| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **WESTVIEW HEALTH CARE CENTER** | **1990 WEST LOUCKS STREET SHERIDAN, WY 82801** |

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| F 000 | INITIAL COMMENTS<br><br>A complaint survey was conducted by Healthcare Licensing and Surveys from 12/12/18 to 12/13/18. The survey was prompted by complaint intake WY00002748.<br><br>The following common abbreviations are used through this document:<br><br>CNA; Certified Nurse Aide<br>MDS : Minimum Data Set<br>RN: Registered Nurse<br>DON: Director of Nursing<br>NA: Nurse Aide<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F 000 | | |
| F 600 SS=G | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, medical | F 600 | Preparation and execution of this | 1/25/19 |

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

Electronically Signed | 01/10/2019

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| F 600 | Continued From page 1<br>record review, review of the facility incident investigations, and policy and procedure review, the facility failed to ensure residents were free of neglect for 1 of 3 sample residents (#43) with a fall which resulted in injury. This failure resulted in actual harm to resident #43. The findings were:<br><br>1. Review of the quarterly MDS assessment dated 10/2/18 showed resident #43 had diagnoses which included non-Alzheimer's dementia. Further review showed the resident was independent with walking in room and corridor, required extensive assistance of 1 staff member for locomotion, dressing, toilet use, and personal hygiene, and extensive assistance of 2 or more staff members for bed mobility and transfers. The following concerns were identified:<br>a. Observation on 12/12/18 at 2:43 PM showed the resident had a bruise located on his/her right hip which was yellow and green around the perimeter and purple in the center. Interview with NA #1 at that time revealed the resident had a fall "approximately 2 weeks ago" and had declined since that time.<br>b. Interview with RN #1 on 12/12/18 at 2:50 PM revealed she was not at the facility when "the fall happened." Interview with the RN at 6:15 PM revealed there was no report of any fall that occurred, an incident form was not completed, "but the evidence showed there was a fall that caused the fracture."<br>c. Observation on 12/12/18 at 4:25 PM showed 2 staff members assisted the resident to transfer from bed to wheelchair. The staff members placed a gait belt around the resident's trunk and assisted him/her to stand. During the transfer, the resident did not place weight on his/her right leg. Further, there was no evidence of pain noted. | F 600 | response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual.<br><br>1. Resident #43 remains in the facility and was reported for injury of unknown origin on 12/8/18. Upon the results of the investigation RN #1, RN #2, and RN #3 were placed into corrective action.<br>2. All residents who have had an adverse incident are at risk of the incident not being documented, assessed according to policy and procedure or reported at the time of the occurrence.<br>3. A). Nursing staff have been educated on reporting adverse events at the time of the occurrence, definitions of what constitutes a fall, the process for incident reporting including injuries of unknown origin as well as alert/event charting after an incident or report of an incident, how to perform a skin assessment according to policy and procedure, monitoring and assisting in rooms/safety precautions, fall huddles immediate and 24 hours post fall as well as reporting a change of condition. | |

