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

PRINTED: 08/10/2017
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 07/27/2017

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 A complaint survey was conducted by Healthcare Licensing and Surveys on 7/24/17 through 7/27/17. The survey was prompted by complaint intakes WY00002440, WY00002454, and WY00002457. The following common abbreviations are used throughout this document: DON- Director of Nursing MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 155 SS=D	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse	F 155	The facility will respect the right of residents to request, refuse, and/or discontinue medical treatment. 1. The Care Plan has been updated for resident #1 to include validation approaches staff can take to assure that he/she feels heard. Resident #1 also did receive a special document listing of his/her PRN and scheduled medications and how they can be taken. 2. All staff training will take place the week of Aug. 21st regarding resident rights related to the right to refuse medications, along with validation techniques. At the September resident council meeting, the Social Worker will discuss resident rights related to the right to refuse medication.	9/8/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Szymanski | TITLE: Administrator | (X6) DATE: 9/8/17

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 SEP 08 2017 Healthcare Licensing and Surveys

3:35 pm 9/13/17 Spoke with Administrator Chris Szymanski and DON Theresa Luther - PoC accepted as written. RS

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F 155	Continued From page 1 medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interview, and review of facility "reports of concern," the facility failed to honor a resident's	F 155	3. At resident care plan meetings, families and residents will receive additional education on their rights regarding medication administration as well as information on their scheduled and PRN medications. The DON and/or Nurse Managers will track the results of the education monthly. 4. The results of the education received at care plan meetings will be reported at the quarterly PI/QI meetings. 5. The DON and/or Nurse Managers will monitor.	

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F 155	Continued From page 2 right to refuse medication. This failure affected 1 of 3 sample residents (#1) reviewed for resident rights. The findings were: Review of the 6/12/17 quarterly MDS assessment showed resident #1 had diagnoses that included anxiety disorder. Further review of the MDS assessment showed the resident had moderate cognitive impairment, was independent in most activities of daily living, required a wheelchair or walker for locomotion, and required daily medication for anxiety. Review of the 7/11/17 master care plan showed behaviors due to post traumatic stress disorder were identified as a concern for this resident. Further review showed the resident struggled to manage his/her behaviors and maintain self-control, had verbal outbursts toward others, and medication administrator could be a trigger that caused anger and behavioral outbursts. Review of the care plan showed interventions to address the resident's behavior included visit with social worker, social worker will act as mediator, apply self-awareness skills, acknowledge and validate concerns and complaints, benzodiazepine (Ativan) scheduled to reduce behavioral outbursts, and visual aids could be provided for medication administration to reduce behavioral outbursts. Review of the medical record and 6/30/17 report of concern showed the resident had an anxiety attack on 6/8/17 and refused to accept the Ativan (medication ordered as needed to reduce anxiety) the nurse offered him/her. Further review showed the nurse then gave the medication along with other scheduled medications and the resident took the medication unknowingly. Further review showed when the resident became aware of receiving the medication without his/her consent,	F 155		

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F 155	Continued From page 3 s/he grew angry. Interview with the resident on 7/25/17 at 9:15 AM revealed the resident's only concern about the incident was that a resident should have the right to refuse medication when s/he did not want it. S/he further stated the staff apologized and "took care of it." Interview with the administrator on 7/27/17 at 12:30 PM revealed she and the DON were aware of the incident and the nurse who administered the medication had been counseled. The administrator further confirmed education regarding resident rights had not been provided for all staff; neither had staff received in-services about the best approach if this same situation should occur again.	F 155		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 280	The facility will assure that resident care plans are updated and accurate. 1. All the care plan face sheets in the resident closets have been removed and CNA staff will be using only the face sheet care plans in the assigned binders on their respective units. 2. The care plans for residents #1, 2, 3, 4, 5, 6, 7, 9, 14, 15, 16, 17, 19, 21, 23, 24 have been updated to make sure that the Kardex is matching the care plan. 3. The DON, Nurse Managers, RN's, LPN's will update the remainder of the care plans. The Unit Clerks will make sure that the Kardex and care plans match. All staff training for nurses and CNA's will take place the week of Aug. 21st regarding care plan updates.	9/8/17

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F 280	Continued From page 4 right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 280	4. A random monthly review of 10% of care plans will be conducted by the DON or Nurse Managers to check for accuracy between the care plan, face sheet and Kardex. 5. The results of the monthly reviews will be reported at the quarterly PI/QI meeting. 6. The DON and/or Nurse Managers will monitor.	

