POC accepted 5/19/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/06/2010
FORM APPROVED
OMB NO. 0938-0391

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 04/22/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set mg: Milligrams RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	Submission of the Plan of Correction shall not be construed as a waiver of this provider's right to contest any and all deficiencies, nor is such submission an admission that the facts are as alleged or that any regulatory violation has occurred. The following is to be considered our Credible Allegation of Compliance.	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225	F225 1 The resident to resident altercations were reported to the State Agency on November 29 and December 29, 2009. For employee #2 the data base of the C.N.A. abuse Registry was checked on April 23, 2010. A record of Nurse Aide Registry check was placed in the personnel file. 2. A review of resident abuse allegation and investigations will be done to ascertain timely reporting.	6-04-10

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

Anna Schultz | 5-11-2010

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.

POC accepted 5/19/10. Call to Anna Schultz Administrator on 5/19/10 @ 4:50pm. je

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Wyoming Dept of Health

MAY 13 2010

Office of Healthcare Licensing and Surveys

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F 225	Continued From page 1 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 review of personnel records and internal abuse investigations, policy review, and staff interview, the facility failed to ensure that 2 of 2 allegations of abuse were reported immediately to the state survey agency and other officials in accordance with State law. In addition, the facility failed to ensure 1 of 1 newly hired CNA, whose record was reviewed, did not have a finding on the State nurse aide registry. The findings were: 1. Review of the facility's abuse investigation documentation revealed the following concerns: a. Review of a resident to resident physical altercation which occurred on 12/25/09 revealed the allegation of abuse was not reported to the state survey agency until 12/29/09. In addition, there lacked evidence that the Department of Family Services (DFS) or law enforcement were	F 225	An audit of personnel files will be done to review completion of all steps of background check which includes a check of the Nurse Aide Abuse Registry. Missing registry checks will be obtained. 3. Department Managers and Charge nurses will be inserviced on the policy and procedures to follow if an allegation of abuse arises, to include the time parameters of reporting and all agencies that need to receive the report. Department Managers and hiring personnel will be inserviced on all the background check steps to be taken for a potential employee prior to hire. Findings from various entities will be printed for insertion in the personnel file. All personnel files will be checked off by the Human Resources Clerk before the record is filed. 4. Abuse allegation reports will be reviewed monthly by the Quality Assurance Committee to assure all entities have been contacted and all action steps have been completed	

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F 225	Continued From page 2 notified of the allegation. b. Review of a resident to resident physical altercation which occurred on 11/26/09 revealed it was not reported to the state survey agency until 12/3/09. Furthermore, the allegation was not reported to DFS or law enforcement. c. During an interview on 4/21/10 at 4:15 PM, the DON stated allegations of abuse, including resident to resident altercations, should be reported to the state survey agency "right away." The DON further stated she was gone when the cited allegations occurred, therefore, the allegations were not reported timely. The DON also stated they do not notify DFS of allegations of abuse involving resident to resident altercations. Review of the facility's "Abuse and Neglect Prevention Standard" (4/09) revealed "Report alleged incidents as required to all local/state/federal agencies within 24 hours of the allegation." Review of Wyoming's Adult Protective Services Act at statute 35-20-103 showed "Any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, exploited, or abandoned or is committing self neglect shall report the information immediately to a law enforcement agency or the department." 2. Review of personnel records revealed employee #2 was a CNA who was hired on 2/15/10. License verification was completed with the Wyoming State Board of Nursing, but there was no documentation that the CNA registry had been checked to see if there were any findings of abuse. Interview on 4/21/10 at 4:30 PM with the DON revealed the facility did not check the CNA registry when hiring CNAs. Furthermore, she did	F 225	in a timely fashion. The Quality Assurance Committee will audit personnel files semi-annually, incomplete files will be returned to the Supervisor for proper completion.	

