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 _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	150 CARING WAY LANDER, WY 82520

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 7/23/18 to 7/26/18. Also reviewed in the course of the survey was complaint intake WY00002613. The following common abbreviations are used throughout this document. BIMS: Brief Interview for Mental Status CDM: Certified Dietary Manager CNA: Certified Nursing Assistant DON: Director of Nursing MDS: Minimum Data Set RD: Registered Dietitian RN: Registered Nurse SLP: Speech Language Pathologist Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written	F 565		8/20/18

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

Electronically Signed | 08/10/2018

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F 565	Continued From page 1 requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on review of resident council meeting minutes and resident and staff interview, the facility failed to ensure grievances from the resident council were acted upon and followed through to resolution for 3 of 3 months reviewed (May 2018, June 2018, July 2018). The findings were: 1. Review of the resident council meeting minutes for May 2018, June 2018, and July 2018 showed concerns were discussed related to call light response times. The following concerns were identified: a. Interview with 9 residents on 7/24/18 at 11 AM revealed there had been no response from the facility in regard to the grievance made about call lights in both May 2018 and June 2018.	F 565	Corrective action to resident(s): Call light response times will be addressed by the Life Enrichment Coordinator with the Resident Council at a meeting August 16th. How problem is identified for other residents and what corrective actions will be taken: The Life Enrichment Coordinator will record all individual and group grievances at every Resident Council meeting. A copy of the meeting minutes will be provided to all department managers. Measures/systemic changes to prevent recurrence:	

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F 565	Continued From page 2 b. Review of the June 2018 and July 2018 resident council minutes section "Old Business" showed no reference to the concern about call lights. c. Interview with the life enrichment coordinator on 7/24/18 at 2:26 PM revealed concerns brought up at council meetings were converted to individual resident grievances and then assigned to the appropriate department head. Further, she verified she did not discuss the resolution of the concerns with the resident council because she thought they were handled individually.	F 565	The Life Enrichment Coordinator will write grievance forms on all individual resident concerns that are discussed during resident council. The grievances will be assigned to department managers responsible for handling the concerns. Group concerns will be recorded on the Resident Council minutes, which will be given to all department managers. The department managers will follow up with the Life Enrichment Coordinator before the next scheduled Resident Council meeting, The Life Enrichment Coordinator will address all resident council group concerns/grievances back to the resident council group meeting the month following the concern. Monitor permanent solution: The Administrator or designee will audit the resident council meeting minutes and the grievance log every month to ensure that grievances have been handled from the previous resident council. Audits will be completed monthly for 12 months or until substantial compliance has been met. This audit will be reported monthly at the Quality Assurance meeting for review and recommendation.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a	F 623		8/21/18

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F 623	Continued From page 3 language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;	F 623		

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F 623	Continued From page 4 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure	F 623		

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F 623	Continued From page 5 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure a transfer notice was issued to 5 of 5 sample residents with hospital transfers (#4, #34, #36, #43, #47). The findings were: 1. Review of the medical records showed resident #4 was transferred to the hospital on 4/1/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 2. Review of the medical record showed resident #34 was transferred to the hospital on 4/26/18 and 7/3/18 for acute changes of condition. In addition the resident was transferred to the hospital on 3/7/18 for a scheduled surgery. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 3. Review of the medical record showed resident #36 went to the hospital due to a change in condition on 3/16/18 and returned on 3/19/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative.	F 623	Corrective action to resident(s): Residents #4, #34, #36, #43, and #47 have been given a written transfer notice for all facility-initiated discharges on the dates indicated in the 2567. How problem is identified for other residents and what corrective actions will be taken: A written resident transfer notice form was developed by the facility and implemented on 8/6/18. The Administrator told the Resident Council about the notice that would be sent on all facility-initiated transfers at August Resident Council Meeting. Measures/systemic changes to prevent recurrence: The Social Services Coordinator or designee will initiate a written "Notice of Transfer and Discharge on all residents who have a facility-initiated discharge or transfer, as soon as practicable. A copy of this notice will be sent to the Long-Term Care Ombudsman and scanned into the resident□s electronic record. Social Service Coordinator, Administrator and Office Manager were trained on the new	

