STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	R-C 08/05/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WY HEALTHCARE &	542 16TH STREET RAWLINS, WY 82301

AUG 22 2005

(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 316} SS=D	483.25(d)(2) QUALITY OF CARE A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and medical record review, the facility failed to ensure staff followed proper technique while providing perineal care for one (#11) of three sample residents who required staff assistance for perineal care. The findings were: Review of the 6/2/05 quarterly Minimum Data Set (MDS) assessment for resident #11 revealed he/she was frequently (daily) incontinent of urine and required total dependence on staff for perineal care. Observation on 8/4/05 at 6:45 PM revealed certified nurse aide (CNA) #5 provided perineal care for the resident. Further observation revealed the CNA used the same area of a wipe three times to cleanse the resident's perineal area, folded the wipe to a clean area, then again used the same area of the wipe two times to cleanse the perineum. According to the authors of "Nursing Assistant", 9th edition, 2004, page 365, a clean area of the cloth (or wipe) must be used for each cleansing stroke.	{F 316}	"Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged of conclusions set fourth 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" F- 316 1.) Resident #11 will receive perineal care. 2.) All incontinent Residents have the potential to be affected. 3.) The SDC or designee will in-service the certified nursing assistants on the Policies and Procedures regarding peri - neal care. 4.) The SDC or Designee will complete random perineal care audit once a week four weeks then monthly for three months. The results of these audits will be presented to the PI committee for further review and intervention as needed. 5.) Compliance Date: 8-11-2005	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicki Hamsel	Executive Director	8/18/2005

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.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535036	A. Building B. Wing	8/5/2005

Name of Facility	Street Address, City, State, Zip Code
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CT	542 16TH STREET RAWLINS, WY 82301

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 07/05/2005	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 07/05/2005	ID Prefix F0353 Reg. # 483.30(a)(1)&(2) LSC	Correction Completed 07/05/2005
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By State Agency	Reviewed By TB 8/5/05	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 6/3/2005		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO