STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTON COUNTY HEALTH SERVICES	**1124 WASHINGTON BLVD NEWCASTLE, WY 82701**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure advanced directives were accurately reflected for 2 of 20 sample residents (#11, #30). The findings were: 1. Review of the Advance Health Care Directive Form dated [DATE] showed resident #30 chose not to prolong life if the resident had an incurable and irreversible condition that would result in death within a relatively short time, became unconscious and, to a reasonable degree of medical certainty, would not regain consciousness, or the likely risks and burdens of treatment would outweigh the expected benefits. Review of the CPR Guidelines for Residents of Weston County Manor dated [DATE] showed the resident wished that cardiopulmonary resuscitation (CPR) Not Be Done and that life support machines Not Be Used to sustain life. The following concerns were identified: a. Review of a physician's orders [REDACTED]. b. Interview with LPN #1 and LPN #2 on [DATE] at 9:40 AM revealed nurses were to follow resident CPR status on the MAR per physician orders. Further interview revealed the facility also recorded the code status in the resident's medical record and on a list at the nurse's station. c. Review of the resident list at the nurse's station on [DATE] at 9:42 AM showed the resident was to receive CPR. d. Interview with the DON on [DATE] at 9:43 AM revealed the nurses would find the code status in the hard chart and electronic record. Further she confirmed the code status was not accurately reflected for resident #30 and the resident's status should be identified as DNR not full code. 2. Review of the POLST (Provider Orders for Life-Sustaining Treatment) form dated [DATE] showed resident #11 chose to have CPR/ Attempt Resuscitation if s/he had no pulse and was not breathing. The following concerns were identified: a. Review of the resident's physician orders [REDACTED]. b. Review of the Wyoming Advance Health Care Care Directive Form signed [DATE] showed a code status of DNR. c. Review of the resident care plan last updated on [DATE] showed a code status of CPR. d. Interview with RN #1 on [DATE] at 9:34 AM revealed she would check a resident's physician orders [REDACTED]. Further interview confirmed the resident's advance directive in the front of the chart was inconsistent with what was present in the physician orders. e. Interview with the DON on [DATE] at 9:58 AM revealed the physical chart should only contain the most recent advance directives, since a nurse would not have the time to compare advance directives when responding to a resident whose heart had stopped.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview the facility failed to implement measures to ensure a safe environment for 1 of 20 sample resident rooms observed (#19). The findings were: 1. Review of the 12/24/19 annual MDS showed resident #19 had a brief interview for mental status (BIMS) score of 4 out of 15 (severely cognitively impaired) and [DIAGNOSES REDACTED]. Review of the care plan last revised on 1/13/20 showed the resident had short term memory loss due to dementia, disorganized thinking, and inattention. Further, the care plan showed the resident requires/benefits from secured unit placement due to exit seeking and wandering. The following concerns were identified: a. Observation on 3/2/20 at 1:26 PM showed the resident had a small white microwave oven which was plugged in and sitting on a stand at the foot of the resident's bed. b. Interview with CNA #1 on 3/4/20 at 9:56 AM revealed the resident's family came in every day and the microwave was used to make tea. c. Interview with the chief executive officer on 3/4/20 at 2 PM revealed the facility had not done a resident safety evaluation on the resident for the microwave .
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure timely repositioning was performed for 1 of 7 sample residents (#50) who required assistance for repositioning and were at risk for skin breakdown. The following concerns were identified: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #50 had [DIAGNOSES REDACTED]. Further review showed the resident was totally dependant on 1 person physical assistance for bed mobility, locomotion on and off the unit, dressing, eating, personal hygiene and bathing and was totally dependant on 2 or more people for toilet use and transfers. Review of the Skin care plan last revised on 11/24/19 showed Assist me to reposition every two hours and prn (as needed). The following concerns were identified: a. Observation on 3/3/20 beginning at 1:49 PM showed the resident was in bed, on his/her back, with a positioning device to the resident's right side. The resident remained in the same position until 4:47 PM (2 hours and 58 minutes), when CNA #2 and CNA #3 entered the room to provide incontinence care and assist the resident out of bed. Continued observation showed the resident was incontinent of bowel and bladder at that time. b. Review of a Braden assessment dated [DATE] showed the resident had a score of 14 (moderate risk for skin breakdown). c. Interview with the DON and compliance educator #1 on 3/05/20 at 8:16 AM revealed staff should follow a resident's care plan and the resident should be positioned at least every 2 hours to prevent skin breakdown. 2. Review of the policy titled Identification, Treatment, and Prevention of Pressure Ulcers last revised on 2/2016 showed I. Determine which residents are at risk for developing pressure ulcers .II. Prevention and early treatment .C. Position Changes and pressure reduction 2. Turning schedules D. Incontinence management 1. Toileting/changing schedules .
F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.**

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

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F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure safety assessments were performed for 2 of 4 sample residents (#13, #20) with bed rails. The findings were: 1. Observation on 3/2/20 at 1:22 PM showed resident #13 had a bed rail present near the head of his/her bed with the call light cord wrapped around it. The bed rail was designed with four gaps, which measured 5 3/4 inches by 3 7/8 inches, 3 3/4 inches by 3 7/8 inches, 5 7/8 inches by 1 3/4 inches on two L-shaped gaps. The following concerns were identified: a. Review of the medical record showed no evidence a safety assessment was performed and no evidence the care plan identified the use of bed rails or risk of entrapment. b. Interview with compliance educator #2 on 3/3/20 at 3:26 PM revealed the resident was using the bed rail to help with repositioning in bed. She confirmed that monitoring, safety assessments, and a care plan would be expected for use of the bed rail, and none were present in the resident medical record. 2. Observation on 3/2/20 at 1:49 PM showed resident #20 had a bed rail present near the head of his/her bed with the call light cord wrapped around it. The bed rail was designed with four gaps, which measured 5 3/4 inches by 3 7/8 inches, 3 3/4 inches by 3 7/8 inches, 5 7/8 inches by 1 3/4 inches on two L-shaped gaps. The following concerns were identified: a. Review of the medical record showed no evidence a safety assessment was performed and no evidence the care plan identified the use of bed rails or risk of entrapment. b. Interview with RN #1 and compliance educator #1 on 3/4/20 at 9:30 AM revealed the bed rail was necessary for the resident to help prevent falls during transfers. They confirmed that monitoring, safety assessments, and a care plan would be expected for use of the bed rail, and none were present in the resident medical record. 3. Review of facility policy titled Restraint Policy, 100.520 last revised 11/2013 showed .10. Restraints shall only be used after a pre-restraining assessment is completed and the interdisciplinary team has tried other alternatives unsuccessfully. If any factors are identified as unfavorable on the pre-restraining assessment tool, devis appropriate interventions and document accordingly in the progress note and on the care plan .14. The continued use of a resident's restraints will be evaluated quarterly and as needed .
F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** Based on medical record review, incident review, staff interview, and policy & procedures review, the facility failed to provide behavioral health services for 2 of 4 residents (#28, #51) with identified behaviors. The findings were: 1. Review of a facility-reported incident with a situation-background-assessment- recommendation (SBAR) dated 2/24/20 and timed 5:51 PM showed residents #28 and #51 had a verbal altercation at a table in a common area, which escalated to physical violence. The following concerns were identified: a. Review of health status notes for resident #51 showed s/he made threats to harm his/her roommate (resident #28) on 2/12/20, 2/19/20, 2/21/20. Review of behavior notes showed an additional threat towards his/her roommate on 2/23/21. Further review showed staff identified the threats were due to resident #28's yelling during two of the events. The progress notes did not show any identification of specific target interventions, and the two residents were not separated to different rooms following any of the four events. Further record review showed there were no care plans related to identified behaviors exhibited by the resident. b. Review of the progress notes for resident #28 from 2/1/20 to 2/29/20 showed s/he had behaviors of yelling out on 2/9/20, 2/10/20, 2/12/20, 2/13/20, 2/14/20, 2/15/20, 2/16/20, 2/17/20, 2/18/20, 2/19/20, 2/21/20, 2/22/20, 2/23/20, and 2/24/20 prior to the altercation. Further review showed the facility staff attempted various interventions to reduce this behavior; however, there were no documented attempts to address the threats the resident received as a result of his/her yelling. 2. Interview with the SSD and social services designee on 3/4/20 at 10:54 AM revealed any behaviors identified by the CNAs and nurses should be documented on the daily census sheets communicated to the DON, which should be discussed in the morning meeting to attempt to identify the cause of the new behaviors and possible solutions. The information would also be emailed to the relevant departments for further review. Further interview revealed social services typically only viewed the CNA documentation of behaviors at the time of the residents' quarterly assessments, and revealed residents #28 and #51 should have received separate rooms following their altercation on 2/24/20. 3. Interview with social services designee on 3/4/20 at 11:44 AM revealed there was no email received regarding the incident between the two residents or the identification of new behaviors. In addition, the SS designee stated they did not have any care plans created or modified following the incident on 2/24/20, and did not identify any new behaviors or non-pharmacological interventions as a result. 