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F 623	Continued From page 6 4. Review of the medical record showed resident #43 was transferred to the hospital on 6/10/18 for an acute change of condition. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative 5. Review of the medical record showed resident #47 was transferred to the hospital via the facility van on 1/18/18 and 7/17/18 for an acute change of condition. On 5/31/18 the resident was transferred to "urgent care" for an acute change of condition and was then transferred to the hospital and admitted to the intensive care unit. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 6. Interview on 7/25/18 at 10:03 AM with the DON and the administrator confirmed the facility did not issue a written notice of transfer with all required information to the resident or the resident's representative.	F 623	process. Monitor permanent solution: The Administrator or designee will complete an audit of all facility-initiated discharges or transfers weekly for eight or more weeks, then monthly for 12 months or until substantial compliance has been met. This audit will be reported monthly at the Quality Assurance meeting for review and recommendation.	
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.	F 657		8/21/18

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F 657	Continued From page 7 (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, and staff interview, the facility failed to ensure the care plan was revised as needed for 1 of 13 sample residents (#155). The findings were: 1. Review of a nurse's note dated 7/11/18 and timed 6:02 PM showed resident #155 was being transferred from urgent care to the hospital for "septic shock to Right Upper Lobe." The resident was readmitted to the facility on 7/17/18. The following concerns were identified: a. Review of a nurse's note dated 7/19/18 and timed 12:49 PM showed the resident "has been observed to have difficulty swallowing and it was reported to this RN by occupational therapist that resident has been coughing when [s/he] drinks water..." The physician was notified and an order was requested for the resident to have nectar thick liquids. b. Review of a physician communication form dated 7/19/18 showed "Resident has been observed to have difficulty swallowing and has	F 657	Corrective action to resident(s): Resident #155□s care plan was updated to state that they were ordered to be on thickened liquids on 7/25/18. How problem is identified for other residents and what corrective actions will be taken: Care plans are in place for all residents at the facility on thickened liquids, stating what consistency they have ordered for liquids. Measures/systemic changes to prevent recurrence: All charge nurses will receive education from the MDS nurses on editing care plans when residents have order changes. The MDS nurses are assigned to double-check all new orders and care plan updates on residents every work day. Monitor permanent solution: The DON or their designee will complete an audit of	

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F 657	Continued From page 8 been coughing when [s/he] drinks water. We do not have in-house speech therapy until the end of next week. Could we have an order for resident to have nector (sic) thick liquids. This will be re-evaluated by SLP when they return to facility." The physician agreed with the request and the order was noted by the DON. c. Review of a "Diet order and Communication" form dated 7/19/18 showed the resident's diet had been changed to "nectar-like" thickened liquids. d. Review of the nutrition care plan revised on 7/25/18 (6 days after liquids had been downgraded) showed the resident was to have a regular diet, regular texture, and nectar thick liquid consistency. 2. Interview on 7/26/18 at 9:34 AM with the DON confirmed the care plan had not been revised until 7/25/18.	F 657	orders and care plan updates weekly for eight or more weeks, monthly for 12 months, or until substantial compliance has been met. This audit will be reported monthly at the Quality Assurance meeting for review and recommendation.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge	F 661		8/21/18