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F 280	Continued From page 5 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of care plans, the facility failed to ensure the care plan was updated and accurate for 16 of 22 sample residents (#1, #2, #3, #4, #5, #6, #7, #9, #14, #15, #16, #17, #19, #21, #23, #24). The findings were: 1. During an interview on 7/27/17 at 9:45 AM the DON stated there was a main/master care plan for each resident in binders located at each nursing station. She stated a one-page care plan was located on the inside of each resident's closet. In addition, she said staff also used a kardex [brief synopsis of information for each resident that was printed out and given to nursing staff]. The DON stated all three were considered the care plan and all three should be accurate. She confirmed issues with the care plans and kardexes not being accurate.	F 280		

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F 280	Continued From page 6 2. Observation of resident #15 on 7/25/17 at 1:30 PM revealed the resident was in bed. There were no motion monitors or alarms visible. Review of the main care plan (last updated 7/18/17) and the posted care plan in the resident's closet showed "motion sensor alarm when I am in bed." Review of the kardex information for the resident showed "Clip Tab [alarm] at All Times, L [left] Motion." During an interview on 7/27/17 at 12:11 PM the DON stated the resident no longer used motion alarms or the Tabs alarm and confirmed the care plans and kardex were not accurate. 3. Observation of resident #2 on 7/25/17 at 8:30 AM revealed the resident was in bed, with one full side rail up on the right side of the bed. However, review of the care plan for falls, updated 6/9/17, showed "New bed 1/4 rails Both sides." During an interview on 7/27/17 at 9:45 AM the DON stated the resident used to have a different bed with quarter side rails, but the bed s/he was currently in had full side rails, and the resident liked the right side rail up. She confirmed the care plan had not been updated. 4. Observation of resident #14 on 7/25/17 at 1:26 PM revealed the resident was in a wheelchair and did not have any alarms/monitors in place. Review of the main care plan and the care plan in the closet (updated 7/17/17) showed no alarms were to be used. However, review of the kardex showed "TABs monitor wc/recliner" and "Clip on bed." During an interview on 7/27/17 at 12:11 PM the DON stated the resident did not use alarms anymore and confirmed the kardex was not correct. 5. Review of the main care plan (last updated 5/4/17) for resident #6 showed on 3/13/17 the	F 280		

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F 280	Continued From page 7 following was added: "R [right] hand contracture, using absorbent cloth or 'carrot'." Review of the care plan in the closet showed the update was not included. On 7/27/17 at 9:45 AM the DON confirmed the care plan in the closet was not updated. 6. Review of the main care plan (updated 6/15/17) showed resident #5 used a TABS alarm at all times, and a motion sensor next to the bed. However, review of the kardex showed "Bed Pressure Alarm" in addition to the TABS and motion sensor. During an interview on 7/27/17 at 12:11 PM the DON stated the resident no longer used a bed pressure alarm and the kardex was inaccurate. 7. Review of the main care plan (updated 6/26/17) for resident #24 showed "Please use 2 staff c [with] toileting/pericare/ADLs if showing/saying sexual behavior." Review of the care plan in the resident's closet (last updated 5/10/17) showed that intervention was not included. During an interview on 7/27/17 at 9:45 AM the DON confirmed the main care plan and the care plan in the closet did not match. 8. Review of the main care plan and the care plan in the closet (both updated 7/25/17) revealed resident #16 utilized a "pin" TABS alarm [safety pin instead of clip]. However, observation on 7/25/17 at 1:46 PM showed the resident was in a recliner with a TABS alarm. A clip, instead of a safety pin, was attached to the resident's shirt. On 7/27/17 at 12:11 PM the DON stated the resident used a clip TABS alarm and confirmed the care plans were not accurate. 9. Review of the medical record showed resident	F 280		

