

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

PRINTED: 06/14/2005
FORM APPROVED
OMB NO. 0938-0391

6/24/05

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/02/2005
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1124 WASHINGTON BLVD NEWCASTLE, WY 82701		
(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 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.	<i>6/27/05</i>	

RECEIVED

JUN 24 2005

**WYOMING DEPT OF HEALTH
HEALTH FACILITIES**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

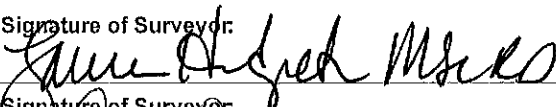
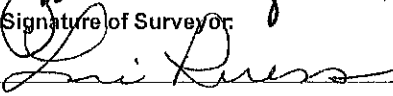
Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 535023	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 6/2/2005
Name of Facility WESTON COUNTY HEALTH SERVICES		Street Address, City, State, Zip Code 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		