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 _____	02/08/2007

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 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to comprehensively assess 1(#37) of 15 sample residents. The findings were:	F 272	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 violations occurred. F272: The facility strives to provide a comprehensive assessment for each Resident. Resident #37 will be assessed by therapies to ensure the least restrictive device is in place. All Residents who require such devices will be assessed by therapies to ensure the least restrictive device is in place. DON or designee will coordinate with therapies, hospice or any other services to ensure assessments are completed. A log will be kept by the DON of the Residents requiring outside services to record that the	

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

NHA — NHA — 2-28-07

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 _____	02/08/2007

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 272	Continued From page 1 Observation on 2/7/07 at 2:20 PM revealed resident #37 was seated in a wheelchair with a seat belt fastened at the waist. During the observation, the resident was unable to remove the belt when requested; s/he just played with the buckle. Review of the 11/20/06 admission Minimum Data Set (MDS) assessment showed the resident utilized a trunk restraint daily. However, review of the completed Resident Assessment Protocol for restraints showed the facility did not address what other measures were attempted prior to using a restraint and whether a seat belt was the least restrictive device which could be used. During an interview on 2/7/07 at 3:25 PM, the MDS coordinator stated "therapy" provided those assessments. She further stated therapy was not asked to assess the resident as s/he was admitted under hospice care.	F 272	F272 Cont'd: appropriate assessments are completed. Log will be reviewed by the Risk Management Team on a weekly basis for one month and randomly once a month thereafter for three months. The log will be taken to the QA Committee at least quarterly.	
F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278	F278: The facility strives to ensure the proper coding is completed on all Minimum Data Sets (MDS). Corrections for the coding of the MDS will be completed for Resident #27 and Resident #53. The MDS Coordinator will be inserviced in the correct coding of the MDS for Residents returning from the hospital. The MDS Consultant will review all such MDS coding prior to submitting to ensure accurate coding for three months.	3/23/07

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 _____	02/08/2007

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 278	Continued From page 2 $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure accurate completion of the Minimum Data Set (MDS) assessments for 2 (#27 and #53) of 13 sample residents who resided in the facility at the time of the survey. The findings were: 1. Medical record review showed the last documented quarterly Minimum Data Set (MDS) assessment for resident #27 was dated 9/15/06. Review of the discharge tracking form showed the resident was discharged, with a return anticipated, on 12/2/06. Further review showed the resident re-entered the facility on 12/5/06, and a 5-day Medicare assessment was completed on 12/13/06. However, it was coded as "None of Above" instead of as a quarterly or significant change MDS assessment. Interview with the MDS coordinator on 12/6/07 at 5:30 PM confirmed that the form should have also been coded as a quarterly assessment. The coordinator stated she was unsure how to code the MDS assessments when residents re-entered the facility. 2. Medical record review revealed a significant	F 278	F278 Cont'd: The MDS Coordinator will keep a log on such review and take it to the QA Committee at least quarterly.	9-23-07

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 _____	02/08/2007

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 278	Continued From page 3 change Minimal Data Set (MDS) for resident #53 was conducted on 8/3/06. The resident was hospitalized three months later secondary to a myocardial infarction. Review of the discharge tracking form indicated a return was anticipated. Further review revealed the resident re-entered the facility on 12/8/06, and a 5-day Medicare assessment was completed on 12/16/06. It was coded as "None of Above" instead of as a quarterly or significant change MDS assessment. Interview with the MDS coordinator on 12/6/07 at 5:30 PM confirmed the form should have also been coded as a quarterly assessment.	F 278		
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS 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 medical record review, staff interview, and family interview, the facility failed to assure care was provided in accordance with the written plan of care for 5 (#6, #21, #24, #27, #50) of 13 sample residents who were living in the facility at the time of the survey . The findings were: 1. Review of the 12/29/06 significant change Minimum Data Set (MDS) assessment showed resident #6 required extensive assistance for bathing. Review of the care plan (revised 1/2/07) showed the resident was supposed to receive a bath two times per week. However, review of the bathing documentation for December 2006 through January 2007 showed the resident did	F 282	F282: The facility strives to ensure services are provided per the care plan. The bathing schedule for Residents #6, #21, #24, #27 and #50 will be reviewed to ensure appropriate number of baths are scheduled per week. The baths schedule for all Residents will be reviewed to ensure appropriate number of baths are scheduled per week. The care plan for all Residents will be reviewed to ensure bathing schedule reflects the care plan. DON or designee will review the staffing patterns to ensure appropriate number of staff are	