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F 661	Continued From page 9 medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a discharge summary which included a recapitulation of the resident's stay for 1 of 1 residents (#41) reviewed for discharge to the community. The findings were: Review of the medical record for resident #41 showed s/he was admitted to the facility on 6/22/18 for rehabilitation. The resident was discharged to the community on 7/13/18. Further review showed no evidence a recapitulation of the resident's stay had been completed. Interview on 7/26/18 at 9:05 AM with the DON verified the discharge summary was not complete. In addition, she stated the facility previously completed the summary on paper, but had converted to an electronic medical record system and in the process failed to carry-over the procedure.	F 661	Corrective action to resident(s): A Nursing Discharge Summary assessment, including a recapitulation of stay, has been completed on all residents who have discharged from the facility since 7/27/18. Resident #41 has a completed Nursing Discharge Summary Assessment. How problem is identified for other residents and what corrective actions will be taken: An audit of all discharges for the last four months identified residents missing a nursing discharge summary assessment and those were completed by the MDS Coordinator. Measures/systemic changes to prevent recurrence: The MDS RN is now responsible for completing all the nursing discharge summaries on her assigned residents, as well as checking to ensure they have been completed on all residents who discharge from the facility.	

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F 661	Continued From page 10	F 661	Monitor permanent solution: The DON or their designee will complete an audit of discharge summaries and recapitulations of stay weekly for eight or more weeks, monthly for 12 months, or until substantial compliance has been met. This audit will be reported monthly at the Quality Assurance meeting for review and recommendation.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, product label and direction information review, and staff interview, the facility failed to implement a system to ensure thickened liquids were provided at the ordered consistency for 2 of 3 residents who received thickened liquids (#22, #155). Observations during the survey showed staff were not knowledgeable about the preparation of nectar-thickened liquids and provided these residents drinks that were too thin, increasing their risk for swallowing and potential aspiration problems. The record reviews for these residents showed they both had recent diagnoses of pneumonia, and had been identified as requiring interventions related to swallowing. This resulted in an immediate jeopardy situation for	F 689	Corrective action to resident(s): On 7/25/18, resident #22 was served a cup of coffee that was not nectar thick. It was then thickened by the C.N.A. assisting at his table. On 7/25/18, it was observed that resident #155 was served a non-thickened beverage by her daughter. The dietary manager spoke with the daughter, who reported that she had known that the resident was on thickened liquids but felt that she was not getting enough to drink and had therefore decided to give her regular liquids. The DON provided education to the resident's daughter on	8/21/18

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F 689	Continued From page 11 these residents. The findings were: 1. Review of speech therapy notes showed resident #22 was evaluated on 6/5/17, 11/9/17, and 6/29/18. The notes from these evaluations showed the resident "presents with a high risk of aspiration." Review of the 6/29/18 evaluation showed the reason for referral was "choking during meal time," and according to the plan the resident would be seen twice weekly for a certification period from 6/29/18 to 9/20/18. Review of the care plan showed the resident had a problem dated 5/18/18 for "Potential risk for infection related to dependence for cares, swallowing/aspiration risk..." In addition, the care plan identified a problem on 6/19/17 related to "Resident is at risk for dehydration r/t [related to] contractures in his hands, dementia, inability to retrieve fluids on his own along with current thickened liquids status." The 9/9/17 intervention for this problem included "Thicken all liquids to nectar thick consistency...Ensure proper consistency of fluids at activities, etc...Offer fluids in wavy straw cups...Needs to sit upright for 30 mins [minutes] after meals." The following concerns were identified: a. Observation on 7/23/18 at 5:20 PM showed CNA #1 prepared thickened coffee for the resident by shaking thickening powder from a "sugar shaker" located on the beverage counter in the dining room. The CNA shook some powder into a wavy straw cup, swirled it and gave it to the resident. At no time did she stir the liquid to check for proper consistency. At 5:27 PM the resident was noted to be coughing. b. Review of the nurse's note dated 7/24/18 and timed at 8:28 AM showed the resident had vomited during the night, had an elevated temperature of 100.5 degrees Fahrenheit (F), and	F 689	7/25/18 regarding thickened liquids and safety. How problem is identified for other residents and what corrective actions will be taken: All team members in the nursing, dietary, and life enrichment departments completed a hands-on competency on thickening liquids per manufacturer instructions. These instructions are posted at the beverage station in the dining room, by the container of thickener. The families/responsible parties of the three residents on thickened liquids were contacted by the DON on 7/25/18 and were asked to allow only team members to prepare thickened liquids for these residents, so that the facility can ensure that liquids are prepared per manufacturer instructions. Measures/systemic changes to prevent recurrence: Nursing, dietary, and life enrichment team members will complete a hands-on competency on thickened liquids annually. New team members in these departments will be educated on thickened liquids at New Employee Orientation and will complete a competency upon hire. Family members of residents on thickened liquids will be asked to allow only team members to prepare beverages for residents. A dietary team member checks the	

