STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON COUNTY HEALTH SERVICES	1124 WASHINGTON BLVD NEWCASTLE, WY 82701

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 3/12/18 to 3/15/18. Also reviewed in the course of the survey was complaint intake WY00002529. The following common abbreviations are used throughout this document. BIMS: Brief Interview for Mental Status DON: Director of Nursing SBAR: Situation, Background, Assessment, Recommendation Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 577 SS=B	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(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 (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(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 years, and any plan of correction in effect with respect to the facility, available for any individual	F 577		4/27/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/06/2018

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.

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F 577	Continued From page 1 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 resident and staff interview, the facility failed to ensure the results of the most recent survey were available for review and residents were made aware of the location of the survey results. The census was 54. The findings were: Group interview with 10 residents on 3/13/18 at 1 PM revealed they were unaware of where survey results were posted. Further, they stated they had not been told they could read the results if they wanted to. Observation on 3/13/18 at 2 PM revealed the survey results were located in a binder on a shelf in the resident solarium. The binder contained survey results for 2016, 2014, and 2013. Survey results from 2017 were not in the binder. Interview with the activities director on 3/13/18 at 3:40 PM revealed she did talk to the residents about the availability of the results, but it had been a long time since it was discussed. Further, she stated the results used to be hung on the bulletin board in the entrance but that board had been taken down recently due to construction. Interview on 3/13/18 at 3:30 PM with the DON confirmed the 2017 survey results were not in the binder.	F 577	Corrective Action: 2017 Survey Results put into Survey Book immediately upon acknowledgement they were missing from the book on 3/13/2018. Book moved to a more visible area right outside the solarium. Identification of Others: Communication via flyer to be delivered to all residents rooms notifying 100% of the residents where to find the survey results. Communication will be sent out via email in monthly newsletter to the residents and their family members where to find results as well. Systemic Changes: Director of Nursing or designee will educate residents monthly during resident council meetings where book is located and that they have access to review at anytime. Monitoring: Survey book will be checked weekly to ensure placement and that last 3 years are in the book. Director of Nursing or designee will bring audit results to monthly QAPI meeting for review and corrective actions taken where necessary until resolved.	

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F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure the bed-hold notice was issued to 1 of 2 sample residents (#46) reviewed for transfer. The findings were: Review of the medical record showed resident #46 was transferred to the hospital with an acute	F 625	Corrective Action: Resident #46 has since returned from hospital within 48 hours of this date of discharge. Identification of Others: Director of Nursing or designee will review	4/27/18

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F 625	Continued From page 3 condition on 11/28/17 and returned on 11/30/17. Further review of the medical record showed no evidence a bed-hold notice was given to the resident or his/her representative. Interview on 3/15/18 at 11:40 AM with the DON verified no bed-hold notice was provided.	F 625	residents who have discharged or transferred and any issues concerning the bed hold policy that had been identified will have follow-up completed and documented. Systemic Changes: Director of Nursing or designee to conduct in-service to the nursing staff & IDT members on importance of all residents discharging or transferring from facility requiring to have bed hold policy given to them upon transfer. Director of Nursing or designee will revise the PointClickCare assessment area to ensure bed hold policy is completed after each discharge or transfer to ensure all residents receive the required policy. Monitoring: Director of Nursing or designee will do daily audit 5 days a week to ensure all residents who discharged or transferred receive the required bed hold policy paperwork. Director of Nursing or designee will bring the audit results to the monthly QAPI monthly for review and corrective actions taken where necessary until resolved.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		4/27/18

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F 656	Continued From page 4 resident rights 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. (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 medical record review, the resident	F 656	Corrective Action:	