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F 280	Continued From page 8 #1 had anxiety attacks, verbal outbursts, and problems with self-control due to post traumatic stress disorder. Review of the master care plan, revised on 7/5/17 showed social services developed specific interventions to use when the resident had panic attacks. Further review showed the interventions were effective in relieving the resident's anxiety. Review of the corresponding care plan posted on the resident's closet door showed this information was lacking. The care plan was reviewed on 7/27/17 at 10:40 AM and at that time the DON stated the care plan posted in the resident's room had not been updated. 10. Review of the IDT (interdisciplinary team) fall review dated 6/13/17 showed resident #3 fell two times on 6/7/17 and the interventions that were added to the care plan to prevent a future fall of this type included motion monitor, bed against the wall, fall mat on the left, bolster mattress, TABS (a fall management alarm system) alarm, and extra low bed. Review of the 6/13/17 master care plan showed staff did not add all of the safety interventions to the care plan; TABS alarm and extra low bed were omitted. The care plan was reviewed on 7/27/17 at 10:40 AM and at that time the DON stated the care plan had not been updated. 11. Review of the IDT fall review dated 6/1/17 showed resident #4 had a non-injury fall. Review of the master care plan, revised 6/1/17 showed the interventions that were added to the care plan to prevent a future fall of this type included non-skid rug next to bed, non-skid strips in front of sink and toilet and instructions for staff not to leave the lift in the bathroom. Review of the corresponding care plan posted on the resident's	F 280		

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F 280	Continued From page 9 closet door showed this information was lacking and the care plan was last updated on 4/27/17. The care plan was reviewed on 7/27/17 at 10:40 AM and at that time the DON stated the care plan posted in the resident's room had not been updated. 12. Review of the medical record showed resident #7 was found on the floor on 5/21/17. Review of the post-fall x-ray results showed the resident had a compression fracture in the back, but it could not be determined whether the fracture occurred with this fall or during a prior event. Review of the 5/23/17 follow-up incident report showed the following fall prevention interventions were implemented: non-skid rugs and strips on the floor and motion monitors on each side of the bed. Review of the master care plan and the care plan posted on the resident's closet door revealed the interventions were not added to either care plan. The care plan was reviewed on 7/27/17 at 10:40 AM and at that time the DON stated the care plan had not been updated. 13. Review of the 6/29/17 master care plan for resident #9 showed s/he did not walk, staff were to encourage transfers with assistance, interventions to address behaviors, discontinue the wrist splint, and instructions to provide emotional support. Review of the corresponding care plan posted on the resident's closet door showed it was revised on 10/24/16 and none of the above interventions had been added. The care plan was reviewed on 7/27/17 at 10:40 AM and at that time the DON stated the care plan posted in the resident's room had not been updated.	F 280		

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F 280	Continued From page 10 14. Review of the nurse's notes, dated 7/13/17, showed resident #17 had a wound behind his/her right ear caused by the positioning of the oxygen tubing on the resident's ear. Further review showed the physician instructed staff to keep pressure off the wound and keep it clean. Observation of the resident on 7/26/17 at 5:30 PM with RN #1 revealed the resident had an open moist uncovered wound behind the right ear. Further observation revealed the oxygen tubing was in direct contact with the wound. At that time the RN stated a dressing should have been placed between the resident's ear and the tubing to prevent pressure and cover the open wound. Review of the master care plan and care plan posted on the resident's door showed the wound was not addressed in either care plan. The care plan was reviewed on 7/27/17 at 10:40 AM and at that time the DON stated the care plan had not been updated. 15. Review of the 2/14/17 physician order sheet for resident #19 showed the dental exam identified heavy food debris and plaque, molars with large abrasives, food trapped, moderate inflammation, the need to clean interproximally, and recommendations for the resident to receive help with cleansing his/her teeth. Review of the kardex, 3/16/17 care plan posted in the resident's room, and 7/20/17 master care plan showed instructions for helping the resident brush his/her teeth, but none included additional directions for cleaning and removing food debris and plaque. Interview with the DON on 7/27/17 at 1:45 PM revealed staff were brushing the resident's teeth routinely, but there was no system for ensuring the cleansing was being done according to the dentist's recommendations.	F 280		

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(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 280	Continued From page 11 16. Review of the master care plan for resident #21 showed "make sure fall mats are up away from the bed when the [resident's name] is up" was added to the fall prevention interventions on 4/6/17. Further review revealed the motion sensor by the bed was removed on 7/2/17. Review of the care plan posted on the resident's closet door showed the above revisions had not been added, and it was last updated on updated on 4/18/17. The care plan was reviewed on 7/27/17 at 10:40 AM and at that time the DON stated the care plan posted in the resident's room had not been updated. 17. Review of the care plan for resident #23 posted on the resident's closet door showed it was last updated on 1/26/17. Further review showed the following interventions were included in the 7/20/17 master care plan but were not added to the care plan posted on the resident's closet door: a. The resident needs to be propelled by others in the wheelchair. b. Partial mechanical lift for transfers. c. Use assistive utensils d. Resident has bowel incontinence. e. The resident no longer receives restorative therapy. f. Drug and behavior monitoring. The care plan was reviewed on 7/27/17 at 10:40 AM and at that time the DON stated the care plan posted in the resident's room had not been updated.	F 280		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	F 323	The facility will attempt to use appropriate alternatives prior to installing a side or bed rail, and assure that effective bed side rail assessments are conducted for each resident. Falls will be investigated thoroughly.	9/8/17

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 _____	C 07/27/2017

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F 323	Continued From page 12 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, review of medical records and post-fall reports, and staff interview, the facility failed to complete a thorough investigation to identify preventative measures for 1 of 11 sample residents (#3) with falls. In addition, the facility failed to complete a safety assessment for 3 of 10 sample residents (#2, #15, #24) who utilized side rails. The findings were: Related to falls: 1. Review of the 6/12/17 admission MDS assessment showed resident #3 had severe cognitive impairment, was recovering from a	F 323	1. Resident #3 has expired. The side rail assessments will be completed for residents #2, 5, and 24. 2. All other resident side rail assessments will be reviewed by the DON and Nurse Manager to assure accuracy. Modifications will be made as needed for those assessments. 3. Any resident who uses side rails will be assessed for safety of use, and the results of the assessment will be reflected on the residents' comprehensive care plan, including any associated risks from the use of the rails. Side rail changes will be added to the care plan face sheet to match the Kardex. 4. Falls will be reviewed to ensure through investigations are completed and appropriate interventions will be added to the care plans as needed. 5. Side rail rounding will be conducted twice/month by the Restorative Aides, Nurse Manager or designated staff member for a random sampling of 10% of the residents to assure compliance with the care plan.	

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F 323	Continued From page 13 traumatic brain injury, was at risk for falls, and required extensive assistance with all activities of daily living. Review of the care plan, last reviewed 6/13/17, showed safety interventions included motion sensor on the left side of the bed, fall pad by the bed, bolster mattress (mattress with high side walls), and the bed positioned against the wall. Review of the post-fall reports showed the facility completed an investigation of an incident that occurred on 6/7/17 at 12:30 AM. This review revealed the resident was found on the floor in his/her room and was assisted to the bathroom after staff determined there were no major injuries. Further review revealed the TABS alarm was activated, but the motion monitor was not, and the fall mat was on the opposite side of the bed. Review of the measures implemented after the fall included a one-to-one sitter, the bed repositioned against the wall, and the motion monitor and fall mat placed on the open side of the bed. Review of a second post-fall report for this resident showed s/he fell again on the same date at 11:30 PM. Review of this report showed the resident was found on the floor next to the bed, the motion monitor had mistakenly been turned off, there was no one-to-one sitter, and the bedrails were up. Further review revealed the physician and family were notified and staff conducted every fifteen minute post-fall assessments to ensure the resident did not have major injuries. Review of the 6/13/17 report completed by the Falls Committee revealed no investigation into to why the bedrails were up and the one-to-one sitter was terminated. During an interview on 7/27/17 at 10:30 AM, the DON stated she did not know why the issue of the siderails had not been addressed because the investigation did not say the resident climbed over the siderails and the siderails should not have	F 323	6. Falls documentation will be audited monthly for three months to ensure investigations are completed and care plans updated . 7. The results of the side rail rounding and falls audits will be reported to the PI/QI Committee quarterly. 8. The DON and/or Nurse Managers will monitor.	

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F 323	Continued From page 14 been up. At that time the DON reviewed the investigation with the surveyor and stated it was not a thorough investigation and acknowledged that thorough investigations help identify preventive measures for future incidents. Related to side rails: 1. Observation on 7/25/17 at 1:30 PM revealed resident #15 was in bed. Each side of the bed had a quarter rail in the up position at the head of the bed. The rails were covered. Review of the medical record showed no evidence an assessment to determine the safety of the bed rails was completed. 2. Observation on 7/25/17 at 8:30 AM showed resident #2 was in bed. A full side rail was in the up position on the right side of the bed. A pillow was placed between the bed rail and the resident's leg. Review of the medical record showed no evidence a safety assessment for the use of the side rail was completed. 3. Observation on 7/26/17 at 2:44 PM revealed resident #24 was in bed. Each side of the bed had a quarter rail in the up position at the head of the bed. The side rails were covered. Review of the medical record showed no evidence an assessment to determine the safety of the side rails was completed. 4. During an interview on 7/27/17 at 12:11 PM the DON confirmed the lack of safety assessments for the side rails utilized by residents #15, #2, and #24. She stated an assessment to determine to safety should be done for all residents who use side rails.	F 323		