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F 689	Continued From page 12 had "Fine crackles noted to bilateral bases upon assessment with diminished sounds noted to all other lobes." The physician was contacted for treatment instructions. c. Review of a nurse's note dated 7/24/18 timed at 1:06 PM showed the resident was sent to the urgent care clinic at approximately 9:30 AM and was then sent to the hospital for further evaluation. d. Review of the 7/24/18 hospital discharge instructions showed the resident was diagnosed with Lobar pneumonia and a urinary tract infection. e. Observation on 7/25/18 at 12:29 PM showed the resident was seated at the dining table, the resident had a cup with thickened water, and also had a cup of coffee. As the resident drank the coffee from the "wavy straw cup" it was noted to be thin. Interview with dietary aide #1 on 7/25/18 at 12:30 PM revealed the coffee did not look to be nectar-thick, she was not sure who prepared it, and she would prepare a new one. At that time, CNA #2 who was sitting next to the resident to assist with eating got up and retrieved a small portion cup of thickening powder. She added it to the remaining coffee which the resident had been drinking. During interview with CNA #2 at that time she stated the coffee was difficult to thicken. CNA #2 revealed she didn't follow specific directions to add thickening powder, but just added it until "it was ready." The CNA had to retrieve more thickening powder to add to the coffee before returning the cup to the resident. f. Interview with the DON and administrator on 7/24/18 at 10 AM verified a contract was in place to provide speech therapy. However, the contracted therapist was on vacation that week. The administrator stated if speech therapy was	F 689	beverages served to each resident with thickened liquids at each meal to ensure they are the proper consistency. This is recorded after each meal. The Registered Dietician has in-serviced all dietary staff on preparation of thickened liquids. This in-service will be scheduled annually. Monitor permanent solution: The Dietary Manager or their designee will complete an audit of thickened liquid preparation for each resident prescribed thickened liquids weekly for eight or more weeks, monthly for 12 months, or until substantial compliance has been met. This audit will be reported monthly at the Quality Assurance meeting for review and recommendation.	

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F 689	Continued From page 13 required while the contracted therapist was on vacation, a therapist could be used from another agency or the hospital. 2. Review of the 6/1/18 quarterly MDS assessment showed resident #155 had a BIMS score of 10/15 (moderate cognitive impairment), required the limited assistance of 1 staff member for eating, and had diagnoses which included respiratory failure and hemiplegia or hemiparesis. Review of the care plan dated 3/6/18 showed the resident had a potential risk for infection related to swallowing issues and was dependent for personal care. The following concerns were identified: a. Review of the medical record showed the resident was admitted to the hospital on 7/11/18. Re-admission orders from the hospital dated 7/17/18 showed the resident had diagnoses which included bacteremia, pneumonia, history of CVA (cardiovascular accident), hypertension and hypoxemia. b. Review of a nurse's note dated 7/19/18 and timed 12:49 PM showed the resident "has been observed to have difficulty swallowing and it was reported to this RN by occupational therapist that resident has been coughing when [s/he] drinks water..." The physician was notified and an order was requested for the resident to have nectar-thick liquids. c. Review of a physician communication form dated 7/19/18 showed "Resident has been observed to have difficulty swallowing and has been coughing when [s/he] drinks water. We do not have in-house speech therapy until the end of next week. Could we have an order for resident to have nector (sic) thick liquids." This will be re-evaluated by SLP when they return to facility." The physician agreed with the request and the	F 689		

