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

PRINTED: 01/04/2010
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
	535027	A. BUILDING _____ B. WING _____	C 12/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(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 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, review of cleaning schedules, and staff interview, the facility failed to ensure floors in a public area were maintained in a sanitary manner. The findings were: Observation on 12/15/09 at 10:20 AM of the "plant room" (room adjacent to the main dining room) revealed soil and numerous dried leaves were scattered on the floor, throughout the room. A plastic fork was lying on the floor. Observation on 12/16/09 at 10:10 AM and again on 12/17/09 at 8:05 AM revealed the floor was in the same condition (including the plastic fork). During an interview on 12/17/09 at 8:10 AM, the housekeeping supervisor (E1) stated resident rooms and public rooms were cleaned once a day, including sweeping the floors. However, when specifically asked about the "plant room," she said that room was only cleaned once a week. She further stated residents did not use that room as much, therefore that room was a not a priority for cleaning. Review of the cleaning schedule showed the "plant room" was initialed as having been cleaned on 12/14/09.		Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations manual.	
		F 253	The facility will continue to ensure that housekeeping and maintenance services are provided to maintain a sanitary, orderly, and comfortable interior. 1. The facility "plant room" was cleaned on 12/17/09. 2. The Environmental Services (Housekeeping) Supervisor will make regular weekly rounds throughout the facility to ensure that areas with resident access that are not routinely used are maintained in a clean and orderly manner.	02/05/10
F 278 SS=F	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeanne Kaiser, NHA | TITLE: Administrator | (X6) DATE: 01/14/10

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.

This POC accepted with agreement between Jeanne Kaiser, Administrator and Tony Mendez on 1/21/10.

1/21/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	C 12/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(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 1 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 $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.	F 253 (cont'd)	3. The "plant room" will be included on quarterly environmental rounds conducted by the Director of Nursing, Housekeeping Supervisor, and Infection Control Coordinator to ensure that all areas are properly maintained. 4. A quality improvement indicator will be developed to include findings of the environmental rounds and the results reported to the Environment of Care Committee with oversight by the Performance Improvement Team (i.e. Quality Improvement Committee) on a quarterly basis. 5. The Environmental Services Supervisor will monitor and the Environmental Services Department Manager will have overall responsibility for compliance.	
	This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure all items on the Resident Assessment Instrument (RAI) and Minimum Data Set (MDS) were completed as required for 15 of 15 sample residents (#4, #10, #13, #16, #27, #28, #32, #36, #40, #58, #67, #75, #78, #80, #82) who had an assessment. The findings were: 1. Review of the Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, Revised December 2008 (Centers	F 278	The facility will continue to ensure that assessments accurately reflect the resident's status, and that all items on the Resident Assessment instrument (RAI) and the Minimum Data Set (MDS) are completed as required. 1. Section V of the RAI for residents #4, #10, #13, #16, #27, #28, #32, #36, #40, #58, #67, #75, #78, #80 and #82 and all other residents will be printed with the appropriate signatures for VB1 and VB3 as they become due, beginning 12/21/09.	02/05/10

This POC accepted with agreed to additions between Jeanne Kaiser, Administrator and Jerry Madden on 1/21/10.