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F 656	Continued From page 5 sign-out log, and resident and staff interview, the facility failed to ensure care plans were developed to meet individual care needs for 2 of 14 sample residents (#10, #28). The findings were: 1. Review of the 12/13/17 annual MDS assessment showed resident #10 had a BIMS score of 13/15 (cognitively intact), had diagnoses which included CVA (cerebrovascular accident) with left hemiparesis, and self-ambulated using a wheelchair. Interview with the resident on 3/13/18 at 9:41 AM revealed a family member came to the facility at 9 AM and 1 PM to accompany him/her off the property so s/he could smoke. The resident obtained a lighter and two cigarettes from the nurse and returned the lighter and the cigarette butts to the nurse when s/he was finished. The resident expressed s/he would like to have more freedom to leave the facility to smoke when s/he chose to. Interview with the DON on 3/14/18 at 10 AM revealed she was trying to balance resident rights with safety. Further, the resident was manipulative and demanding of staff related to smoking. Interventions were developed and staff were educated on the restrictions. Review of the care plan, last revised 12/26/17, showed it addressed the resident's smoking, however the parameters of the restrictions, and the staff interventions were not included. 2. Review of the 1/16/18 quarterly MDS assessment showed resident #28 had a BIMS score of 15/15 (cognitively intact), had diagnoses which included anxiety disorder, depression, and unspecified pulmonary disease, self-ambulated with the use of an electric wheelchair, and used oxygen. Interview with the resident on 3/12/18 at 2:27 PM revealed s/he had money in his/her	F 656	Resident #10 care plan revisions to include the parameters of the smoking restrictions and the staff interventions. Resident #28 care plan development to include this resident leaving independently in electric wheelchair. Identification of Others: Director of Nursing or designee will complete 100% chart audit of the residents□ that smoke to ensure their smoking restrictions and staff interventions are included in their care plan. Director of Nursing or designee will complete 100% chart audit of the residents□ who leave facility independently in their electric wheelchair to identify if care plans are missing for those residents as well. Systemic Changes: Director of Nursing or designee to conduct in-service to the nursing staff & IDT members on the importance of developing care plans as well as revising them when situation changes for the residents. Monitoring: Director of Nursing or designee will do monthly audit on all residents who smoke to ensure current restrictions / staff interventions accurately reflects their current status. Director of Nursing or designee will do monthly audit on all residents who leave	

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F 656	Continued From page 6 possession, signed him/herself out of the facility and shopped in a store across the street from the facility. In addition, s/he took a phone and had the number of the facility in case s/he needed assistance. Review of an "Education Record" dated 9/29/17 showed the resident had been assessed for safety and educated on the risks of leaving the facility independently. Review of the resident sign-out log showed the resident had signed him/herself out 12 times to go shopping between 7/31/17 and 9/30/17 and signed out "for a stroll" 4 times between 9/28/17 and 9/30/17. Review of the care plan, last revised 1/24/18, showed no evidence a plan of care had been developed related to the resident leaving the facility independently. 3. Interview with the DON on 3/15/18 at 9:30 AM confirmed the care plans had not been fully developed.	F 656	facility in their electric wheelchair independently to ensure the care plan accurately reflects their current status. Director of Nursing or designee will bring the audit results to the monthly QAPI meeting for review and corrective actions taken where necessary until resolved.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(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. (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).	F 657		4/27/18

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F 657	Continued From page 7 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 observation, medical record review, and staff interview, the facility failed to ensure the comprehensive care plan was revised as needed to reflect the resident's current needs for 3 of 14 sample residents (#8, #31, #46). The findings were: 1. Review of the medical record for resident #8 showed s/he was admitted on 6/6/15 with diagnoses that included congestive heart failure, cardiac pacemaker, and chronic obstructive pulmonary disease. Review of the quarterly MDS assessment dated 12/12/17 showed the resident had a BIMS score of 11(moderate cognitive impairment) and required set-up help with activities of daily living (ADLs). The following concerns were identified: a. Review of change of condition nursing notes showed the resident had incidents of running/bumping into residents with his/her electric wheelchair on 9/22/17, 1/25/18 and 1/26/18. b. Review of the nursing care plan, last revised on 12/26/17, showed the resident had a history of reckless driving in the power chair. The	F 657	Corrective Action: Resident #8 care plan changes to be initiated to reflect the non-use of the electric wheelchair at this time. Resident #31 no longer resides at facility. Resident #46 care plan changes to be initiated to reflect the appropriate/accepted interventions to ensure that this resident is getting enough fluids throughout the day as per the resident/responsible party wishes/desires. Identification of Others: Director of Nursing or designee will complete 100% chart audit on all residents who use an electric wheelchair currently or in the last 90 days to identify if care plans are missing for those residents as well. Any identified resident's care plan will be modified as appropriate. Director of Nursing or designee will complete 100% chart audit on all residents who have expressed wishes to be comfort measures to identify if care	

