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

PRINTED: 05/27/2015
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 01 - MAIN BUILDING 01 B. WING	05/20/2015

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
K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, 2-story building of Type II (000) construction built in 1982 and renovated in 1992 with an addition in 2010. The building was equipped with a supervised, automatic wet sprinkler system with a dry and an antifreeze branch and an addressable fire alarm system. The facility had a capacity of 94 Medicare and Medicaid beds with a census of 77.	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	The facility will continue to ensure that doors provide resistance of the passage of smoke. 1. Facility maintenance staff adjusted the door closure of the Administration Office Storage Room on 5/21/2015 to provide proper latching. 2. Facility maintenance staff adjusted the door closure of the first floor Employee Lounge on 5/21/2015 to provide proper latching. 3. The Director of Plant Operations removed the door wedges at the kitchen and dishroom on 5/19/2015. 4. All doors will be inspected by maintenance staff as part of the quarterly facility Hazard Assessments to ensure proper latching and to ensure that no devices are impeding the closure of any doors.	6/17/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeanne Kaiser MHA | TITLE: Administrator | (X6) DATE: 6/10/2015

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.

RECEIVED
WY Dept of Health
JUN 10 2015
Healthcare Licensing and Surveys

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GS7E21 Facility ID: WY0033 If continuation sheet Page 1 of 4

POC Accepted V.A Phone Call with Administrator Jeanne Kaiser on 6/29/15 @ 3:10pm
34354 S

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide doors that resisted the passage of smoke in 3 of 12 smoke compartments. The findings were: 1. Observation on 05/19/15 at 3:35 PM revealed the Administration Office Storage Room door would not latch and close completely into the door frame and would not provide resistance to the passage of smoke. At the time of the observation, the Facility Maintenance Director acknowledged the door would not latch into the frame. 2. Observation on 05/19/15 at 4:25 PM revealed the Employee Lounge door on the first floor would not latch and close completely into the door frame and would not provide resistance to the passage of smoke. At the time of the observation, the Facility Maintenance Director acknowledged the door would not latch into the frame. 3. Observation on 05/19/15 at 4:55 PM revealed both the Kitchen and Dishroom doors were blocked open with wood wedges impeding the self closing device. At the time of the observation, the Facility Maintenance Director acknowledged the doors being blocked open. Ref: 2000 NFPA 101, Section 19.3.6.3.1	K 018	5. Facility staff will be educated on the requirement that devices, including wedges, are not to be used to block open doors. 6. Quarterly facility Hazard Assessments will be conducted by maintenance staff to ensure that all doors provide resistance of the passage of smoke. 7. Results of the quarterly Hazard Assessments are reviewed at the quarterly Environment of Care Committee, with oversight by the facility-wide Quality Improvement/Performance Improvement (QI/PI) Committee. 8. The Director of Plant Operations will monitor to ensure compliance.	
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in	K 070	The facility will ensure that portable space heating devices are not used in patient sleeping rooms.	5/22/2015

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K 070	Continued From page 2 non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure portable space heating devices were not used in patient sleeping rooms. The finding were: Observation of rooms #201 and #205 on 05/19/15 from 4:45 PM to 4:48 PM revealed portable space heaters being used in the rooms. At the time of the observations, the space heaters were on and being used by the residents. The Facility Maintenance Manager acknowledged the use of the space heaters at the time of the observations. Ref: 2000 NFPA 101, Section 19.7.8	K 070	1. The space heaters were removed from rooms #201 and #205 by facility maintenance staff on 5/22/2015. 2. All resident rooms were inspected on 5/22/2015 to ensure there were no other space heaters in uses, and the Director of Nursing was made aware that space heating devices are not allowed in resident rooms. 3. Residents will be notified at the next Resident Council Meeting scheduled 6/24/2015 that space heaters are not permitted in patient sleeping rooms. 4. Quarterly facility Hazard Assessments will be conducted by maintenance staff to ensure that space heating devices are not in any patient sleeping rooms. 5. Results of the quarterly Hazard Assessments are reviewed at the quarterly Environment of Care Committee, with oversight by the facility-wide Quality Improvement/Performance Improvement (QI/PI) Committee. 6. The Director of Plant Operations will monitor to ensure compliance.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress free of	K 072		

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K 072	Continued From page 3 all obstructions or impediments to full instant use. The findings were: Observation of all first floor corridors on 05/19/15 from 3:35 PM to 4:30 PM revealed multiple wheelchairs and patient lifts stored in the corridor obstructing the means of egress. At the time of the observations, the Facility Maintenance Manager acknowledged the items being stored in the corridors. Ref: 2000 NFPA 101, Sections 19.2.1 and 7.1.10	K 072	1. The facility will continue to maintain means of egress free of all obstructions or impediments to full instant use. 2. Facility staff removed the wheelchairs and patient lifts from the corridors on 5/19/2015. 3. Facility staff will be inserviced on 6/17/2015 regarding proper storage of resident equipment when not in immediate use, to prevent obstruction of full egress in the corridors. 4. Quarterly facility Hazard Assessments will be conducted by maintenance staff to ensure that there are no obstructions or impediments to egress. 5. Results of the quarterly Hazard Assessments are reviewed at the quarterly Environment of Care Committee, with oversight by the facility-wide Quality Improvement/Performance Improvement (QI/PI) Committee. 6. The Director of Plant Operations will monitor to ensure compliance	6/17/2015