4. Interview with the MDS coordinator on 3/4/20 at 2:40 PM revealed resident #51 did not have any care plans created for behaviors, and no documented interventions to address those behaviors. 5. Interview with compliance educator #2 on 3/5/20 at 8:18 AM revealed the nurses complete daily census sheets based on any new behaviors or events that occurred on their shift; the daily census sheets are then discussed in the IDT morning meeting. a. Review of the February Daily Census Sheets completed by the nurses each day showed resident #28 was being reviewed daily for behaviors with an onset date of 2/10/20, and resident #51 was being reviewed daily for behaviors with an onset date of 1/31/20. The census sheets did not document any information on interventions related to those behaviors. b. Review of the February Daily Clinical Meeting Sheets showed resident #28's behaviors were discussed in the IDT morning meeting on 2/11, 2/12, 2/21, and 2/27, and resident #51's behaviors were discussed on 2/14, 2/18, 2/19, 2/26, and 2/27. Further review showed no evidence of discussion about the nature of the residents' behaviors or the development of non-pharmacological interventions. 6. Review of the facility policy titled Resident-to-Resident Altercations last revised 08/2010 showed If two residents are involved in an altercation, staff will .2.d. Review the events with the Nursing Supervisor and Director of Nursing, including interventions to try to prevent additional incidents .f. Make any necessary changes in the care plan approaches to any or all of the involved individuals . g. Document in the resident's clinical record all interventions and their effectiveness .
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure residents were free from unnecessary [MEDICAL CONDITION] medication for 2 of 6 residents (#28, #51) reviewed for unnecessary medication use. The findings were: 1. Review of the significant change MDS assessment dated [DATE] showed resident #28 did not participate in the interviews related to cognition, but was reportedly oriented to location, with impairments in his/her orientation to time and remembering staff names and faces. Further review showed the resident had delusions, verbal behavioral symptoms, other behavioral symptoms, and rejection of care coded 1 to 3 days of the week and the behavioral symptoms were noted to significantly interfere with the resident's care and significantly disrupt the care or living environment for other residents. The following concerns were identified: a. Review of the resident's care plan last modified on 3/4/20 showed the resident was receiving [MEDICAL CONDITION] medications with interventions related to administering medications, evaluating the resident for risks/benefits of medication use, and monitoring for adverse reactions to the medications. The care plan did not identify specific target behaviors related to the medication use or non-pharmacological person-centered interventions to be attempted prior to use of [MEDICAL CONDITION] medications. b. Review of the resident's February 2020 MAR (medication administration record) showed the resident was prescribed [MEDICATION NAME] (antipsychotic) 15mg by mouth one time a day on 2/28/20 for agitation and behaviors. Review of the February 2020 treatment administration record (TAR) showed the nurses were to document if the resident had a behavior, attempted to use non-pharmacological interventions, the outcome of those interventions, and note specific concerns. Further review of the TAR showed the presence of verbal/physical behaviors for 16 days in February; however, the TAR did not have information noted about interventions. c. Review of a physician action report dated 3/3/20 showed a request sent to the physician for a [DIAGNOSES REDACTED]. There was no response from the physician present in the chart at that time. d. Review of the February nursing progress notes

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) showed the resident had verbal behaviors for 19 days in February and the notes did not show any attempts of resident-specific non-pharmacological interventions. 2. Review of the quarterly MDS assessment dated [DATE] showed resident #51 had [DIAGNOSES REDACTED]. Further review showed the resident had a history of [REDACTED]. The following concerns were identified: a. Review of the resident's care plan showed the resident was to receive [MEDICATION NAME] for behavior management and interventions included monitoring for medication side effects. There were no specific target behaviors or non-pharmacological interventions identified. b. Review of the resident's February 2020 MAR indicated [REDACTED]. Review of the February 2020 TAR showed nurses were to document if the resident had a behavior, attempted to use non-pharmacological interventions, the outcome of those interventions, and note specific concerns. Further review of the TAR showed the presence of verbal/physical behaviors for 16 days in February; however, it did not show any information about the interventions used. c. Review of nursing progress notes showed the resident had verbal behaviors towards others for 17 days in February, but the notes showed no attempts to try any resident-specific non-pharmacological interventions. 