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 _____	08/29/2018

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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 from 8/26/18 to 8/29/18. The following common abbreviations are used throughout this document: ADL: Activities of Daily Living. 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		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		10/12/18

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

Electronically Signed | 09/21/2018

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 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure residents' advance directive preferences were up to date for 1 of 2 sample residents (#35) reviewed for advance directives. The findings were: Observation on 8/28/18 at 7:59 AM showed a red sticker was located next to resident #35's name at the entrance to his/her room. Interview with CNA #1 on 8/28/18 at 9:02 AM revealed a red dot next to a resident's name indicated the resident was designated as DNR (do not resuscitate). Review of the August 2018 recapitulation of physician orders and the resident's advanced directive care plan showed the resident's preference was DNR; however, review of the resident's WyoPOLST (Wyoming Provider Orders	F 578	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 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.	

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F 578	Continued From page 2 of Life Sustaining Treatment) document dated 6/20/18 indicated the resident's preference was to have CPR (cardiopulmonary resuscitation) and receive full treatment in the event of a medical emergency. Interview with the DON on 8/28/18 at 4:41 PM confirmed the resident had recently changed his/her advance directive preference and verified the care plan, physician's order, and sticker next to the resident's name had not been updated to reflect the change.	F 578	1. Resident #35 code status was updated in his care plan, physician orders and on his door to reflect the changes in his advanced directives. 2. All residents are at risk of not having their advanced directives reflected appropriately in the physician orders, care plans and stickers on their doors. 3.Social Service Director and Nursing staff were educated by the Director of Nursing or designee about the importance of updating advanced directives and reflecting any changes in the physician orders, care plans and the stickers located on the residents door. 4. A 100% audit will be conducted by DON or designee to ensure all advanced directives are reflected appropriately in the physician orders, care plans and the stickers located on the residents doors. Thereafter, a random monthly audit will be conducted monthly for three months to ensure advanced directives are current and are reflected appropriately in physician orders, care plans as well as the stickers located on the resident doors. 5. Results of these audits completed by the DON or designee will be reviewed at the Performance Improvement meetings monthly for three months or until substantial compliance has been met. Performance improvement meetings consist of at a minimum the Executive Director, Director of Nursing,the 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	

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F 578	Continued From page 3	F 578	implements appropriate plans of action to correct identified quality deficiencies.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(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. §483.12(c)(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 resident and staff interview, medical record review, and policy and procedure review, the facility failed to report allegations of abuse for	F 609	1. Resident #40 remains in the facility. No other reportable occurrences have taken place and no negative outcomes have	10/12/18

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F 609	Continued From page 4 1 of 2 sample residents (#40) with allegations of verbal and/or physical abuse. The findings were: 1. Review of the annual MDS assessment dated 6/29/18 showed resident #40 had a brief interview for mental status (BIMS) score of 12 (cognitively intact) and no evidence of hallucinations or delusions. The following concerns were identified: a. Interview with the resident on 8/27/18 at 8:35 AM revealed his/her prior roommate threatened to kill him/her and the facility moved the resident into his/her current room. b. Review of a "Concern & Comment" form dated 8/2/18 showed "Resident's daughter contacted SS [social services] to request a room change. Daughter stated that resident called her saying that [his/her] roommate "hit [him/her]" SS [social services] met w/ [with] resident and roommate. Resident denied [s/he] "was hit, but afraid [s/he] may be hit." Roommates family was present during the interaction [and] states there was "no incident." c. Review of a "social services" note dated 8/3/18 and timed 11:45 AM showed "SS [social services] received call from Resident's daughter, [name] requesting an immediate room change for her [resident]. She states that Resident call [sic] her stating that [his/her] roommate "hit [him/her] and that [s/he] is scared." SS [social services] met with Resident and [his/her] roommate separately. Resident stated that [s/he] "was not hit", but is afraid that [s/he] "may be". Roommate's grand daughters were visiting during the reported interaction, and stated that roommate had not "gotten out of the chair, and no words exchanged". Resident has previously made the same accusations with no apparent basis. DON was notified and spoke with Resident's daughter. Staff will accommodate	F 609	resulted in the incident not being reported. 2. All residents involved in allegations of resident to resident altercations are at risk of Administration failing to report the incident to appropriate agencies within the required two hour timeframe per federal regulation. Executive Director will complete a 100% audit of investigation log to ensure all investigations regarding resident to resident altercations have been reported as required by federal regulation. Five out of five investigations for resident to resident altercations were reported in accordance with federal regulation. 3. Executive Director will re-educate the Social Service Director and Director of Nursing regarding the reporting requirement to the state survey agency for any allegation of abuse/neglect/exploitation/or mistreatment including resident to resident altercations. Report should be submitted within the two hour reporting requirement per federal regulation. Random monthly audits x three months will be completed by Executive Director to ensure all allegations of resident to resident altercations that are investigated are also reported to the state survey agency within 2 hours per federal regulation. 4. Results of these audits completed by the Executive Director will be reviewed during the Performance Improvement meetings for three months or until the committee is able to determine the process in place is effective.	

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F 609	Continued From page 5 Resident's and Family's request for a room change. Resident will be moved to [room number]." d. Interview with the DON and social services director on 8/29/18 at 9:52 AM revealed the resident had changed rooms related to allegations of being hit by a roommate. Further interview revealed no incident reports were completed because the nurse stated there was no evidence of an altercation. It was confirmed that an investigation was completed for the 8/2/18 allegation, however, no allegations were reported to the state survey agency. e. Review of the policy titled "Reporting Alleged Abuse" last revised 2/7/17 showed "...3. All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin (e.g. bruising and skin tears) will be promptly reported to the administrator and/or director of nursing...6. The charge nurse will complete and sign the Incident Report and notify the physician and the resident's responsible party of the occurrence. The incident will be reported immediately to the administrator or his designated representative and the director of nursing...12. Federal requirements mandate that facilities must ensure all allegations of abuse, neglect, exploitation, or mistreatment are reported immediately to their state survey agency..."	F 609		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:	F 640		10/12/18

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F 640	Continued From page 6 (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or,	F 640		

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F 640	Continued From page 7 for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a discharge MDS assessment was completed as required for 1 of 1 sample residents (#1) reviewed for late transmissions. The findings were: Review of the medical record for resident #1 showed s/he was admitted to the facility on 3/27/18 and transferred to an assisted living facility on 6/1/18. Further review showed no evidence a discharge MDS assessment was completed (89 days post discharge). Interview with the MDS coordinator on 8/29/18 at 12:10 PM confirmed the discharge MDS assessment had not been completed.	F 640	1. Discharge MDS for resident #1 has been completed, transmitted and accepted. 2. Four residents who were discharged in the past month are at risk for not having a discharge MDS completed. 3. The MDS Coordinator will be re-educated regarding the RAI process for completing discharge assessments. 4. MDS Coordinator will complete a 100% audit of all discharge assessments for the last 90 days. MDS Coordinator will pull a missing OBRA report from CASPER reporting every 2 weeks to ensure that all discharge assessments are completed. A random monthly audit x 3 months of discharged residents will be completed by the MDSC or Health Information Director thereafter for three months to ensure all discharge assessments are completed. 5. Results of these audits completed by the MDSC/HIMD will be reviewed during the Performance Improvement meetings for three months or until the committee is able to determine the process in place is effective.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C	F 644		10/12/18

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F 644	Continued From page 8 of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a pre-admission screening and resident review (PASARR) II was completed for 1 of 2 sample residents (#16) who had a serious mental disorder, intellectual disability, or related condition. The findings were: 1. Review of the business office file for resident #16 showed a level I PASARR was completed at the time of admission; however, a PASARR II was not completed at that time related to the resident not having a diagnosis that would trigger the level II review. 2. Review of the annual MDS assessment dated 6/3/18 showed resident #16 was not currently considered by the state Level II PASARR process to have a serious mental illness and/or intellectual disability or related condition. Further review showed the resident had diagnoses which included anxiety disorder and manic depression.	F 644	1. PASARR level 2 was submitted for Resident #16 for diagnosis of major depression and anxiety. 2. All residents with a psychiatric diagnosis are at risk for not having a PASARR level 2 completed upon admission or readmission. 3. Social Services Director, Health Information Director and Admissions Director will be educated on the importance of completing the PASARR level 2 and which diagnosis require it. 4. A 100% audit will be completed by DON or designee of all residents with a psychiatric diagnosis to determine if a PASARR level 2 was completed if required. A monthly audit x 3 months will be conducted by SSD of new residents with psychiatric diagnosis to ensure a PASARR level 2 is completed appropriately and according to federal regulation.	

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F 644	Continued From page 9 3. Interview with the social services director on 8/29/18 at 10:12 AM revealed new diagnoses should be communicated to the social services director and she should initiate the Level II PASARR process. Further, it was revealed she was not aware resident #16 had a diagnosis of manic depression and confirmed the diagnosis would trigger a Level II PASARR.	F 644	5. Results of these audits completed by the DON or designee will be reviewed during the Performance Improvement meetings for three months or until the committee is able to determine the process in place is effective.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		10/12/18

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F 758	Continued From page 10 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure psychotropic medications were appropriately provided to 1 of 5 sample residents (#18) who were reviewed for unnecessary medications. The findings were: 1. Review of the annual MDS assessment dated 6/9/18 showed resident #18 had diagnoses which included anxiety, depression, and manic depression, and did not exhibit symptoms of depression during the look back period. Further, the resident was coded as having no behaviors during the look back period. The following concerns were identified: a. Review of the physician orders for resident #18 showed the resident had an order for	F 758	1. An updated physician/NP risk benefit statement was obtained for resident #18. 2. All residents receiving a psychoactive medication are at risk for not having a gradual dose reduction or risk benefit statement completed according to LCCA policy and federal regulation. 3. Nurse managers will be educated regarding the importance of updating the risk benefit statement and gradual dose reduction per LCCA policy as well as ensuring the care plans are updated quarterly. 4. A 100% facility audit will be completed by the DON or designee of all residents receiving psychoactive medications to ensure the gradual dose reductions have	

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F 758	Continued From page 11 Cymbalta (antidepressant) delayed release 30 mg (milligrams) capsule by mouth daily with a start date of 7/31/16. b. Review of a "mental" assessment completed on 8/8/18 and timed 9:38 AM showed the resident was alert and responsive with no behaviors exhibited. c. Review of a "Physician/NP Risk/Benefit statement" for the resident showed the Cymbalta was used for treatment of depression and was last reviewed on 6/1/17. d. Interview with RN #2 on 8/29/18 at 1:08 PM revealed the facility had not completed a gradual dose reduction or risk benefit statement for the resident since 6/1/17. e. Review of the policy titled "Psychopharmalogical Medication Management" last revised on 8/23/17 showed "...Residents who use these drugs receive gradual dose reduction and behavioral interventions, unless clinically contraindicated in an effort to discontinue these drugs...Gradual dose reduction efforts and/or determinations for no gradual dose reductions will be documented in the resident's care plan at least quarterly...After longer than one year of drug therapy, attempt drug reduction once per year. If GDR is unsuccessful after two or more attempts, further reduction may be "clinically contraindicated." Documentation is needed in the individual's record why additional dose reductions will cause impairment, psychiatric instability, or exacerbate the underlying psychiatric disorder."	F 758	been attempted per regulation as well as the physician/NP risk benefit statement completed and the care plans updated. A random monthly audit x3 months will be completed by the DON or designee thereafter to ensure gradual dose reductions as well as the physician/NP risk benefit statement are completed and care plans have been updated. 5.Results of these audits completed by the DON or designee will be reviewed during the Performance Improvement meetings for three months or until the committee is able to determine the process in place is effective.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		10/12/18

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 _____	08/29/2018

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F 759	Continued From page 12 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy and procedure review, and review of professional standards, the facility failed to maintain a medication error rate of five percent or less. The error rate for medication administration pass was 8 errors (affecting residents #34 and #35) out of 46 opportunities, resulting in a 17.39% error rate. The findings were: 1. Observation during medication administration on 8/28/18 at 8:56 AM showed RN #3 prepared hydrocodone/acetaminophen (narcotic pain reliever) 7.5/325 milligram (mg) liquid, docusate (stool softener) 50 mg/5 milliliter (mL) - 30 mL liquid, and 4 drops of Mi-Acid gas relief (reduce bloating) 20 mg liquid together into a plastic cup. She then crushed escitalopram (treat depression/anxiety disorder) 20 mg tablet, baclofen (muscle relaxant) 20 mg tablet, and Lisinopril (treat high blood pressure) 30 mg tablet together. The RN then combined the crushed medications with the liquid medications and administered the medications through resident #35's gastrostomy tube (G-tube). The following concerns were identified: a. Interview with RN #3 on 8/28/18 at 9:11 AM, confirmed the pills were crushed together, combined with the liquids, and administered through the G-tube. b. Interview with the DON on 8/29/18 at 1:50 PM revealed it was the expectation of the facility for nurses to follow the facility policy when administering medications through the G-Tube. c. Review of the policy titled "Procedure for Administering PO Medications through an Enteral	F 759	1. Resident #35 has no negative outcomes related to receiving crushed and liquid medications combined through the G tube. Resident #34 had no negative outcomes related to receiving crushed Aspirin and Omeprazole. 2. All 5 residents who receive crushed medications are at risk for receiving those medications crushed when they should not be crushed according to LCCA policy and federal regulation. The Facility has one resident with a G-tube which is resident #35. 3. All nurses will be re-educated regarding the appropriate administration of medications via G-tube as well as the list of medications that should not be crushed, chewed or cut according to LCCA policy and federal regulation. 4. A random weekly audit/observation will be conducted x 4 weeks and monthly thereafter for 3 months by the DON or designee to include residents #34 and #35 to ensure the appropriate administration of medication via G-tube is being followed as well as ensuring residents are administered crushed medications per policy and regulation. If non compliance is noted during an observation immediate re-education and/or corrective action will occur. 5. Results of these audits completed by the DON or designee will be reviewed during the Performance Improvement meetings for three months or until the	

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F 759	Continued From page 13 Feeding Tube" last revised 6/26/06 showed "...4. If more than 1 medication is being given, give each separately, rinsing the tube with 5 ml-10 ml of warm water between each medication..." d. Review of the "Nursing Interventions and Clinical Skills" by Perry, Potter, and Ostendorf (2016), sixth edition showed: "Implementation for Administering Medications Through A Feeding Tube ... 13. ...b. To administer more than one medication, give each separately and flush between medications with 15 to 30 mL of water..." 2. Observation on 8/28/18 at 7:54 AM showed RN #4 prepared medications for resident #34 which included one Aspirin (pain reliever) 81 mg (milligrams) EC (enteric coated) tablet and one omeprazole (acid reflux reliever) 20 mg delayed release capsule. The nurse crushed the Aspirin, separated the omeprazole capsule, mixed the crushed Aspirin and the omeprazole granules into yogurt, and administered the medications to the resident. The following concerns were identified: a. Interview with RN #1 on 8/28/18 at 7:57 AM confirmed the aspirin order was for delayed release and delayed release medications should not be crushed. b. Review of the resident's physician orders on 8/28/18 at 8:11 AM showed omeprazole 20 mg and Aspirin 81 mg were both ordered as delayed release. Further review showed no evidence of a physician's order to crush medications. b. Review of the facility's "Do not crush, chew, or cut" list provided by the facility on 8/28/18 showed "...aspirin EC (enteric coated) may NOT crush...contents from capsules, short-acting and long-acting which can be opened mat [sic] be crushed if short-acting but, long acting contents should not be crushed, they should be placed onto of the [sic] applesauce or	F 759	committee is able to determine the process in place is effective.	

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F 759	Continued From page 14 other...Enteric coated products need to remain whole until they reach intestines. Crushing these products eliminates the purpose of them being coated..."	F 759		