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| F 600 | Continued From page 2<br>d. Interview with CNA #1 on 12/13/18 at 8:14 AM revealed she was told there had been a fall; however, no fall was documented.<br>e. Review of the "Monthly Flow Report" from 11/1/18 to 11/30/18 showed the resident was documented as independent for bed mobility 65 out of 91 entries, for transfers 62 out of 90 entries, for walk in room 77 out of 90 entries, for walk in hallway 59 out of 90 entries, for locomotion on unit 33 out of 90 entries, for locomotion off the unit 30 out of 90 entries, for toileting 30 out of 118 entries, and for personal hygiene 24 out of 90 entries. Review of the "Monthly Flow Report" From 11/30/18 to 12/12/18 showed the resident was not marked as independent for any activities of daily living entries. Further, the resident was marked extensive assistance, total assistance, or activity did not occur for bed mobility, transfers, walk in room, walk in hallway, locomotion on unit, locomotion off unit, toileting, and personal hygiene for all entries made during that time period.<br>f. Review of a progress note entry dated 12/4/18 and timed 10:52 AM showed "Res [resident] noted decline. Res ext [extensive] assist of 1-2 [1 to 2 staff members] with cares. Not communicating. Res pocketing food per report. Res is using w/c [wheelchair] for mobility. Will evaluated[sic] how [s/he] can take meds [medications] when [s/he] gets up at [his/her] usual time here shortly."<br>g. Review of a physician's "Nursing Home Progress Note" dated 12/4/18 and timed 5:53 PM showed "...[resident's name] is seen today in routine home rounds. [His/her] daughter really has some concerns about [his/her] decline..."<br>h. Review of a skin assessment dated 12/6/18 and untimed showed the resident had a | F 600 | All staff have been educated on Abuse and Neglect and the reporting requirements.<br>B). Staff will discuss any adverse events, changes in condition or function and any injuries of unknown origin during daily rounds/report.<br>C). A 100% audit of all Long Term Care residents will be conducted by the DON or designee to determine if there has been a decline in ADL function. This audit will occur weekly for 4 weeks then monthly thereafter for three months. If any problem is noted immediate re-education and/or corrective action with take place.<br>A 100% audit of adverse incidents will be conducted by the DON or designee to ensure policies and procedures have been followed. This audit will occur weekly for 4 weeks then monthly thereafter for three months. If any problem is noted, immediate re-education and/or corrective action will take place.<br>A 100% audit of skin assessments on those residents who have had an adverse incident will be completed to ensure they are conducted per policy and procedure. This audit will occur weekly for 4 weeks then monthly thereafter for three months. If any problem is noted, immediate re-education and/or corrective action will take place.<br>4. Results of these 3 aforementioned audits completed by the Director of Nursing will be reviewed at the Quality Assurance/Performance Improvement (QAPI) meetings monthly for three months or until substantial compliance has been met and the committee is able | |

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| F 600 | Continued From page 3<br>"bruise" identified on his/her right thigh.<br>i. Review of a "progress note" entry dated 12/7/18 and timed 5:40 PM showed "While getting the resident up for evening meal staff noticed that [his/her] right hip was significantly swollen. Upon nursing assessment the hip was notably swollen, had a large healing bruise to [his/her] right femur/hip area. Bruise measured 7 cmx3 cm [sic] center of the bruise is light purple and the outside is yellowish/green. Hip was abducted [moved away from the body midline] and adducted [moved toward the body midline] and resident showed no s/s [signs/symptoms] of pain, and denied pain. When lying flat right leg appears shorter than left leg. When standing resident would not put any weight on the right leg [s/he] would pick it up off the floor leaving[his/her] toes touching the floor. Spoke with DON and the decision was made that it would be beneficial to have the resident examined at the hospital..."<br>j. Review of an "EMS [emergency medical services]" note dated 12/7/18 and timed 5:26 PM showed "...RN reports the pt. [patient] has been unwilling to bear weight or ambulate, and has been guarding [his/her] right hip. She reports that [s/he] has a bruise and some swelling on [his/her] right hip. She reports that [s/he] has had no falls and no other trauma. She states that she is unsure how the patient got the bruise. She states that [s/he] was normally ambulatory a couple of weeks ago...pt. appears to be favoring [his/her] left side, and is unwilling to bear weight on right leg. Right leg appears shorter and externally rotated. Large bruise noted to lateral right thigh with various colors and appears to be at least several days old..."<br>k. Review of a facility investigation reported to the State Survey Agency on 12/8/18 at 11:45 AM showed the administrator was informed the | F 600 | to determine the process in place is effective. The monthly Quality Assurance/performance Improvement meetings consist of at a minimum the Executive Director, Director of Nursing, and Medical Director, and additional staff as needed. The Performance Improvement committee identifies issues with respect to which quality assessment and assurance activities are necessary and develops and implements appropriate plans of action to correct identified quality deficiencies. | |

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| F 600 | Continued From page 4 | F 600 | | |

resident was found to have a fracture and bruise to his/her right hip on 12/7/18 at 9:55 PM. Further review showed the facility interviewed a RN who revealed on 11/30/18 the resident was "trying to sit down or stand up from the w/c" and the nurse positioned herself behind the resident "and lowered [him/her] to the floor." Further review showed "this incident could have possibly lead to [his/her] injuries. The RN admitted she failed to report and follow policy..."

l. Review of the "Progress Note" entries for November 2018 and December 2018 showed there were no entries made between 11/8/18 and 12/4/18.