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F 225	Continued From page 3 not know all CNAs working in long term care needed to be included on the CNA registry, or that the registry needed to be checked prior to hire. Review of the facility's "Abuse and Neglect Prevention Standard" (4/09) revealed "The State Nurse Aide Abuse Registry is checked on all potential employees."	F 225		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of dietary cards, and staff interview, the facility failed to ensure the care plan was revised	F 280	**F280** 1. For Resident #1 refer to F325 regarding revisions to the care plan. 2. For Plan of Correction see F325	6-04-10

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F 280	Continued From page 4 as needed for 1 of 12 sample residents (#1). The findings were: 1. Refer to F325 for details regarding the facility's failure to revise the care plan related to nutritional interventions for resident #1.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on random observation, staff interview, and medical record review, the facility failed to ensure staff adhered to professional standards of practice related to medication administration for residents residing in 1 of 2 halls (A Hall) and following or clarifying physicians' orders for 2 of 12 (#25, #29) sample residents. The findings were: 1. According to Smith, Duell, and Martin in "Clinical Nursing Skills Basic to Advanced Skills," 7th Edition, 2008, staff should "Compare drug container label to the medication sheet (MAR) three times...Sign out for the narcotic on the narcotic sheet after taking narcotic out of the drawer." Failure to follow these professional standards of practice was identified in the following instances: a. Observation on 4/20/10 at 7:39 AM showed RN #2 prepared and administered medications for resident #40. The RN read the label on the individual blister packs once but never compared it with the medication administration record	F 281	**F281** **1.** Licensed Nurses # 1 and 2 were immediately inserviced on the Facility expectation of following proper procedures in medication administration, specifically: reading the label on the medication and comparing it to the MAR and the notation on the narcotic administration record when the medication is given. Residents #40, 15 and 27 are receiving medication as ordered. The physician order for resident # 25 wound treatment has been	6-04-10

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F 281	Continued From page 5 (MAR). The RN only read the name staff had printed on each lid of the individual stock medication bottles. She never read the label containing the complete name and dosage amount, nor did she compare the label to the MAR. Additional observation revealed the RN continued this practice with other residents in her care. The RN was assigned the A Hall where twenty-three residents resided. On 4/20/10 at 12:30 PM, the RN confirmed she read the name on the lid of the stock medication bottles. The RN stated she "felt comfortable" as she knew the medications. However, the RN acknowledged she was taught to compare medication labels with the MAR three times before administering medications. On 4/21/10 at 4:30 PM, the DON stated she expected staff to read the labels on medication containers and compare the label with the MARs. The DON stated, "We should know what we're giving." b. A random narcotic count on 4/21/10 at 1:30 PM revealed the narcotic count was inaccurate for two of three narcotics selected. The card for resident #15's hydrocodone 5/500 mg contained 16 tablets, but the narcotic count sheet revealed there should have been 17 tablets at that time. Also, the card for resident #27's clorazepate 3.75 mg contained 32 tablets where as the count sheet indicated there should have been 33 tablets at that time. Interview with RN #1 at that time revealed she gave both the medications at 8 AM that morning, but had not yet signed them out on the narcotic count sheets. She went on to say she signed out all the narcotics she gave throughout the day at the end of her shift. Interview on 4/21/10 at 3 PM with the DON revealed her expectation was that nurses sign out narcotics at	F 281	clarified. The PT/INR monthly lab test for resident # 29 has been ordered. 2. Physicians orders for wound treatment will be audited to assure that the current order is being followed and clarification orders obtained as needed. The records for residents with physician's orders for anti-coagulant therapy will be audited to assure that PT/INR lab orders are being followed. 3. Licensed Nurses will receive additional inservice on proper medication administration to include: reading labels on the container, checking the MAR and the label, signing out narcotics on the narcotic administration record when given, the process of noting clarification orders and recording accurately on the treatment record, and following the facility protocols for PT/INR for anticoagulant therapy. Random, periodic observations of medication administration will be	