3. Interview with RN #1 on 3/4/20 at 9:43 AM revealed the nurses and CNAs were expected to document new behaviors in their charting and the information would be used to create a situation-background-assessment- recommendations (SBAR), and would be used to contact the physician to request [MEDICAL CONDITION] medications as needed. 4. Interview with the SSD and social services designee on 3/4/20 at 10:54 AM revealed any behaviors identified by the CNAs and nurses were documented on the daily census sheets communicated to the DON, which should be discussed in the morning meeting to attempt to identify the cause of the new behaviors and possible solutions. The information would also be emailed to the relevant departments for further review. Further interview revealed social services typically only viewed the CNA documentation of behaviors at the time of the residents' quarterly assessments, and revealed residents #28 and #51 should have received separate rooms following an altercation on 2/24/20. 5. Interview with social services designee on 3/4/20 at 11:44 AM revealed there was no email received regarding the incident between the two residents or the identification of new behaviors. In addition, the social services designee stated they did not have any care plans created or modified following the incident on 2/24/20, and did not identify any new behaviors or non-pharmacological interventions as a result.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure infection prevention practices were implemented for 1 of 7 sample residents (#50) with perineal care observations. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #50 had [DIAGNOSES REDACTED]. Further review showed the resident was totally dependant on 1 person physical assistance for bed mobility, locomotion on and off the unit, dressing, eating, personal hygiene and bathing and was totally dependant on 2 or more people for toilet use and transfers. The following concerns were identified: a. Observation on 3/3/20 at 4:47 PM showed CNA #2 and CNA #3 assisted the resident with perineal care. The CNAs donned gloves and unfastened the resident's brief. The CNA performed perineal care on the resident's genitalia by wiping front to back and clean to dirty. The CNAs positioned the resident on his/her left side and CNA #2 removed the resident's brief, which was soiled with urine, and placed a clean brief under the resident. The CNA performed perineal care to the residents buttock and identified the resident had been incontinent with stool. During the perineal care, the clean brief became soiled with feces and the CNA removed it and replaced it with a clean brief. The CNA finished removing the feces from the resident, discarded the soiled wipes, and attached the clean brief. Without removing the soiled gloves, the CNA adjusted the resident's shirt and pulled up his/her pants. The CNA grabbed the resident's sling, placed her hands on the resident's shirt and pants and assisted to the resident to roll so the sling could be placed under him/her. The CNA removed the gloves, obtained the lift, and attached it to the sling. The resident was transferred from the bed to the wheelchair and CNA assisted the resident out of the room. The CNA assisted the resident to the dining room, positioned the resident at the table, and left the dining room. Hand hygiene was not performed until the CNA was leaving the dining room. b. Interview with the DON and compliance educator #1 on 3/5/20 at 8:19 AM revealed staff were expected to remove gloves after providing perineal care and hand hygiene should be performed upon room entry, after removal of gloves, and after care to prevent cross contamination. 2. Review of the policy titled Hand Hygiene last revised on 11/2016 showed .Hand Hygiene is generally considered the most important single procedure for preventing healthcare associated infections .1. Indications for Handwashing and Hand Antisepsis .C. Decontaminate hands before having direct contact with patients .E. Decontaminate hands after contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). F. Decontaminate hands after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled .H. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. I Decontaminate hands after removing gloves .6. Other Aspects of Hand Hygiene .E. Change gloves during patient care if moving from a contaminated-body site to a clean-body site . 3. Review of the policy titled Standard Precautions last revised on 11/2013 showed .Gloves: To be worn when touching blood, body fluids, secretions, excretions, mucous membranes, non-intact skin and other contaminated items, i.e., equipment. Gloves do NOT take the place of hand hygiene. Hands are to be washed after removing gloves. Gloves should be changed between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms .