QB 4/3/13

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	02/28/2013

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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: DON- Director of Nursing RN - Registered Nurse LPN - Licensed Practical Nurse CNA- Certified Nurse Aide MDS- Minimum Data Set CAA- Care Area Assessment MAR- Medication Administration Record Less commonly used abbreviations will be annotated in each deficiency	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents who were determined unsafe for self-administration of medications did not give their own medication for 1 of 2 sample residents who self-administered (#14). The findings were: Review of the medical record for resident #14 showed s/he had diagnoses that included heart failure, chronic obstructive pulmonary disease and dementia. Review of the active medication list for the resident showed s/he was ordered Albuterol inhaler, 2 puffs, every 4 hours as	F 176	The facility will continue to ensure that residents who are determined unsafe for self-administration of medications will not give their own medications. 1. A new medication administration evaluation was completed for Resident #14 on 03/15/2013 (copy attached) and the results will be provided to all licensed staff members who provide care for this resident. 2. The Albuterol inhaler was removed from the possession of Resident #14 on 03/01/2013. As the resident is emotionally attached to this device, he has retained an inhaler that is empty and does not contain any medication.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joanne Kaiser, NHA — TITLE: Administrator — (X6) DATE: 03/22/2013

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.

accepted per phone call w/ Ellen Dudek, DON on 4/3/13 @ 10 AM

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F 176	Continued From page 1 needed for shortness of breath. Interview with RN #1 on 2/27/13 at 10 AM revealed the resident self-administered an Albuterol inhaler which s/he carried with him/her. The RN then verified the medication was not monitored to determine how often the resident self-medicated. In addition, interview with LPN #1 revealed before she administered any additional medication for shortness of breath, the resident was asked when s/he had last used the inhaler. Interview with the pharmacist on 2/27/13 at 2:30 PM revealed the resident was not supposed to have an Albuterol inhaler for self-administration because s/he overused the medication. Review of the medication administration evaluation last dated 3/1/12 showed the resident could not manage his/her own medication independently. Further, the resident required nursing staff to administer medications.	F 176	3. All residents who have been evaluated as unsafe to self-administer medications will be monitored by nursing staff to ensure they do not have independent access to any medications. 4. All staff will be educated by the Director of Nursing at staff meetings regarding the care of residents who are deemed as unsafe to self-administer medications. 5. A Quality Improvement (QI) indicator will be developed to monitor all residents who are unsafe for self-administration of medications, and the results of this monitoring will be reported to the facility's Quality Improvement/Performance Improvement (QI/PI) Committee on a quarterly basis until resolved. 6. The Director of Nursing will monitor.	04/03/2013
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES 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 and staff interview, the facility failed to assure adequate housekeeping in the facility laundry room. The findings were: Observation on 2/27/13 at 9 AM revealed a significant accumulation of lint and dirt on the air vent located on the wall over one of three washing machines in the laundry room. The air vent was approximately 2 feet by 4 feet. Interview	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 wall vent in the laundry room was cleaned on 03/05/2013.	

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F 253	Continued From page 2 with the laundry supervisor at the time of the observation confirmed the findings and verified the vent needed to be cleaned.	F 253	2. Cleaning of the laundry room wall vent will be added to the preventive maintenance program to generate an automatic work order for cleaning this vent on at least a quarterly basis and more often as needed and reported by the Laundry Manager. 3. The laundry room will be inspected during quarterly environmental rounds conducted by the Director of Plant Operations and the Infection Control Practitioner, and the results of these inspections will be reported to the Environment of Care (EOC) Committee with oversight by the QI/PI Committee on a quarterly basis. 4. The Director of Plant Operations will monitor.	04/03/2013
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to develop a comprehensive care plan to include measurable goals and interventions to meet resident needs for 5 of 13 sample residents (#4, #11, #14, #15, #47). The findings were: 1. Observation on 2/27/13 at 11:45 AM showed	F 279	The facility will continue to ensure that comprehensive care plans are developed to include measurable goals and interventions to meet the residents' needs.	