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 _____	02/08/2007

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 282	Continued From page 4	F 282		

not always receive two baths per week. For example:

a. The week of 12/3/06, the resident only received one bath.

b. The week of 12/17/06, the resident only received one bath.

c. The week of 12/31/06, the resident was not bathed.

d. The week of 1/21/07, the resident only received one bath.

2. Review of the 1/4/07 quarterly MDS assessment revealed resident #24 required extensive assistance for bathing. Review of the care plan (revised 1/9/07) showed the resident was supposed to receive two baths per week. However, review of the bathing documentation for December 2006 through January 2007 showed the resident did not always receive two baths per week. For example:

a. The week of 12/10/06, the resident was bathed once.

b. The week of 12/31/06, the resident was not bathed.

c. The week of 1/7/07, the resident was bathed once.

d. The week of 1/21/07, the resident was bathed once.

3. Review of the 11/9/06 quarterly Minimum Data Set (MDS) assessment showed resident #21 required extensive assistance with bathing. Review of the current care plan showed the resident was to receive two baths a week. Review of the "Patient Care Flow Sheets" showed the resident did not receive two baths during the weeks of 11/16/06 and 11/28/06, 12/14/06, and 12/29/06, and 1/1/07, 1/8/07, 1/23/07 and 1/29/07. There was no

F282 cont'd:
available to adhere to the bathing schedule. A log will be created by the DON to list the Resident name, care plan number of baths per week, the bathing schedule and completed baths each week. The Risk Management Team will review the completed log weekly for one month and once a month thereafter for three months.

The log will be taken to the QA Committee at least quarterly. 3-23-07

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 _____	02/08/2007

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 282	Continued From page 5	F 282		

documentation as to the reason the resident's baths were not given.

4. According to the 9/15/06 quarterly MDS assessment, resident #27 required extensive assistance with bathing, and the current care plan instructed staff to provide 2 baths per week. Review of the "Patient Care Flow Sheets" showed the resident was documented as receiving one bath during the weeks of 11/5/06 and 11/22/06, 12/8/06, 12/15/06, 12/18/06, 1/7/07, and 1/27/07. In addition, the documentation showed the resident was not bathed during the first week in January. There was no documentation as to the reason the resident was not bathed as planned.

5. Review of the 12/28/06 significant change MDS showed resident #50 required total assistance with bathing. Review of the current care plan showed the resident was to have two baths per week. Review of the "Patient Care Flow Sheets" showed one bath was documented during the weeks of 11/7/06 and 11/14/06, 12/5/06 and 12/26/06, and 1/2/07, 1/9/07 and 1/23/07.

6. On 2/7/07 9:03 AM, the MDS coordinator and licensed practical nurse (LPN) #11 stated baths were documented on the "Patient Care Flow Sheets." The MDS coordinator reviewed the documentation and stated baths were "hit and miss."

