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

PRINTED: 01/16/2018
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 12/29/2017

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 12/26/17 through 12/29/17. This survey was prompted by complaint intakes WY000002481, WY000002496, WY000002509, and WY000002530. The following common abbreviations are used through this document: CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 610	It is the practice of this facility to ensure that in response to allegations of abuse, neglect, exploitation, or mistreatment, this facility must: Have evidence that all alleged violations are thoroughly investigated. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	2/12/2018

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

Chief Executive Officer CEO 1/26/18

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.

The Plan of Correction was accepted on 2/1/18. Administrator Doug McMillan was notified on 2/1/18 at 3:49pm.

Jean Yanni

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F 610	Continued From page 1 by: Based on review of facility investigations, policy and procedure review, and staff interview, the facility failed to complete a thorough investigation for 2 of 4 sample residents (#4, #10) who had injuries of unknown origin. The findings were: 1. Review of resident incidents revealed resident #10 had a bruise of unknown origin located approximately halfway up the shin, towards medial aspect on 11/1/17. Additionally, the resident had several purple discolorations on the arms and legs on 11/20/17. The purple areas were noted to be on the left upper, inner and outer arm, left wrist, left hand, left leg, two areas to right upper arm, right wrist, and two areas on right leg. Review of the patient incident forms revealed these injuries of unknown origin were not thoroughly investigated to determine the cause of the injuries. 2. Review of resident incidents revealed resident #4 had a purple area on the left lower extremity and also a light blue area to the left lower extremity distal to knee on 12/22/17. Additionally, the resident had a bruise to the left middle toe at the base of the nail and to the tip of left great toe on 11/27/17. Review of the patient incident forms revealed these injuries of unknown origin were not thoroughly investigated to determine the cause of the injuries. 3. Review of the facility policy and procedure titled "Abuse-identification, Prevention and Reporting of Crime Against a Resident" revealed "all reports of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident's funds or property must be reported immediately to the	F 610	1. Resident #10 bruises of unknown origin were not thoroughly investigated to determine the cause of the injuries. Probable cause of bruises to the upper extremities was, per staff interviews, to have been caused by resident bumping arms on the raised toilet seat arms. The wound care nurse was consulted and recommended that resident would benefit from protective sleeves, for which the resident declines to wear. Skin assessments were initiated by the wound care nurse. The arms of the toilet seat were padded on 1/5/18, after infection control nurse consulted for appropriate material choice. 2. Resident #4 bruises of unknown origin were not thoroughly investigated to determine the cause of the injuries. No cause was determined. The resident's bruises have resolved as of 1/4/18 per the wound care nurse and an intervention initiated for skin assessments	

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F 610	Continued From page 2 Administrator for a thorough investigation, which will include interviews of residents, roommates, family members, and any other individuals who may have knowledge of the allegation." 4. Interview with the DON on 12/28/17 at 4:20 PM confirmed the facility failed to thoroughly investigate these injuries of unknown origin.	F 610	An audit of all occurrence reports for November through present will be reviewed for documentation of injuries of unknown origin by the DON/designee, to ensure no other injuries of unknown origin had occurred. Any injuries of unknown origin identified by this audit will be reported to the Administrator/designee, who will complete a thorough investigation which will include interviewing residents, roommates, family members and any other individuals who may have knowledge of the allegation. Any injuries of unknown origin investigated by the Administrator/designee identified as having unknown cause of origin will be reported to the State Survey Agency within 5 working days of identification by the Administrator/designee. (PLEASE SEE CONTINUATION PAGE FOR F610)	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to ensure 1 of 2 sample residents (#1) with skin care needs received appropriate and timely interventions. In addition, the facility failed to ensure 1 of 5 sample residents (#2) who were at risk for falls received post-fall nursing assessments and monitoring. The findings were: 1. Review of the 8/21/17 admission and 11/9/17 quarterly MDS assessments revealed resident #1 was at risk for developing pressure ulcers, but had not developed pressure ulcers. This review revealed the resident did not have cognitive impairment and required extensive assistance with activities of daily living such as repositioning,	F684	It is the practice of this facility to ensure that Quality of care is a fundamental principle that applies to all treatment and care provided to this facility's residents. Based on the comprehensive assessment of a resident, this facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	2/12/2018

F610 (continued)

The Staff was educated by the DON on 1/3/18 on the Importance of an immediate investigation as to what caused the injury of unknown origin, if the resident can tell what the cause is, other witnesses to the incident and charting showing results of the investigation. The Staff will be educated by the DON/designee on the Policy "Abuse-Identification, Prevention and Reporting of Crime Against a Resident", as well as the requirement of reporting any injury of unknown origin to the Administrator/designee immediately upon discovery and completing the appropriate documentation.