m. Interview with the DON and administrator on 12/13/18 at 8:40 AM revealed if the nurse had followed the facility's policy the resident would have been placed on follow up with routine monitoring. This may have resulted in sooner injury identification, and it was the facility's expectation for staff to document all changes in a resident's condition. The decline in ADLs also should have resulted in resident monitoring related to a change in condition. Further, it was revealed administration should have been notified of the bruise on 12/6/18 when the skin check was performed and an investigation would have been initiated at that time; however, the investigation was not initiated until the hospital notified the administrator on 12/7/18 that the resident had a bruise and fracture that were "several days old."

n. Review of a policy titled "Change in a Resident's Condition" last revised 3/2010 showed "1. All changes in the resident's condition will be recorded in the resident's medical record. Such changes or conditions include, but are not limited to: Any accident/incident involving the resident. Any change in the resident's mental, physical, or emotional status..."

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| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, medical record review, and review of the facility incident investigations, the facility failed to ensure an timely investigation was initiated for 1 of 3 sample residents (#43) with an injury of unknown origin. The findings were:<br><br>1. Review of the quarterly MDS assessment dated 10/2/18 showed resident #43 had diagnoses which included non-Alzheimer's dementia. Further review showed the resident was independent with walking in room and corridor, required extensive assistance of 1 staff member for locomotion, dressing, toilet use, and personal hygiene, and extensive assistance of 2 or more staff members for bed mobility and transfers. The following concerns were identified: | F 610 | 1. Resident #43 remains in the facility and was reported for injuring of unknown origin on 12/8/18.<br>2. Any resident with an injury of unknown origin is at risk of staff and administration failing to report the incident to appropriate agencies within 2 hours per federal requirements.<br>3. Executive Director or designee will educate all staff regarding timeliness for reporting any allegation of abuse/neglect, resident to resident altercations as well as any injuries of unknown origin to the Executive Director, Director of Nursing and/or Social Services Director. Reports should be submitted no later than 2 hours upon knowledge of incident per federal | 1/25/19 |

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| F 610 | Continued From page 6<br>a. Observation on 12/12/18 at 2:43 PM showed the resident had a bruise located on his/her right hip which was yellow and green around the perimeter and purple in the center.<br>b. Review of a skin assessment dated 12/6/18 and untimed showed the resident had a "bruise" identified on his/her right thigh.<br>c. Review of a "progress note" entry dated 12/7/18 and timed 5:40 PM showed "While getting the resident up for evening meal staff noticed that [his/her] right hip was significantly swollen. Upon nursing assessment the hip was notably swollen, had a large healing bruise to [his/her] right femur/hip area. Bruise measured 7 cmx3 cm [sic] center of the bruise is light purple and the outside is yellowish/green. Hip was abducted [moved away from the body midline] and adducted [moved toward the body midline] and resident showed no s/s [signs/symptoms] of pain, and denied pain. When lying flat right leg appears shorter than left leg. When standing resident would not put any weight on the right leg [s/he] would pick it up off the floor leaving [his/her] toes touching the floor. Spoke with DON and the decision was made that it would be beneficial to have the resident examined at the hospital..."<br>d. Review of an "EMS [emergency medical services]" note dated 12/7/18 and timed 5:26 PM showed "...RN reports the pt. [patient] has been unwilling to bear weight or ambulate, and has been guarding [his/her] right hip. She reports that [s/he] has a bruise and some swelling on [his/her] right hip. She reports that [s/he] has had no falls and no other trauma. She states that she is unsure how the patient got the bruise. She states that [s/he] was normally ambulatory a couple of weeks ago...pt. appears to be favoring [his/her] left side, and is unwilling to bear weight on right | F 610 | requirements.<br>4. Executive Director will audit all allegations including injuries of unknown origin to ensure the proper notification to State and local agencies. This audit will occur weekly for 4 weeks then monthly for three months thereafter.<br>5. Audits completed by the Executive Director will be discussed monthly at our Performance Improvement meetings for three months or until substantial compliance has been met and the committee is able to determine the process in place is effective. | |

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| F 610 | Continued From page 7<br>leg. Right leg appears shorter and externally rotated. Large bruise noted to lateral right thigh with various colors and appears to be at least several days old..."<br>e. Review of a facility investigation reported to the State Survey Agency on 12/8/18 at 11:45 AM showed the administrator was informed the resident was found to have a bruise to his/her right hip on 12/7/18 at 9:55 PM.<br>f. Interview with the DON and administrator on 12/13/18 at 8:40 AM revealed administration should have been notified of the bruise on 12/6/18 when the skin check was performed and an investigation would have been initiated at that time; however, the investigation was not initiated until the hospital notified the administrator on 12/7/18 that the resident had a bruise and fracture that were "several days old." | F 610 | | |
| F 684 SS=G | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, medical record review, review of the facility incident investigations, and policy and procedure review, the facility failed to ensure a change of condition was assessed for 1 of 4 sample residents (#43) with a fall. This failure resulted in actual harm to | F 684 | 1. Resident #43 remains in the facility and was reported for injury of unknown origin on 12/8/18. Upon the results of the investigation RN #1, RN #2, and RN #3 were placed into corrective action.<br>2. All residents who have had an adverse | 1/25/19 |

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| F 684 | Continued From page 8 | F 684 | | |

resident #43. The findings were:

1. Review of the quarterly MDS assessment dated 10/2/18 showed resident #43 had diagnoses which included non-Alzheimer's dementia. Further review showed the resident was independent with walking in room and corridor, required extensive assistance of 1 staff member for locomotion, dressing, toilet use, and personal hygiene, and extensive assistance of 2 or more staff members for bed mobility and transfers. The following concerns were identified:

a. Observation on 12/12/18 at 2:43 PM showed the resident had a bruise located on his/her right hip which was yellow and green around the perimeter and purple in the center. Interview with NA #1 at that time revealed the resident had a fall "approximately 2 weeks ago" and had declined since that time.

b. Interview with RN #1 on 12/12/18 at 2:50 PM revealed the she was not at the facility when "the fall happened." Interview with the RN at 6:15 PM revealed there was no report of any fall that occurred, an incident form was not completed, "but the evidence showed there was a fall that caused the fracture."

c. Observation on 12/12/18 at 4:25 PM showed 2 staff members assisted the resident to transfer from bed to wheelchair. The staff members placed a gait belt around the resident's trunk and assisted him/her to stand. During the transfer, the resident did not place weight on his/her right leg. Further, there was no evidence of pain noted.

d. Interview with CNA #1 on 12/13/18 at 8:14 AM revealed she was told there had been a fall; however, no fall was documented.

e. Review of the "Monthly Flow Report" from 11/1/18 to 11/30/18 showed the resident was

incident are at risk of the incident not being documented, assessed according to policy and procedure or reported at the time of the occurrence.

3. A). Nursing staff have been educated on reporting adverse events at the time of the occurrence, definitions of what constitutes a fall, the process for incident reporting including injuries of unknown origin as well as alert/event charting after an incident or report of an incident, how to perform a skin assessment according to policy and procedure, monitoring and assisting in rooms/safety precautions, fall huddles immediate and 24 hours post fall as well as reporting a change of condition. All staff have been educated on Abuse and Neglect and the reporting requirements.

B). Staff will discuss any adverse events, changes in condition or function and any injuries of unknown origin during daily rounds/report.

C). A 100% audit of all Long Term Care residents will be conducted by the DON or designee to determine if there has been a decline in ADL function. This audit will occur weekly for 4 weeks then monthly thereafter for three months. If any problem is noted immediate re-education and/or corrective action with take place. A 100% audit of adverse incidents will be conducted by the DON or designee to ensure policies and procedures have been followed. This audit will occur weekly for 4 weeks then monthly thereafter for three months. If any problem is noted, immediate re-education and/or corrective action will take place.