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F 279	Continued From page 3 resident #14 had loose dentures partially protruding from his/her mouth. In addition, the resident received oxygen through a nasal cannula. The following concerns were identified: a. Review of the 10/4/12 physician progress note showed the resident was slumped over in a chair and his/her lower plate was nearly out of his/her mouth. When aroused, the physician observed the resident as s/he "sucked it back into place." Review of the dental care plan last updated on 12/14/12 showed the resident was dependent on the staff for care of his/her dentures. However, the plan did not include any interventions related to the loose dentures or what care needed to be provided. b. Review of the "Active Medications" list found on the electronic medical record showed the resident had 3 different doses of Albuterol (used for shortness of breath) ordered to be given as needed. In addition, s/he also received Advair 2 times daily, an inhaler used to reduce exacerbations of chronic obstructive pulmonary disease. Further, the resident had an order for Roxinal for dyspnea (air hunger) or pain. Review of the oxygen care plan last dated 12/14/12 showed the resident received oxygen at 4 liters via nasal cannula and the resident received an inhaler or nebulizer. It did not show how frequently the resident's oxygen saturations were to be monitored or at what level they were to be maintained. The care plan also did not show specific interventions for shortness of breath and when each type of medication or treatment should be implemented. 2. Review of the medical record for resident #11 showed diagnoses to include dementia and cerebral vascular accident with right sided	F 279	1. Resident #14 and his responsible party were interviewed on 03/15/2013 and agreed to further evaluation by a dentist for possible denture replacement. A dental appointment was obtained and scheduled for 03/21/2013 for Resident #14. The Care Plan for Resident #14 will be updated to reflect the results of that dental appointment and the resident's dental needs. 2. A physician's order was obtained on 03/07/2013 discontinuing the duplicative Albuterol orders for Resident #14. A new physician's order was obtained on 03/15/2013 for Resident #14 to receive oxygen at four (4) liters per minute to keep the resident's oxygen saturation greater than or equal to 90%, and to check oxygen saturations at least weekly and as needed. The Care Plan for Resident #14 will be updated to reflect this information. 3. The Care Plan of Resident #11 will be revised to address goals and interventions for pain management, care related to dementia, and all other care area needs.	

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F 279	Continued From page 4 weakness. Review of the 12/21/12 quarterly MDS assessment showed the resident's cognitive skills were severely impaired. The 12/21/12 Quarterly Nursing Review for pain showed the resident was taking medication for chronic gout and peripheral neuropathy and had Norco and Tylenol for breakthrough pain. The following concerns were identified: a. Review of the care plan for pain last revised on 12/13/12 only showed s/he received the pain medications. It did not include the resident's goal for pain management, his/her indicators of pain or any non-pharmacological interventions. b. Review of the 6/29/12 admission MDS care area assessment showed the resident triggered for dementia and a care plan was to be completed. Review of the care plan for Orientation/Behaviors showed the resident was confused about time and place but s/he was "oriented to people." In addition, it showed the resident was aphasic and had a difficult time communicating. The care plan did not include any goals or interventions related to his/her dementia. 3. Review of the medical record for resident #4 showed s/he had diagnoses including diabetes mellitus, ischemic heart disease, chronic obstructive pulmonary disease (COPD) and was dependent on continuous oxygen therapy. The quarterly MDS assessment dated 12/4/12 showed the resident was moderately cognitively impaired and required extensive assistance with activities of daily living (ADL's). The MDS further showed the resident had a indwelling urinary catheter and required continuous oxygen therapy. Review of the CAA indicated the resident should have care plans for assistance with ADL's,	F 279	4. The Care Plan of Resident #4 will be revised to address goals and interventions regarding assistance with Activities of Daily Living, (ADL's) oxygen, bowel and bladder, psychoactive medications, vision, hearing and communication impairment, activities, and all other care area needs. 5. The Care Plan of Resident #15 will be revised to address goals and interventions regarding cognitive loss/dementia, psychosocial wellbeing, ADL function including dressing and undressing, daily hygiene, assistance with bathing, and all other care area needs. 6. The Care Plan of Resident #47 will be revised to address goals and interventions for denture care, toileting, and all other care area needs. 7. As each resident's care plan comes due for its regular quarterly review and with any change in condition, it will be revised to reflect goals and interventions for assisting staff in providing care to the resident.	

