RECEIVED
WY Dept of Health
APR 03 2013
Healthcare Licensing and Surveys

4/3/13

PRINTED: 03/14/2013
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0033	A. BUILDING _____ B. WING _____	02/28/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
SNH	LIC REGS FOR NURSING HOMES WYOMING DEPARTMENT OF HEALTH AGING DIVISION RULES AND REGULATIONS FOR PROGRAM ADMINISTRATION OF NURSING CARE FACILITIES CHAPTER 11 Section 5. Organization and Administration. (a) Governing Body. "The Nursing Care Facility shall have a governing body which has the legal authority and responsibility to operate the Nursing Care Facility. The governing body shall: ...(v) The administrator shall enforce the rules and regulations relative to the level of health care and safety of residents and for the protection of their personal and property rights." This REQUIREMENT was not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure resident safety and/or supervision for 1 resident (#1) of the facility who was allowed to smoke. Review of a facility-resident contract and letter of policy violation showed the facility was aware the resident was not safe to smoke; however, allowed the unsafe practice to continue. The findings were: Review of the 1/9/13 physician progress note showed resident #1 was admitted on 4/10/11 and had diagnoses which included end-stage COPD (chronic obstructive pulmonary disease). The physician also noted the resident continued to	SNH	The facility will continue to ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistive devices to prevent accidents. 1. Resident #1 is no longer using cigarettes, lighters, or matches, and is using a battery-operated electronic cigarette. 2. Resident #1 has been advised to notify staff prior to leaving the building, and staff will monitor the resident's safety outside through use of the facility's security camera. 3. A wheelchair management assessment (copy enclosed) was conducted for Resident #1 on 02/27/2013 which reflects that the resident is able to independently manage a wheelchair. 4. A Morse Fall Scale assessment (~~copy enclosed~~) was conducted on Resident #1 on 03/15/2013 which reflects that the resident is at low risk for falls.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joanne Kaiser, NHA | TITLE | (X6) DATE: 4/3/2013

STATE FORM 6899 IIC611 If continuation sheet 1 of 4

Accepted w/change on 4/3/13 by [illegible]

QR 4/3/13

PRINTED: 03/14/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0033	A. BUILDING: _____ B. WING _____	02/28/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
SNH	Continued From page 1 smoke "about four cigarettes a day. [S/he] is admonished not to smoke when [s/he] has [his/her] oxygen on." Review of the resident care plan showed a problem identified was "risk of injury while using oxygen and smoking." The review dates documented with this care plan were: 4/5/12, 4/16/12, 7/5/12, 10/4/12, and most currently 1/3/13. The goal was for the resident to have no injuries related to smoking. The documented interventions showed "educate and remind [resident) of risks and safety precautions quarterly at minimum." The care plan showed no other interventions had been added or discontinued. Review of the 1/4/13 quarterly assessment note related to the resident's cognition and socialization, showed the resident had moderate impairment based on a tool used to determine mental status known as "BIMS" (brief interview for mental status) score of 8 out of 15. The note further showed this was a decline in cognition based on his/her previous score of 14 out of 15. Additionally, this assessment note showed the "social worker re-educated the resident on hazards of smoking while oxygen is in use." The following concerns were identified related to safety for this resident: a. Observation on 2/25/13 at 1:02 PM showed resident #1 was outside on the sidewalk about 50 feet from the facility entrance smoking a cigarette while his/her oxygen was in use. The resident had an oxygen canister affixed to the back of his/her wheelchair and used a nasal cannula (tube like apparatus which is inserted into nostrils) to breath the oxygen flowing from the tank. Within a minute into the observation, RN #2 walked out the main entrance and turned off the resident's oxygen tank. The RN did not stay with the resident, and the resident was not supervised by any other staff at that time. b. Review of a document titled "Release of	SNH	5. The Care Plan for Resident #1 was revised on 02/27/2013 to reflect that resident no longer smokes, uses a battery-operated electronic cigarette, is reminded to advise the staff before leaving the building, and will be monitored by security camera when outside the building. 6. Staff was educated on 02/27/2013, 02/28/2013, and 03/20/2013 regarding the care plan for Resident #1 related to non- smoking, and how to ensure the resident's safety. 7. The environment of safety and supervision for all residents will be monitored through quarterly environmental rounds conducted by the Director of Nursing, Plant Operations Director and Infection Control Practitioner, and any areas of concern addressed immediately. 8. The results of environmental rounds will be reported to the Environment of Care Committee with oversight by the QI/PI Committee on a quarterly basis. 9. The Director of Nursing will monitor.	3/20/2013

SB 4/3/13

PRINTED: 03/14/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0033	A. BUILDING: _____ B. WING _____	02/28/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
SNH	Continued From page 2 Responsibility For Smoking" showed the resident and facility representative signed the release on 3/9/12. Review of the release showed the facility policy did not allow smoking anywhere in the building or on the property. However, the document further showed the resident was assuming "all risks" related to choosing to smoke. The risks were shown as "may include, but are not limited to: burns, falls, fracture, injury by vehicle, respiratory disease and infections, and other risks including possible death from injury, accident, or illness." c. Review of a letter to the resident dated 6/26/12 from the facility showed on 6/21/12 the resident had been found smoking in his/her room in the facility. The letter described the violation to the smoking policy and advised the resident that "Any further occurrences...will result in immediate removal of all smoking materials from your possession, and possible further action to discharge you from the facility." d. Interview with the DON on 2/26/13 at 3:15 PM verified she was aware the resident went outside and smoked multiple times daily. The DON further revealed the resident had signed the release and the facility felt that this was okay and they did not provide staff to supervise the resident because it would take staff away from other residents. However, the DON acknowledged this was an unsafe practice because the resident did not always turn off the oxygen when smoking and serious injury could result. She further verified the resident did not keep his/her own smoking materials, they were kept at the nurses desk and the resident had to ask for them. e. Interview with CNA #1 on 2/26/13 at 2:40 PM, RN #2 on 2/26/13 at 4:45 PM, and the administrator on 2/26/13 at 4 PM, all revealed it was commonly known the resident smoked daily without supervision, and at times did so with	SNH		

4/3/13

PRINTED: 03/14/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0033	A. BUILDING: _____ B. WING _____	02/28/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
SNH	Continued From page 3 his/her oxygen in use. Furthermore, they all three verified the plan of care was to allow the resident to do so at his/her own risk. On 2/26/13 at 4 PM, the administralor was notified of the immediate jeopardy. The nursing facility's action plan included immediate changes to include: a. An assessment of the resident's smoking and safety completed 2/26/13 b. Agreement by the resident to immediately stop smoking, with all smoking materials removed from the resident on 2/26/13 c. The resident's family was advised and agreed to not provide the resident with any future smoking materials involving ignition source such as matches or lighters. d. The resident was offered and accepted the option to use a battery operated electronic cigarette. e. The facility staff were educated on the new practice/care plan for the resident related to smoking f. The facility policy and procedure that smoking is not permitted anywhere in the building or on the grounds is and will be strictly followed. The action plan was accepted on 2/27/13 at 10:17 AM, and the immediate jeopardy was removed on 2/27/13 at 12:30 PM.	SNH		