DEPARTMENT OF HEALTH AND HU N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

6/24/05

PRINTED: 06/14/2005
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
	535023	A. BUILDING _____ B. WING _____	R 06/02/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON COUNTY HEALTH SERVICES	1124 WASHINGTON BLVD NEWCASTLE, WY 82701

(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 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 staff interview and observation, the facility failed to ensure leftovers were stored according to policy. Findings were: On 4/4/05 at 1 PM during the initial tour of the kitchen, the following concerns were observed: Observation on 4/6/05 at 9:45 AM revealed a tray in the walk-in refrigerator with several foil wrapped leftovers. "R Pork 3/24" was written on one of the packages. In another refrigerator a covered plastic bucket containing seven peeled hard boiled eggs was labeled with the date 3/30. Interview with the dietary manager on 4/6/05 at 10:30 AM and with the consulting dietitian on 4/7/05 at 10 AM, revealed that the facility policy was to keep leftovers for a maximum of 5 days. Revisit on 6/2/05 revealed leftover soups stored in the refrigerator that were dated 5/20/05.	{F 371}	**F371** **The facility will store, prepare, distribute, and serve food under sanitary conditions by:** **1) FSS will educate staff on policy regarding storage of leftover food.** (Kept for 5 days only or discarded if quality below Standard) **2) FSS will implement use of a checklist to monitor storage of left over foods. Checklist will include dates and signatures of who has checked food label dates** **3) PM cook will be responsible to complete checklist daily.** **4) Food Service Supervisor will monitor checklist and will report to Quality Assurance committee.**	6/27/05

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HEALTH FACILITIES

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/22/05

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.

Accepted w/changes, reviewed w/ Joann Farnsworth on 6/24/05

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

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Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535023	A. Building B. Wing	6/2/2005

Name of Facility	Street Address, City, State, Zip Code
WESTON COUNTY HEALTH SERVICES	1124 WASHINGTON BLVD NEWCASTLE, WY 82701

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 F0241 Reg. # 483.15(a) LSC	Correction Completed 05/06/2005	ID Prefix F0365 Reg. # 483.35(d)(3) LSC	Correction Completed 05/06/2005	ID Prefix F0428 Reg. # 483.60(c)(1) LSC	Correction Completed 05/06/2005
ID Prefix F0520 Reg. # 483.75(o)(1) LSC	Correction Completed 05/06/2005	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date: 4/3/05
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date: 4/13/05

Followup to Survey Completed on: 4/7/2005

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO