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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

(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 151 SS=D	483.10(a)(1)&(2) EXERCISE OF RIGHTS The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on confidential resident interview and staff interview, the facility failed to ensure residents were provided the opportunity to vote in the November 2006 election. The facility census was 43. The findings were: Confidential interview of ten residents on 11/28/06 at 1:30 PM revealed, with the exception of one, residents were unaware of the recent November 2006 election. Further interview revealed residents had a desire and interest in voting but did not have election information or absentee ballots. Interview with the activity director on 11/29/06 at 3:15 PM revealed she had asked residents if they wanted to vote, however, ten residents verbalized they had no recollection of being asked.	F 151	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* **F -151 Exercise of Rights** **Corrective Action for Identified Residents** No Residents were identified **Identification of Residents with Potential to be Affected** All residents with the desire to vote have the potential to be affected. **Corrective Action to Prevent Recurrence** The Staff Development Coordinator or designee will inservice, by January 1, 2007, the facility Department Heads, including the Activities Director, on the right of the residents to exercise their right to vote. This inservice will also include the importance of keeping residents informed of up coming local, state and federal election. The Activities Director will develop a written plan on how to accomplish this notification and how the facility will assist interested residents to obtain absentee ballots. This plan will also include how the facility plans to assist interested residents with transportation to voting places. This plan will be submitted to the facility Executive Director (Administrator) for approval by the	Completion Date: Jan 14, 2007
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director 12-22-06

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

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F 157	Continued From page 1 status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and family interview, the facility failed to notify the family of a change in condition which required a change in care and services, for one (#30) of 12 sample residents. The findings were: During the initial tour on 11/27/06 at 3:51 PM, interview with licensed practical nurse (LPN) #29 revealed she identified resident #30 as having a bacterial resistant infection. She described the wound area as a pressure sore in the left gluteal (buttock) fold. On 11/28/06 at 9:28 AM, observation and interview with LPN #28 revealed	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* Performance Improvement Committee (Quality Assurance) **Monitoring/Quality Assurance** After approval of the facility plan by the Performance Improvement Committee, the plan will be submitted by the Activities Director to the Resident Council for information and input. A random poll of 10 percent of the facility's residents to determine resident satisfaction with the facility plan will be done monthly for 6 months by the Activities Director or designee. The results of the poll will be reported to the Performance Improvement Committee (Quality Assurance) monthly by the Activities Director or designee. At the completion of the 6-month polls, the Committee will determine the need for any further audits/reports. **The Activities Director will be responsible for continued compliance.** **Correction date: January 14, 2007**	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 157	Continued From page 2 the resident had a stage two pressure sore to the left gluteal fold (pelvic ischium). The LPN further stated the sore was cultured and an antibiotic was initiated approximately one week ago. Review of the resident's medical record revealed resident progress notes dated 4/6/06 (no time) which documented the notification to a nurse by a certified nurse aide of a "4 cm [centimeter] diameter open area to gluteal fold. MD [physician] called...." Review of documentation failed to reveal notification of the family in regard to the pressure sore or the more recent wound culture and treatment with an antibiotic. Interview on 11/29/06 at 2:48 PM with LPN #28 and medical record review at that time revealed no documentation regarding notification of the family related to the pressure sore culture and antibiotic decision. Interview with a family member on 11/28/06 at 8:30 PM revealed the family first found out about the pressure sore approximately two months ago. The family member further stated approximately two years ago, the resident had a fall which required hospitalization; the family was not contacted at the time. The interview revealed at that time the family decided someone from the facility should contact them for anything and a note was placed in the front of the medical record. Review of the medical record confirmed a note with family contact information was on the face sheet of the medical record. The note instructed staff to call a named family member for any concern "regardless how minor."	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* **F -157 Notification of Changes** **Corrective Action for Identified Resident** The family member to Resident # 30 has been re-notified and updated for the pressure ulcer and the use of the antibiotic as of 12/20/06. **Identification of Residents with Potential to be Affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence**	Completion Date: Jan 14, 2007
F 167 SS=B	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.	F 167	The Staff Development Coordinator or designee will inservice the licensed nurses by January 8, 2007. The inservice will include information on the requirement of notifying the resident and, if known, the resident's legal representative or interested family member when there is a change in resident's condition which requires a change	

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

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F 167	Continued From page 3 The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.	F 167	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.*	
F 170 SS=E	This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure one complaint survey was posted. The findings were: Observation on 11/29/06 at 9:22 AM of the past survey results revealed a complaint survey investigation from 9/7/06 was not posted with the previous annual survey results. During an interview with the director of nursing on 11/29/06 at 9:30 AM, she confirmed the survey was not posted. 483.10(i)(1) MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on confidential resident interview, interview with the postal service staff, and staff interview, the facility failed to ensure residents received their mail on Saturdays. The census was 43. The findings were: Confidential interview with ten residents on 11/28/06 at 1:30 PM revealed residents did not	F 170	in care and services. I.e. Pressure ulcer with subsequent need for antibiotic treatment and falls with subsequent care needs. **Monitoring/Quality Assurance** The Director of Nursing or designee will audit facility's compliance with notification of resident and, if known, the resident's legal representative or interested family member when there is a change in the resident's condition which requires a change in care and services. Audits will be done weekly for 6 weeks. At the completion of the audits the Director of Nursing will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. **The Director of Nursing will be responsible for continued compliance.** Correction date: January 14, 2007 **F -167 Examination of Survey Results** **Correction of Identified Requirement** The complaint survey with exit date of 9-7-	Completion Date: Jan 14, 2007

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

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F 170	Continued From page 4 receive mail on Saturdays. Interview with the city postal staff on 11/30/06 at 10 AM revealed mail was delivered to the facility every day Monday through Saturday. During an interview with the activity director on 11/29/06 at 3:15 PM, she confirmed the mail was not delivered to residents on Saturday because she did not work and the business office was closed on Saturdays.	F 170	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.*	
F 176 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure during random review that one resident (#22), who self administered an inhaled medication, received an interdisciplinary assessment to determine if the resident was safe to self administer medications. The findings were: Review of the medication administration record for resident #22 on 11/28/06 at 8:55 AM revealed the 8 AM DuoNeb (a medication used to dilate the airways) unit dose medication for the resident was not signed off as given. Interview with licensed practical nurse (LPN) #33 at that time revealed the medication was "set-up" for the resident and the resident took the medication whenever s/he was ready. Review of the medical record failed to reveal an interdisciplinary assessment for self administration. Review of the quarterly 10/31/06 Minimum Data Set assessment revealed the facility determined the	F 176	06 was posted as of 11-28-06. **Identification of Residents with Potential to be Affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence** The Staff Development Coordinator or designee will inservice by January 8, 2007 the facility Department Heads on the requirement that all recent surveys must be posted in a place readily available to residents. If the survey is removed from it's posting place for any reason, i.e. copying, a note should be placed at posting place of when survey was removed and by whom and approximate time when it will be replaced. **Monitoring/Quality Assurance** The Executive Director (Administrator) or designee will audit weekly for 6 weeks for compliance with posting of most recent surveys. At the completion of the audits, the Executive Director will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will	

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

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F 176	Continued From page 6 resident had a short term memory problem and was moderately impaired for cognitive skills. Interview with the director of nursing (DON) and medical record review at the same time on 11/28/06 at 5:44 PM revealed the resident was not assessed for medication self-administration. The DON stated currently the facility had no residents who self administered medications.	F 176	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.*	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225	then determine the need for any further audits/reports. **Responsible Party** **The Executive Director will be responsible for continued compliance.** Correction date: January 14, 2007 **F-170 Mail** **Corrective Action for Identified Requirement** Currently a weekend designee is delivering mail to residents on Saturdays. **Identification of Residents with Potential to be Affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence** The facility will develop a system to ensure delivery of mail to residents on Saturdays. The weekend manager on duty will deliver mail or if unavailable, the duty will be designated to the Charge Nurse. **Monitoring/Quality Assurance**	Completion Date: Jan 14, 2007