1/21/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	C 12/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(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 for Medicare and Medicaid Services), page 3-238, revealed the RN coordinating the Resident Assessment Protocol (RAP) assessment process signs at section VB1, and the person facilitating the care planning decision-making signs at VB3. Review of the following RAIs revealed no section V, and therefore no signatures at VB1 and VB3: a. The 6/12/09 significant change RAI for resident #58. b. The 1/28/09 admission RAI for resident #78. c. The 10/16/09 significant change RAI for resident #67. d. The 7/28/09 annual RAI for resident #75. e. Resident # 32 for a 3/14/09 and 6/23/09 RAI assessment. f. Resident #36 for a 1/21/09 RAI assessment. g. Resident #40 for a 4/25/09 RAI assessment. h. Resident #80 for a 8/30/09 14 day RAI assessment. i. Resident #82 for a 4/24/09 and 7/23/09 RAI assessment. j. Resident # 10 for a 11/2/09 RAI assessment. k. Resident #16 for a 9/18/09 RAI assessment. l. Resident #27 for a 8/19/09 RAI assessment. m. Resident #4 for a 4/28/09 RAI assessment. n. Resident #13 for a 3/9/09 and 11/9/09 RAI assessment. o. Resident #28 for a 10/15/09 and 11/25/09 RAI assessment. During interviews on 12/15/09 at 11 AM and	F 278 (cont'd)	2. Section R of the MDS for residents #75, #67, #78, #58, #2, #36, #40, #80, #82, #10, #16, #27, #4, #13 and #28 and all other residents will be printed with the appropriate signatures for R2a as they become due, beginning 12/21/09. 3. All residents' MDS and RAI forms will be available in print form or in the electronic record with the appropriate signatures as required. 4. The software contractor has been contacted to develop a computer generated form that will meet the requirements. Until such time that an acceptable computer generated form is available, a manual form will be utilized which contains the required information and signatures. 5. A quality improvement indicator will be developed to ensure that the required Section V of the RAI and Section R of the MDS are printed and contain appropriate signatures. The MDS Coordinator will monitor and report the findings to the Director of Nursing on a monthly basis. The Director of Nursing will report the findings to the organization-wide QI Committee on a quarterly basis until resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	C 12/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(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 11:37 AM, the MDS coordinator (E3) confirmed there was not a section V on the hard copy RAI, and therefore no signature lines for VB1 and VB3. Review of the RAI in the computer confirmed no signature lines for VB1 and VB3. 2. Review of the Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, Revised December 2008 (Centers for Medicare and Medicaid Services), page 3-211, revealed the RN assessment coordinator was required to sign and certify that the assessment was complete in item R2a. Review of the following MDS assessments revealed no section R, and therefore no signature at R2a: a. The 10/23/09 quarterly MDS assessment for resident #75. b. The 7/24/09 quarterly MDS assessment for resident #67. c. The 10/9/09 quarterly MDS assessment for resident #78. d. The 12/9/09 quarterly MDS assessment for resident #58. e. Resident # 32 for a 3/14/09, 6/23/09, and 7/23/09 RAI assessment. f. Resident #36 for a 1/21/09 and 11/24/09 RAI assessment. g. Resident #40 for a 4/25/09 and 11/28/09 RAI assessment. h. Resident #80 for a 8/30/09 RAI assessment. i. Resident #82 for a 1/22/09, 4/24/09, and 7/23/09 RAI assessment. j. Resident # 10 for a 11/2/09 RAI assessment. k. Resident #16 for a 9/18/09 and 12/01/09 RAI assessment.	F 278		

1/21/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	C 12/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(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 4 l. Resident #27 for a 8/19/09 and 11/20/09 RAI assessment. m. Resident #4 for a 4/28/09, 7/24/09 and 10/24/09 RAI assessment. n. Resident #13 for a 3/9/09, 9/3/09 and 11/9/09 RAI assessment. o. Resident #28 for a 10/15/09 and 11/25/09 RAI assessment. During an interview on 12/16/09 at 11:30 AM, the MDS coordinator (E3) confirmed there was no section R on the quarterly MDS assessments, and therefore no signature line for R2a.	F 278		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure safe food handling practices during one of two meal service observations. The findings were: 1. Observation of dietary aide (E2) during trayline service on 12/16/09 in the 2nd floor kitchen unit revealed the following hand hygiene concerns: a. At 12:10 PM, the dietary aide came off of the elevator carrying a container of applesauce, and then opened the door to the kitchen unit. The	F 371	The facility will continue to ensure that safe food handling practices are utilized within the facility. 1. The Registered Dietitian (RD) Director of Nutrition Services provided 1:1 education for dietary aides E2 and E4 regarding proper safe food handling practices specific to gloving and hand washing. 2. An on-line hand washing competency module will be revised and assigned to facility staff, to include all members of the Nutrition Services staff. 3. An inservice on hand washing will be provided to dietary staff on 01/20/09 by the Director of Nutrition Services. (RD)	02/05/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	C 12/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(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 5 dietary aide then donned a pair of gloves, without washing her hands first. She then dished up applesauce into plastic cups for the meal. At 12:15 PM, she removed those gloves, and then donned a new pair of gloves, again, without washing her hands first. b. At 12:20 PM, the dietary aide opened the refrigerator with her gloved hand. Without discarding the goves and washing her hands after touching the contaminated refrigerator door handle, the aide began food preparation tasks consisting of direct contact with food that would not receive any addtional cooking. She used the same gloved hand to remove two pieces of bread to make a sandwich. After she made the sandwich, she reached into a bag of potato chips, with the same gloved hand, and removed some potato chips to place on the resident's plate. c. During an interview on 12/17/09 at 10:25 AM, the dietary aide stated hands were supposed to be washed after removing gloves, and prior to donning gloves. The dietary aide stated that sometimes she got busy and forgot. She also stated it wad difficult to put gloves on after hand washing, because the hands were wet. When asked if she should have washed her hands after touching the refrigerator door handle, she stated she did not consider the door handle a contaminated surface. She then stated "I guess I should...I don't know who [else] touched it." 2. Continuous observation on 12/15/09 at 8:30 AM of the breakfast meal in the east dining room revealed a dietary aide (E4) was wearing gloves and cleaning the counter and table surfaces with a sanitizing solution. The task was temporarily interrupted when the dietary aide went into the kitchen, removed a prepared bowl of hot cereal from the food cart and served it to a resident.	F 371 (cont'd)	4. A Quality Improvement indicator will be developed by the Registered Dietitian to include weekly observations of food handling practices. The results of these observations will be reported to the Director of Nutrition Services (RD) who will further report the results to the organization-wide QI Committee on a quarterly basis. 5. The Director of Nutrition Services will monitor.	