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F 281	Continued From page 6 the time they are giving the narcotics. 2. Medical record review showed resident #25 developed a Stage II pressure ulcer on the left great toe on 2/6/10. Further review showed the wound became worse, and staff faxed a request for a treatment change on 2/28/10. The suggested changes to cleanse daily with Sea Cleanse, apply skin prep at wound edges, and apply intrasite gel and a calcium alginate dressing covered with a Band-Aide were authorized by the physician on 3/1/10. Review of the March 2010 recapitulation of orders showed the physician's signature was dated 3/19/10. Due to the later date and the discrepancy, orders for the resident's wound treatment (cleanse the wound with Sea Cleanse and cover with a Comfeel dressing) became questionable. The following concerns were identified: a. The treatment order requested on 2/28/10 was signed on 3/1/10 and faxed back to the facility. However, it was not noted until 3/8/10, a delay of eight days. b. The March recapitulation of orders was not signed by the physician until 3/19/10, over half way through the month. Further, the orders were not reviewed for accuracy prior to sending them to the physician; nor were they noted after the physician signed them and discrepancies clarified. d. On 4/20/10 at 5:08 PM LPN #1 confirmed that the most recent order, dated 3/19/10, was the one staff should have been following. However, she stated staff were actually following the faxed order dated 3/1/10, but had not clarified the discrepancy between the two. Review of the treatment record confirmed the LPN's statement.	F 281	done monthly by the Director of Nursing or Designee. New or changed orders for anticoagulant therapy will be reviewed by the Risk Management Team weekly to assure that PT/INR orders have been implemented. PT/INR lab results will be reviewed monthly by the Risk Management Team. Orders for wound treatment will be reviewed by the Risk Management team monthly. 4. The Quality Assurance Committee will review the medication pass observations, audits of treatment orders, audits of changes to physician's orders, and anticoagulant therapy. Results of audits will be review for 6 months for continued compliance and direct further corrective action as needed.	

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F 281	Continued From page 7 Review of Smith, Duell, and Martin in "Clinical Nursing Skills Basic to Advanced Skills," 7th Edition, 2008, revealed that if an order is "questionable for any reason, the physician must be notified for clarification." 3. Review of the medical record showed resident #29 was admitted on 1/6/10. According to physician orders, the resident received Coumadin (anticoagulant) 2.5 mg 1 1/2 tablets everyday except Monday, Wednesday and Friday when the resident only received 1 tablet. Review of the facility's standing orders for residents on anticoagulant therapy (dated 8/29/05) revealed a PT/INR [prothrombin time/international normalized ratio] laboratory test was to be done every month and the results faxed to the physician. Further review of the medical record revealed PT/INR laboratory results were lacking. During an interview on 4/21/10 at 3:22 PM, the DON stated there were standing orders in place, and resident #29 should have had a PT/INR done monthly. Review of the Wyoming Nurse Practice Act of July 2005, pages 3-6, revealed nurses must practice under the direction of a physician.	F 281		
F 282 SS=D	483.20(k)(3)(i) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interviews, the facility failed	F 282	**F282** 1. For resident # 36, the compression glove/sleeve is being applied daily. For resident # 42, see F311 and F325 2. An audit of care plans of residents with orders for compression gloves/sleeves will be done to assure appropriateness of the care plan.	6-04-10

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F 282	Continued From page 8 to ensure care was provided in accordance with the written plan of care for 2 of 12 sample residents (#36, #42). The findings were: 1. Review of an occupational therapy evaluation dated 11/4/09 showed resident #36 had swelling in the left hand, so a compression glove was ordered. Review of the current care plan dated 2/9/10 showed the resident was supposed to wear a compression sleeve [compression glove] to the left arm. Observation on 4/20/10 at 7:26 AM revealed CNA #1 dressed the resident. The CNA did not put the compression glove on the resident's left hand. Additional observations on 4/20/10 at 9 AM, 9:55 AM and 10:30 AM revealed the resident was not wearing the glove. During an interview on 4/20/10 at 3:01 PM, the resident stated staff did not always remember to put the glove on his/her left hand. On 4/21/10 at 2:10 PM, CNA #1 confirmed the resident was supposed to wear the compression glove during the day. 2. For details related to the facility's failure to implement the restorative and nutritional care plans for resident #42, please refer to citations F311 and F325, respectively.	F 282	Interventions will be implemented, changed or continued as indicated. 3. Nursing staff will be inserviced on following the interventions as listed on the care plan. A list of all residents who need compression gloves/sleeves will be compiled and maintained by the Director of Nursing or designee and random weekly observations to assure the resident has had the compression glove/sleeve applied will be conducted. Issues identified will be corrected immediately. 4. Results of weekly observation of the application of compression gloves/sleeves as described in the care plan will be reviewed by the Quality Assurance Committee for recommendation and continued compliance. Results will be reviewed for three months and reevaluated.	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review,	F 311	**F311** **1.** The restorative plan of care for resident #42 will be evaluated and modified to better match this resident's cognitive receptivity and physical ability (and fluctuations	6-04-10

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F 311	Continued From page 9 and staff interview, the facility failed to provide restorative services as planned for 1 of 2 sample residents (#42) who required those services. The findings were: Observation on 4/20/10 at 10:20 AM showed resident #42 required assistance for transfers. According to the care plan, the resident was to receive restorative services three times a week to maintain his/her current ability to transfer. Review of the treatment plan, dated 1/28/10, showed the resident was to perform three repetitions of sitting to standing, increasing to ten repetitions as tolerated; the total time for restorative services was listed as fifteen minutes per day for each of the three days. Review of the restorative documentation sheets showed staff were to document the number of minutes per day each worked with the resident. Review of the restorative documentation for February 2010 showed the program was not initiated until 2/8/10 and, according to the documentation, was only provided three times a week for one week during that month. Furthermore, when the program was provided, it was for only three minutes per day instead of fifteen. Review of the documentation for April 2010 showed the dates and days were indicated correct, but the restorative aide had drawn lines which overlapped on the 8th,15th, and 22nd of the month, thus marking out eight days per week. In addition, restorative services were provided for fifteen minutes only once during the month. On 4/21/10 the DON reviewed the restorative documentation at 3:35 PM, but was unable to explain it. During an interview on 4/22/10 at 10:30 AM, a restorative aide, CNA #3, stated restorative services had not been provided if they were not documented. The CNA further stated she was	F 311	thereof) to participate in restorative activities. 2. The care plans of residents with severe cognitive impairment and fluctuating ability to participate in a restorative program will be reviewed and modified for appropriateness. 3. The IDT team and Restorative staff will be inserviced on how and when to document the resident's inability, either cognitively or physically, to participate in Restorative activities and to modify the plan of care for frequency, duration or repetitions when appropriate; and to implement restorative activities when the plan of care is developed or modified. The Restorative staff will be inserviced on how to document on the flow sheets so that the document is clear and intelligible. The flow sheets of the resident's restorative program will be audited weekly by the Interdisciplinary Team at the Risk Management meeting. Amendments to the care plan will be made as needed. 4. Weekly audits of the restorative flow sheets and care plans will be	

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F 311	Continued From page 10 unable to explain the documentation for April 2010. At 10:54 AM that day, the CNA stated the facility was short of help in February 2010, and the restorative staff had been assigned to provide routine resident care; therefore, restorative services were not provided as planned.	F 311	reviewed by the Quality Assurance Committee monthly for recommendation continued compliance. Results will be reviewed for six months and reevaluated.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, family and staff interview, and review of policies and procedures, the facility failed to ensure staff provided catheter care in a manner that prevented or minimized urinary tract infections (UTIs) for 1 of 2 sample residents (#3) with catheters. The findings were: Observation on 4/21/10 at 9:30 AM showed resident #3 had an indwelling urinary catheter in place. Interview with a family member present during the observation revealed the resident had chronic UTIs and was on antibiotics continuously. Review of the medical record confirmed that statement. Observation at 1:43 PM that afternoon showed CNA #1 emptied the catheter drainage	F 315	F315 1. The drainage spout of the catheter of resident #3 has been cleaned. 2. Catheter care of other residents with catheters has been reviewed for appropriate sanitizing technique. 3. Nursing staff will be inserviced on the correct procedures to use in emptying the drainage bag. Competency checklist will be completed for nursing personnel in catheter care techniques. Periodic, random skills check will be done monthly for catheter care. 4. Completed catheter skills checks will be reviewed monthly by the Quality Assurance committee for recommendation and continued compliance. Results will be	6-24-10

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WESTWARD HEIGHTS CARE CENTER	150 CARING WAY LANDER, WY 82520

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F 315	Continued From page 11 bag without cleansing the drain spout. During an interview at 2:12 PM that afternoon, the CNA stated she should have cleansed the spout with an alcohol wipe. Review of the facility's 2001 policy and procedure entitled "Emptying a Urinary Drainage Bag" showed staff should "Wipe the drain with an alcohol sponge or swab" before replacing the drain tube back into the holder on the bag. Interview with the infection control practitioner on 4/22/10 confirmed staff were taught to cleanse the drainage spout.	F 315	reviewed for six months and reevaluated.	
F 325 SS=D	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of dietary cards, the facility failed to ensure staff provided care and services to minimize or eliminate nutritional impairment for 2 of 10 sample residents (#1, #42) reviewed for nutritional status. The findings were: 1. Review of the 3/1/10 quarterly MDS assessment showed resident #42 had experienced a significant weight loss. Review of	F 325	**F325** 1. Resident #42 is receiving a variety of finger foods along with a regular meal tray. Staff will continue to offer encouragement to eat and to remain in the dining room for meals. This resident is offered finger food throughout the day to encourage adequate nutritional intake. The diet card will be reviewed and updated as appropriate. For resident # 1, protein powder has been added to the care plan and the diet card so that the resident receives it three times a day at meals. 2. Residents with weight loss are reviewed weekly by the Interdisciplinary Care Team for correct diet plan, food intake and weight changes.	6-04-10

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F 325	Continued From page 12 nutrition information, dated 2/25/10, showed the change was a loss of 11.7% in 180 days. According to physician's orders and the care plan dated 3/2/10, the resident was to receive a regular diet of mechanical soft consistency. Dietary staff were to provide fortified foods,a high calorie liquid supplement, finger foods, and a boiled egg at meals. The resident ate at the assisted table, and nursing staff were to encourage good food intake, provide cueing, assist the resident as needed, and offer alternative foods if the resident refused those first provided. Observation during four meals revealed the following concerns: a. During the evening meal on 4/19/10, the resident sat at the assisted table with a CNA seated across the table. The resident ate independently (under 25 %), but no cueing, assistance, or alternatives were offered. Finger foods consisting of two cookie bars and a cheese stick were served, but the resident did not eat them. The resident left independently at 5:53 PM. Staff made no attempt to encourage the resident to return. b. At breakfast on 4/20/10 the resident was again seated at the assisted table and was served at 8:25 AM. By 9 AM the resident had eaten a couple of bites of the cookie bars and cheese stick. S/he had not touched the main meal, and no assistance, cueing, or alternatives were provided by the CNA seated across the table from the resident. c. At 5:30 PM the resident was served a bag of snack mix and a cheese stick with the evening meal on 4/20/10. At that time, no CNA was at the assisted table where the resident was seated. The resident took a bite of the main meal then started to leave at 5:38 PM. The resident's tablemate stopped the resident from leaving and	F 325	Dietary and nursing staff will be inserviced on following the diet plan on the diet card, implementing diet changes timely, updating diet cards timely, cueing and assisting residents with cognitive decline, those who resist verbal prompting, and how to re-approach the resident when appropriate. 3. Random, weekly observation will be made in the dining room for accuracy of adherence to the diet card, and staff providing assistance and cueing to residents with food intake issues. Diet cards of those residents with weight changes will be examined weekly for accuracy by the Risk management Team. Deviations from standard will be corrected immediately. 4. Results of weekly review of nutritional intake, weight management and dining room observations will be reviewed by the Quality Assurance committee for recommendation and continued compliance.	

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F 325	Continued From page 13 then encouraged him/her to eat. The resident took the snack mix bag and left at 5:41 PM. No staff intervention occurred until the alarm on the resident's wheelchair rang as the resident tried to leave the facility. The resident was returned to the facility at 5:43 PM, and the dietary manager enlarged the opening in the snack mix bag at 5:45 PM and then left the table. The resident ate a bite of the cheese stick, then moved both finger foods away. At 5:49 PM a CNA made one attempt to get the resident to eat and drink; the CNA moved away at 5:51 PM without offering an alternative, and the resident left the dining room at 5:52 PM. A visitor returned the resident to the dining room and encouraged him/her to eat, but the resident took the cheese stick and left at 5:54 PM. This time staff did not notice the resident's absence and no one brought him/her back to the dining room. d. The resident's lunch meal was served at 12:32 PM on 4/21/10, and a CNA was seated across from the resident. However, the only assistance she provided was to offer to cut up the peach slice the resident attempted to cut for thirteen minutes before the CNA noticed. After the resident refused, no other assistance, cueing, or alternative was offered until 12:53 PM when the CNA offered the supplement provided with the meal; the resident refused and left the dining room. e. During an interview on 4/21/10 at 1:50 PM, the dietary manager stated they were to serve a boiled egg with meals, but she confirmed they did not do so at all meals. The manager reported that the resident became resistive when pushed too hard to eat. She stated the resident had gained two pounds in April 2010. Review of the weights confirmed this statement. f. Even though it was care planned, a boiled	F 325		

