PRINTED: 05/02/2005
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 _____	04/21/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 164 SS=D	483.10(d)(3) FREE CHOICE The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and medical record review, the facility failed to ensure privacy for 1 (#5) of 13 sample residents. The findings were: Review of the 3/11/05 significant change Minimum Data Set (MDS) assessment for resident #5 revealed the resident was totally dependent on staff for toileting. On 4/19/05 at 9:50 AM observation revealed certified nurse aide (CNA) #4 placed the resident on the bedpan. Observation revealed the CNA did not close the	F164	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations manual. The facility will continue to ensure the resident's right to privacy and confidentiality. 1. Resident #5 was interviewed by the Director Nursing on 5/12/05 and the resident expressed that her privacy and dignity have been protected while care is being provided. She communicated that staff are closing the privacy curtain and window curtain as necessary when providing her care. Director of Nursing found both the privacy curtain and window curtain pulled while care was provided to Resident #5 on 5/12/05. 2. A staff inservice was conducted on 4/22/05 with excellent attendance, focusing on the issue of right to personal privacy. Review of the need to pull privacy curtains and window curtains while providing care was discussed. A copy of the staff sign-in sheet is enclosed. 3. The right to personal privacy is being monitored on a daily basis by the charge nurses, the Staff Development Coordinator/RN, and the Director of Nursing, through routine rounds on the nursing units.	6/1/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joanne Kaiser — TITLE: ADMINISTRATOR — (X6) DATE: 5/13/05

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.

approved corrections per J. Kaiser Telephone 5/17/05 JMK

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F 164	Continued From page 1 window covering to the resident's room which was ground level and faced the street. The resident was visible from the street when the window covering was not drawn. Interview with the resident on 4/21/05 at 10:45 AM revealed he/she would prefer the window covering be closed when receiving personal care. Interview with the staff development coordinator on 4/21/05 at 11 AM revealed the expectation for privacy was to close the window covering while performing personal care.	F164	4. A monthly Quality Improvement (QI) monitor will be developed to reflect the monitoring of the right to personal privacy of the residents. The results will be reported to the organization-wide QI Committee at the next quarterly meeting and ongoing until resolved. 5. The Staff Development Coordinator/RN will monitor, and the Director of Nursing will have overall responsibility for compliance with the right to personal privacy.	
F 241 SS=E	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and medical record review, the facility failed to assure residents were treated in a dignified manner for three (#12, #21, #50) of 13 sample residents and at least four (#4, #16, #26, #60) non-sample residents. Staff failed to maintain dignity in the areas of dining, entering personal space, and clothing references. The facility census was 74. The findings were: 1. Observation on 4/18/05 from 6:10 PM to 6:35 PM revealed CNA #2 stood while assisting resident #21 and resident #26 with dining, and while she cued resident #16 to eat. The observation revealed staff at two other assisted dining tables who remained seated while feeding residents. The observation also revealed the	F241	The facility will continue to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1. A staff inservice was conducted on 4/22/05 with excellent attendance, focusing on the issue of quality of life. The expectation of assisting residents in the dining room was reviewed to include sitting to feed the residents, specifically including Resident #2 and Resident #21, and all other residents who require full assistance with dining. A copy of the staff sign-in sheet is enclosed. 2. On 4/22/05, the tables in the dining room were moved to allow two tables of the same height to be positioned together. The entire dining room was arranged so that no two tables were together that were not the same height. Review of this arrangement was provided to the staff at the meeting on 4/22/05. 3. A review of the need to knock on resident doors and wait for a response prior to entering was provided to staff at the staff meeting on 4/22/05.	6/1/05

