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 _____	01/11/2024

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 A recertification survey was conducted by Healthcare Licensing and Surveys from 1/8/24 through 1/11/24. The following common abbreviations are used throughout this document: ADON: Assistant Director of Nursing DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff and resident interviews, the facility failed to monitor the resident's access site upon return from dialysis treatment for 1 of 1 sample resident (#33) who received dialysis at an off-site dialysis center. The findings were: 1. Observation of resident #33 on 1/8/24 at 4:09 PM showed a bandage visible on his/her upper right chest. Interview with the resident at that time revealed s/he received dialysis three times a	F 698	CORRECTION TO RESIDENT AFFECTED: 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 occurred. The following is to be considered our Credible Allegation of Compliance.	2/9/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/03/2024

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F 698	Continued From page 1 week at an off-site dialysis center. The following concerns were identified: a. Review of physician's orders showed the only order related to dialysis was for staff to record the resident's weight following dialysis. There lacked any orders related to the monitoring of the resident's dialysis access site. b. Review of the resident's care plan for hemodialysis initiated 8/23/23 showed "Monitor/document/report PRN [as needed] signs/symptoms of infection to access site: redness, swelling, warmth or drainage" and "Monitor/document/report PRN for signs/symptoms of the following: bleeding, hemorrhage, bacteremia, septic shock." The care plan did not instruct staff to immediately monitor the status of the access port upon return from the dialysis center to observe for bleeding or other complications. c. Review of the December 2023 and January 2024 medication and treatment administration records and progress notes since December 1, 2023 showed no documentation that the resident's access site was monitored upon return from the dialysis center. d. During an interview on 1/10/24 at 3:23 PM the resident stated staff did not observe his/her access site when s/he returned from dialysis. e. On 1/10/24 at 3:24 PM RN #1 was asked what monitoring the resident received following a dialysis treatment. The RN stated they only needed to record the resident's weight, which the dialysis center usually recorded for them. f. On 1/11/24 at 8:23 AM the DON stated the facility did not have policies related to the monitoring of the access site. She confirmed the care plan only instructed for PRN monitoring and further confirmed there was no documentation to show staff were monitoring the access site.	F 698	Provide education to the charge nurse to monitor and document the dialysis port site for sign and symptoms for infection such as swelling, drainage, redness, warmth to touch, or any pain or discomfort on a daily basis on resident #33. Charge nurse to notify the dialysis center and the provider with any concerns as indicated for resident #33. Order is in place on Point Click Care for resident #33. Frontline team member such CNA will be educated to report any abnormal finding to the charge nurse. All these are in place, care plan updated, PCP notified with order in place on PCC. SYSTEM CHANGES (IDENTIFICATION AND CORRECTION FOR OTHER RESIDENTS POTENTIALLY AFFECTED): Documentation will be auditing weekly x 90 days from 1/11/24 and will be audited as needed and as indicated. All findings will be reported to QAPI. MONITORING PROCESS FOR THE SYSTEM CHANGE INCLUDING FREQUENCY AND PERSON RESPONSIBLE DON or designee will complete documentation auditing weekly x 12 weeks to ensure resident dialysis access site is monitor daily per care plan.	

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		2/9/24

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F 880	Continued From page 3 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, review of manufacturer's instructions, and policy review, the facility failed to ensure infection prevention practices were followed by staff during 1 of 6 medication pass observations which affected residents (#5, #20). The findings were: 1. Continuous observation on 1/9/24 starting at 11:38 AM showed LPN #1 obtained a blood glucose level on resident #20. After the procedure was completed, the glucometer was returned to	F 880	CORRECTION TO RESIDENT AFFECTED: 1:1 education provided to the nurse identified on 2567 on how to properly clean glucometer between residents #5 and resident #20. (this nurse was the first one to be inserviced) SYSTEM CHANGES (IDENTIFICATION AND CORRECTION FOR OTHER RESIDENTS POTENTIALLY	

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F 880	Continued From page 4 the medication cart without being disinfected by the LPN. At 12:23 PM LPN #1 obtained a blood glucose level on resident #5 using the same glucometer. After the procedure was completed, the glucometer was returned to the medication cart without being disinfected by the LPN. 2. Interview on 1/9/24 at 12:37 PM with LPN #1 confirmed she had not disinfected the glucometer between residents. 3. During an interview on 1/9/23 at 3:12 PM the infection control nurse and the MDS coordinator both confirmed the facility did not have any residents with known blood borne pathogens. 4. Interview on 1/10/24 at 2 PM with the DON and ADON revealed it was the facility's expectation to clean the glucometers between resident use. 5. Review of the manufacturer's instructions provided by the DON on 1/11/24 at 8:35 AM showed " Cleaning & Disinfecting Guidelines...Wash hands after taking off gloves. Contact with blood presents a potential infection risk. We suggest cleaning and disinfecting the meter between patient use .... using a commercially available EPA-registered disinfectant detergent or germicide wipe." 6. Review of the facility policy titled "Blood Glucose Monitoring Equipment and Supplies" provided by the DON on 1/11/23 at 9:54 AM showed "...Clean and disinfect blood glucose meters between uses when equipment is shared..."	F 880	AFFECTED): Competency all qualified staff (nurses, Medication aides, CNA II) on proper procedure for cleaning and disinfecting blood glucose meter after each use by 1/25/2024. Education was provided to all nurses, medication aides, CNA II and those who were not competencied in person or at the January nursing meeting were assigned the meeting on NetLearning our online education platform. The competency education includes Finger stick glucose level competency (VHS), VSL specific cleaning products/use, 2 pages from the glucometer owner's manual explaining cleaning and disinfection FAQ, CMS requirements, approved cleaners for device. MONITORING PROCESS FOR THE SYSTEM CHANGE INCLUDING FREQUENCY AND PERSON RESPONSIBLE Infection Prevention nurse or designee will perform weekly audits r/t blood glucose meter cleaning and disinfection weekly for 12 weeks from 1/11/2024. Timely feedback will be provided to qualified staff based on audit results. All results will be reported to QAPI	