Corrected page 12/27/06

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

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F 176	Continued From page 5 resident had a short term memory problem and was moderately impaired for cognitive skills. Interview with the director of nursing (DON) and medical record review at the same time on 11/28/06 at 5:44 PM revealed the resident was not assessed for medication self-administration. The DON stated currently the facility had no residents who self administered medications.	F 176	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.*	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225	then determine the need for any further audits/reports. **Responsible Party** **The Executive Director will be responsible for continued compliance.** Correction date: January 14, 2007 **F-170 Mail** **Corrective Action for Identified Requirement** Currently a weekend designee is delivering mail to residents on Saturdays. **Identification of Residents with Potential to be Affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence** The facility will develop a system to ensure delivery of mail to residents on Saturdays. **Monitoring/Quality Assurance**	Completion Date: Jan 14, 2007

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

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F 225	Continued From page 6 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of facility documents, the facility failed to report abuse allegations to the State Survey Agency (SSA) for two of three allegations reviewed. The findings were: Review of the facility abuse allegation file revealed a resident to resident abuse was investigated on 1/13/06 and another allegation involving different residents was investigated on 1/26/06. However, review of the SSA records revealed the SSA did not receive notification of either allegation. Interview with the administrator on 11/30/06 at 8:30 AM revealed both incidents were prior to his employment at the facility and he was unable to explain why the SSA was not notified of the allegations.	F 225	*~~This Plan of Correction is the center's credible~~ allegation of compliance.* *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 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.* The Activities Director or designee will do weekly audits for 6 weeks to monitor compliance with Saturday mail delivery. At the completion of the audits the Activities Director or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. **Responsible Party** **Activities Director will be responsible for continued compliance.** Correction Date: January 14, 2007 **F-Tag 176** **Self Administration of Medication** **Corrective Action for Identified Residents**	Completion Date: Jan 14, 2007
F 241 SS=D	483.15(a) DIGNITY 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 and staff interview, the facility failed to ensure staff treated residents in a	F 241	Resident #22 was assessed on 12/20/06 by the Interdisciplinary Team (IDT) for safety in self-administering his/her own medications. She no longer self-administers DuoNeb. **Identification of Residents with potential to be Affected** Any resident who wants to self-administer	

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F 241	Continued From page 7 manner which maintained their dignity during one of two meal observations in the assisted dining room. The findings were: Observation of the assisted dining room on 11/27/06 from 5:40 PM to 6:30 PM revealed certified nurse aide (CNA) #7 assisted seven residents with their meal while standing the entire time; never being at eye level with any of the residents. Interview with the director of nursing on 11/30/06 at 8:45 AM revealed the CNA should have been seated while assisting the residents with their meal.	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* his or her own medication has the potential to be affected.	
F 243 SS=E	483.15(c)(1)-(5) PARTICIPATION IN RESIDENT & FAMILY GROUPS A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to provide a private meeting place for resident council meetings. The findings were: Confidential interview with residents on 11/28/06 at 1:30 PM revealed the usual meeting place for the resident council was in the activities area.	F 243	**Corrective Action to Prevent Recurrence** The facility will identify any resident who expresses a desire to self-administer his/her own medications will have an assessment completed prior to allowing resident to do so. The Interdisciplinary Team will complete "Assessment for Self-Administration of Medication" found in the Briggs catalog for this assessment. Re-assessments will be completed quarterly on residents who are allowed to self-administer their own medications to ensure continued safety. An in-service will be given by the Director of Nursing or designee, by January 14, 2007, on the facilities policy and procedure of Self-Administering of Medications, to the nursing staff and the Interdisciplinary Team. **Monitoring/Quality Assurance** The Director of Nursing or designee will audit compliance of assessments weekly for 4 weeks then monthly for 2 months, the as directed by the Performance Improvement	

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F 243	Continued From page 8 Observation on 11/27/06 through 11/30/06 revealed there were closeable doors on one end of the activity area but not the other. Observation of the resident council meeting on 11/28/06 at 1:30 PM revealed three housekeepers and two certified nurse aides walked through or near the area during the meeting; one housekeeper opened the closed doors to enter the meeting area without regard to resident privacy. During an interview with the director of activities on 11/29/06 at 3:15 PM, she confirmed council meetings were not held in a private area.	F 243	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* Committee. Reports will be brought to the Performance Improvement Committee (Quality Assurance) for review and continued monitoring.	
F 248 SS=D	483.15(f)(1) ACTIVITIES 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 interview, and medical record review, the facility failed to ensure staff provided activities based on individual need for one (#20) of eleven sample residents. The findings were: Review of the initial 7/1/06 Minimum Data Set (MDS) assessment for resident #20 revealed s/he enjoyed music, reading, writing, religion/spiritual activities, television, and conversation. Review of the Resident Assessment Protocol (RAP) summary dated 7/1/06 revealed the area of activities required comprehensive assessment. Review of the RAP module revealed an activity care plan should be developed. Review of the 11/15/06 care plan revealed interventions	F 248	**Responsible Party** **Director of Nursing or Designee** **Correction Date** January 14, 2006 **F-225 Treatment of Residents** **Corrective Action for Identified Residents** No residents were identified **Identification of Residents with Potential to be Affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence** The Staff Development Coordinator will inservice the Department Heads by January 8, 2007 on the requirement that the State Survey Agency (SSA) be notified of all allegation of abuse	Completion Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