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F 241	Continued From page 2 availability of chairs and rolling chairs which the staff member could use. A second observation on 4/21/05 from 8:30 AM to 8:36 AM revealed CNA #3 stood to assist resident #26 with dining until she was relieved by a CNA who entered the dining room with resident #21. Interview with the director of nursing (DON) on 4/20/05 at 9:02 AM revealed staff should be seated when assisting residents with dining. 2. Review of the 12/2/04 initial and the 2/17/05 quarterly Minimum Data Set (MDS) assessments revealed resident #12 had no cognitive impairment. Observation of the first floor dining room on 4/18/05 at 6:21 PM revealed the resident was seated at a table lower than all of the other tables in the dining room. Observation revealed there was no space between the resident's knees and the underneath of the table top. During an interview with the resident on 4/19/05 at 8 AM he/she stated the table was too low and was uncomfortable. The patient stated he/she wished it was the same height as the table next to it. The resident further stated he/she had asked staff about it and they had said it would be fixed but nothing had been done yet. Measurements taken on 4/19/05 at 2:04 PM by the surveyors which revealed the table was 24.5 inches from the floor to the top of the table. The table stood end-to-end with another table which was measured at 28.6 inches from floor to table top. Interview with the director of nursing on 4/20/05 at 4:30 PM revealed the table had been lowered to accommodate a resident who was no longer at the facility. 3. The following concerns were identified regarding staff entering the personal space of residents;	F 241	4. Staff was inserviced on not referring to clothing protectors as "bibs" at the staff meeting on 4/22/05. Dietary staff was provided a memo to educate them in this regard with a signature sheet to acknowledge that they have read and understand the material in the memo. 5. The residents' quality of life is being monitored on a daily basis by the charge nurses, the Staff Development Coordinator/RN, and the Director of Nursing, through routine rounds on the nursing units. 6. A monthly Quality Improvement (QI) monitor will be developed to reflect the monitoring of the quality of life of the residents. Attached is a copy of the Patient Care Monitor tool. The results will be reported to the organization-wide QI Committee at the next quarterly meeting and ongoing until resolved. 7. The Staff Development Coordinator/RN will monitor, and the Director of Nursing will have overall responsibility for compliance with quality of life.	

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F 241	Continued From page 3 a. Observation on 4/19/05 at 9:15 AM revealed licensed practical nurse (LPN) #1 knocked on the door to room 207 as she entered the room. The LPN did not wait for a response from resident #50, who was inside the room, before she entered the resident's personal space. b. Observation on 4/19/05 at 11:39 AM showed certified nurse aide (CNA) #1 entered room 212 without knocking first. Non-sample resident #60 was inside the room. During an interview on 4/21/05 at 8:30 AM, the staff development coordinator (SDC) stated staff received education on dignity. The SDC stated staff were instructed to knock on doors and to wait for a response from the resident prior to entering the room. 4. Observation on 4/19/05 at 8:05 AM in the second floor dining room revealed dietary aide #1 referred to the clothing protector as a "bib". Six residents, including sample resident #50, were seated at the tables next to where the dietary aide was standing.	F 241		
F 248 SS=E	483.15(f)(1) QUALITY OF LIFE The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, medical record review, and review of the posted activity calendar, the facility failed to assure activities occurred as planned. In addition,	F 248	The facility will continue to provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. 1. The facility's daily schedule of activities will be prominently posted in each unit's dining area to ensure residents are informed about the upcoming activities scheduled for that day, and the location where they will be held. Residents needing transportation to other units to attend the activity will be provided assistance by staff and volunteers. Residents will be informed of the posting of the daily activity schedule at the next Resident Council meeting.	6/1/05 # Rev 19 must be specifically referenced.

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F 248	Continued From page 4 the facility failed to develop goals and document the interventions and responses for one-to-one activities for one of one sample residents (#19) who self-isolated himself/herself. The findings were: 1. Review of the posted activity calendar for April 2005, which was posted in several locations throughout the building, showed on 4/19/05 at 10:30 AM, a "social" was scheduled to occur. The following concerns were identified: a. Observation of the second floor on 4/19/05 from 9 AM until 11:44 AM revealed no group activities occurred. There was no "social" on the second floor. On 4/19/05 at 10:40 AM, resident #67 was observed walking in the hallways. An interview with the resident at that time revealed "...nothing is happening, so I'm just walking." During an interview on 4/21/05 at 9:10 AM, the activity director stated the social occurred downstairs. She stated residents from upstairs could attend "if they asked." b. Observation on 4/19/05 from 10:26 AM to 10:48 AM revealed a scheduled activity "social" was held in the first floor lounge area. The observation revealed cookies and juice were given as a snack, but no topics of interest were presented for conversation. Eight residents were in attendance, but they sat and had a snack. At 10:37 AM the volunteer passing out cookies and juice was asked by the surveyor if someone does something to get the residents to interact. The volunteer replied, "This is as good as it gets." The observation revealed residents did not interact or socialize and the person responsible for the "social" was a facility volunteer. No facility activity personnel were observed nor did they intervene. When interviewed on 4/21/05 at 9:10 AM, the activity director stated the purpose of the social	F 248	2. Activities that are being conducted primarily by volunteers will be monitored by Activities staff to ensure there is meaningful interaction with residents occurring during the activity. 3. A scheduled activity that is cancelled will be replaced by a substitute activity whenever possible, and the change in the activity schedule will be noted on the daily schedule posted in each unit's dining room so that residents are informed of the change. 4. Activities that require the assistance of other staff to provide the activity, will be organized in a manner to ensure that the necessary staff is aware of expectations for the activity and where to locate any necessary items. Resident assistance will be provided to attend the activity. 5. Residents who are identified as needing to receive one to one activities, including Resident #19, will have care plan interventions developed addressing the resident's individualized goals for the one to one visits, what the interventions will consist of, who will be conducting the one to one visits, and the resident's response. 6. A number of items appropriate for activities use in the dementia Special Care Unit (SCU) have been purchased and are in use to provide specialized, structured activities in the SCU. SCU residents will also continue to be afforded the opportunity to attend activities occurring in other areas of the facility, and will be assisted to attend these activities as appropriate.	

