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 05/02/2019

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 complaint survey was conducted by Healthcare Licensing and Surveys on 5/1/19 through 5/2/19. The survey was prompted by complaint intake WY000002822.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		6/14/19

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

Electronically Signed | 05/22/2019

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F 656	Continued From page 1 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop an individualized care plan for 1 of 2 sample residents (#3) who had urinary incontinence. The findings were: Review of the 2/11/19 quarterly MDS showed resident #3 was admitted to the facility on 11/10/17 with diagnoses which included muscular weakness, history of falling, sleep apnea, apraxia [inability to perform purposeful movements], pulmonary hypertension, and osteoarthritis. The review showed the resident required extensive assistance of one staff member for toileting, was on a toileting program, and was frequently incontinent of urine. The following concerns were identified: a. Continuous observation on 5/1/19 from 3:45 PM until 8:35 PM (4 hours and 50 minutes) showed the resident was not toileted, asked if s/he needed to toilet, or checked for incontinence by staff. The resident was toileted and provided urinary incontinence care at 8:35 PM. b. Review of the resident's incontinence care plan, last revised on 2/21/19, confirmed the resident had bladder incontinence with impaired mobility and physical limitations. For the goal, the	F 656	Correct deficiency to individual: MDS Nurse updated Resident #3's care plan to include offer toileting every two hours and provide incontinence care when needed. How others are identified and correction to others in similar situations: A review of all bowel and bladder care plans will be completed on or before 5/31/19 to identify residents who have current toileting needs or incontinence. MDS Coordinator or designee will be responsible for reviewing and updating the care plan to ensure individualized interventions are in place. Measures/systemic changes to prevent recurrence: MDS Coordinator educated to the Bowel and Bladder Standard. Focusing on the assessment, planning and interventions piece to ensure individualized care planning. MDS nurse will be educated to the Comprehensive Care Plan policy. MDS Nurse will be educated by the DON no later than 5/24/19.	

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F 656	Continued From page 2 plan showed, "Will be continent during waking hours through the review date." However, the interventions failed to specify individualized staff guidance to accomplish the goal, and showed, "Monitor/document signs and symptoms of UTI [urinary tract infection]: pain, burning, blood tinged urine, cloudiness, no output, dark urine, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns PRN [as needed]...Perineal care PRN." c. Interview with the DON on 5/2/19 at 9 AM confirmed the care plan for resident #3 was not individualized with specific interventions to address the goal of remaining continent while awake.	F 656	Monitor permanent solution: DON or their designee will complete 2 chart audits weekly for the next 60 days then PRN based on findings to ensure that residents' care plan interventions are individualized for incontinent residents. Care plan corrections will be made at the time of the audits. Results of these audits will be presented at the monthly Quality Assurance and Performance Improvement (QAPI) meetings.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		6/14/19

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F 690	Continued From page 3 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide timely assistance for 1 of 2 sample residents (#3) who required incontinence care assistance from staff. The findings were: Review of the 2/11/19 quarterly MDS showed resident #3 was admitted to the facility on 11/10/17 with diagnoses which included muscular weakness, history of falling, sleep apnea, apraxia [inability to perform purposeful movements], pulmonary hypertension, and osteoarthritis. The review showed the resident required extensive assistance of one staff member for toileting, was on a toileting program, and was frequently incontinent of urine. The following concerns were identified: a. Continuous observation on 5/1/19 from 3:45 PM until 8:35 PM (4 hours and 50 minutes) showed the resident was not toileted, asked if s/he needed to toilet, or checked for incontinence	F 690	Correct deficiency to individual: Direct care staff will offer toileting and provide incontinent care per care plan interventions and bowel/bladder program for resident #3. How others are identified and correction to others in similar situations: A review of toileting schedules will be completed on or before 5/31/19 to identify residents who have current toileting needs or incontinence. Direct care staff will offer toileting and provide incontinent care per care plan interventions and bowel/bladder programs. Measures/systemic changes to prevent recurrence: Nurses and CNAs will be educated before June 14, 2019 regarding where to find interventions, when to report changes,	

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F 690	Continued From page 4 by staff. The resident was toileted and provided urinary incontinence care at 8:35 PM by CNAs #1 and #2. b. Interview with CNAs #1 and #2 on 5/1/19 at 8:35 PM revealed their usual routine was to check the resident every 2 hours for incontinence, and provide toileting assistance as required. They both confirmed the resident had not been checked or offered toileting assistance from 3:45 PM until 8:35 PM, and s/he was incontinent of urine at that time, though not saturated. c. Review of the resident's incontinence care plan, last revised on 2/21/19, confirmed the resident had bladder incontinence with impaired mobility and physical limitations. For the goal, the plan showed, "Will be continent during waking hours through the review date." However, the interventions failed to specify individualized staff guidance to accomplish the goal, and showed, "Monitor/document signs and symptoms of UTI [urinary tract infection]: pain, burning, blood tinged urine, cloudiness, no output, dark urine, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns PRN [as needed]...Perineal care PRN." d. Interview with the DON on 5/1/19 at 8:40 PM confirmed it was her expectation for staff to toilet resident #3 every two hours or provide incontinence care at that time.	F 690	expectations of care, bowel and bladder standard, as well as, following individualized care plan interventions. Monitor permanent solution: Two observational audits will be completed weekly for 60 days then PRN based on findings of residents requiring toileting assistance and incontinent care being completed per resident care plan and/or bowel/bladder programs by ADON or designee. Results of these audits will be presented at the monthly Quality Assurance and Performance Improvement (QAPI) meetings.	