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F 248	Continued From page 9 included reading to the resident, 1:1 visits, and exploring small group activities of interest. The following concerns were identified: a. Review of the 7/11/06 resident progress notes for activities revealed the resident requested the activity director to read to him/her one to two times per week and that s/he enjoyed the book "Chicken Soup for Horses". However, review of the 7/06 individual participation record revealed activity staff offered reading or talking books to the resident only one time and during the month of 8/06 only two times. Review of the medical record revealed there was no participation record for September of 2006. Continued review of the individual participation records revealed during 10/06 and 11/06 activity staff did not read or provide a talking book to the resident at any time. b. Review of the 10/06 and 11/06 individual participation record revealed the resident primarily watched television. There was no evidence of 1:1 visits or other activities except visiting with his/her spouse. c. During an interview with the activity director on 11/30/06 at 9:45 AM, she confirmed activities should be more individualized for this resident.	F 248	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* **Monitoring/Quality Assurance** The Executive Director (Administrator) will do weekly audits for two months to monitor compliance with reporting allegations of abuse to the SSA. The Executive Director will report monthly for 2 months to the Performance Improvement Committee (Quality Assurance). At the completion of the weekly audits for 2 months, the Committee will determine the need for any further audits and reports. **Responsible Party** **The Executive Director will be responsible for continued compliance.** Correction Date: January 14, 2007	
F 250 SS=G	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and medical record review, the facility	F 250	**F-241 Dignity** **Corrective Action for Identified Residents** No residents were identified. However, the facility's staff is now sitting and are at eye level with residents when assisting residents with meals. **Identification of Residents with Potential**	Completion Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 250	Continued From page 10 failed to ensure the social service needs were met for one (#20) of eleven sample residents. The findings were: Review of the medical record revealed resident #20 was admitted on 6/25/06 with diagnoses including multiple sclerosis and depression. Review of the 7/7/06 medical history and physical (H & P) revealed the resident was diagnosed with multiple sclerosis in the 1980's and has not ambulated since 1997. Further review of the H & P revealed the resident had surgery in 1/06 for a sacral decubitus ulcer. Review of the 11/15/06 care plan revealed anxiety and depression were identified as problems. Continued review revealed interventions for anxiety included: observe for early signs of agitation or increasing anxiety and report, encourage discussion of fear/anxiety, and to observe for situations that cause the increased anxiety and remove if possible. Review of the care plan revealed interventions for signs and symptoms of depression included: encourage the resident to verbalize his/her fears and concerns, allow for quality time to communicate, be sensitive to non-verbal communication, provide quality listening time, encourage to express feelings in 1:1 visits, and to rule out pain, thirst, hunger, need to urinate, being too hot or cold, a noisy environment or other internal/external factors. The following concerns were identified: a. Review of the 6/29/06 2130 (9:30 PM) resident progress notes revealed "very upset crying suicidal ideas et [and] thoughts." Review of the entire medical record revealed there was no evidence the physician was notified of the resident's suicidal ideation. There was no evidence a psychological evaluation was considered. b. Review of the social services 7/6/06	F 250	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* **to be Affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence** The Staff Development Coordinator or designee will inservice by January 9, 2007 the certified nurse aides (C.N.A.) on the requirement to sit and be at eye level with residents when assisting them with meals. This is to preserve residents' dignity. **Monitoring/Quality Assurance** The Director of Nursing (DNS) or designee will do weekly audits for 6 weeks to monitor compliance with C.N.A.s sitting to be at eye level with residents when assisting them with meals. At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine need for further audits and reports. **Responsible Party** **The Director of Nursing will be responsible for continued compliance.**	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 250	Continued From page 11 resident progress notes revealed: "After 2 questions on the depression scale, [the resident] became very upset and started crying." Review of the entire medical record revealed there was no follow-up attempt to perform the depression scale, no notification of the physician or consideration of having a counselor or psychologist/psychiatrist to evaluate the resident's depression. c. Review of the resident progress notes for 7/5/06 revealed Lexapro (anti depressant) was ordered. Review of the 7/6/06 0810 (8:10 AM) progress notes revealed the resident refused to take the Lexapro. However, review of the entire medical record revealed there was no evidence non-pharmacological interventions were attempted. d. Review of the 11/06 Medication Administration Record (MAR) revealed Zyprexa (antipsychotic) was ordered. Review of the 11/1/06 1000 (10:00 AM) resident progress notes revealed the resident developed a rash from the Zyprexa. The physician was notified and the medication was discontinued. However, review of the medical record revealed there was no evidence non-pharmacological interventions were attempted. e. Review of the 8/7/06 1430 (2:30 PM) nursing resident progress notes revealed: "[The resident] is very upset, crying, asking repeatedly 'What do I do?'" Review of the medical record showed no evidence the interventions included in the care plan were implemented or psychological support was provided for the resident. f. Review of the 9/14/06 0930 (9:30 AM) activities resident progress notes revealed "Resident at X's [times] cont's [continues] getting depressed over [his/her] illness." Review of the medical record revealed there was no evidence	F 250	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* Correction Date: January 14, 2007 **F-Tag 243 Private Meeting Area** **Corrective Action for Identified Residents** No specific residents were identified. **Identification of Residents with potential to be affected** Any resident has the potential to be affected. **Corrective Action to Prevent Recurrence** The Administrators office has been converted into a General Conference room. This room will be used for Resident council, family meetings, and staff meetings. The Administrator or designee will in-service facility staff on the importance of providing a private meeting place for residents without interruptions from staff. **Monitoring/Quality Assurance** An audit tool will be completed at the end of each resident council meeting for 3 months.	Completion Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 250	Continued From page 12 psychological support was offered to the resident or the care plan interventions were implemented. g. Review of the resident progress notes revealed only two 1:1 visits were documented (on 7/11/06 and 9/15/06). Further review of this note revealed the resident requested the activity director to read to him/her one to two times per week. However, review of the activity individual participation record and the remaining medical record documentation revealed there was no evidence the resident's request was honored. h. Review of the 11/22/06 1330 (1:30 PM) resident progress notes revealed "Res [resident] tearful et upset stating she felt she had been ignored." Interview with the resident on 11/28/06 at 8:30 AM revealed s/he did not want to be in the nursing home, that s/he does not like being in the facility and wanted to go home. Interview with the social service director on 11/29/06 at 2:15 PM revealed she had not spent much time with the resident "because she was not the resident's angel." She further stated she had not thought about counseling or psychiatric evaluation but she thought it was a "good idea." Interview with the activity director on 11/30/06 at 9:45 AM revealed the resident was becoming more isolated and withdrawn. She further stated the resident was often anxious, hopeless, tearful and crying. She stated the resident preferred to stay in his/her room and had lost interest in activities. Interview with the director of nursing on 11/29/06 at 5:15 PM revealed the resident was frequently	F 250	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* The audit will determine whether or not the facility provided a private meeting place for residents. Audits will be reviewed monthly by the Performance Improvement Committee (Quality Assurance). After 3 months further need for audits will be determined by the Performance Improvement Committee (Quality Insurance). **Responsible Party** **Administrator or Designee** **Correction Date** January 14, 2006 **F-Tag 248** **Activities** **Corrective Action for Identified Residents** Resident # 20 care plan will be reviewed and residents request by the Activity Director to set up activities to meet the residents needs and requests. **Identification of Residents with potential to be affected**	Completion Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 250	Continued From page 13 agitated and made repeated requests for help. She further stated on some days the resident would put his/her call light on repeatedly.	F 250	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.*	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to ensure all resident accessible areas were cleaned and maintained during random observations. The findings were: Environmental observations revealed the following concerns related to areas accessible to residents: a. Observation on 11/27/06 at 3:51 PM revealed there was a blanket in the corner of the resident phone booth and a piece of crumpled paper on the desk. Observation on 11/28/06 at 9:45 AM and again on 11/29/06 at 8:47 AM, with the administrator, revealed the phone booth condition remained unchanged. Interview with the administrator at that time revealed the phone booth area should be cleaned. b. Observation on 11/27/06 at 5:46 PM revealed there was a fan in the room of resident #29 which was running. The observation revealed strands of built up dust particles were blowing vertically outward as the fan operated. Interview with the resident at that time revealed the fan had not been cleaned for "sometime." c. Observation on 11/28/06 at 7:12 AM revealed the wooden baseboards throughout the	F 253	Any resident has the potential to be affected. **Corrective Action to Prevent Recurrence** The Activity Director will re-view care plans and residents requested activated per the MDS and Care Plan schedule and change of condition and update the residents activities to meet the residents individualize needs. **Monitoring/Quality Assurance** The Activities Director will do random audits on individual participation records weekly for 6 weeks. At the completion of the audits the Activities Director will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. **Responsible Party** **The Activities Director will be responsible for continued compliance.** **Correction Date** January 14, 2007	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 253	Continued From page 14 facility had nicks extending below the finished wood surface into the untreated wood. The observation also revealed areas of wear where the finished, cleanable wood surface was gone, exposing the wood. The administrator confirmed the observation with the surveyor on 11/29/06 at 8:47 AM. e. Observation of the windows in the restorative dining area revealed there was a thick film coating on the windows. Observation of the dining room windows on 11/30/06 at 10:51 AM revealed the windows were coated with a dirty build up which obstructed the view when the windows had direct sunshine. Interview with the administrator on 11/29/06 at 8:47 AM confirmed the restorative dining windows were obstructed related to hard water build up from the summer sprinkler system. Interview with the maintenance director on 11/30/06 at 10:51 AM revealed the windows were last cleaned in August 2006. He stated window cleaning did not have a routine schedule. f. Observation of the shower room (next to room #7) with the administrator on 11/29/06 at 8:47 AM revealed the shower had blackened grout in one corner and soap scum build up on one wall. Interview with the administrator at that time revealed the facility had attempted to scrub the areas, but were unable to remove the discoloration. g. Observation with the administrator on 11/29/06 at 8:47 AM revealed door frames and/or door corner moldings were loose on entryways to rooms #42, #46, and #49. Interview with the administrator at that time revealed the facility did have a system in which staff could report items in need of repair.	F 253	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* **F Tag 250** **Social Services** **Corrective Action for Identified Residents** Social Services and Activity Director have Re-assessed Resident #20 for social services needs by interviewing the resident; Completing the Mini Mental, Depression scale, Ability-Focused Activity Assessment done 12/21/2006. Resident care plan has been updated to meet the activities and social service needs as indicated by the assessments to meet the Medical-related social service needs. **Identified Residents with potential to be affected** Any resident has the potential to be affected. **Corrective Action to Prevent Recurrence** The Social Services Director will conduct individual resident interviews at the time of the resident's evaluation as indicated by the MDS schedule. The assessments will determine those residents requiring medical-related social services intervention. Social Services Director and Activity Director will	Completion Date: Jan 14, 2007
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS	F 272	be in-serviced on medical-related social	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