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F 248	Continued From page 5 was for socialization, not food. 2. Review of the posted activity calendar for April 2005 showed on 4/20/05 at 1:30 PM, a "book club" activity was scheduled to occur. Observation on 4/20/05 at 1:30 PM revealed no "book club" activity on the first or second floors. Interview on 4/19/05 at 1:45 PM with the activity assistant revealed the book club did not occur because "we finished the book last week." During an interview on 4/21/05 at 9:10 AM, the activity director stated another activity was not substituted for the book club, which did not occur. 3. Review of the March and April 2005 activity calendars revealed a movie was planned for 2:00 PM on Saturdays. Confidential interview with nine residents on 4/19/05 revealed the facility scheduled a movie every Saturday, but often the movie was not available. Two residents stated they would really like to be able to watch the movies as scheduled. During an interview on 4/21/05 at 9:10 AM, the activity director stated whether or not the movie occurred depended on which staff member was working, and if the staff member invited residents. 4. Interview with resident #19 on 4/18/05 at 5:52 PM revealed the resident chose to remain in his/her room and seldom joined any activity on the daily activity calender. The resident stated his/her preference to watch TV, read the newspaper, and receive visitors in his/her room. Medical record review revealed a care plan (completion date 3/14/05) which documented the resident liked to watch TV, refused to participate in activities, read the newspaper every morning, and received 'one to one' visits as an intervention. Interview with the activity director on 4/21/05 at	F 248	7. A Quality Improvement monitor will be developed to determine the residents' overall satisfaction with the facility's Activities program. Each cognitively intact resident will be interviewed by the Activities staff to determine their current satisfaction level with the activities program. Residents will also be surveyed bimonthly at each Resident Council meeting regarding their satisfaction level with the activities program. The results of these interviews and surveys will be reported to the organization-wide Quality Improvement (QI) committee on a quarterly basis for the next year. 8. The Activities Coordinator will monitor, and the Administrator will have overall responsibility for compliance.	

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F 248	Continued From page 6	F 248		

9:06 AM revealed the 'one to one' intervention for the resident included checking to see if he/she needed anything and ensuring the resident got the newspaper and mail. The director stated a volunteer came twice a week to visit with the resident and the resident visits "with all the housekeepers." The director stated 'one to one' visits were tracked by each residents' name being highlighted on the daily visit sheet but visit goals, interventions, and responses were not documented. During the interview, the director stated visits from friends and family were counted as 'one to one' visits. Activity notes dated 2/28/05 documented "staff does 1 - 1 [one to one] with [resident #19]..." The note did not address the resident's individualized goal, the interventions done, or the response of staff visits.

5. According to the posted activities on the bulletin board dated 4/19/05, "Charles and pups" were scheduled in the secured care unit (SCU) at 10 AM. Interview with licensed practical nurse (LPN) #3 at 11:40 AM on 4/19/05 revealed Charles and pups did not arrive until about 11 AM.

According to the posted activities dated 4/20/05, manicures were scheduled at 10 AM and cooking was at 2 PM. Interview with certified nurse aide (CNA) #4 on 4/20/05 at 2:40 PM revealed one resident went out of the SCU for a manicure and the rest slept. The CNA stated no residents went out for cooking. The CNA further stated there were no planned activities in the SCU that day and nothing was happening. Observation at that time showed 6 of the 10 residents were sleeping in recliners or wheelchairs in the common area, 3 were napping in bed, and 1 was wandering aimlessly in the hall.