1/12/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	C 12/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(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 6 After serving the resident, the dietary aide returned to the cleaning task. She wore the same pair of gloves for both tasks and did not perform hand hygiene between tasks. 3. The registered dietitian (E5) was interviewed on 12/16/09 at 5 PM. She stated her expectation was that staff would wash their hands before handling or preparing food, and would re-wash their hands when changing tasks. Review of the facility's "Employee Health" policy provided by the registered dietitian revealed: "Hands and the exposed portions of the arms will be washed at the following times...Immediately before engaging in food preparation, working with exposed food, clean equipment and utensils....During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks..." In addition, "...Gloves do not take the place of handwashing and will be discarded when soiled or torn...Hands will be washed after removal of gloves." Reference: According to Food Code 2009, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE SERVICE and SINGLE-USE ARTICLES and...(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands.	F 371		
F 441	483.65(a) INFECTION CONTROL	F 441		

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

PRINTED: 01/04/2010
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
	535027	A. BUILDING _____ B. WING _____	C 12/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(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 441 SS=E	Continued From page 7 The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff performed glucose tests in a manner that minimized the spread of infection for 5 of 5 residents (#5, #11, #17, #18, #22) who were observed having their glucose levels checked. Additionally, the facility failed to maintain resident care equipment in a clean, sanitary manner. The findings were: Continuous observation on 12/15/09 from 10:45 to 11:10 AM revealed registered nurse (E6) went from room to room using the same glucometer to perform glucose tests for residents #5, #11, #17, #18 and #22. After performing the test for each resident, the RN removed her gloves and pulled the used blood stained scan strip from the glucometer with her uncovered hands. She then disposed of the scan strip, placed the glucometer on the bedside table and washed her hands. She did not clean the glucometer until she had completed glucose testing for all five residents. However, it was noted during the observation that	F 441	The facility will continue to ensure that an infection control program is maintained. 1. The Staff Development Coordinator Registered Nurse (SDC-RN) provided 1:1 education on 12/16/09 to registered nurse E6 regarding the correct procedure for performing glucose tests. 2. The competency module for performance of glucose tests was revised to clearly include the requirement for cleaning the glucometer between patients with an approved germicidal wipe. 3. An inservice was provided by the SDC-RN on 1/13/10 regarding the correct procedure for performing glucose tests, including appropriate infection control measures. 4. A Quality Improvement indicator will be developed by the SDC-RN to include observations of performance of blood glucose tests, with the results reported to the D.O.N. The SDC-RN will monitor and the D.O.N. will report the monitoring results to the Infection Control Committee with oversight by the organization-wide QI Committee.	02/05/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	C 12/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(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 441	Continued From page 8 none of the five resident's had any contact with the glucometer or a contaminated strip. At that time she used an alcohol wipe to clean the machine. Interview with the RN on 12/15/09 at 11:10 AM, showed she did not wear gloves when she disposed of the scan strip because she "forgot." During an interview on 12/16/09 at 10 AM, the staff development coordinator said the glucometer manufacturer recommended staff clean and sanitize the glucometer with "Sani Cloth" (a germicidal solution), not alcohol, after resident use. During an interview on 12/16/09 at 11:55 AM, the administrator said the mistakes that the RN (E6) made on 12/15/09 should not have occurred because all staff, including that RN, had received inservice training about performing glucose tests and using effective infection control practices. Review of the facility's Glucometer Skills Checklist, dated 2009, revealed the checklist was used for yearly competency training for staff to assure staff were properly trained to use the glucometer. Additional review of the checklist showed the blood glucose testing procedure specifically required staff to wear gloves when they removed the used scan strip from the glucometer. Review of the facility's policy and procedures entitled "Accu-Check Whole Blood Glucose Testing", effective 11/17/04 and reviewed on 8/12/09, showed the guidelines included: "Follow protocol for disposal of blood-contaminated items in compliance with regulation for universal precautions. Disinfect unit between patients with approved germicidal."	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	C 12/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(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

1/21/10