The Administrator/designee will monitor all reports of injuries of unknown origin to ensure that thorough investigations are completed, that the State Survey Agency is notified within 5 working days of the incident and that if the alleged violation is verified appropriate corrective action is taken.

The results of the audit and monitoring process will be presented by the Administrator/designee at the next monthly QAPI meeting.

The Administrator/designee will present the results of the continued monitoring process at the monthly QAPI meetings for the next 6 months and/or until 90% compliance is obtained, for minimum of 3 consecutive months or for a long as deemed by the QAPI team members.

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F 684	Continued From page 3 mobility, and transfers. Review of the care plan, updated 11/21/17, showed diagnoses included peripheral neuropathy, chronic back pain, chronic obstructive lung disease, and morbid obesity. Preventive skin care measures included "an indwelling catheter to keep skin dry" and "use a lift with a slide sheet to transfer." Interview with the resident on 12/27/17 at 9:30 AM revealed s/he had "sore" areas on his/her buttocks and coccyx that developed over 2 weeks ago, and the CNAs had been applying an ointment that was not effective. On 12/27/17 at 11:40 AM and again on 12/28/17 at 10 AM, 5 sheared skin areas were observed on the resident's buttocks and coccyx. Further observation revealed each area was a vertical line approximately one half centimeter wide by 2 to 4 centimeters long. At the time of the observations, the pad positioned under the resident's buttocks had large moist and stained areas of ointment mixed with blood-tinged drainage from the sheared areas. Interview with the DON on 12/28/17 at 11:20 AM revealed the wound care nurse was responsible for performing and documenting weekly skin assessments for high risk residents. She further stated she was unable to provide evidence weekly assessments had been completed for the resident. Review of the skin care documentation with the wound care nurse on 12/28/17 at 12:20 PM revealed previously broken skin areas on the resident's buttocks were healed on 12/3/17 and documented skin assessments after that date were lacking. Interview with the wound care nurse at that time revealed she last assessed the resident's skin on 11/30/17; and she did not perform routine head to toe assessments for high	F 684	A) 1. Resident #1 skin was assessed by the wound care nurse on 12/28/17. Wound care orders were changed at this time and a resident position change every 2 hours schedule was initiated. Wound documentation show improvement in healing of sheared areas. Nursing notes have also documented on several occasions that the resident is noncompliant with the position change schedule, as well as resident's use of self-application of perfumed lotion and scratching of the skin with multiple inappropriate objects. An order was obtained from the physician on 1/14/18 for Cetaphil to be applied. And on 1/17/18 a long handled bath sponge was given to the resident to rub the skin to avoid damage from use of inappropriate methods. 2. An audit of all residents' nurses' notes for November through present for documentation of skin issues will be completed by the Director of Nursing/designee. 3. Any residents identified by this audit to have wounds will be assessed by the Wound Care Nurse and appropriate wound care orders will be obtained. The Wound Care nurse will assess each wound weekly. The Staff nurses will provide individualized wound care and assessments per Physician orders obtained by the Wound Care Nurse.	

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F 684	Continued From page 4 risk residents. She further stated she relied on direct care staff to report newly developed areas, and none had been reported for this resident until 12/28/17. At that time she also verified the CNAs failed to report the open areas observed on 12/27/17. Interview on 12/28/17 at 12:28 AM with the wound care nurse revealed she assessed the resident after staff reported the resident had been observed by a surveyor. During the interview the wound care nurse stated her assessment revealed the following concerns that needed to be addressed: a. Staff technique for repositioning contributed to the sheared areas and staff education was needed. b. The resident needed to be monitored for prolonged periods of being up. c. The various pads and cushions that were being used needed to be evaluated. d. The ointment that was being used needed to be replaced with a more effective treatment. Review of the wound care policy and procedure, not dated, showed staff were directed to measure, document, and track all wounds and ulcers. 2. Review of the 9/30/17 quarterly MDS assessment revealed resident #2 had severe cognitive impairment and was totally dependent on staff for mobility, positioning, and transfers. Review of the medical record showed the resident fell backwards out of the shower chair on 10/9/17 when the wheels of the shower chair were caught in the doorway threshold. Review of the investigation of the incident showed the CNA caught the resident as s/he was falling and assisted him/her to the floor. Further review revealed the assessed injuries at the time of the	F 684	4. Any residents identified at any time or upon admit to be at risk for skin concerns or admitted with existing wounds will be assessed weekly by the Wound Care Nurse. 5. The staff was educated on 1/3/18 by the DON on notifying the Wound Care Nurse with new wounds so that they can be assessed and orders for care obtained and weekly monitoring will be occurring. The staff will be reeducated by the DON/designee on the appropriate way to document all skin concerns, the requirement of notifying the Wound Care Nurse at the time of identification of a wound and the changes made to the documentation process as well as the weekly wound meetings. 6. The results of the audit will be presented at the next QAPI monthly meeting by the DON/designee. Audits will continue by the Wound Care Nurse and will be presented at the QAPI monthly meetings by the DON/designee for the next 6 months and/or until 90% compliance is obtained for a minimum of 3 consecutive months or as long as deemed by the QAPI team members. (PLEASE SEE CONTINUATION PAGE FOR F684)	

F684 A) (continued)

7. Weekly IDT Wound Care meetings consisting of but not limited to the Director of Nursing, Wound Care Nurse, MDS Coordinator, nurse and Dietitian will be initiated to ensure that wounds are assessed weekly by the wound care nurse, that improvement of wounds is occurring, that wounds without improvement within 2 weeks have been presents to the physician for a change in wound care orders or continue current orders per physician discretion, that residents identified to be at risk for wounds are assessed weekly by the Wound Care Nurse, that new wounds are assessed and orders for wound care are obtained and implemented by the Wound Care Nurse, that causes of wounds are identified and rectified appropriately when applicable. The current wound assessment documentation will be reviewed and revised to enable continuation of wound assessments to populate as interventions until the Wound Care Nurse deems the wound resolved for 2 weeks.

8. The results of the weekly IDT wound care meetings will be presented at the monthly QAPI meeting by the DON/Designee.

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F 684	Continued From page 5 fall included a bruise on the finger, an old yellowish large bruise on the left knee, and a small bruise on the right knee. Review of the post-fall nursing assessments and nursing notes showed one nurse assessed the resident on 10/11/12, and one nurse assessed the resident on 10/12/17. Further review showed a bruise on the left leg was noted during the assessments. This review also showed no additional assessments were completed until 10/16/17 when nurses documented the resident had a swollen left leg. Review of the medical record showed the resident was transported to the emergency department that same day and diagnosed with a fractured left leg. Review of the physician's note, dated 10/21/17, revealed the fracture could have been the result of severe osteoporosis, and not related to the fall. Interview with the DON on 12/28/17 at 3:30 PM revealed the expectation was for staff to complete assessments every shift for three days after a fall. The DON further stated she did not know why staff had not done this after the resident's fall.	F 684	B) 1. Resident #2 was assessed by a nurse on 10/11/17, 10/12/17 and on 10/16/17, at which time the resident was assessed by a physician. 2. All residents' charts with falls in the months November through present will be reviewed by the DON/designee for fall charting to ensure that post fall assessments were completed each shift for 72 hours after the fall occurred. 3. The fall documentation was updated on 1/12/18 to ensure that the initial fall assessment will populate an every shift assessment for the next 72 hours after the fall occurred. Injuries noted in the fall documentation will populate a wound assessment that will be on going until resolved. 4. The staff was educated on 1/3/18 by the DON on current fall expectations of the staff to document and assess the resident for the appropriate time frame. The staff will be educated on the new fall assessment documentation and the requirement of completion of the documentations by the DON/designee. (PLEASE SEE CONTINUATION PAGE FOR F684)	

F684
B)
(continued)

5. The results of the audit will be presented at the next monthly QAPI meeting by the DON/designee.

6. Weekly IDT Fall meetings will continue to ensure that completions of fall assessments and documentations have occurred for each shift for the 72 hours post fall, that appropriate interventions are initiated to prevent future falls when applicable, that care plans and kardex are updated to ensure staff is aware of these changes, that any injuries are addressed appropriately according to the physician orders, and that wounds are added to the weekly IDT wound care meetings for weekly assessments by the Wound Care Nurse.

7. Results of the weekly IDT Fall meetings will be presented at the monthly QAPI meetings by the DON/designee for 6 months and/or until 90% compliance is obtained for a minimum of 3 consecutive months or as long as deemed by the QAPI team members.