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F 325	Continued From page 14 egg was not served with any of the four meals observed during the survey, and the dietary department served finger foods the resident would not eat. Review of finger foods the resident liked showed ice cream was checked three times, but it was not served at all. Furthermore, nursing staff failed to consistently provide assistance and cueing or offer alternatives; if the resident refused once, staff made no other attempt to get him/her to eat. 2. Review of the Nutrition Risk Review dated 3/27/10 showed resident #1 weighed 135.3 pounds and had exhibited some non-significant weight loss. Review of the resident's weight on 4/20/10 showed the resident's weight was 137.4 pounds. Review of the current orders showed the diet order for the resident included one scoop of protein powder in a food item of choice three times per day. Review of a note written by the registered dietitian (RD) on 4/6/10 showed the protein powder three times per day was to be continued. The following concerns were identified: a. Review of the current care plan dated 3/30/10 showed the protein powder was not addressed. b. Observation of tray line service in the kitchen on 4/19/10 at 5:15 PM and on 4/21/10 at 12:25 PM revealed protein powder was not added to any of the resident's food items. c. Review of the diet card for the resident with the dietary manager (DM) on 4/21/10 at 2:40 PM revealed the protein powder was not included. The DM confirmed staff were not adding a scoop of protein powder to the resident's food.	F 325	**F356 on following page**	
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on	F 356		6-04-10

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F 356	Continued From page 15 a daily basis: o Facility name. o The current date. o 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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. 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 and staff interview, the facility failed to post the required nursing staff data in the format specified by the regulation and to make changes as they occurred. The findings were: Observation on 4/20/10 showed licensed nurse	F 356	**F356 continued** 1. The name of the facility has been added to the daily staffing form. 2. Administrative Nurses and Charge Nurses will be inserviced on the required contents of the posted staffing report and the required accuracy thereof. 3. The staff scheduler will do a random, periodic, weekly audit of the posted staffing reports for three months. Inaccurate postings will be corrected and the author who penned the report will be alerted. 4. Audits of the daily staffing form will be reviewed by the Quality Assurance Committee for recommendation and continued compliance.	6-04-10

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F 356	Continued From page 16 staffing consisted of RN #2 and LPN #2. The LPN stated she had been called in that morning and arrived around 7 AM. Review of the posted staffing information at 5 PM that evening revealed the name of the facility was not identified and the data was incorrect. At that time the DON confirmed the inaccuracy. She stated the RN who was scheduled to work that day had called off and was replaced by an LPN, but the data had not been changed on the posted information. On 4/22/10 at 8:10 AM the DON stated the nurses were responsible for changing the posted information at the beginning of each shift. She also confirmed the posted information lacked the name of the facility.	F 356	F363	6-04-10
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, review of the menu, and staff interview, the facility failed to ensure the menu was followed during 1 of 3 meals observed. The findings were: Review of the menu (approved by the dietitian on 12/28/09) posted in the kitchen for the evening meal on 4/19/10 revealed the menu consisted of: quiche, spinach, a muffin, a fruit cup, and a cookie. Observation of trayline service on 4/19/10	F 363	1. The menu is being followed and appropriate substitutions are being made and recorded as needed. 2. The Dietary Staff will be inserviced on following the menu as written, checking for inventory prior to meal service, and when necessary, making and recording appropriate menu substitutions. 3. The Dietary Manager will audit the following of menus and making substitutions for five meals weekly for three months. If procedures are not followed, corrections will be made immediately.	