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F 279	Continued From page 5 oxygen, bowel and bladder, psychoactive medications, vision, hearing and communication impairment, and activities. The following concerns were identified: a. Review of the resident's care plan last updated on 11/29/12 showed care plans for the following; Dressing/Grooming, Dental, Range of Motion/Restorative, Transfers/Ambulation, Oxygen, Psychotropic medications, Psychosocial, Vision, Hearing, Communication, Bowel and Bladder, Bathing, Dietary, Spiritual, and Activities. No concise interventions and no goals were listed in the care plans. b. Interview with the MDS coordinator on 2/28/13 at 9:40 AM revealed s/he was responsible for developing and updating resident care plans. The interview further revealed,"If there is no resolution for a problem, [we] really don't have interventions or goals for that problem." The MDS coordinator further revealed the care plan, "Focuses on problems that require a resolution, otherwise the care plan is cumbersome." 4. Review of the care plan for resident #15 last reviewed on 12/13/12 showed a variety of areas that included ADL needs, psychosocial, vision, pain, oxygen, communication, and activities. These areas included facts about the resident or problems for this resident; however, there were no goals or interventions documented to assist staff in providing care to the resident. Review of the 9/17/12 CAA notes for cognitive loss/dementia and psychosocial well being showed a care plan was to be developed. Additionally, the 9/18/12 ADL function CAA note showed the resident had an increased risk of dependence on others and did not use the call light. The resident "will wave someone over if	F 279	8. The members of the Interdisciplinary Care Plan team will participate in the "What's New from CMS and Effectively Linking CAAs to the Care Planning Process" educational telephone conference on 03/21/2013, sponsored by the Office of Healthcare Licensing and Surveys and Mountain Pacific Quality Health. 9. A QI indicator will be developed to monitor residents' Care Plans to ensure they include measurable goals and interventions to meet the residents' needs, and the results will be reported to the QI/PI Committee on a quarterly basis. 10. The Director of Nursing will monitor.	04/03/2013

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F 279	Continued From page 6 [s/he] needs help getting up from a chair to use the toilet for example." A decision not to care plan was made for this area. However, the 12/13/12 care plan addressed ADL needs such as "I do need help with dressing and undressing. I also need help to complete my daily hygiene...please help me with bathing." There was no documentation to show what care was to be provided by staff or what the resident's preferences were related to bathing. 5. Review of the 12/27/12 CAAs for resident #47 showed the areas including communication, ADL function, urinary incontinence/indwelling catheter, falls, dental care, pressure ulcers, and psychotropic drug use were assessed. With the exception of falls, there was a decision made to not care plan for these areas. Review of the resident care plan showed it was last reviewed on 12/20/12. Although the decision not to care plan was made, these areas were shown on the care plan as facts about the resident such as "I have upper and lower dentures. They fit and work fine" or "I ask staff to help me with toileting on a routine schedule throughout the day and night." These resident needs were identified; however, there were no goals or interventions documented to assist staff in providing the care to the resident.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation	F 281	The facility will continue to ensure that the services provided or arranged by the facility meet professional standards of quality.	

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F 281	Continued From page 7 and staff interview, the facility failed to ensure the daily dose of warfarin was verified by nursing with a physician's order for 1 of 13 sample residents (#14) and 1 non-sample resident (#10) observed to have received warfarin during the medication pass. The findings were: According to Perry, Potter and Elkin. Nursing Interventions and Clinical Skills, 5th edition: "It is essential that you verify the accuracy of every medication you give to the patient with the patient's orders. If the medication order is incomplete, incorrect, or inappropriate or if there is a discrepancy between the written order and what is on the MAR, consult the prescribers."Further, "When a medication is prepared in a dose other than is the dose ordered, the chance of errors increase...high-risk medications such as insulin or warfarin (Coumadin)" need the calculation of the dose checked by a second nurse. The following concerns were identified: 1. Review of the medical record for resident #14 showed s/he had diagnoses to include atrial fibrillation. Review of the Resident INR (international normalization ratio)/Warfarin (anticoagulant) Flow Sheet showed a weekly dose of the medication warfarin but did not show the daily dose to be administered. Further review of the physician's orders did not show the daily dose to be given, only a weekly dose. Review of the electronic active medication list for warfarin showed the daily dose to be given. 2. An observation on 2/25/13 at 5:33 PM showed resident #10 received warfarin 2 mg. Review of the INR Warfarin Flow Sheet showed an order for	F 281	1. The process used by the Registered Pharmacist to complete the Resident INR/Warfarin Flow Sheets will be revised to include the daily dose of warfarin to be administered to equal the weekly dose as ordered. 2. The Registered Pharmacist will review and revise the warfarin flow sheets for Resident #10, Resident #14, and all other residents receiving warfarin therapy.~~(copies enclosed)~~ 3. The Director of Pharmacy will monitor the warfarin flow sheets on a monthly basis and report the results of monitoring to the QI/PI Committee on a quarterly basis. 4. The Director of Pharmacy will be responsible for compliance.	04/03/2013