Observation on 4/21/05 at 9:05 AM showed

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F 248	Continued From page 7 all 10 residents seated around the dining tables in the SCU, but no activities were occurring and nothing was scheduled. Review of the bulletin board showed the only information posted was the date, April 21, 2005. Interview with the activity director on 4/21/05 at 9:10 AM revealed the facility did not have an activity program specifically developed for residents in the SCU.	F 248		
F 281 SS=D	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, and medical record review, the facility failed to ensure medications were distributed according to professional standards for 2 (#5, #50) of 13 sample residents and one non-sample resident (#46). The findings were: 1. On 4/19/05 at 8:02 AM observation during a medication pass showed registered nurse (RN) #1 set medications on the bedside table for resident #5 and then left the room. When asked if the resident was care planned for self administration of medications, the RN pointed to the medication administration record (MAR) and read the instructions "...must be observed." The RN further stated the resident would not take the medications without food so she (the RN) would go back later to see if the resident took them with breakfast. Interview with the resident at 8:30 on 4/19/05 confirmed he/she preferred taking the medications with food. Reconciliation of the medications with the	F 281	The facility will continue to ensure that services provided or arranged by the facility meet professional standards. 1. New assessments for determining residents' capability to self-administer medications were conducted on Residents #5, #50, and #46, copies attached The results of the new assessments will be noted on the Medication Administration Record (MAR) to inform nurses of the ability or inability of the resident to self-administer medications and added to the resident's care plan. A physician's order will be obtained prior to the self-administration of medications. 2. The Staff Development Coordinator/RN and/or Director of Nursing will routinely monitor medication passes at least bi-weekly on each nursing unit for the next three (3) months. Immediate 1:1 inservice will be provided for any observed nurse regarding any practice that is not consistent with policy and/or accepted professional standards.	6/1/05

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F 281	Continued From page 8 physician's orders showed the following order originally dated 1/24/05: "Unsafe for pre-poured medications. They must be observed by nursing." Review of the February, March, and April 2005 MARs showed those instructions were printed on each form. According to the 1/24/05 self-administration of medication assessment, the resident was not safe to self-administer medications; nor was the resident care planned for self-administration of medications. 2. Observation on 4/19/05 at 8:05 AM revealed sample resident #50 seated at a table in the second floor dining room. Licensed practical nurse (LPN) #1 put a medication cup containing pills in front of the resident, then walked out of the dining room. The LPN did not observe the resident take his/her medications. Review of the medication administration record (MAR) for 4/19/05 revealed the resident received the following 8 AM medications: Calcium carbonate 500 milligrams (mg), ASA (aspirin) 81 mg, Vitamin D 400 international units (iu), Plendil (Calcium channel blocker) 2.5 mg, hydrochlorothiazide (diuretic) 25 mg, Omega 3 (2 gelcaps), and Neurontin (anticonvulsant, which may also be given for pain) 600 mg. Review of the medication administration evaluation tool, reviewed by the interdisciplinary team on 12/2/04, showed the resident was assessed as unsafe for pre-poured medications. Review of the recapitulation of physician orders dated 3/29/05 and the 4/05 MAR also showed the resident was un-safe for pre-poured medications. During an interview on 4/19/05 at 2:45 PM, LPN #1 stated the resident should be observed to take his/her medications because the resident "...drops them." 3. Observation on 4/19/05 at 8:20 AM revealed	F 281	3. Following the three (3) months, the DON will report the results of the observation of medication passes to the organization-wide Quality Improvement (QI) Committee. 4. The Director of Nursing will monitor and will be ultimately responsible for compliance.	

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F 281	Continued From page 9 non-sample resident #46 seated at a table in the second floor dining room. LPN #1 put a medication cup containing pills in front of the resident, then walked back to the medication cart. The cart was located around the corner, and the resident was not in view from the cart. The LPN did not observe the resident take his/her medications. Review of the MAR for 4/19/05 revealed the resident received the following 8 AM medications: Pepcid (Histamine H-2 receptor blocker) 20 mg, Furosemide (diuretic) 20 mg, Maxzide (antihypertensive) 25 mg, Dilantin (anticonvulsant) 100 mg, Potassium chloride 10 milliequivalent (mEq), Senekot 8.6 mg, Isoptin S.R. (calcium channel blocker) 120 mg, Carbamazepine (anticonvulsant) 400 mg, Zoloft (antidepressant) 50 mg, Primidone (anticonvulsant) 250 mg, and haloperidol (antipsychotic) 0.5 mg. Review of the 6/24/04 medication administration evaluation tool showed the resident may have some confusion, and the resident/family requested that nursing administer medications. Review of the 3/1/05 recapitulation of physician orders also revealed the resident/family requested that nursing administer medications. 4. Interview with the director of nursing (DON) on 4/20/05 at 9:10 AM revealed the order, "Unsafe for pre-poured medications," meant that licensed nurses must actually watch the resident take the medications. The DON further stated this had been discussed with the licensed nurses and they were aware they actually had to watch residents take medications when this order was written. Review of the facility's 10/03 policy and procedure, "Self-Administration of Drugs/Compumed", revealed residents "...may not be permitted to administer...any medication in	F 281		

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F 281	Continued From page 10 their rooms unless so ordered. In writing, by the attending physician..." According to the 3rd edition of "Nursing Interventions & Skills" by Elkin, Perry, and Potter, a nurse should remain with the resident "until the medication is taken...Do not leave medication at the bedside without a prescriber's orders to do so."	F 281		
F 318 SS=D	483.25(e)(2) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of restorative records, the facility failed to provide restorative exercises as assessed by the facility for two (#5, #6) of nine residents. The findings were: 1. Review of the March 2005 physician orders for resident #5 revealed he/she was admitted with diagnoses including fractured right ankle, fractured left femur, arthritis, and osteoporosis. Review of the 1/24/05 initial and 3/11/05 significant change Minimum Data Set (MDS) assessments revealed the resident had functional limitations in both arms, limitation in one hand, limitation in both legs with partial loss of voluntary movement, and limitation in the right foot with partial loss of voluntary movement. Observation on 4/19/05 from 8:30 AM through 11:30 AM revealed the resident required staff assistance	F 318	The facility will continue to ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. 1. Resident #5 was reviewed on 5/11/05 and will continue to require upper and lower extremity exercises three (3) times per week. 2. Resident #6 was reviewed on 5/11/05 and will continue to require ambulation as tolerated three (3) to five (5) times weekly. 3. The DON and Restorative Nurse/RN met with the Restorative Aides on 5/11/05 to review expectations in meeting the restorative needs of the residents. A copy of the sign in sheet is attached. 4. Over the next three (3) months, a weekly restorative meeting will be held with the Restorative Nurse/RN and Restorative Aides to assure that the restorative plans of care are being met by the program. 5. Following the initial three (3) months, results of compliance with meeting the restorative needs will reported to the organization-wide QI Committee and ongoing until resolved. 6. The Restorative Nurse/RN will monitor with the DON being responsible for overall compliance with meeting the restorative needs.	6/1/05

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F 318	Continued From page 11	F 318		

with care. The following concerns were identified:

a. Review of the Restorative Services Flow Sheet - Level II revealed the resident was assessed as a high level for need of restorative therapy. The review further revealed the resident was assessed to require upper and lower extremity exercises three times weekly.

b. Review of the 1/11/05 physical therapy recommendation for services revealed the resident needed complete lower extremity exercises three times per week to maintain lower extremity strength with a start date of 1/24/05.

c. Review of the occupational therapy recommendation for services dated 1/11/05 revealed the resident needed upper extremity range of motion exercises with progression to theraband three to five times per week. Goals identified were to increase strength and range of motion in the right upper extremity and to increase strength in the left upper extremity. The identified start date was 1/24/05.

d. Review of the February, March, and April 2005 restorative aide monthly charting forms revealed the resident did not receive the recommended minimum of three range of motion exercise sessions per week. The range of motion exercises were recorded as follows:

1. Week of 1/30-2/5/05: two range of motion sessions on 2/2/05 and 2/4/05,
2. Week of 2/6-2/12/05: two sessions on 2/8/05 and 2/9/05,
3. Week of 2/13-2/19/05: two sessions on 2/15/05 and 2/18/05,
4. Week of 2/20-2/26/06: two sessions on 2/23/05 and 2/25/05,
5. Week of 2/27-3/5/05: one session on 2/28/06.
6. Week of 3/6-3/12/05: one session on 3/9/06,

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F 316	Continued From page 12 7. Week of 3/13-3/19/05: two sessions on 3/15/05 and 3/18/05, 8. Week of 20-3/26/05: two sessions on 3/21/05 and 3/26/05, 9. Week of 4/3-4/9/05: one session on 4/6/05, 10. Week of 4/10-4/16/05:one session on 4/16/05, and 11. Week of 4/17-4/23/05:one session on 4/20/05. e. Interview with the staff development coordinator who served as the restorative nurse on 4/21/05 at 11 AM revealed restorative exercises were sometimes missed because residents refused them, were ill, or because the restorative staff were assigned to work on the units. Review of the restorative notes revealed there was no documented evidence regarding why the exercises were not performed as recommended. 2. Review of the March 2005 physician's orders for resident #6 revealed he/she was admitted with diagnoses including cerebral vascular accident (stroke) with deficits, past fractured right hip, and osteoporosis. Review of the 12/9/04 initial MDS assessment revealed the resident had no range of motion limitations. Review of the 2/28/05 significant change MDS assessment revealed the resident had declined in functional limitations of one leg with partial loss of voluntary movement. Observation on 4/19/05 from 8:30 AM through 11:30 AM revealed the resident required staff assistance for care. The following concerns were identified: a. Review of the Restorative Services Flow Sheet - Level II revealed the resident was assessed as a high level for need of restorative therapy. The review further revealed the resident	F 316		

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F 318	Continued From page 13 was assessed to require ambulation as tolerated three to five times weekly. b. Review of the 3/11/05 physical/occupational therapy recommendation for services revealed the resident needed ambulation three to five times per week to maintain his/her current level of function with a start date of 3/15/05. c. Review of the March and April 2005 restorative aide monthly charting forms revealed the resident was not ambulated the minimum of three times per week as recommended. Ambulation was recorded as follows: 1. Week of 3/13-3/19/05: two sessions on the 3/15/05 and 3/19/05, 2. Week of 4/10-4/16/05: one session on 4/15/05, and 3. Week of 4/17-4/23/05: two sessions on 4/17/05 and 4/20/05. d. Interview with the staff development coordinator who served as the restorative nurse on 4/21/05 at 11 AM revealed restorative exercises were sometimes missed because residents refused them, were ill, or because the restorative staff were assigned to work on the units. Review of the restorative notes revealed there was no documented evidence regarding why the exercises were not performed as recommended.	F 318		
F 323 SS=D	483.25(h)(1) QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible This REQUIREMENT is not met as evidenced by:	F 323	The facility will continue to ensure that the resident environment remains as free of accident hazards as is possible. 1. On 4/21/05 the Virex 256 was removed from the East soiled utility room and relocated to a locked housekeeping closet.	6/1/05

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F 323	Continued From page 14 Based on observation and staff interviews, the facility failed to store hazardous chemicals and "sharps" (sharp or contaminated equipment and supplies) out of reach of residents. The findings were: 1. Observation of the facility on 4/20/05 at 3:05 PM showed a spray bottle of Virex 256, a disinfectant, connected per hose to the water faucet in the East soiled utility room. The door to the utility room had no lock, and the room was accessible to residents. Review of the label on the disinfectant bottle revealed eye contact and internal ingestion should be avoided. Observation on 4/21/05 at 9 AM showed the bottle was still connected to the water faucet. During an interview on 4/21/05 at 9:42 AM, the director of nursing (DON) stated the disinfectant should be removed. 2. On 4/20/05 at 3:10 PM observation of the East women's tub room showed a sharps container with a key in the lock. The container held used items, such as syringes and needles, and was accessible to residents since the door to the tub room did not lock. 3. On 4/20/04 at 3:40 PM observation of the second floor resident lounge opposite room 216 revealed a 32 ounce can of turpentine. The can was unsealed and accessible to residents. According to the label, turpentine is combustible and harmful or fatal if swallowed. Interview with the administrator on 4/21/05 at 11:40 AM revealed no one knew how long the can of turpentine had been in the cabinet. 4. Observation of the first floor activity kitchen on 4/20/05 at 4:15 PM revealed several knives with	F 323	2. On 4/21/05, the key was removed from the sharps container and given to the Housekeeping Supervisor. 3. On 4/21/05, the 32 ounce can of turpentine was removed and discarded. 4. On 4/21/05, the several knives with serrated blades, potato peeler, two barbeque forks, and scissors were relocated to locked cabinets in the kitchen area. 5. The Housekeeping Supervisor will monitor the use of housekeeping chemicals to ensure they are properly located and secured, and will also monitor the sharps containers to ensure they are properly secured. 6. The Activities Coordinator will monitor any potentially hazardous utensils or chemicals used or kept in the activity kitchen and activities areas to ensure they are kept secured when not in use or under direct supervision. 7. The safety officer or designee from the Plant Operations department will conduct monthly environmental safety rounds throughout the facility to ensure that the resident environment remains as free of accident hazards as is possible. A report of these rounds will be provided to the Director of Nursing, the Administrator, and to the organization-wide Environment of Care Committee, which meets on a bi-monthly basis. In addition, the Infection Control nurse will also conduct quarterly rounds to identify potential hazards, and will report the results of those rounds to the Director of Nursing, Administrator, and to the bi-monthly organization-wide Environment of Care Committee. 8. The Safety Director/Director of Plant Operations will monitor and have overall responsibility for compliance.	