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F 689	Continued From page 14 order was noted by the DON. d. Review of a "Diet order and Communication" form dated 7/19/18 showed the resident's diet had been changed to "nectar-like" thickened liquids. e. Observation on 7/25/18 at 8:40 AM showed the resident was served un-thickened water in a wavy straw cup. Interview with the dietary manager at this time confirmed the water was not thickened and the dietary manager was observed to replace the un-thickened water with prepackaged thickened water. 3. Interview with the consultant RD on 7/24/18 at 2:52 PM revealed she was not aware of the specific thickening/thickened products used by the facility at that time. She stated the speech therapist had provided education in the past related to thickened liquids. The RD further stated the product directions would be expected to be followed to meet the desired consistency. 4. Interview with the CDM on 7/24/18 at 12:33 PM revealed liquids were thickened using a powder contained in a "sugar shaker" on the counter. The dietary manager demonstrated the procedure by shaking the powder into the liquid and then stirred the beverage until it was the correct consistency; adding more thickener as needed. Further, she stated the facility did not use measuring devices because the amount needed varied depending on the temperature of the liquid being thickened. There was no instructional chart located on the beverage counter. 5. Review of the manufacturer's instructions, provided by the facility, for the thickening powder showed a chart for how much thickener was needed for different amounts and types of liquids	F 689		

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F 689	Continued From page 15 to achieve nectar, honey, or pudding consistency. The directions showed for 4 ounces of coffee/tea 3-1/2 to 4 teaspoons should be added. For 8 ounces the amount of thickener was shown to be 7 to 9 teaspoons. The instructions also informed the user to "1. Scoop and level off recommended amount of Thick-It Instant Food and Beverage Thickener using enclosed measuring spoon. 2. Slowly add Thick-It Instant Food and Beverage Thickener to the liquid while stirring briskly with a spoon, fork or whisk until thickener has dissolved. Let thickened liquid stand 30 seconds to 1 minute to achieve desired consistency and serve..." 6. On 7/25/18 at 3:03 PM, the administrator was notified of the immediate jeopardy. The facility's removal plan included the following corrective actions: a. Education to all nursing and dietary staff working on 7/25/18 on directions and process for thickening liquids. Additional staff will be educated on the process prior to returning to work. b. Family members of residents who receive thickened liquids were provided education and asked to allow staff to prepare the thickened liquids. c. A monitoring system was put into practice to ensure the physician's orders for thickened liquids were followed. A list of residents with these orders and the thickening directions was placed in a drawer for staff to access in the drink area. The dietary manager or designee was assigned to complete spot checks of the thickened consistency of drinks. The removal plan was accepted on 7/25/18 at 5:33 PM, and the immediate jeopardy was removed on 7/26/18 at 10:08 AM. However, deficient practice remained at a scope and severity of D (isolated	F 689		

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F 689	Continued From page 16 noncompliance with potential for more than minimal harm that is not Immediate Jeopardy).	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure, the facility failed to ensure medications available for use were not expired in 1 of 2 medication carts (A hall cart). The finding were:	F 761	Corrective action to resident(s): The two insulin vials that did not have an open date recorded on the item or the packaging were put in a locked bin for destruction on 7/24/18. One vial of insulin was replaced by a stock medication from	8/21/18

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F 761	Continued From page 17 1. Observation on 7/24/18 at 4:57 PM of the A hall medication cart revealed 1 opened multiple-use vial of Humalog 100 unit/milliliter with no written open date. Further, observations revealed 1 open multiple-use vial of Lantus 100 unit/milliliter with no written open date. 2. Observation on 7/25/18 at 11:03 AM of the A hall medication cart revealed 2 cards (a total of 111 tablets) of hydrocodone-APAP 5-325 mg that expired on 7/6/18. 3. Interview with RN #1 on 7/25/18 at 11:03 AM confirmed the medications were expired and still available for use. 4. Review of the policy titled, "Medication storage and utilization," dated 2/2018, showed ..."10. All multi-dose vials, bottles, and containers will be dated when opened. 11. Multi-dose vials which have been opened or accessed should be discarded within 28 days unless the manufacturer specifies a different date for that opened vial."	F 761	the pharmacy, which was available in the facility refrigerator. The second vial of insulin was replaced by the pharmacy and picked up at Shopko the evening of 7/24/18. The two cards of expired Hydrocodone were destroyed by two administrative nurses on 7/25/18. The pharmacy was contacted to send replacement cards for the resident. How problem is identified for other residents and what corrective actions will be taken: The DON checked expiration dates and open dates on all medications in the facility (carts and med room) on 7/30/18-8/1/18. Any medications nearing their expiration date were placed in locked bin for destruction and pharmacy was contacted for replacements. Measures/systemic changes to prevent recurrence: The night shift nurses have been assigned to check all medications weekly. The night shift weekly duty log has been updated to reflect this assignment. Monitor permanent solution: The DON or their designee will complete an audit of medication expiration and open dates weekly for eight or more weeks, monthly for 12 months, or until substantial compliance has been met. This audit will be reported monthly at the Quality Assurance meeting for review and recommendation.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		8/21/18

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F 812	Continued From page 18 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) 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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of monitoring logs, review of maintenance records, and review of product labels, the facility failed to implement a system that ensured dietary staff were knowledgeable regarding the importance of taking action to correct inadequate final rinse temperatures of the dish-machine, and implementing alternatives to ensure resident dinnerware and utensils were effectively sanitized to minimize the potential for food-borne illness in 1 of 1 food preparation areas (kitchen). The census was 54. Further, the facility failed to ensure appropriate hand-hygiene techniques in 1 of 1 food preparation areas (kitchen), and failed to ensure proper dating and labeling of pre-thickened beverage products in 2 of 2 storage areas (resident room, beverage	F 812	Corrective action to resident(s): Starting 7/23/18, the dishwasher was put out of service until the appropriate temperatures could be reached. Disposable products were used as able, and the remaining dishes were washed in the three-compartment sink in the kitchen. On 7/24/18 it was verified that the water temperatures were appropriate and the facility was able to resume use of the dishwasher. Education was provided to team members starting 7/25/18 on the need to dispose of thickened beverages in resident rooms after 8 hours.	

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F 812	Continued From page 19 refrigerator in the dining room). The findings were: Regarding inadequate final rinse temperatures of the dish machine: 1. Review of the July 1-23, 2018 dish-machine temperature log showed the hot water rinse temperature was recorded twice per day for the month with the exception of 7/3/18 and 7/22/18 when there were no temperatures recorded. Of the times when hot rinse temperatures were recorded, there were 27 temperatures that were shown to be less than 180 degrees Fahrenheit (F). There were no notes on the log to show corrective actions taken. Interview with the CDM on 7/23/18 at 3:09 PM revealed she was aware the rinse temperatures had been problematic since after the installation of the new booster heater. The CDM revealed the recorded temperatures were taken by looking at the temperature gauge located on the outside of the machine. The manager verified an internal temperature was not taken by using a temperature strip indicator or a holding thermometer. The manager also stated there were times when the maintenance director was contacted to fix the problem, and it would be okay for a few days. She further acknowledged the dish-machine continued to be used although the temperatures were not sufficient. 2. Review of the invoice for the dish-machine booster heater showed it was dated 4/16/18. Review of the May 2018 hot rinse temperatures for the dish-machine showed the temperatures were recorded 3 times daily with the exception of 5/1, 5/2, 5/3, and 5/4, when there were no temperatures recorded for the "breakfast	F 812	The four multi-serving cartons of thickened beverages in the beverage refrigerator were discarded. The hand sanitizer dispenser in the kitchen was removed on 7/26/18. How problem is identified for other residents and what corrective actions will be taken: Any time the dishwasher temperature is below 150 degrees F wash or 180 degrees F rinse it will be marked out of service, facility maintenance is contacted, and the backup process of washing in the three-compartment sink and using disposable products is initiated. Team members have been educated on the need to dispose of thickened beverages after 8 hours. Dietary team members have been educated on marking an open date on the multi-serving cartons of thickened water. Education has been provided to dietary team members regarding handwashing in the kitchen and not using hand sanitizer. Measures/systemic changes to prevent recurrence: Education was given to all dietary and maintenance staff present on 7/23/18 about appropriate dishwashing temperatures and the backup process. All dietary team members have been trained on the use of the temperature log, used at every meal, and what to do if temperatures are out of range.	

