50 AM confirmed she should have cleaned resident #18's wheelchair prior to transferring him/her back into the wheelchair. e. Interview with the infection control practitioner on 7/27/17 at 9:25 AM confirmed her expectation was for staff to clean a wheelchair that was touched by urine prior to placing a resident in the chair.	F 441		