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| F 684 | Continued From page 9<br>documented as independent for bed mobility 65 out of 91 entries, for transfers 62 out of 90 entries, for walk in room 77 out of 90 entries, for walk in hallway 59 out of 90 entries, for locomtion on unit 33 out of 90 entries, for locomotion off the unit 30 out of 90 entries, for toileting 30 out of 118 entries, and for personal hygiene 24 out of 90 entries. Review of the "Monthly Flow Report" From 11/30/18 to 12/12/18 showed the resident was not marked as independent for any activities of daily living entries. Further, the resident was marked extensive assistance, total assistance, or activity did not occur for bed mobility, transfers, walk in room, walk in hallway, locomotion on unit, locomotion off unit, toileting, and personal hygiene for all entries made during that time period.<br>f. Review of a progress note entry dated 12/4/18 and timed 10:52 AM showed "Res [resident] noted decline. Res ext [extensive] assist of 1-2 [1 to 2 staff members] with cares. Not communicating. Res pocketing food per report. Res is using w/c [wheelchair] for mobility. Will evaluated[sic] how [s/he] can take meds [medications] when [s/he] gets up at [his/her] usual time here shortly."<br>g. Review of a physician's "Nursing Home Progress Note" dated 12/4/18 and timed 5:53 PM showed "...[resident's name] is seen today in routine home rounds. [His/her] daughter really has some concerns about [his/her] decline..."<br>h. Review of a skin assessment dated 12/6/18 and untimed showed the resident had a "bruise" identified on his/her right thigh.<br>i. Review of a "progress note" entry dated 12/7/18 and timed 5:40 PM showed "While getting the resident up for evening meal staff noticed that [his/her] right hip was significantly swollen. Upon nursing assessment the hip was | F 684 | A 100% audit of skin assessments on those residents who have had an adverse incident will be completed to ensure they are conducted per policy and procedure. This audit will occur weekly for 4 weeks then monthly thereafter for three months. If any problem is noted, immediate re-education and/or corrective action will take place.<br>4. Results of these 3 aforementioned audits completed by the Director of Nursing will be reviewed at the Quality Assurance/Performance Improvement (QAPI) meetings monthly for three months or until substantial compliance has been met and the committee is able to determine the process in place is effective. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535039 | A. BUILDING _____ B. WING _____ | C 12/13/2018 |

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

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| F 684 | Continued From page 10 | F 684 | | |

notably swollen, had a large healing bruise to [his/her] right femur/hip area. Bruise measured 7 cmx3 cm [sic] center of the bruise is light purple and the outside is yellowish/green. Hip was abducted [moved away from the body midline] and adducted [moved toward the body midline] and resident showed no s/s [signs/symptoms] of pain, and denied pain. When lying flat right leg appears shorter than left leg. When standing resident would not put any weight on the right leg [s/he] would pick it up off the floor leaving[his/her] toes touching the floor. Spoke with DON and the decision was made that it would be beneficial to have the resident examined at the hospital..."

j. Review of an "EMS [emergency medical services]" note dated 12/7/18 and timed 5:26 PM showed "...RN reports the pt. [patient] has been unwilling to bear weight or ambulate, and has been guarding [his/her] right hip. She reports that [s/he] has a bruise and some swelling on [his/her] right hip. She reports that [s/he] has had no falls and no other trauma. She states that she is unsure how the patient got the bruise. She states that [s/he] was normally ambulatory a couple of weeks ago...pt. appears to be favoring [his/her] left side, and is unwilling to bear weight on right leg. Right leg appears shorter and externally rotated. Large bruise noted to lateral right thigh with various colors and appears to be at least several days old..."

k. Review of a facility investigation reported to HLS on 12/8/18 at 11:45 AM showed the administrator was informed the resident was found to have a fracture and bruise to his/her right hip on 12/7/18 at 9:55 PM. Further review showed the facility interviewed a RN who revealed on 11/30/18 the resident was "trying to sit down or stand up from the w/c" and the nurse positioned herself behind the resident "and

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| F 684 | Continued From page 11 | F 684 | | |

lowered [him/her] to the floor." Further review showed "this incident could have possibly lead to [his/her] injuries. The RN admitted she failed to report and follow policy..." The nurse was suspended pending investigation on 12/8/18. The facility notified the State Survey Agency, local law enforcement, and the resident's family.

l. Review of the "Progress Note" entries for November 2018 and December 2018 showed there were no entries made between 11/8/18 and 12/4/18.

m. Interview with the DON and administrator on 12/13/18 at 8:40 AM revealed if the nurse had followed the facility's policy the resident would have been placed on follow up with routine monitoring. That may have resulted in sooner injury identification, and it was the facility's expectation for staff to document all changes in a resident's condition. The decline in ADLs should have also resulted in resident monitoring related to a change in condition. Further, it was revealed administration should have been notified of the bruise on 12/6/18 when the skin check was performed and an investigation would have been initiated at that time; however, the investigation was not initiated until the hospital notified the administrator on 12/7/18 that the resident had a bruise and fracture that were "several days old."

n. Review of a policy titled "Change in a Resident's Condition" last revised 3/2010 showed "1. All changes in the resident's condition will be recorded in the resident's medical record. Such changes or conditions include, but are not limited to: Any accident/incident involving the resident. Any change in the resident's mental, physical, or emotional status..."