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F 363	Continued From page 17 from 5:15 PM until 6 PM revealed cookies were not included on any of the resident trays. During an interview at 6 PM, cook #1 stated no cookies were served because there were none. When asked about a substitute, the cook replied she did not substitute anything for the cookie because the residents had already received a muffin and fruit cup with their meal. During an interview on 4/20/10 at 2 PM, the dietary manager (DM) stated the cook was responsible for substituting an item of similar nutritive value if an item wasn't available. The DM stated something should have been served in place of the cookie.	F 363	4. Audits of adherence to the menu will be reviewed monthly for six months by the Quality Assurance Committee for recommendation and continued compliance.	
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, physician progress notes were not complete in 1 of 12 sample residents charts (#34). The findings were: 1. Review of the medical record showed resident #34 was admitted on 9/25/09. Review of the physician's progress notes showed no evidence the physician reviewed the resident's total program of care or wrote progress notes during	F 386	F 386 1. As noted, physician progress notes for resident # 34 were obtained and placed on the medical record on 4-21-2010 2. Records of residents of this physician will be audited. Missing notes will be requested of the physician and placed on the medical record. 3. The physician will be provided a list of the components required in a complete progress note. A checklist form will be provided to this physician and other visiting physicians to use in the formulation of their progress notes for their respective residents. This Physician's progress notes will be audited monthly for timeliness and	6-04-10

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F 386	Continued From page 18 visits on 11/3/09 and 11/25/09. Interview with the director of health information management on 4/20/10 at 5:10 PM confirmed progress notes lacked the required information. The director produced this information on 4/21/10 at 2:36 PM. She stated it had been faxed to the facility from the physician's office.	F 386	thoroughness. Observations of deviation from standard will be brought to the attention of the physician and the Medical Director for correction.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	4. Audits of physician progress notes will be reviewed by the quality assurance committee monthly for the next 12 months for recommendation and continued compliance. **F441** 1. The sanitizing solution for sanitizing the bath tub has been correctly diluted, properly labeled spray bottles have been ordered, the correct contact time of ten minutes is being adhered to, all used water containers in resident's rooms are removed to the dish washing area prior to fresh water pitchers being distributed, dressing changes for resident #52 are being done according to nursing services policy and procedure.	6-04-10

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F 441	Continued From page 19 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on random observation, staff interview, and review of policies and procedures, Material Safety Data Sheets (MSDS), and competency evaluations, the facility failed to ensure staff adhered to practices designed to prevent the spread of infections. The findings were: 1. Observation on 4/20/10 at 11:20 AM showed CNA #3 was rinsing off the disinfectant used to clean the shower on B Hall. The smell of the disinfectant was so strong it irritated the surveyor's nose. Interview with the CNA at that time revealed she did not mix the solution, nor did she know how it should be mixed. The CNA stated she allowed three to five minutes contact time for the disinfectant before rinsing it off. She further stated she would sometimes rinse it twice if the strong smell remained. Review of the label on the disinfectant bottle, entitled Pro Chem Disinfectant Cleaner, showed a contact time was not indicated. However, review of the undated "Procedure for Cleaning Shower Area" showed staff were to "Allow the disinfectant to remain on surfaces for ten minutes." This information was posted outside the shower door, but after reading it, the CNA reiterated that she did not allow a ten minute contact time before removing the disinfectant. Interview with the DON on 4/22/10 at 8:22 AM	F 441	Dressing changes for resident # 23 are no longer needed as the wound is healed. 2. Nursing staff will be inserviced on the proper procedures, dilution rate and contact time for sanitizing the bath tubs. Nursing staff will be inserviced in procedures to follow to avoid cross contamination while changing water pitchers. Nursing staff will be inserviced on proper hand hygiene and glove use when changing dressings on wounds. 3. Skills checks will be completed by the Staff Development Coordinator or Designee for nursing staff who clean bath tubs, pass water carafes and provide dressing changes on wounds. Periodic, random audits of staff performance will be completed monthly.	