7. On 2/5/07 at 5:48 PM, while observing the evening meal, family members of two non sample residents provided unsolicited comments regarding the facility. They stated the only concern they had with the facility was they did not

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 _____	02/08/2007

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 282	Continued From page 6 think the facility was giving their mother enough baths. The family members stated their mother received on average less than two baths per week.	F 282		
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a hazard free environment in 1 of 2 bathing rooms and in 1 of 33 resident rooms. The findings were: The tub in the bathing room on the "A" hallway was observed on 2/7/07 at 3:48 PM. The footrest on the transfer chair of the tub was noted to be cracked exposing a 3-inch sharp, jagged plastic edge. Interview with the maintenance director at that time revealed the exposed edge represented a safety hazard to the residents when using the tub and stated that the foot rest would be replaced. Observation on 2/5/07 at 4:33 PM and on 2/7/07 at 2:55 PM revealed one side of the handle on the bottom drawer of a chest of drawers was broken away from the drawer and the sharp metal attachment was exposed and facing into the room. Interview with the maintenance director on 2/7/07 at 2:55 PM revealed the exposed edge represented a potential safety hazard to any resident, staff or family member who walk past the damaged handle.	F 323	F323: The facility strives to ensure that the environment remains as free of accident hazards as is possible. The plate on the transfer chair of the tub will be replaced. The handle to the Resident room chest of drawers will be replaced. Maintenance Director will add these two items to the log of maintenance rounds. Maintenance Director will inservice all staff on the items that may present a safety hazard and how to ensure the items are corrected timely. Maintenance	
F 329	483.25(l) UNNECESSARY DRUGS	F 329		

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 _____	02/08/2007

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 329 SS=D	Continued From page 7 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide physician documentation which delineated appropriate medical reasons for continued use of an antipsychotic medication without attempting a gradual dose reduction for 1 (#50) of 3 sample residents who received antipsychotic medications. The findings were: Medical record review revealed resident #50's physician ordered the antipsychotic medication,	F 329	F323 Cont'd: Director will include safety hazards in the orientation of all new staff. The log will be reviewed by the Risk Management Team weekly for one month and monthly thereafter for six months. Maintenance Director will present safety hazard inspection log to the QA Committee at least quarterly. F329: The facility strives to ensure each Resident's drug regimen is free from unnecessary drugs. The physician will document his decision regarding the dosage reduction trial of Resident #50. The DON and/or designee will review the medical record for all Residents who have an antipsychotic drug regimen to ensure all such drugs have the	3-2307

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 _____	02/08/2007

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 329	Continued From page 8 Risperdal 1 milligram, twice daily on 2/20/05. Review of medication administration records revealed the resident received the medication as ordered for the preceding two years. Review of the entire medical record showed no evidence of an attempted dose reduction. There was no physician documentation that the benefits of continued use of the antipsychotic without an attempted dose reduction outweighed the risks, or that this was the most appropriate medication to control the resident's symptoms. During an interview on 2/6/07 at 3:35 PM, the Minimum Data Set coordinator reviewed the record and stated the physician wrote an order to attempt a dose reduction on 10/17/06, and the facility received that order on 10/24/06. However, the hospice nurse talked with the physician on 10/24/06, then wrote a verbal order on that date to continue Risperdal 1 mg twice daily. After reviewing the medical record further, the MDS coordinator confirmed the lack of documentation by the physician regarding the medical reasons for continuing the medication at the same dose. The coordinator also confirmed lack of information in the hospice documentation.	F 329	F329 Cont'd: appropriate reduction program and/or documentation from the physician as to why the reduction should not take place. A log will be created to track such drugs, reduction trials and/or documentation for no trial. The log will be reviewed by the Risk Management Team weekly for one month and monthly thereafter for six month. The DON or designee will bring the log to the QA Committee at least quarterly.	3-23-07
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 334	F334: The facility strives to ensure that the policies for administering the flu and pneumococcal vaccines are followed.	

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 _____	02/08/2007

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 334	Continued From page 9	F 334		

immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive

F334 Cont'd: 1. The education of Resident #6 and/or the Resident's legal representative will be included in the medical record.
2. The DON will document a late entry in the medical record of Resident #24 reflecting the reason the influenza vaccine was not given.

3. It will be determined if Resident #49 does have an allergy to eggs or if it is a food preference. The medical record will be updated with the findings. If the Resident #49 is not allergic to eggs, the influenza vaccine will be administered per policy in the future.

4. Policy entitled "Immunization of Residents" will be reviewed at a nursing service inservice meeting. The policy will be dated as reviewed.

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 _____	02/08/2007

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 334	Continued From page 10 the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policies, and staff interview, the facility failed to assure the medical records for 3 (#6, #24, #49) of 5 residents reviewed for vaccination status contained all required elements or that residents with contraindications to vaccination were assessed prior to vaccination for three of five residents reviewed for vaccination. The findings were: 1. Review of the medical record showed resident #6 received the influenza vaccine on 11/16/06. Further review of the medical record showed no evidence the resident was educated prior to receiving the vaccine. There was an influenza vaccination consent form, but it was not signed. On 2/7/07 at 2:30 PM, the director of nursing (DON) stated the medical record did not document education. 2. Review of the medical record did not show evidence resident #24 received the influenza vaccine, nor was there documentation stating why the resident was not vaccinated. On 2/7/07	F 334	F334 Cont'd: At the time of the administration of the next influenza vaccine, a log will be created by the DON to include Resident, documentation of education, any refusal and any contraindications of administering the vaccine. At the time of the administration of the pneumococcal vaccine, a log will be created by the DON to include Resident, documentation of education, any refusal and any contraindications of administering the vaccine. The logs will reviewed by the Risk Management Team following the administration of the vaccines. The logs will be taken to the QA Committee at the meeting following the administration of the vaccines. 3-23-07	

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 _____	02/08/2007

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 334	Continued From page 11 at 2:30 PM, the DON stated the resident was ill at the time they vaccinated residents. The DON stated the medical record did not document the reason that the vaccination was not given. 3. Review of the immunization records for resident #49 revealed a November 2005 immunization record that stated the resident was allergic to eggs and was not to receive a flu vaccination. Further review of the resident's record and the facility's immunization records revealed the resident received a flu vaccination in November 2006. Interview with licensed practical nurse (LPN) #11 revealed the vaccination should not have been given. Additional interview with the director of nursing revealed the facility should have contacted the resident's physician if there were any contraindications to administering the vaccine. 4. Review of the facility's undated policy entitles "Immunization of Residents" revealed that "prior to the immunization, the resident or legal representative would be provided information and education. In addition, the policy stated the education would be documented in the individual resident's medical record. The policy also established that all residents all residents will be offered flu and pneumococcal vaccination unless the vaccine is medically contraindicated...vaccines may be administered per the physician orders after the resident has been assessed by the physician for medical contraindicators for each vaccine."	F 334		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371		

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 _____	02/08/2007

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 371	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to assure liquid nutritional supplements in 2 of 3 refrigerators were labeled with the thaw date. The findings were: Observation of items stored in the reach-in refrigerator in the kitchen on 2/5/07 at 3 PM revealed a cardboard box which contained 23 cartons (4 ounces each) of thawed "Mighty Shake" nutritional supplements. The instructions printed on the cartons revealed the product was to be used within 14 days of thawing. The box and cartons were not labeled with a thaw date. Observation of the reach-in refrigerator again on 2/6/07 at 4:55 PM revealed 19 cartons of thawed "Mighty Shakes," which were also not labeled with the thaw date. Observation of the unit refrigerator (located in the room with the ice machine) on 2/6/07 at 3:35 PM revealed 7 cartons of thawed "Mighty Shakes," which were not labeled with the thaw date. During an interview on 2/7/07 at 2:10 PM, the dietary manager confirmed the supplements in the reach-in refrigerator and unit refrigerator were not labeled with thaw dates. The dietary manager stated that without a thaw date marked on the carton, there was no way to know when they were thawed.	F 371	F371: The facility strives to distribute food under sanitary conditions. All "Mighty Shakes" that were not frozen on February 8, 2006, will be replaced with those containers thawed and dated at the time of being thawed out. The Mighty Shakes have been replaced from the reach-in refrigerator in the kitchen and the unit refrigerator in the ice machine room. Dietary Manager will audit the Mighty Shakes to ensure appropriate dates are placed on the package at the appropriate time daily for two weeks and randomly thereafter. Dietary Manager will take the audits to the QA Committee at least quarterly.	3-23-07
F 386 SS=B	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and	F 386		