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F 657	Continued From page 8 interventions included education which was provided on 9/29/17 regarding safe operation. The resident received a motorized conveyance evaluation and was approved to operate the electric wheelchair. Further interventions included speed was to be turned down on the wheelchair and staff were to monitor for reckless driving. c. Interview with the DON on 3/14/18 at 12:27 PM revealed the electric wheelchair was taken away from the resident in January after the last incident. d. Review of the care plan continued to show interventions related to resident use of the electric wheelchair. e. Interview with the DON on 3/15/18 at 9:30 AM confirmed the care plan had not been revised. 2. Review of the medical record showed resident #31 was admitted on 1/15/18 with diagnoses that included hypertension, GERD (gastro-esophageal reflux disease), hypothyroidism and dementia. Review of the significant change MDS assessment dated 1/18/18 showed the resident required extensive assistance of 2 to 3 persons for ADLs. Further review of the medical record showed the resident developed respiratory symptoms and failed to improve. The following concerns were identified: a. Review of the care plan initiated 6/14/16 showed interventions related to behaviors, dementia, ADLs, incontinence, toilet use, nutrition and recent infections. b. Review of the SBAR communication record on 2/22/18 at 2:48 PM showed the daughter wanted medications and oxygen therapy stopped. A physician order placed the resident on complete comfort care. c. Review of the care plan failed to show	F 657	plans are missing for those residents as well. Any identified resident's care plan will be modified as appropriate. Director of Nursing or designee will complete 100% chart audit on all residents who are at risk for fluid deficit to identify if care plans are missing for those residents as well. Any identified resident's care plan will be modified as appropriate. Systemic Changes: Director of Nursing or designee to conduct in-service to the nursing staff & IDT members on the importance of developing care plans as well as revising them when situation changes for the residents. Director of Nursing or designee to conduct in-service to the nursing staff, IDT members and Physicians on the process of establishing comfort measure wishes/desires to include care plan revisions as per resident and / or family member wishes/desires. Monitoring: Director of Nursing or designee will do monthly audit on all residents who utilize electric wheelchair to ensure the care plan accurately reflects their current status. Director of Nursing or designee will do daily audit 5 days as week during clinical review (review of orders, SBARS, Progress Notes) to identify any resident who may have opted to be comfort measure to ensure the care plan accurately reflects their current status.	

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F 657	Continued From page 9 revisions related to comfort care. d. Interview with the DON on 3/15/18 at 10 AM confirmed the care plan had not been revised to reflect the resident's comfort care status. 3. Review of the quarterly MDS assessment dated 2/13/18 showed resident #46 had a BIMS score of 13/15 (cognitively intact) and required extensive assistance of 2 persons with bed mobility, transfers, dressing, toileting, and eating. Further review showed the resident had no swallowing issues and was on a regular diet with mechanical soft consistency. Diagnoses included chronic pain, diabetes mellitus type 2, hypertension, and hypothyroidism. The following concerns were identified: a. Observation on 3/13/18 at 12:11 PM showed the resident was seated at a table in the dining room in his/her wheelchair and appeared to be sleeping. During the observation, multiple staff members attempted to wake the resident during the meal time. Continued observation showed at 12:39 PM the resident was wheeled out of the dining room without eating or drinking. Observation on 3/13/18 at 2:45 PM showed the resident was in bed in his/her room sleeping. The bedside table with a water cup was out of the reach of the resident. Interview on 3/15/18 at 9:55 AM with CNA #1 revealed the resident often slept through meals and throughout the day. b. Review of the 2/13/18 nutrition assessment showed the resident was at moderate risk, recommendations included continuing current care plan and following intake readings. Lab values, skin assessment, estimated calories, fluid intake, and protein needs were assessed. c. Review of the current physician's orders showed the resident was prescribed Furosemide (diuretic medication) 20 milligram (mg) once daily	F 657	Director of Nursing or designee will do daily audit 5 days as week during clinical review (review of orders, SBARS, Progress Notes) to identify any resident who may not be receiving adequate fluid intake to ensure the care plan accurately reflects their current status and appropriate interventions are in place. Director of Nursing or designee will bring the audit results to the monthly QAPI monthly for review and corrective actions taken where necessary until resolved.	

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F 657	Continued From page 10 every other day and Furosemide 40 mg once daily every other day. d. Review of the 2/21/18 care plan showed the resident was at risk for dehydration related to diuretic use. The nurse was to document, monitor, and report any signs or symptoms of dehydration including: decreased or no urine output, concentrated urine, cracked lips, new onset confusion, dizziness, fever, thirst, fatigue, weakness, and the staff was to offer and encourage increased fluids. Further review of the care plan showed it failed to include interventions for the staff to take when the resident slept through meals and throughout the day. e. Interview on 3/14/18 at 11:50 AM with the DON revealed the resident had a history of sleeping through meals and throughout the day, and a history of urinary tract infections. Further she stated the interventions in the care plan did not give clear indications that the resident was getting enough fluids. Additionally, she stated the care plan needed to be updated to ensure the resident was getting enough fluids throughout the day.	F 657		