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F 323	Continued From page 15 serrated blades which varied from three to six inches in length, a potato peeler, two long-handled barbecue forks with three-inch tines, and a pair of sharp scissors with six-inch blades. All of the aforementioned items were either on the counter, in unlocked drawers, or in unlocked cabinets which were accessible to residents. Interview with the DON on 4/20/05 at 4:30 PM revealed the kitchen was for resident use, and she could not guarantee that confused residents were always supervised. The DON stated the kitchen had been in use for approximately one month.	F 323		
F 329 SS=D	483.25(l)(1) QUALITY OF CARE 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. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to assure one of one sample residents (#25) who received a hypnotic medication (psychotropic medication used for sleep) did not receive it unnecessarily. The findings were: Review of a telephone order dated 2/16/05 showed the physician ordered Temazepam (a hypnotic) nightly if needed for resident #25.	F 329	The facility will continue to ensure that each resident's drug regimen is free from unnecessary drugs. 1. Physician was called on 4/27/05 regarding use of Temazepam for resident #25. Attached is a copy of the nurse's notes regarding the conversation as well as a new physician order to continue this medication on a regular schedule. 2. A form has been developed (copy attached) to fax to the physician on or prior to day 10 of the initiation of any hypnotic medication. All nurses will be educated regarding the use of this form at the May 25th staff meeting. 3. The Medication Review Team will monitor monthly for compliance and report the results of their findings quarterly to the Pharmacy and Therapeutics Committee. 4. The Social Worker will monitor and the Director of Nursing will be ultimately responsible for compliance.	6/1/05

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F 329	Continued From page 16 According to the February, March and April 2005 medication administration records (MARs), the resident received Temazepam every night from 2/17/05 through 4/19/05. Interview with registered nurse #2 on 4/20/05 at 5 PM revealed she just took the medication to the resident every night as he/she "always requests it." According to the 2005 PDR Nurse's Drug Handbook, Temazepam is for short term use only as "Prolonged administration is not recommended because physical dependence and tolerance may develop." Review of the entire medical record with the director of nursing (DON) on 4/20/05 at 5:15 PM failed to show physician documentation explaining why the hypnotic medication was prescribed for more than short term use. In addition, the facility failed to provide evidence that other possible reasons for insomnia (e.g., depression, pain, noise, light, caffeine) were eliminated. Interview with the DON on 4/21/05 at 9:45 AM confirmed the facility lacked a physician's statement which supported continued use of the medication or documented that the benefits of daily consecutive use outweighed the risks.	F 329		
F 371 SS=D	483.35(h)(2) DIETARY SERVICES The facility must 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 facility policies, the facility failed to assure nutritional supplements were labeled with the thaw date. The supplements were located in refrigerators in the main kitchen and in two of	F 371	The facility will continue to store, prepare, distribute, and serve food under sanitary conditions. 1. Frozen products, including Mighty Shake supplements, will be labeled by dietary staff with an expiration date when they are removed from the freezer to thaw, before being sent to the nursing units for use.	6/1/05

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F 371	Continued From page 17 three unit kitchens. The findings were: 1. Observation in the refrigerator in the main kitchen on 4/18/05 at 3:26 PM revealed three cardboard boxes containing approximately 40 cartons (4 ounces) of thawed Mighty Shake supplements. The instructions on the carton revealed the product was to be used within 14 days of thawing. The cardboard boxes were not labeled with a thaw date, nor were the individual cartons. Interview with dietary aide #2 on 4/18/05 at 3:40 PM revealed she was not sure when the supplements were thawed. 2. Observation on 4/18/05 at 3:51 PM in the special care unit refrigerator revealed one thawed carton of Mighty Shake supplement. The carton was not labeled with the thaw date. Interview at that time with licensed practical nurse (LPN) #2 revealed she was not aware when the supplement was thawed. 3. Observation on 4/18/05 at 3:59 PM and on 4/20/05 at 8:00 AM in the East unit refrigerator revealed approximately 23 thawed cartons of Mighty Shake. The cartons were not labeled with the thaw date. Interview on 4/18/05 at 3:59 PM with certified nurse aide (CNA) #2 revealed she was not aware when the supplements were thawed. 4. Interview on 4/20/05 at 8:15 AM with the food production supervisor revealed the supplements should be labeled with the thaw date. She stated staff not labeling the supplements was "...an ongoing problem". Interview on 4/20/05 at 8:50 AM with the food service director revealed the supplements should be labeled with the thaw date.	F 371	2. Nursing staff will be advised at the scheduled May 25, 2005 staff meeting to check the expiration date of all food products before providing them to the resident, and to dispose of any product that is beyond the expiration date or not marked with an expiration date. 3. The diet technician will monitor the dates of thawed products on a daily basis to ensure stored products contain expiration dates and are not expired, and will report the results of the monitoring to the Registered Dietitian/Director of Nutrition Services, who will have overall responsibility for compliance	