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F 812	Continued From page 20 temperatures." Of these temperatures recorded, there were 2 times (5/3/18 at dinner and 5/21/18 at breakfast) when the temperatures were less than 180 degrees F. There was nothing documented in the area for corrective action. 3. Review of the June 2018 hot water rinse temperatures for the dish-machine showed temperatures were recorded 3 times daily. There were 38 times when the temperature was recorded as less than 180 degrees F. There were two days when a corrective action note was made: on 6/6/18 and on 6/29/18 notes showed "advised maintenance." 4. Observation on 7/23/18 at 2:10 PM as the dish machine was in use, showed the final rinse temperature on the display was 171 degrees F. Interview with dietary aide #1 at that time revealed she was not aware what temperature was required. Review of the log showed the "PM" temperature had not yet been recorded for the day. Interview with dietary aide #2 at that time stated the rinse temperature had been a problem, and she reported it to maintenance "last Thursday." She also verified the plan was to continue using the machine. 5. A test of the dish-machine hot water temperature was done on 7/23/18 at 4:56 PM by the surveyor and witnessed by the CDM. The machine was a 2 temperature machine which displayed the wash temperature and also the rinse temperature. The test was done using indicator stickers (thermolables) designed to turn black when the dish surface reaches 160 degrees F when run through the dish machine cycle (160 degrees F at the dish/rack surface reflects 180 degrees F at the manifold, which is the area just	F 812	A typed reminder has been posted on the resident beverage refrigerator for all team members to write open dates on cartons of thickened water. Nursing assistants have been assigned tasks in the electronic record for picking up thickened beverages from resident rooms at 10:00PM daily. If beverages are prepared for residents on thickened liquids during the night, they are again picked up and disposed of a 5:00AM so that the thickened product is not consumed after 8 hours. An annual in-service on handwashing with food preparation is scheduled to be completed by the Registered Dietician. All new team members will complete a competency on hand hygiene with the Infection Prevention nurse during New Employee Orientation. Monitor permanent solution: The administrator or designee will complete random audits of dishwasher wash and rinse temperatures. The Certified Dietary Manager or designee will complete random audits on open dates on the multi-serving cartons of thickened liquids. The DON or designee will complete an audit on thickened liquids in resident rooms. The Infection Prevention nurse or	

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F 812	Continued From page 21 before the final rinse nozzle where the temperature of the dish-machine is measured). During the test the facility's label and the surveyor's label both failed to turn black. 6. Interview with the maintenance director on 7/24/18 at 10:15 AM revealed he had called to have the dish-machine booster heater serviced and was having difficulty in getting service scheduled. He stated he did not have documentation of when these calls were made. Further, he recalled times when the dietary staff requested him to come check the machine related to low temperatures, and stated these are documented on the maintenance log. When notified, he would adjusted the temperature and they continued to use it. 7. Review of the maintenance log from 5/27/18 to 7/9/18 showed 3 entries related to low temperature readings of the dish-machine. These dates were 6/7, 6/29 and 7/1. The dates when the work was documented as completed on the log were 6/8/18 and 7/2/18. 8. According to Food Code 2017, U.S. Public Health Service: 4-501.112 "(A) Except as specified in (B) of this section, in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90oC (194oF), or less than: (1) For a stationary rack, single temperature machine, 74oC (165oF); or (2) For all other machines, 82oC (180oF)." Regarding proper dating and labeling of pre-thickened beverage products:	F 812	designee will complete random audits of hand hygiene in the kitchen All of these audits will be completed weekly for eight or more weeks, monthly for 12 months or until substantial compliance has been met. These audits will be reported monthly at the Quality Assurance meeting for review and recommendation.	