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F 441	Continued From page 20 revealed the contact time required for the disinfectant during a shower cleaning had not changed. On 4/22/10 at 8:40 AM, the infection control practitioner (ICP) stated she did not know what solution was used to disinfect the shower. She reviewed the MSDS, but was unable to locate information for Pro Chem disinfectant. After checking with the CNAs, the ICP stated they were using the whirlpool disinfectant but pouring it into the Pro Chem bottle, a practice that was not acceptable. The ICP did not know how the disinfectant was being diluted or if it was being used at full strength. Review of the MSDS form for the whirlpool disinfectant failed to reveal a contact time requirement. However, the information specified that the disinfectant could cause eye and skin irritation and could be harmful if "spray mist is inhaled." 2. Observation on 4/20/10 at 11:15 AM showed domestic aide #1 was passing clean containers of ice water to the residents in B Hall. The CNA entered each resident's room, picked up the dirty water containers, removed the lids, and dumped the water in the sink, splashing some of it onto her fingers and hands. The aide then placed the dirty containers and lids on the bottom shelf of a cart. Without performing any type of hand hygiene, she then picked up clean containers and took them into the resident's room. When questioned immediately after the observation, the aide stated she was taught to perform hand hygiene when moving from dirty items to clean ones; however, she confirmed she had not performed hand hygiene while passing water to the residents. 3. Observation on 4/20/10 at 10:55 AM revealed RN #2 performed a dressing change to a wound	F 441	4. The skills checklist and audits of tub cleaning, water carafe distribution and dressing changes will be reviewed by the Quality Assurance Committee for the 6 months for recommendation and continued compliance.	

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F 441	Continued From page 21 on the left heel of resident #52. The RN washed her hands and put on gloves before she started the dressing change. She then removed the dirty dressing, cleansed the wound, and applied a clean dressing without changing gloves. Continued observation on 4/20/10 at 11:15 AM revealed the RN did another dressing change on the left hip of resident #23. Again, the RN washed her hands and put on gloves before she started the dressing change, but she removed the dirty dressing, cleansed the wound, and placed a clean dressing on the wound without changing her gloves. Interview at that time with the RN revealed if there had been a lot of "goop" on the dirty dressings, she would have changed her gloves before applying the clean dressings. Review of the facility's Nursing Services Policy and Procedure manual under standard precautions for infection control revealed, "...e. Change gloves, as necessary, during the care of a resident ... (when moving from a "dirty" site to a "clean" one.)" Also, review of the facility's Clean Dressing Competency check list showed the nurse should remove gloves and either wash or sanitize hands after she removed the dirty dressing and before she applied the clean dressing.	F 441		
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by:	F 518	**F518** **1.** RN #1 has received inservice on steps to be taken in the event of a bomb threat. C.N.A. #2 was a temporary agency staff no longer assigned to this facility.	6-04-10

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 518	Continued From page 22 Based on staff interviews and review of the facility's disaster manual, the facility failed to adequately train 2 of 5 staff who were interviewed regarding disaster procedures. The findings were: Review of the facility's "Bomb Threat" procedure for the person that was answering the call revealed s/he was to listen carefully to what was being said and to any background noises. S/he was to prolong the conversation as long as possible and not put the caller on hold. In addition, s/he was to fill out the Bomb Threat Checklist and give it to another staff member. Staff interviews revealed the following concerns: a. During an interview on 4/21/10 at 1:05 PM, CNA #2 stated if she answered the phone and it was a bomb threat, she would put the caller on hold and tell the charge nurse. b. Interview on 4/21/10 at 1:15 PM with RN #1, who was the charge nurse, revealed if she answered the phone and it was a bomb threat she would notify administration and see what they wanted her to do. Interview on 4/21/10 at 2:10 PM with the staff development coordinator (SDC) revealed staff received disaster preparedness in-services during orientation and then annually. However, she stated CNA #2 was an agency employee and had not received the in-service. She went on to acknowledge RN #1 had worked at the facility for two years and there was no documentation she had attended any in-services on disaster preparedness.	F 518	2. Staff in all Departments will be inserviced on Emergency Preparedness procedures and specifically steps to take in a bomb threat. Orientation to the Emergency Manual will be added to the orientation checklist for temporary agency personnel. 3. Periodic, random audits will be done by the Maintenance Supervisor or designee to quiz individuals on what to do in the event of a bomb threat. Anyone not knowing all appropriate steps will immediately be inserviced. 4. Audits of staff knowledge of emergency procedures will be reviewed by the Quality Assurance Committee monthly for twelve months for continued recommendation and compliance.	