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F 281	Continued From page 8 a weekly dose of the medication but did not include the daily dose. Review of the electronic active medication list showed the daily doses to be given was; 3 mg on Sunday, Tuesday, Wednesday, Friday and Saturday, 2 mg to be given on Monday and Thursday. According to the electronic medication list, the resident was administered the appropriate warfarin dose. 3. Interview with RN #1 on 2/27/13 at 10 AM revealed the daily dose of warfarin came from the pharmacy and was found on the MAR. She checked for the correct dose by adding the daily doses to ensure they equaled the weekly dose of the medication ordered. Further, she stated her practice was to total the doses from Sunday through Saturday. 4. Interview with the pharmacist on 2/27/13 at 2:30 PM revealed the pharmacy determined the daily doses of warfarin and placed the daily dose on the electronic MAR. In addition, he stated the start of the weekly dose was dependent on when the blood work was drawn for the INR. The start date of the new dose could be any day of the week. The pharmacist then verified there was no written physician order for the daily dose to be given, only the weekly dose. 5. Interview with the DON on 2/28/13 at 8:15 AM acknowledged she was unaware the nurses did not receive written physician orders for the daily doses of warfarin. Further, she expected daily doses to be written for the medication.	F 281		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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F 323	Continued From page 9 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure resident safety and/or supervision for 1 resident (#1) of the facility who was allowed to smoke. Review of a facility-resident contract and letter of policy violation showed the facility was aware the resident was not safe to smoke; however, allowed the unsafe practice to continue. Therefore, this resulted in an immediate jeopardy for this resident. The findings were: Review of the 1/9/13 physician progress note showed resident #1 was admitted on 4/10/11 and had diagnoses which included end-stage COPD (chronic obstructive pulmonary disease). The physician also noted the resident continued to smoke "about four cigarettes a day. [S/he] is admonished not to smoke when [s/he] has [his/her] oxygen on." Review of the resident care plan showed a problem identified was "risk of injury while using oxygen and smoking." The review dates documented with this care plan were: 4/5/12, 4/16/12, 7/5/12, 10/4/12, and most currently 1/3/13. The goal was for the resident to have no injuries related to smoking. The documented interventions showed "educate and remind [resident] of risks and safety precautions quarterly at minimum." The care plan showed no	F 323	The facility will continue to ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistive devices to prevent accidents. 1. Resident #1 is no longer using cigarettes, lighters, or matches, and is using a battery-operated electronic cigarette. 2. Resident #1 has been advised to notify staff prior to leaving the building, and staff will monitor the resident's safety outside through use of the facility's security camera. 3. A wheelchair management assessment ~~(copy enclosed)~~ was conducted for Resident #1 on 02/27/2013 which reflects that the resident is able to independently manage a wheelchair. 4. A Morse Fall Scale assessment ~~(copy enclosed)~~, was conducted on Resident #1 on 03/15/2013 which reflects that the resident is at low risk for falls.	

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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 _____	02/28/2013

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

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F 323	Continued From page 11 other risks including possible death from injury, accident, or illness." c. Review of a letter to the resident dated 6/26/12 from the facility showed on 6/21/12 the resident had been found smoking in his/her room in the facility. The letter described the violation to the smoking policy and advised the resident that "Any further occurrences...will result in immediate removal of all smoking materials from your possession, and possible further action to discharge you from the facility." d. Interview with the DON on 2/26/13 at 3:15 PM verified she was aware the resident went outside and smoked multiple times daily. The DON further revealed the resident had signed the release and the facility felt that this was okay and they did not provide staff to supervise the resident because it would take staff away from other residents. However, the DON acknowledged this was an unsafe practice because the resident did not always turn off the oxygen when smoking and serious injury could result. She further verified the resident did not keep his/her own smoking materials, they were kept at the nurses' desk and the resident had to ask for them. e. Interview with CNA #1 on 2/26/13 at 2:40 PM, RN #2 on 2/26/13 at 4:45 PM, and the administrator on 2/26/13 at 4 PM, all revealed it was commonly known the resident smoked daily without supervision, and at times did so with his/her oxygen in use. Furthermore, they all three verified the plan of care was to allow the resident to do so at his/her own risk. On 2/26/13 at 4 PM, the administrator was notified of the immediate jeopardy. The nursing facility's action plan included immediate changes to include:	F 323	5. The Care Plan for Resident #1 was revised on 02/27/2013 to reflect that resident no longer smokes, uses a battery-operated electronic cigarette, is reminded to advise the staff before leaving the building, and will be monitored by security camera when outside the building. 6. Staff was educated on 02/27/2013, 02/28/2013, and 03/20/2013 regarding the care plan for Resident #1 related to non- smoking, and how to ensure the resident's safety. 7. The environment of safety and supervision for all residents will be monitored through quarterly environmental rounds conducted by the Director of Nursing, Plant Operations Director and Infection Control Practitioner, and any areas of concern addressed immediately. 8. The results of environmental rounds will be reported to the Environment of Care Committee with oversight by the QI/PI Committee on a quarterly basis.	

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F 323	Continued From page 12 a. An assessment of the resident's smoking and safety completed 2/26/13. b. Agreement by the resident to immediately stop smoking, with all smoking materials removed from the resident on 2/26/13. c. The resident's family was advised and agreed to not provide the resident with any future smoking materials involving ignition source such as matches or lighters. d. The resident was offered and accepted the option to use a battery operated electronic cigarette. e. The facility staff were educated on the new practice/care plan for the resident related to smoking. f. The facility policy and procedure that smoking is not permitted anywhere in the building or on the grounds is and will be strictly followed. The action plan was accepted on 2/27/13 at 10:17 AM, and the immediate jeopardy was removed on 2/27/13 at 12:30 PM. However, deficient practice remianed at a scope and severity of D (No actual harm with potential for more than minimal harm this is not immediate jeopardy).	F 323	9. The Director of Nursing will monitor.	03/20/2013
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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.	F 329	The facility will continue to ensure that each resident's drug regimen is free from unnecessary drugs and that appropriate assessments are conducted for the use of PRN (as needed) medications.	

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F 329	Continued From page 13 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 observation, medical record review and staff interview, the facility failed to perform initial and follow-up assessments for prn (as needed) medications for 6 of 13 sample residents (#1,#4, #11, #14, #15, #30). In addition, the facility failed to ensure duplicate medication therapy was not provided for 1 of 13 sample residents (#14). The findings were: 1. Medical record review showed resident #30 was admitted to the facility on 9/14/11 with diagnoses that included Alzheimer's dementia, and lumbar disc disease with chronic back pain. The MDS quarterly assessment dated 12/17/12 showed the resident was moderately cognitively impaired and had, "vocal complaints of pain." The CAA showed the resident triggered for pain related to lumbar disc disease and took prn medications for occasional pain. The resident's	F 329	1. The pain management regimen will be reviewed for Resident #30 and pain assessments implemented for three (3) times per day for the use of pain medications. Pain assessments will be conducted prior to and 30-45 minutes after administration of PRN (as needed) pain medications. A comfort scale pain assessment will be used for Resident #30 due to her dementia diagnosis. 2. Resident #4 will receive a respiratory assessment prior to and after administration of PRN (as needed) nebulizer treatments. 3. The pain management regimen will be reviewed for Resident #15. ~~Per enclosed copy of the CT scan of 01/16/2013 and the fall follow-up note of 01/17/2013, please note that there were no fractured ribs sustained by this resident.~~ Pain Assessments will be conducted on Resident #15 at least daily and upon use of PRN (as needed) pain medications.	

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F 329	Continued From page 14 care plan up-dated 12/13/12 showed the resident was at risk for pain. A review of the resident's MAR showed a physician's order dated 6/13/12 for Tylenol 325 mg (milligrams) one caplet every 4 hours prn. The following concerns were identified: a. Observation of a medication pass on 2/25/13 at 12:00 PM showed RN #2 gave the resident Tylenol 325 mg. The nurse informed the resident the Tylenol was for his/her headache. The resident's pain was not assessed. Review of the medical record showed no follow-up evaluation was done to assess the effectiveness of the Tylenol given for the resident's headache. b. Review of the resident's MAR showed the resident had received Tylenol 325 mg prn at least daily from 1/21/13 through 1/25/13. A review of the resident's medical record further showed the last pain assessment was done on 1/20/13 and there was no documentation why Tylenol was given prn. c. Interview with RN #3 on 2/27/13 at 4:30 PM revealed pain assessments were not documented every time a prn medication was given for pain. The interview additionally revealed RN #3 worked on the secured unit with residents that were cognitively impaired and unable to verbalize their pain. The RN denied using a pain scale to assess pain stating, "I know my residents, and when I document their pain I document their symptoms such as guarding." 2. Review of the medical record showed resident #4 was admitted to the facility on 3/5/11 with diagnoses including ischemic heart disease and chronic obstructive pulmonary disease (COPD). Review of the medical record showed a physician's order dated 1/24/12 for Duoneb	F 329	4. A sleep assessment will be conducted on Resident #1 to evaluate the use of Ativan for insomnia, and other options attempted based on the results of the assessment. When the PRN Ativan is used, its effectiveness will be documented in the resident's medical record. 5. The drug regimen of resident #14 was reviewed, and on 03/07/2013 the attending physician discontinued the orders for ProAir and PRN DuoNeb, leaving one scheduled DuoNeb nebulizer treatment twice per day, and one order for Albuterol PRN. Pre and post-therapy respiratory assessments will be conducted for use of PRN nebulizer treatments for Resident #14, and the resident will be assessed for pain four (4) times per day. 6. A pain management review was conducted on Resident #11, and pain assessments were arranged for twice per day, in addition to assessments prior to and after administration of PRN pain medication.	