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 _____	02/08/2007

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 386	Continued From page 13	F 386		

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, the facility failed to assure physicians wrote, signed, and dated progress notes at each visit for 3 (#6, #14, #27) of 13 sample residents who resided in the facility at the time of the survey. The findings were:

1. Review of nursing notes showed resident #14 had a physician visit on 10/23/06. However, review of the medical record showed no physician progress note for that date. On 2/7/07 at 2:30 PM, the director of nursing (DON) confirmed there was no progress note for that visit.

2. Review of the physician's progress notes for resident #6 showed three undated progress notes in the medical record between other documentation dated 7/26/06 and 12/21/06. On 2/7/07 at 2:30 PM, the DON stated that a review of the nursing notes showed the visits occurred on 10/3/06, 12/8/06 and 12/13/06. The DON confirmed the progress notes lacked dates. Review of faxed documentation from the facility on 2/14/07 showed the copies of the progress notes at the physician's office contained handwritten dates for the 10/3/06 and 12/13/06

F386:: The facility strives to ensure the physician writes, signs and dates the progress notes in the medical record.

1. Resident #14 will have the medical record include the physician progress note for the visit of 10/23/06 obtained from the medical record at the physician's office.

2. Resident #6 will have the medical record documentation for physician progress notes for visits between 7/26/06 and 12/21/06 dates to correspond with documentation in the medical record at the physician's office.

3. Resident #27 will have the medical record documentation for physician progress notes for visits after admission and between 9/29/06 and 12/22/06 dates to correspond with documentation in

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 _____	02/08/2007

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 386	Continued From page 14 visits. However, the progress notes in the medical record had not been dated. 3. Review of physician's progress notes for resident #27 revealed two notes that were signed, but not dated. The first note was written after the resident's admission, and the second occurred between 9/29/06 and 12/22/06. Review of faxed documentation provided by the facility on 2/14/07 showed two progress notes which contained handwritten dates of 10/3/06 and 12/13/06. However, the progress notes that were in the medical record were not dated.	F 386	F386 Cont'd: the medical record at the physician's office. The Medical Record Director will create a log to include the Resident name, date of admission, and date of required physician visits. The Medical Record Director and/or DON will review the log and medical records on a monthly basis to six month and randomly thereafter, to ensure all physician documentation is signed and dated. The logs will be brought to the QA Committee meeting at least quarterly.	3-23-07
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure physician visits occurred as required for 6 (#20, #21, #24, #31, #37, #50) of 13 sample residents who were living in the facility at the time of the survey. The findings were: 1. Review of the physician's progress notes and nursing notes for resident #24 showed no physician visits (excluding podiatry) between 8/31/06 and 12/5/06. On 2/7/07 at 2:30 PM, the director of nursing (DON) confirmed there had	F 387	F387: The facility strives to ensure physician visit the Resident as required by regulation. Residents #20, #21, #24, #31, #37 and #50 will have visits by the primary care physician.	

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 _____	02/08/2007

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 387	Continued From page 15	F 387		

been no physician visit in that timeframe.

2. Review of the physician's progress notes and nursing notes for resident #14 revealed no physician visits had occurred since 11/20/06. On 2/7/07 at 2:30 PM, the DON confirmed there had been no physician visit since 11/20/06.

3. Review of the admission face sheet for resident #50 revealed he/she was admitted on 2/3/05. Review of physician's progress notes and nursing documentation for the past year showed the physician saw the resident on 3/5/06, 11/18/06, and 1/17/07. Interview with the DON on 2/7/07 at 2:30 PM confirmed lack of physician visits every 60 days. Information faxed by the facility on 2/14/07 showed additional visits on 5/24/06 and 9/4/06. However, there lacked physician's visits every 60 days as required.

4. According to the admission sheet, resident #21 was admitted on 5/8/06. Review of physician progress notes and nursing notes showed documentation the physician saw the resident on 5/9/06, 6/15/06, and 8/10/06. The physician missed a visit in July 2006; therefore, visits every 30 days for the first 90 days were not provided.

5. Review of the admission face sheet showed resident #37 was admitted on 11/8/06. According to the physician's progress notes and the nursing documentation, the only physician's visit since the resident's admission occurred on 11/18/06. Information faxed by the facility on 2/14/07 showed an additional physician's visit on 1/17/07. However, there was no physician visit between those dates, therefore, there was not a physician's visit every 30 days as required.

F387 Cont'd: The Medical Record Director will create a log for all facility Residents which will include the dates for required physician visits and the dates the dates the physician completed the visit.

The DON and/or designee will audit the logs on a monthly basis for six months and randomly thereafter to ensure all Residents are included on the log and the physician visits are timely.

The audit of the logs will be taken to the QA Committee meeting at least quarterly. 3-23-07

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 _____	02/08/2007

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 387	Continued From page 16 6. Review of the medical record for resident #31 revealed the resident had a lapse between physician visits. Review of the physician's progress notes revealed the physician wrote progress notes during a visit on 8/31/06 and again on 12/5/06 (over three months later).	F 387	F444 The facility strives to ensure appropriate hand washing. An inservice will be given on 3/1/07 regarding proper hand washing emphasizing washing of hands after taking off gloves when providing care. DON and/or designee will observe hand washing techniques while staff are providing care on a random basis weekly for one month and randomly on a monthly basis thereafter for three months. If improper technique is used, training will be provided at the time of the observation. Audit results of observations will be brought to the QA Committee at least quarterly. F502 The facility strives to ensure laboratory services meet the needs of the Residents.	3-23-07
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on 1 of 4 observations (resident #21) of perineal care and review of policies and procedures, the facility failed to ensure staff completed appropriate handwashing after each direct resident contact for which handwashing was required. The findings were: Observation on 2/6/07 at 7:50 AM showed certified nurse aide (CNA) #15 assisted resident #21 into the bathroom. The resident had been incontinent of urine, but also urinated while on the toilet. After providing perineal care, the CNA removed her gloves, then laid out a wash cloth and towel for the resident's use, picked up a trash bag, and folded up and removed a pad on the resident's bed. While holding the trash bag and pad in one hand, the CNA wet the wash cloth and assisted the resident with washing his/her face. At no time during this observation did the CNA wash her hands. Review of the facility's undated policy and procedure entitled "Hand	F 444		

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 _____	02/08/2007

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 444	Continued From page 17 Washing" revealed, "Hands should be thoroughly washed before and after providing resident care."	F 444		
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory tests were completed as ordered for 1 (#50) of 13 sample residents who lived in the facility at the time of survey. The findings were: Review of the recapitulation of orders from May 2006 through November 2006 showed an order for the following yearly laboratory tests: complete blood count, chemical metabolic panel, thyroid stimulating hormone test. According to the orders, these tests were to be completed in June. Review of test results showed no evidence the tests were actually done. Interview with the director of nursing (DON) on 2/6/07 at 1:25 PM revealed the resident went on hospice care in May 2006. The DON stated the facility does not request tests ordered yearly when a resident is on hospice. After reviewing the record, the DON confirmed there was no order to discontinue the tests.	F 502	F502 Cont'd: Laboratory tests for Resident #50 will be obtained or stopped per physician order. Physician order will be placed in the medical record. DON and/or designee will coordinate with the Hospice staff to review orders for Residents enrolling in the Hospice program. A log will be created to list the Residents under Hospice care which will include the Resident's name, date of enrolling in the Hospice program, orders reviewed and services required. The log will be brought to the Risk Management Team whenever a Resident is enrolled in the Hospice program. The result of the log will be brought to the QA Committee at least quarterly.	3-23-07