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F 812	Continued From page 22 1. Observation on 7/24/18 at 8:55 AM showed a clear mug with a lid on the dresser in the room of resident #22. The liquid in the mug was opaque and appeared to be thin when the cup was picked up. There was no date or label on the cup/lid. Interview with CNA #3 at that time revealed it was the resident's thickened water. Interview with domestic aide #1 on 7/24/18 at 10:43 AM revealed there were 2 residents in that hallway that received thickened water in their rooms. The aide stated she had training in the past from the SLP on how to thicken beverages. She stated there was a powder thickener and also a prepared pre-thickened product which was water or juice. The aide said the schedule was to provide these thickened beverages to the resident rooms twice daily, at approximately 9:45 AM and 2 PM. Observation on 7/25/18 at 12:41 PM showed thickened water in the sippy mug on the dresser in the resident's room. There was no label of any kind on the cup or lid. 2. Observation on 7/25/18 at 11:28 AM showed 4 open multi-serving cartons of thickened beverages located in the beverage refrigerator located in the dining room. The cartons failed to include a date when the product had been opened or was to be discarded. The package information showed the product it was good for 8 hours in ambient air temperature, or up to 7 days if refrigerated. Interview with the CDM on 7/25/18 at 11:28 AM revealed once a carton was opened they used the product within 7 days, so she was not aware they required a date. 3. Interview with the CDM on 7/26/18 at 8:50 AM revealed the system for leaving thickened beverages in the resident rooms needed to be revised to ensure the appropriate time frame was	F 812		

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 _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	150 CARING WAY LANDER, WY 82520

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F 812	Continued From page 23 followed. 4. According to Food Code 2017, U.S. Public Health Service: 3-501.17 "(A)...refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days." Regarding hand hygiene: Observation in the kitchen on 7/25/18 at 11:38 AM showed the CDM used hand gel upon entering the kitchen and, without washing her hands, donned gloves to prepare resident beverages. At 11:39 AM dietary aide #1 handled the refrigerator door and, without hand washing, donned gloves to prepare a grilled sandwich. At 11:53 AM cook #1 used hand gel between tasks and prior to donning gloves to serve the noon meal. At no time during this observation did the cook wash his hands. During the observation it was noted there was a hand gel dispenser in the kitchen near the service window. The staff who were observed using the hand gel used this dispenser or the one on the wall just outside the entrance of the kitchen. Interview with the CDM on 7/26/18 at 8:50 AM revealed she was not aware there was a hand gel dispenser located in the kitchen, she further verified the expectation was to wash hands when they became contaminated and prior to glove use.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 24 According to Food Code 2017, U.S. Public Health Service 2-301.14 "FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms ...(H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands." According to Food Code 2017, U.S. Public Health Service 2-301.12 "(A) Except as specified in (D) of this section, FOOD EMPLOYEES shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a HANDWASHING SINK ...(B) FOOD EMPLOYEES shall use the following cleaning procedure in the order stated to clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands and arms: (1) Rinse under clean, running warm water ... (D) If APPROVED and capable of removing the types of soils encountered in the FOOD operations involved, an automatic handwashing facility may be used by FOOD EMPLOYEES to clean their hands or surrogate prosthetic devices."	F 812		