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F 329	Continued From page 15 2.5/0.5 mg/3ml (milliliters) via nebulizer treatment (breathing treatment) every 4 hours as needed. The following concerns were identified: a. Review of the MAR showed the resident received Duoneb nebulizer treatments on 2/22/13, 2/23/13 and 2/24/13. Further review of the MAR and medical records showed no documentation why the Duoneb was given to the resident. b. Interview with LPN#1 on 2/27/13 at 10:10 AM revealed s/he was responsible for giving prn medications including nebulizer treatments. Interview further revealed nursing does not perform lung assessments prior to administering nebulizer treatments or after the treatments are completed. LPN #1 stated lung assessments should be done prior to administering prn nebulizer treatments and after the treatments are completed. 3. Review of the 1/16/13 nurses' notes showed resident #15 was assessed for a fall on 1/16/13 with complaints of pain to the sternum. At that time the resident rated the pain as 10 on a 1 to 10 scale with 10 being the worst pain. Review of a 1/17/13 fall follow-up note showed the resident was being treated for three fractured ribs. Review of the January 2013 MAR showed the resident had orders dated 1/17/13 for hydrocodone/APAP 5/500 mg 1 or 2 tablets every 4 hours as needed for pain. Continued review showed the resident was administered the PRN pain medication once on 1/18/13 and 1/19/13, four times on 1/20/13 and once on 1/30/13. Review of this MAR, and the nurses notes failed to show any documentation of a pain assessment prior to administering these doses of medication or any indication of its effectiveness. Interview with RN	F 329	7. The staff will be educated regarding the use of numerical, visual and comfort scales for assessment of all residents with pain, conducting pain assessments for use of PRN pain medications, and regarding the need for pre and post respiratory assessments for the use of PRN breathing treatments. 8. The use of PRN medications will be monitored by the Staff Development Registered Nurse to ensure that appropriate assessments are conducted for the use of PRN medications. The results of this monitoring will be reported to the Medication Safety Committee with oversight by the QI/PI Committee on a quarterly basis. 9. The Director of Nursing will monitor to ensure compliance.	04/03/2013

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F 329	Continued From page 16 #4 on 2/27/13 at 11:30 AM verified pain assessments were not done each time a prn medication was given. 4. Review of the 12/17/12 physician's progress note for resident #1 showed s/he had "difficulty getting and staying asleep." In the note, the physician documented Ativan 0.5 mg as needed at bedtime was being used "occasionally" to treat the sleep problem. Review of the February 2013 MAR showed the resident received the PRN Ativan 16 times from 2/1/13 to 2/26/13. Review of this MAR and the February 2013 nursing notes failed to show any assessment of the insomnia or documentation of what other options may have been tried prior to the administration of these PRN doses. In addition, there was no documentation to show if the medication was effective. 5. Review of the history and physical dated 1/10/13 for resident #14 showed s/he had diagnoses to include chronic obstructive pulmonary disease (COPD), chronic atrial fibrillation and dementia. Review of the electronic medication list showed the resident received the following medications for his/her shortness of breath and COPD: Albuterol Sulfate 2 actuations (puffs) every 4 hours as needed (prn), Albuterol Sulfate 2.5 mg inhaler every 2 hours prn and Albuterol/Ipratropium 3 ml inhaler every 6 hours prn. In addition, the resident received Advair (maintenance therapy for airflow obstruction) 2 times daily and Roxinal (morphine sulfate) for shortness of breath or pain 2-4 mg every 2 hours prn. Review of the medication administration history showed the resident received doses of all	F 329		

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F 329	Continued From page 17 the prn medications in February 2013. The following concerns were identified: a. Review of the nurses' notes for January and February 2013 showed the resident received a nebulizer treatment for shortness of breath. There was no documentation to show an assessment was completed before the medication was administered to include pulse rate and lung sounds. Further, lung sounds were not assessed after the nebulizer treatment to determine if the medication was effective. b. Interview with LPN #1 on 2/27/13 at 10:15 AM revealed she determined which Albuterol dose to administer based on whether the previous dose given was effective. Further, she did not assess the resident's lungs before or after treatment. c. Interview with the pharmacist on 2/27/13 at 2:30 PM revealed the resident should not be on 3 different Albuterol treatments for prn use. He stated it was a duplication of therapy. Further, he acknowledged the 3 different doses of Albuterol were missed during the monthly review of medications. 6. Review of the 12/21/12 nursing review for pain showed resident #11 took allopurinol and gabapentin for chronic gout and peripheral neuropathy. In addition, the resident took Norco and Tylenol for breakthrough pain as needed. Review of the electronic medication list showed the resident was ordered acetaminophen/hydrocodone 5/325 mg (Norco) 1 tablet every 4 hours as needed for pain. Review of the medication administration history showed the resident received Norco 2 times in February 2013. Review of the nurses' notes did not indicate the location and intensity of the pain prior to	F 329		

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F 329	Continued From page 18 administration of the Norco or effectiveness of the medication after it was given. Interview with RN #1 on 2/27/13 at 10 AM revealed she did not always complete pain assessments, she stated she could tell when the resident was hurting. 7. Interview with the DON on 2/28/13 at 8:15 AM stated her expectation for pain medication and breathing treatments was that the nursing staff assess residents before and after their administration. Further, she stated with the implementation of the electronic medical record, assessments were not completed as frequently as they were with paper charts. 8. Review of the facility's policy and procedure titled, "Pain Management" dated 5/99 showed the following; "...3. The patient will be instructed on using the self-reporting measurement scale. Numerical pain scale of 0-10. 0= no pain, 5 is moderate pain, 10 is worst possible pain. In the event that a patient is unable to self report [pain] using the numerical scale a visual scale will be used [Wong-Baker Faces Pain Scale]. 4. Check success of intervention for oral medication in one hour. 5. Record pain intensity and response to interventions on the MAR-Pain Assessment sheet....7. Evaluate the patient's pain to circumstances of onset, duration, location, intensity, quality, relieving and aggravating factors. 8. Review with the patient at each MDS assessment and before discharge the interventions used and their efficiency."	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371	The facility will continue to ensure that areas where food is stored, prepared, distributed and served are maintained in a sanitary manner.	

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F 371	Continued From page 19 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 review of the cleaning schedule, the facility failed to ensure 2 of 5 kitchens (main and activity kitchens) were maintained in a sanitary manner. The findings were: 1. Observation of the main kitchen on 2/25/13 at 10:15 AM showed the hood vents in the baking area and also in the main cook area of the kitchen were not clean. Both of these hood vents had visible build-up of dust and grease. In addition, the two convection ovens in the main cook area had thick accumulations of burned on food inside the ovens. Review of the cleaning schedule showed the hood vents were last cleaned in the baking area on 1/6/13, and the cook's ovens and hood vents were shown to have been done on 1/3/13. Interview with the director of nutrition services on 2/26/13 at 9:30 AM verified these items needed more frequent cleaning. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 2. Observation on 2/27/13 at 10 AM showed the	F 371	1. The hood vents and convection ovens in the main kitchen were cleaned on 02/26/2013. 2. The refrigerator and microwave oven in the activity kitchen were cleaned on 02/27/2013. 3. A cleaning schedule was developed for the ovens and hood in the main kitchen, and for the activity kitchen to ensure the appliances are cleaned on a regular basis. ~~(Copy enclosed)~~ 4. The sanitation of all kitchens will be monitored though quarterly environmental rounds conducted by the Director of Nursing, Plant Operations Director, and Infection Control Practitioner and the results reported to the Environment of Care (EOC) Committee with oversight by the QI/PI Committee on a quarterly basis. 5. The Director of Nursing and Director of Nutrition Services will monitor.	04/03/2013

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F 371	Continued From page 20 activity kitchen, which was available for residents and staff, had food equipment in need of cleaning. The outside of the refrigerator door was soiled with a brownish substance. In addition, the interior of the microwave oven was soiled with splatters of food. Interview with the activity director on 2/27/13 at 11:50 AM verified there was no cleaning schedule for the kitchen. She stated the staff used the kitchen mostly; however, it was also used for the residents. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "...(B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by:	F 411	The facility will continue to assist residents in obtaining routine and 24-hour emergency dental care to meet their needs. 1. Resident #14 and the responsible party were interviewed on 03/15/2013 and agreed to having a new dental evaluation conducted. A dental appointment has been scheduled for 03/21/2013 for evaluation of Resident #14's dentures. 2. A speech therapy consult will be obtained to evaluate Resident #14's risk for choking.	

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F 411	Continued From page 21 Based on medical record review, observation and staff interview, the facility failed to ensure dental services were provided to meet resident needs for 1 of 1 sample residents (#14) with improperly fitting dentures. The findings were: Observation on 2/25/13 at 3:10 PM and on 2/27/13 at 11:45 AM showed resident #14 had loose dentures partially protruding from his/her mouth. The annual nursing review dated 7/10/12 showed the resident had bone loss of the lower jaw and his/her dentures had little to rest on. Further, the note showed the resident had severe scoliosis causing him/her to lean to the left resulting in the dentures protruding out of his/her mouth, and the resident was a risk for problems with eating. The following concerns were identified: a. Review of the 7/20/12 dental exam report completed by the dentist showed the resident's gums were in good condition. There was no further documentation related to the resident's loose dentures. b. Review of the 10/4/12 progress notes showed the physician observed the resident sitting slumped over in the chair with his/her lower plate nearly out. When the resident was aroused, s/he "sucked" the dentures back in and put them in place. Review of the 12/31/12 Quarterly Nutrition Assessment showed the resident was on a mechanical soft diet and was having difficulty swallowing his/her food. The document further stated his/her difficulty was related, in part, to the dentures constantly falling out. The resident's diet was changed to softer foods. c. Interview with the dietary clinician on 2/28/13 at 10:40 AM revealed the resident refused to remove his/her dentures during meals.	F 411	3. Resident #14 will be closely monitored by nursing staff during meal times to ensure his safety. 4. All residents will be screened at least annually by a dentist to ensure dental needs are met, and residents who have dental needs at other times will be promptly referred to a dentist for care. 5. A QI indicator will be developed to monitor the provision of dental services and the results will be reported on a quarterly basis to the QI/PI Committee. 6. The Social Worker will monitor.	04/03/2013

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4/3/13

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

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 _____	02/28/2013

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 411	Continued From page 22 In addition, a speech consult was not recommended because the resident did not have a swallowing problem but had difficulty chewing. She further stated the change in diet texture helped with reducing the resident's choking. Interview with the DON on 2/28/13 at 8:15 AM revealed she was aware the resident had loose dentures and acknowledged s/he may need a more through dental examination. In addition, she stated a risk assessment for choking had not been completed.	F 411		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure duplicate drug therapy was identified for 1 of 13 sample residents (#14). The findings were: Review of the history and physical dated 1/10/13 showed resident #14 had diagnoses to include chronic obstructive pulmonary disease (COPD), chronic atrial fibrillation and dementia. Review of the electronic medication list showed the resident	F 428	The facility will continue to ensure that the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and that irregularities are reported to the attending physician and Director of Nursing, and acted upon. 1. The drug regimen of Resident #14 was reviewed and the physician discontinued the duplicate Albuterol treatments on 03/07/2013. See also Plan of Correction for F329. 2. All residents drug regimens will be reviewed at least once a month by a licensed pharmacist and any irregularities, including duplicate therapy, will be reported to the attending physician and Director of Nursing, and acted upon.	

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PR 4/3/13

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F 428	Continued From page 23 received the following medications for his/her shortness of breath and COPD: Albuterol Sulfate 2 actuations (puffs) every 4 hours as needed (prn), Albuterol Sulfate 2.5 mg inhaler every 2 hours prn, and Albuterol/Ipratropium 3 ml inhaler every 6 hours prn. Review of the medication administration history showed the resident received each of the prn medications in February 2013. The following concerns were identified: a. Interview with LPN #1 on 2/27/13 at 10:15 AM verified the resident had duplicate Albuterol medications that were administered. c. Interview with the pharmacist on 2/27/13 at 2:30 PM revealed the resident should not be on 3 different Albuterol treatments for prn use. He stated it was a duplication of therapy. Further, he acknowledged the 3 different doses of prn Albuterol were missed during past monthly reviews of medications.	F 428	3. The licensed pharmacist will report results of the monthly drug regimen reviews to the QI/PI Committee on a quarterly basis. 4. The Pharmacy Director will monitor to ensure compliance.	04/03/2013

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