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F 371	Continued From page 18 5. Review of the facility's policy "Outdated Food" (number 8021 IC-29, revised 1/04) showed all foods stocked in patient care areas will have a "use by" date marked on them.	F 371		
F 429 SS=D	483.60(c)(2) PHARMACY SERVICES The pharmacist must report any irregularities to the attending physician and the director of nursing. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policies and procedures, the facility failed to assure the pharmacist reported irregularities for 2 of 13 sample residents (#12, #25). The findings were: 1. Review of the April 2005 physician's orders revealed resident #12 was admitted with diagnoses including vertigo, hypertension, peptic ulcer disease, and gastroesophageal reflux disease. The review further revealed a physician's order dated 11/19/04 for Xanax (antianxiety/sedative/hypnotic) as needed. Review of the Medication Administration Records (MARs) for 11/04, 12/04, 1/05, 2/05, 3/05, and 4/05 revealed the resident had not received any doses of Xanax. Review of the 3/8/05 pharmacy drug regimen review revealed a recommendation to the physician to discontinue the medication because the resident had not used in since it was ordered. Review of the physician's orders and progress notes revealed the physician had not discontinued or addressed the utilization of Xanax. Interview with the director of nursing	F 429	The facility will continue to ensure that the pharmacist will report any irregularities to the attending physician and the director of nursing on a timely basis. 1. The reviewing pharmacist will examine the charts of residents on a weekly basis to determine if there are any drug irregularities. When reviews of all residents on a nursing unit are completed, a report of any drug irregularities will immediately be forwarded to the facility's Director of Nursing, who will ensure that any irregularities are addressed with the attending physicians in a timely manner. After the drug review of all facility residents is completed, a monthly summary report will be compiled by the reviewing pharmacist and forwarded to the Director of Nursing, the Medical Director and the Administrator within no more than two weeks of the end of the month of the review. 2. The monthly drug regimen review completed by the pharmacist in March, 2005 was received by the facility on April 25, 2005, (copy attached) and included recommendations for discontinuation of the Xanax order for resident # 12, and to change the temazepam order for resident #25. These recommendations have both been forwarded to the residents' attending physicians and have been addressed through changes in the medication orders. See also F329. 3. The Chief Pharmacist will monitor and have overall responsibility for compliance.	6/6/05

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F 429	Continued From page 19	F 429		

(DON) on 4/20/05 at 4:50 PM revealed the process for drug regimen review was for pharmacy to provide her with the drug irregularity report monthly. Once she received the report, she notified and discussed any concerns or recommendations with the physician. Interview with the DON on 4/21/05 at 8 AM revealed she had not yet received the drug irregularity report for March 2005 from the pharmacy so she was unaware of the recommendation.

2. Review of a telephone order dated 2/16/05 showed the physician ordered Temazepam (a hypnotic) nightly, if needed, for resident #25. According to the February, March and April 2005 medication administration records (MARs), the resident received Temazepam every night from 2/17/06 through 4/19/05. According to the 2005 PDR Nurse's Drug Handbook, Temazepam is an hypnotic (sleeping medication) which should be prescribed for short term use only. Review of the entire medical record with the director of nursing (DON) on 4/20/05 at 5:15 PM showed no documentation from the physician that the benefits outweighed the risks for continuous, long term use. Review of a form found on the pharmacist's desk with a notation dated 3/8/05 revealed the pharmacist identified the continual use of Temazepam but failed to report it to the physician or director of nursing. Review of the facility's 3/15/05 policy and procedure entitled "Monthly Pharmacy Report" revealed, "The pharmacist will prepare a written report for submission to the administrator.. or the medical director...The report will contain at a minimum the following data: Irregularities...any justification for the continued use of medication in question...reports to doctors or nurses..." Interview with the director of nursing on 4/21/05 at

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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 _____	04/21/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 429	Continued From page 20 8:45 AM verified she had not received the irregularities report for March 2005, a time lapse of six weeks after it was completed.	F 429		