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 _____	10/14/2021

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 10/11/21 to 10/14/21. The following abbreviations are used throughout the document: DON - Director of Nursing MDS - Minimum Data Set	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure resident assessments accurately reflected their health status for 1 of 22 sample residents (#25). The findings were: 1. Review of the 5/20/21 admission MDS assessment showed resident #25 was admitted with diagnoses which included glaucoma, pain in right and left knee, generalized weakness, cognitive communication deficit and generalized anxiety. Further review showed the resident did not have a feeding tube. The following concerns were identified: a. Observation on 10/11/21 at 5:24 PM showed the resident in the dining room eating dinner. Review of the care plan, with a revision date of 8/25/21, showed the resident was on a regular diet with meal fortification. b. Review of the 8/23/21 quarterly MDS	F 641	Correct deficiency to individual: Resident #25 MDS assessment was updated to reflect that she was not receiving nutrition through feeding tube. Protect Residents from similar situations: Audit of all residents' most recent MDS assessment to be completed by MDS Coordinator to ensure there were no other assessments coded incorrectly in the nutrition section. Measures/Systemic Changes to prevent reoccurrence: Education provided to consultant dietician about the miscoded feeding tube on 10/21/21. New process of checking accuracy of the assessment will be performed by MDS coordinator before completion or submission.	11/19/21

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

Electronically Signed | 11/04/2021

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F 641	Continued From page 1 assessment showed the resident had a feeding tube. c. Interview on 10/12/21 at 4:52 PM with the DON revealed the resident did not have a feeding tube. d. Interview on 10/12/21 at 4:56 PM with the MDS coordinator revealed the resident did not have a feeding tube, and the entry was placed by mistake. She further stated the dietician filled the nutrition section on the MDS assessment, and there wasn't a process to double check entries for accuracy.	F 641	Monitor permanent solution: Each assessment will be double-checked by MDS Coordinator or designee prior to submittal each week for 90 days. A monthly audit of all MDS assessments completed within the previous month will be completed by MDS coordinator or designee and reported to QAPI for three months.	
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 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 complete a	F 644	Correct deficiency to individual: Social Services Coordinator (SSC)	11/19/21

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F 644	Continued From page 2 Preadmission Screening and Resident Review (PASARR) level II as required for 1 of 22 residents (#45) reviewed for PASARR needs. The findings were: 1. Review of the 9/30/19 annual MDS assessment showed resident #45 was admitted to the facility on 10/6/17 with diagnoses which included atrial fibrillation, heart failure, hypertension, gastric esophageal reflux disease, diabetes mellitus, cerebral vascular attack, hemiplegia, anxiety, edema, retention of urine, pain, and iron deficiency. The following concerns were identified: a. Review of progress notes dated 7/6/21 at 10:10 AM showed the resident was seeing dead squirrels hanging outside the window. b. Review of the 9/22/21 annual MDS assessment showed additional diagnoses of hallucinations and delusional disorders had been included to the original list. Further review of the assessment showed a PASRR level II was not recorded. c. Interview with the Director of Social Services and the DON on 10/12/21 at 5:07 PM revealed the staff did not recognize the diagnoses would trigger a level II PASARR. It was confirmed that a PASARR Level II had not been initiated.	F 644	submitted PASRR Level I review on 10/18/2021 for resident #45 to include psychiatric diagnosis of F22-Delusional Disorders and F41.9-Anxiety Disorder, unspecified. PASRR Level I review returned as needing referral for PASRR Level II evaluation of Mental Illness. Psychosocial evaluation completed by Licensed Professional Counselor on 10/25/2021. All required documentation submitted to WY Health on 10/25/2021 for Level II determination report. Wyoming PASRR Level II Determination Summary Report returned to SSC on 10/26/2021. Level II determined nursing facility placement is appropriate, placement authorized; specialized services are not required. SSC implemented PASRR Level II care plan for resident #45 with recommendations received from WY Health reviewer. SSC informed family and physician of resident #45 the PASRR Level II Determination Summary Report. Protect residents from similar situations: 100% audit of all residents completed for PASRR Level II triggering diagnoses. Residents identified out of compliance with Coordination of PASSAR and Assessment to be submitted for PASRR Level I and Level II review if applicable. Measures/Systematic Changes to prevent reoccur: Social Services Coordinator, Administrator, and Business Office Manager to participate in additional	

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F 644	Continued From page 3	F 644	training and education regarding PASRR processes. First educational training completed 10/27/21 with Benefits Quality Control Manager related to PASRR processes. All new mental illness or related diagnosis for residents within facility to be reviewed once a week at RISK meeting to determine if criteria is met for PASRR Level I and Level II reviews. If criteria are met, PASRR Level I reviewed, and PASRR Level II, if required. Monitor permanent solution: Each new diagnosis being added to resident medical records related to mental illness or intellectual disability to be reviewed by Social Services Coordinator or their designee during the weekly risk meeting. Audit to be monitored monthly at QAPI for three months.	
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.	F 732		11/19/21

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F 732	Continued From page 4 (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of the nursing staff postings, and staff interview the facility failed to ensure the information on the posted 24 hour nursing staff information was maintained and updated to reflect the actual hours work for 17 of 17 days. The census was 53. The findings were: 1. Observation on 10/11/21 through 10/14/21 of the posted 24 hour nursing staff information showed only the number of hours each care level was scheduled to work. 2. Review of the posted 24 hour nursing staff information from 9/28/21 through 10/11/21 failed to show the actual hours worked by the registered	F 732	Correct deficiency to individual: To correct deficiency to all individuals the staffing sheet has been updated accordingly to add “actual hours” worked and correcting when staffing assignments change on the floor as of 10/21/21. Protect residents from similar situations Staffing sheet to be updated and checked each shift by one nurse to ensure appropriate staffing for all residents. Education provided on 10/21/21 to all nurses during October 2021 nurses meeting regarding updates to staffing sheet.	

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F 732	Continued From page 5 nurses, licensed practical nurses or licensed vocational nurses, and certified nurse aides responsible for resident care per shift. 3. Interview on 10/13/21 at 9:14 AM with the DON confirmed the posted 24 hour nursing staff information failed to include the actual hours worked of the resident care staff.	F 732	Measures/Systematic Changes to prevent reoccur: Charge nurse to ensure accurate changes to staffing sheet to allow for changes with staffing assignments. For example, when there is a call in, the staffing sheet will be updated immediately. Staffing coordinator or designee to double check staffing sheets daily and as indicated. This can go under systematic changes Double check completed by DON (Director of Nursing) or designee. New staffing sheet designed to display “actual hours worked.” New staffing sheets initiated on 10/21/21. Monitor permanent solution DON or designee will audit the double check monitoring process to be completed daily every week for 3 months to ensure each day was updated and accurately reflects the hours worked. Audit results to be monitored monthly at QAPI.	