(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 272	Continued From page 15 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, and resident and staff interviews, the facility failed to complete a comprehensive assessment of all needed areas for two (#4, #20) of 12 sample residents. The findings were:	F 272	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* services by 1/2/2007 and followed up by the District Director of Clinical Operations by 1/3/2007. **Monitoring/Quality Assurance** The Executive Director will develop an audit to monitor the areas of concern listed above. Audits will be completed weekly for 4 weeks and then monthly. At the completion of the audits the Executive Director will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. **Responsive Party** **The Executive Director will be responsible for continued compliance.** **Correction Date** January 14, 2007	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 272	Continued From page 16 1. Review of current physician orders (dated 11/23/06) showed resident #4 was ordered Ambien (sedative-hypnotic) 1 milligrams (mg) at bedtime and Xanax (antianxiety) 0.25 mg four times per day as needed for anxiety. Review of the November 2006 medication administration record (MAR) showed the resident received Xanax ten times from 11/24/06 through 11/28/06. Review of the 10/5/06 psychoactive medication quarterly evaluations showed the resident received Xanax for anxiety and Ambien for insomnia. Review of a 11/29/06 physician progress note showed the resident had longstanding insomnia and also had anxiety. During an interview on 11/29/06 at 2:50 PM, the resident stated he/she had trouble sleeping, and had been taking a pill for it for five years. Review of the medical record showed no evidence a comprehensive sleep assessment was completed to determine the resident's usual sleep pattern/disturbance and possible reasons for insomnia such as noise, pain, side effects of medication, stress, etc. In addition, there was no comprehensive assessment to determine possible reasons for the resident's anxiety. During an interview on 11/30/06 at 9:25 AM, the director of nursing (DON) stated there were no comprehensive assessments for insomnia or anxiety. 2. Review of the 7/1/06 annual Minimum Data Set (MDS) assessment for resident #20 revealed s/he required comprehensive assessment in the areas of urinary incontinence, feeding tube, dental care, and cognitive impairment. Review of the Resident Assessment Protocol (RAP) modules revealed the assessments did not include possible causes or complications.	F 272	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* **F-Tag 253 Environment** **Corrective Action for Identified Residents** There were no residents identified however the following areas have been corrected. A) The blanket and crumpled piece of paper have been removed from the phone booth. B) The fan in resident 29's room was cleaned on 12/1/06. C) The wooden baseboards identified by the survey will be refinished so that no untreated wood is exposed by 1/14/07. D) The restorative dining window and the dining room windows on the inside were cleaned on 12/14/06. The outside windows will be cleaned weather permitting. E) The blackened grout in the shower room has been removed. The soap scum build up in the shower room has been cleaned. A bid has been received to replace the tile. F) The entry door frames and moldings into rooms 42, 46, and 49 will be secured by 1/14/07. **Identification of Residents with potential to be Affected**	Completion Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 272	Continued From page 17 In addition, review of the 7/1/06 MDS assessment revealed the resident experienced pain. Review of the pain assessment completed on 9/30/06 revealed the following sections were blank: "other non-verbal", "quality of life/activities of daily living", and "cause of pain." Further review of this document revealed instructions to "Complete all sections below." Interview with the director of nursing on 11/29/06 at 5:15 PM revealed the form should be completed in its entirety.	F 272	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* Any resident has the potential to be affected by the cleanliness of the environment.	
F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278	**Corrective Action to Prevent Recurrence** The Administrator or designee will provide an in-service to the facility staff on the importance of the cleanliness of the facility using the above issues as examples of what to watch for. A cleaning schedule for windows has been made. The Administrator will do weekly environmental rounds to check on status of cleanliness in the facility. Areas of concern identified by these rounds will be assigned by Administrator or designee to an employee to fix identified area. Administrator will follow-up with the employee to ensure timely correction of the identified area. **Monitoring/Quality Assurance** The Administrator or designee will do above weekly rounds for 2 months and then monthly for 2 months. These round reports will be brought to the Performance Improvement Committee for evaluation and review. Continued monitoring will be	

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

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	535036	A. BUILDING _____ B. WING _____	11/30/2006

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F 278	Continued From page 18 material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure Minimum Data Set (MDS) assessments were accurate for five (#4, #20, #21, #26) of 12 sample residents. The findings were: 1. Review of the 11/22/06 quarterly MDS assessment showed resident #26 was occasionally incontinent of bladder. However, review of the November 2006 activities of daily living (ADL) flow sheet showed the resident was continent. On 11/29/06 at 9:30 AM, the MDS coordinator stated the resident was not incontinent, therefore the assessment was not accurate. 2. Review of the 6/27/06 annual MDS assessment revealed resident #4 had fallen in the past 30 days. However, review of nursing notes failed to show evidence of a fall in the previous 30 days. During an interview on 11/29/06, the director of nursing (DON) stated the resident's last fall was 2/11/06, therefore the assessment was inaccurate. 3. Review of the medical record for resident #21 showed the last quarterly assessment was dated 7/17/06. There were no other OBRA assessments since that date. On 11/29/06 at 5:20 PM, the MDS coordinator stated the 10/18/06 Medicare PPS assessment should also have been coded as a quarterly OBRA assessment. 4. Review of the 7/1/06 MDS assessment for	F 278	*~~This Plan of Correction is the center's credible allegation of compliance.~~* *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 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.* determined by the Performance Improvement Committee: **Responsible Party** **Administrator or Designee** **Correction Date** January 14, 2006 **F-272 Comprehensive Assessments** **Corrective Action for Identified Residents** Residents # 4 and 20 will have a new Comprehensive MDS with RAPS completed. All associated assessments will be completed with the new assessment. The anxiety and sleep assessment for #4 will completed as they are sub-sections of the Kindred Behavior Assessment. This assessment will potentially aide in determining the root cause of the sleep disturbance. Results of the assessments will be reviewed by the Interdisciplinary team, copies to Pharmacy Consultant and Physician for feedback on appropriate interventions, and justification for continued medication use. **Identification of Residents with Potential**	Completion Date: Jan 14, 2007

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
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F 278	Continued From page 19 resident #20 revealed signatures in section AA9 were dated as 7/2/06, 7/3/07, and 7/5/06. Review further revealed the R2b date was 7/1/06. According to the Centers for Medicaid and Medicare Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, December 2002, Revised August 2005 section AA9, page 3-11, instructs: "All staff responsible for completing any part of the MDS [Minimum Data Set],..., and/or tracking forms must enter their signatures, titles, sections they completed, and the date they completed those sections. Section R2. "page 3-211, instructs "Federal regulations at 42 CFR 483.20 (i)(1) and (2) require the RN Assessment Coordinator to sign, date and certify that the assessment is complete in Items R2a and R2b. The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. Interview with the MDS coordinator on 11/30/06 at 9:30 AM confirmed the R2b date should not have been signed prior to the completion of the assessments. In addition, review of section V, the Resident Assessment Protocol (RAP) summary dated 7/1/06 revealed the care planning decision sections were all blank. Interview with the MDS coordinator on 11/30/06 at 9:30 AM revealed the facility had purchased a new computerized MDS program and she was unfamiliar with the form so she left areas blank.	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* **to be Affected** All residents have the potential to be affected since all residents have MDS assessments and triggered RAPS. **Corrective Action to Prevent Recurrence** 1- A 10% sample of residents will have an audit of triggered RAPS and completed assessments to validate that all appropriate assessments have been completed. 2- Future MDS of each resident will have an assessment comparison report to validate the need or lack thereof for an MDS with RAPS. **Monitoring/Quality Assurance** The Director of Nursing (DNS) or designee will do monthly audits for 3 months to monitor compliance with ensuring that the appropriate assessments required with triggered RAPS are completed.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280	At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports.	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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SOUTH CENTRAL WY HEALTHCARE &	542 16TH STREET RAWLINS, WY 82301

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F 280	Continued From page 20 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure one (#32) of 11 sample residents had his/her care plan revised and/or updated. The findings were: Observation during the initial tour revealed resident #32 had a transfer pole in his/her room. Observation on 11/28/06 at 1 PM revealed the resident used the transfer pole and the assistance of two certified nurse aides when transferring from a wheelchair to the bed. Interview with the physical therapy assistant on 11/30/06 at 10:26 AM revealed the resident used the transfer pole for two months. Review of the resident's current care plan failed to reveal interventions which included the use of a transfer pole.	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* further audits and reports. **Director of Nursing will be responsible for continued compliance.** Correction date: January 14, 2007 **F 278 Resident Assessment** **Corrective Action for Identified Residents** MDS for residents #4, #20, #21, and #26 will be modified to show correct coding. The date/signature in A9 for resident #20 cannot be corrected. **Identification of Residents with Potential to be Affected** All residents have the potential to be affected since all residents have MDS. **Corrective Action to Prevent Recurrence** A sample of 4 residents per week with new MDS will have an audit of MDS coding during a weekly meeting. The meeting shall use triggered Quality Indicators as identifiers of items requiring validation. The meeting shall include Director of Nursing, Utilization Coordinator, Social Services and Activities Director. These meetings will be conducted weekly for 12 weeks.	Completion Date: Jan 14, 2007
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

Corrected Copy 12/27/06

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
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F 280	Continued From page 20 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure one (#32) of 11 sample residents had his/her care plan revised and/or updated. The findings were: Observation during the initial tour revealed resident #32 had a transfer pole in his/her room. Observation on 11/28/06 at 1 PM revealed the resident used the transfer pole and the assistance of two certified nurse aides when transferring from a wheelchair to the bed. Interview with the physical therapy assistant on 11/30/06 at 10:26 AM revealed the resident used the transfer pole for two months. Review of the resident's current care plan failed to reveal interventions which included the use of a transfer pole.	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* **Director of Nursing will be responsible for continued compliance.** Correction date: January 14, 2007 **F 278 Resident Assessment** **Corrective Action for Identified Residents** MDS for residents #4, #20, #21, and #26 will be modified to show correct coding. **Identification of Residents with Potential to be Affected** All residents have the potential to be affected since all residents have MDS. **Corrective Action to Prevent Recurrence** A sample of 4 residents per week with new MDS will have an audit of MDS coding during a weekly meeting. The meeting shall use triggered Quality Indicators as identifiers of items requiring validation. The meeting shall include Director of Nursing, Utilization Coordiator, Social Services and Activities Director. These meetings will be conducted weekly for 12 weeks.	Completion Date: Jan 14, 2007
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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
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F 281	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of policies and procedures, the facility failed to ensure staff followed policies and procedures and/or standards of practice when carrying out physician orders (for resident #15, #26), assessing resident status (for resident #20, #22), and documenting medications (resident #22). The facility census was 43. The findings were: Regarding deficient practice related to following physician orders: 1. Review of a 8/25/06 physician's order showed resident #26 was supposed to be weighed weekly. However, review of the weight tracking sheet located in the medical record showed the resident was only weighed twice in October. In November, the resident was weighed on the 5th, but was not weighed again until the 22nd. Review of the computerized weight history provided by the facility confirmed the missing weights. During an interview on 11/30/06 at 9:25 AM, the director of nursing (DON) stated there should be weekly weights, and was not sure why they were not done. According to the Wyoming Nursing Practice Act 2005 and Administrative Rules and Regulations, page 3-6, the nurse shall function under the direction of a licensed physician. 2. Review of the 11/06 physician's orders for resident #15 revealed s/he was admitted with diagnoses including benign prostatic hypertrophy (BPH). Review also revealed the resident received the medication Ditropan (prevents	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* **Monitoring/Quality Assurance** At the completion of the audits the Director of Nursing (DNS) or designee will report compliance to the Performance Improvement Committee (Quality Assurance DNS, Utilization Coordinator, Social Services and Activities Director). The Committee will then determine the need for further audits and reports. **Director of Nursing will be responsible for continued compliance.** Correction date: January 14, 2007 **F-280 Comprehensive Care Plans** **Corrective Action for Identified Residents** Resident #32's Care Plan has been updated to include use of the transfer pole. Identification of Residents with Potential to be Affected All residents have the potential to be	Completion Date: Jan 14, 2007

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

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F 281	Continued From page 22 bladder spasms) and Flomax (used to treat symptoms of BPH). Review of the 7/6/06 drug regimen review (DRR) revealed the pharmacist recommended discontinuation of the Ditropan because the drug was known to have a high risk of adverse drug reactions with the disease. In addition, the pharmacist recommendation on the 7/6/06 DRR noted the combination of the Ditropan and Flomax had potential to counteract each other. Further review of this DRR revealed the physician wrote a note to discontinue the Ditropan on 7/14/06. The following concerns were identified: a. On 10/6/06, (89 days later) licensed practical nurse #33 noted the order. b. Review of the resident's Medication Administration Record (MAR) revealed the resident received the Ditropan daily throughout July, August, and September despite the fact the physician ordered the drug be discontinued on 7/14/06. c. Review of the 10/06 MAR revealed the medication was finally discontinued on 10/4/06. d. Interview with the director of nursing on 11/29/06 at 5:30 PM revealed facility practice was for nursing to transcribe the recommended order from the DRR to a telephone order and sent to the physician for signature. She further stated the medication was given in error from 7/14/06 through 10/4/06 because the nurse did not follow the facility protocol for transcribing orders. According to the Wyoming Nursing Practice Act 2005 and Administrative Rules and Regulations, page 3-6, the nurse shall function under the direction of a licensed physician. Regarding deficient practice related to assessment of resident status:	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* affected since all residents have Comprehensive Care Plans. Corrective Action to Prevent Recurrence The Interdisciplinary team will be inserviced on writing a comprehensive care plan and updating it to reflect the care provided. **Monitoring/Quality Assurance** An audit of 4 care plans per week for 12 weeks will be conducted to validate the care plan accurately reflects the care provided. Corrections will be made to care plans, which do not accurately reflect care provided. At the completion of the audits the Director of Nursing (DNS) or designee will report compliance to the Performance Improvement Committee (Quality Assurance Committee: DNS, UC, Social Services and Activities Director.) The Committee will then determine the need for further audits and reports. **Director of Nursing will be responsible for continued compliance.**	

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
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F 281	Continued From page 23	F 281	*This Plan of Correction is the center's credible allegation of compliance.*	

1. Observation of medication pass on 11/28/06 at 8:28 AM revealed license practical nurse (LPN) #29 assessed the radial (wrist) pulse for a minute, then administered Lanoxin 0.125 mg (a cardiac medication which increases the force and velocity of heart contractions) to resident #22. Interview at that time revealed the nurse stated she took a radial pulse. The nurse stated she knew she needed to take an apical pulse (counting the heart rate by listening to the chest) prior to Lanoxin. Review of the facility's policy and procedure titled, "Medication Administration," #PRO 62002, instructed staff to take vital signs or tests before administration of medication if such action applied. According to the 2005 edition of "PDR Nurse's Drug Handbook," a nursing intervention required prior to Lanoxin administration included obtaining an apical pulse for one minute.

2. Review of the 11/06 physician's orders revealed resident #20 had diagnoses including multiple sclerosis and chronic skin ulcers. Review of the 7/1/06 annual Minimum Data Set (MDS) assessment revealed s/he had pain in his/her back and soft tissue areas. Review of the physician's 11/30/06 progress notes revealed the resident "has pain with any movement." Further review of the 11/06 physician's orders revealed an order for pain assessment every shift using the scale of 0-10 (10 being the most severe). Interview with the director of nursing on 11/29/06 at 5:15 PM revealed there were two twelve-hour nursing shifts. Review of the 11/06 Medication Administration Record (MAR) revealed on the following dates a pain assessment was performed on only one of the two shifts: 11/5, 11/6, 11/7, 11/8, 11/12, 11/14, 11/15, 11/16,

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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 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.

Correction date: January 14, 2007

F-281 Comprehensive Care Plans

Corrective Action for Identified Residents

Completion Date: Jan 14, 2007

1-Residents with orders for weekly weights are being weighed per facility protocol.
2- Ditropan for resident #15 has been discontinued per physicians order on 10/25/2006.
3- All licensed nurses will be inserviced on the requirement for taking an apical pulse prior to giving Lanoxin. Apical pulse is being taken by Nursing prior to giving Lanoxin for Resident #29.

4- A new pain assessment has been started for resident #20.

5- Nurse #33 has correctly signed for administration of medication for resident #22.

6- All nurses will be inserviced by January 8, 2007 for proper Administration of Medication/Self Administration Policy.

7- Nurse #33 has corrected the Medication

See also POC for F176, added per request of Cheryl NOTA by 12/27/06 @ 10AM LBiddy RN

Corrected copy 12/27/06

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 281	Continued From page 23 1. Observation of medication pass on 11/28/06 at 8:28 AM revealed license practical nurse (LPN) #29 assessed the radial (wrist) pulse for a minute, then administered Lanoxin 0.125 mg (a cardiac medication which increases the force and velocity of heart contractions) to resident #22. Interview at that time revealed the nurse stated she took a radial pulse. The nurse stated she knew she needed to take an apical pulse (counting the heart rate by listening to the chest) prior to Lanoxin. Review of the facility's policy and procedure titled, "Medication Administration," #PRO 62002, instructed staff to take vital signs or tests before administration of medication if such action applied. According to the 2005 edition of "PDR Nurse's Drug Handbook," a nursing intervention required prior to Lanoxin administration included obtaining an apical pulse for one minute. 2. Review of the 11/06 physician's orders revealed resident #20 had diagnoses including multiple sclerosis and chronic skin ulcers. Review of the 7/1/06 annual Minimum Data Set (MDS) assessment revealed s/he had pain in his/her back and soft tissue areas. Review of the physician's 11/30/06 progress notes revealed the resident "has pain with any movement." Further review of the 11/06 physician's orders revealed an order for pain assessment every shift using the scale of 0-10 (10 being the most severe). Interview with the director of nursing on 11/29/06 at 5:15 PM revealed there were two twelve-hour nursing shifts. Review of the 11/06 Medication Administration Record (MAR) revealed on the following dates a pain assessment was performed on only one of the two shifts: 11/5, 11/6, 11/7, 11/8, 11/12, 11/14, 11/15, 11/16,	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* Correction date: January 14, 2007 **F-281 Comprehensive Care Plans** **Corrective Action for Identified Residents** 1-Residents with orders for weekly weights are being weighed per facility protocol. 2- Ditropan for resident #15 has been discontinued per physicians order on 10/25/2006. 3- All licensed nurses will be inserviced on the requirement for taking an apical pulse prior to giving Lanoxin. 4- A new pain assessment has been started for resident #20. 5- Nurse #33 has correctly signed for administration of medication for resident #22. 6- All nurses will be inserviced by January 8, 2007 for proper Administration of Medication/Self Administration Policy. 7- Nurse #33 has corrected the Medication	Completion Date: Jan 14, 2007

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
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SOUTH CENTRAL WY HEALTHCARE &	542 16TH STREET RAWLINS, WY 82301

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F 281	Continued From page 24 11/17, and 11/26. Additionally, review of the 11/06 MAR showed on 11/18/06 no pain assessments were completed. Regarding deficient practice related to medication documentation: Review of medication reconciliation after medication pass on 11/28/06 at 8:55 AM for resident #22 revealed the following documentation issues on the resident's medication administration record (MAR): a. Observation during medication pass earlier at 8:28 AM revealed licensed practical nurse (LPN) #33 administered potassium 10 mEq (milliequivalent). During reconciliation at 8:55 AM, the LPN had not documented the medication was given. Interview at 8:55 AM on 11/28/06 with the LPN revealed she had forgotten to sign the medication off as given. b. Further review of the MAR revealed the 8 AM dose for DuoNeb (a medication used to dilate the airways) was not documented. Interview with the LPN #33 at 8:55 AM revealed the medication was left at the resident's bedside for self-administration. Review of the resident's medical record revealed it lacked a interdisciplinary assessment for the resident to self-medicate. According to "Nursing Interventions and Clinical Skills," copyright 2000, medication administration included remaining with the resident until the medication was taken. The authors further stated the nurse should not leave medications at the bedside without a physician's order to do so. Interview with the director of nursing on 11/28/06 at 5:44 PM revealed the resident was not assessed for medication self-administration and the facility had no current residents who self administered medications.	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* Administration Record to indicate she gave the 0800 dose of Klonipin. per request Dof NDON 12-27-06 10/19/06 **Identification of Residents with Potential to be Affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence** 1-Director of Nursing or Designee will audit MAR for proper documentation monthly for three months. 2- Director of Nursing or Designee will audit residents with weekly weight orders for current weights/compliance with physician orders, weekly for 12 weeks. 3- Director of Nursing or Designee will monitor Medication Pass of one nurse per shift monthly for three months. **Monitoring/Quality Assurance** At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

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F 281	Continued From page 25 c. Review of the MAR at 8:55 AM on 11/28/06 revealed LPN #33 had signed that the 8 AM and the noon doses of Klonopin (an anticonvulsant) were administered. Interview with the LPN revealed she had not given either of the doses and should not have signed the MAR indicating she had administered the medications. Review of the facility's policy and procedure titled, "Medication Administration," #PRO 62002, instructed staff to document medication administration on the MAR after administration. The policy further instructed staff to review the MAR at the end of each medication pass to ensure necessary doses were administered and documented.	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* Committee (Quality Assurance Committee: Director of Nursing, Utilization Coordinator, Social Services and Activities Director.) The Committee will then determine the need for further audits and reports. **Director of Nursing will be responsible for continued compliance.**	
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to follow the care plan for two (#15, #20) of ten sample residents. The findings were; 1. Review of the medical record revealed resident #20 was admitted on 6/25/06 with diagnoses including multiple sclerosis and depression. Review of the 11/15/06 care plan revealed anxiety and depression were identified as problems. Continued review revealed interventions for anxiety included: observe for early signs of agitation or increasing anxiety and report,	F 282	Correction date: January 14, 2007 **F-282 Comprehensive Care Plans** **Corrective Action for Identified Residents** Resident #20 will have a new Care Plan written with the completion of her new comprehensive assessment. (See F 272) Weekly Weights have been d/c from resident #15 careplan, but will be weighed weekly per facility policy. **Identification of Residents with Potential to be Affected** All residents have the potential to be affected since all residents have Comprehensive Care Plans. **Corrective Action to Prevent Recurrence** The Interdisciplinary Team will be	Completion Date: Jan 14, 2007

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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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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F 281	Continued From page 25 c. Review of the MAR at 8:55 AM on 11/28/06 revealed LPN #33 had signed that the 8 AM and the noon doses of Klonopin (an anticonvulsant) were administered. Interview with the LPN revealed she had not given either of the doses and should not have signed the MAR indicating she had administered the medications. Review of the facility's policy and procedure titled, "Medication Administration," #PRO 62002, instructed staff to document medication administration on the MAR after administration. The policy further instructed staff to review the MAR at the end of each medication pass to ensure necessary doses were administered and documented.	F 281	~~This Plan of Correction is the center's credible allegation of compliance.~~ *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 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.* Committee (Quality Assurance Committee: Director of Nursing, Utilization Coordinator, Social Services and Activities Director.) The Committee will then determine the need for further audits and reports. **Director of Nursing will be responsible for continued compliance.**	
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to follow the care plan for two (#15, #20) of ten sample residents. The findings were; 1. Review of the medical record revealed resident #20 was admitted on 6/25/06 with diagnoses including multiple sclerosis and depression. Review of the 11/15/06 care plan revealed anxiety and depression were identified as problems. Continued review revealed interventions for anxiety included: observe for early signs of agitation or increasing anxiety and report,	F 282	Correction date: January 14, 2007 **F-282 Comprehensive Care Plans** **Corrective Action for Identified Residents** Resident #20 will have a new Care Plan written with the completion of her new comprehensive assessment. (See F 272) **Identification of Residents with Potential to be Affected** All residents have the potential to be affected since all residents have Comprehensive Care Plans. **Corrective Action to Prevent Recurrence** The Interdisciplinary Team will be	Completion Date: Jan 14, 2007

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

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	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

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F 282	Continued From page 26 encourage discussion of fear/anxiety, and to observe for situations that cause the increased anxiety and remove if possible. Review of the care plan revealed interventions for signs and symptoms of depression included: encourage the resident to verbalize his/her fears and concerns, allow for quality time to communicate, be sensitive to non-verbal communication, provide quality listening time, encourage to express feelings in 1:1 visits, and to rule out pain, thirst, hunger, need to urinate, being too hot or cold, a noisy environment or other internal/external factors. The following concerns were identified: a. Review of the 8/706 1430 (2:30 PM) nursing resident progress notes revealed "[The resident] is very upset, crying, asking repeatedly 'What do I do?'" Review of the medical record showed no evidence the interventions included in the care plan were implemented. b. Review of the 9/14/06 0930 (9:30 AM) activities resident progress notes revealed "Resident at X's [times] cont's [continues] getting depressed over [his/her] illness." Review of the medical record revealed there was no evidence the care plan interventions were implemented. c. Review of the 11/22/06 1330 (1:30 PM) resident progress notes revealed "Res [resident] tearful et upset stating she felt she had been ignored." Review of the medical record revealed there was no evidence the care plan interventions were implemented. d. During an interview with the director of nursing on 11/29/06 at 5:15 PM, she stated the care plan should have been followed. In addition, review of the 11/06 physician's orders for this resident revealed s/he had a gastrointestinal tube placed for fluids and nutrition. Further review revealed an order to provide a minimum of 1800 cubic centimeters	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* inserviced on writing a comprehensive care plan and updating it to reflect the care provided. **Monitoring/Quality Assurance** At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance Committee: Director of Nursing, Utilization Coordinator, Social Services and Activities Director.) The Committee will then determine the need for further audits and reports. **Director of Nursing will be responsible for continued compliance.** Correction date: January 14, 2007 **F -Tag 309** **Quality of Care** **Corrective Action for Identified Residents** Resident #21 no longer resides with in this facility. The CMS 2567 inaccurately identified this resident.	Completi on Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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SOUTH CENTRAL WY HEALTHCARE &	542 16TH STREET RAWLINS, WY 82301

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F 282	Continued From page 27 (cc) of fluids per day. Review of the 11/15/06 care plan revealed the resident was to have his/her intake and output recorded every shift. However, review of the intake and output flow sheet for 11/06 revealed there was no intake of fluids recorded from 11/1/06 through 11/28/06. Review of the individual resident meal intake record for 11/06 revealed no fluid intake was documented. Interview with the director of nursing on 11/29/06 at 5:15 PM revealed the intake and output record should have been completed as indicated on the care plan. 2. Review of the 10/10/06 care plan for resident #15 revealed s/he required weekly weights. However, review of the weight records revealed only one weight was recorded in 10/06 and only two were recorded during November as of 11/27/06.	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* **Identification of Residents with potential to be affected** Any resident with pain or on pain medications. **Corrective Action to Prevent Recurrence** Staff Development Coordinator (SDC) or designee will provide an inservice to the Licensed staff on the facility's Pain Management Program by January 14, 2007.	
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and medical record review, the facility failed to provide adequate pain management for one (#21) of ten sample residents. The findings were: Review of the 11/06 physician's orders revealed resident #21 had diagnoses including multiple	F 309	**Monitoring/Quality Assurance** The Director of Nursing (DNS) or designee will do random audits on the Pain Management Program weekly for 6 weeks. At the completion of the audits the Director of Nursing will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. **Responsible Party** The Director of Nursing will be responsible	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 28	F 309	*This Plan of Correction is the center's credible allegation of compliance.*	

sclerosis and chronic skin ulcers. Review of the 7/1/06 annual Minimum Data Set (MDS) assessment revealed s/he had pain in his/her back and soft tissue areas. Review of the 11/15/06 care plan revealed pain related to the resident's diagnoses was identified as a problem. Further review of the care plan revealed interventions included: administer pain medication per the physician's orders and monitor for effectiveness, assess the characteristics of pain (location, duration, quality, aggravating/alleviating factors, radiation, and intensity) and document, assess the effectiveness of pain medication and report to the physician is not effective, and assess and document non-pharmacological interventions for pain relief (e.g. heat, cold, massage, positioning, music). The following concerns were identified:

a. Review of the 11/06 Medication Administration Record (MAR) revealed the resident rated his/her pain at 4 out of 10 (10 being the most painful) at 2 PM on 11/1/06. Review of the same MAR revealed the resident did not receive pain medication until 8:30 PM (6 1/2 hours later). Review further revealed the resident's pain was elevated to a 5 of 10 at 10 PM.

b. Review of the 11/06 MAR revealed the resident's pain was 6 of 10 at 2 PM on 11/3/06. Review of the same MAR revealed the resident did not receive pain medication until 3:20 PM (1 1/2 hours later).

c. Review of the 11/06 MAR revealed the resident's pain was 4 of 10 at 10 PM on 11/8/06. Review of the same MAR revealed the resident did not receive any pain medication until the following morning (11/9/06) at 8:45 AM (10 hours and 45 minutes later).

d. Review of the 11/06 MAR revealed the

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for continued compliance.

Correction Date

January 14, 2007

F-Tag 314
Pressure Sores

Completion Date: Jan 14, 2007

Corrective Action for Identified Residents

Resident # 30's wound was re-cultured on 12/07/06 and Tetracycline was ordered. The MRSA (Methicillin-Resistant Staphylococcus Bacteria) is shown to be sensitive to this medication.

Identification of Residents with potential to be affected

Any resident with Pressure Sores have the potential to be affected

Corrective Action to Prevent Recurrence

Staff Development Coordinator (SDC) or Designee will inservice by 1-10-07 the licensed nurses on:

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 29 resident's pain was 4 at 6 AM on 11/13/06 but did not receive pain medication until 2:30 PM (8 1/2 hours later). The resident's pain was again 4 of 10 at 10 PM but did s/he did not receive pain medication until 11:30 PM (1 and 1/2 hours later). e. Interview with the director of nursing on 11/29/06 at 5:15 PM revealed the times of pain noted on the MAR might not be accurate but the expectation was that a resident should receive pain medication when s/he had pain unless contraindicated by physician's orders. Review of the 10/31/06 facility policy on pain management revealed the following statement: "The center's practice to assist each resident with pain to maintain or achieve the highest practicable level of well being and functioning." f. Review of the physician's 11/30/06 progress notes revealed the resident "has pain with any movement." g. Interview with the resident on 11/28/06 at 8:30 AM revealed s/he had frequent muscle spasms in his/her legs that were painful. When asked if the pain was controlled by the medications and treatments provided by the facility, the resident said "no."	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* 1. After a Culture and Sensitivity test comparing ordered medication to ensure that the identified organism is sensitive to the ordered medication. If not sensitive, informing the physician and obtaining an order for an appropriate medication. **Monitoring/Quality Assurance** The Director of Nursing (DNS) or designee will do weekly audits for 6 weeks to monitor compliance with ensuring that the appropriate medications is prescribed for any culture and sensitivity test. At the completion of the audits the Director of Nursing will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. **Responsible Party** **The Director of Nursing will be responsible for continued compliance.** **Correction Date** January 14, 2007	
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314		

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

(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 314	Continued From page 30 by: Based on observation, medical record review, and staff interview, the facility failed to ensure appropriate treatment for one (#30) of two sample residents with pressure sores. The findings were: During the initial tour on 11/27/06 at 3:51 PM, interview with licensed practical nurse (LPN) #29 revealed she identified resident #30 as having a bacterial resistant infection. The LPN stated the infection was in the left gluteal (buttock) fold (a pressure area). On 11/28/06 at 9:28 AM, observation and interview with LPN #28 revealed the resident had a stage two pressure sore to the left gluteal fold (pelvic ischium). The LPN further stated the sore was cultured and an antibiotic was initiated approximately one week ago. Review of the resident's medical record revealed resident progress notes dated 4/6/06 (no time) which documented the initial finding of the pressure sore area by notification to a nurse from a certified nurse aide of a "4 cm [centimeter] diameter open area to gluteal fold. MD [physician] called...." Further review of resident progress notes showed on 7/30/06 at 3 PM the pressure sore was documented as positive for methicillin-resistant Staphylococcus aureus (MRSA), (an antibiotic resistant bacteria), and on 8/10/06 (no time) the area was identified as a stage III "4 cm (centimeter) by 2 cm." Review of the 10/26/06 at 11 AM resident progress notes revealed documentation the area was healed to a stage II. Yet, review of the medical record revealed the following concerns related to pressure sore healing: a. Resident progress notes dated 11/12/06 at 11:57 AM note a "foul smell from stage III on glute [gluteal area]." On 11/14/06 at 10:30 AM "C&S [culture and sensitivity] obtained from	F 314	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* **F-Tag 318** **Range of Motion** **Corrective Action for Identified Residents** Resident #15 was re-evaluated by Therapy and was discontinued from the restorative program per the evaluation. Resident #20 also was re-evaluated by Therapy and frequency for restorative nursing has been established for the resident. **Identification of Residents with potential to be affected** Any resident that has been placed on the restorative program has the potential to be affected. **Corrective Action to Prevent Recurrence** The facility will identify all residents that are receiving a restorative nursing program and review all the orders to assure that the residents needs are meet by establishing specific frequencies that meet the needs of the residents by 1-14-2007. New residents placed on a restorative program will have specific frequency order at the time the Therapy referral is done to meet the	Completion Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

(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 314	Continued From page 31 wound to left buttock area." Then on 11/20/06 at 10 AM the nurse documented faxing the results of the C & S to the physician. b. Review of physician orders revealed on 11/21/06 the physician ordered Augmentin (antibiotic). Review of the C & S report dated 11/17/06 revealed the MRSA was not sensitive to Augmentin. c. Interview and medical record review with director of nursing (DON) on 11/28/06 at 3:33 PM revealed she was unaware of the Augmentin's resistance to MRSA. The DON confirmed the reason for the medication was to treat the infection in the left gluteal pressure sore.	F 314	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.*	
F 318 SS=D	483.25(e)(2) RANGE OF MOTION 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 staff interview and medical record review, the facility failed to ensure restorative exercises were provided as required for two (#15, #20) of two sample residents who were supposed to receive restorative services. The findings were: 1. Review of the 11/06 physician's orders revealed resident #20 was admitted with diagnoses including multiple sclerosis. Review of the 7/1/06 Minimum Data Set (MDS) assessment revealed s//he had functional limitations on both sides with partial loss of voluntary movement of	F 318	residents needs. **Monitoring/Quality Assurance** The Restorative Nurse or designee will do weekly audits of all restorative orders for 6 weeks to monitor compliance. At the completion of the audits the Restorative Nursing will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. **Responsible Party** **The Restorative Nursing will be responsible for continued compliance.** **Correction Date** January 14, 2007 **F-Tag 323 Hazards** **Corrective Action for Identified Residents** No residents were identified however the following issues have been or are scheduled	Completion Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

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F 318	Continued From page 32 the arms, hands, legs, and feet. Review of the restorative referral on 11/9/06 revealed the resident required passive range of motion (PROM) to increase his/her range of motion (ROM) and to prevent contractures. Review of the 11/06 restorative program daily record and the referral revealed there were no frequencies established for restorative exercises. Interview with the restorative nurse on 11/30/06 at 9:15 AM revealed if there were no frequencies written on the referral, the practice was to provide the exercises seven days per week. Review of the restorative daily record revealed from the start of therapy date of 11/9/06 through 11/29/06 the resident did not receive ROM exercises seven days per week. The resident received no therapy on 11/11, 11/12, 11/21, and 11/22. Further review of the restorative progress notes for those days revealed there was no explanation as to why restorative services were not provided. 2. Review of the 11/06 physician's orders for resident #15 revealed s/he was admitted with diagnoses including arthritis and osteoporosis. Review of the 4/7/06 initial MDS assessment revealed the resident had functional limitations on both sides with partial loss of voluntary movement of the arms and hands. Further review revealed limitation of one leg and foot with partial loss of voluntary movement. Review of the restorative/rehabilitation nursing program completed on 6/19/06 revealed the resident required upper extremity restorative exercises six times per week to maintain his/her upper extremity strength and range of motion. Review of the restorative daily record for 10/06 revealed the resident did not receive restorative services six times per week during the weeks of 10/15 through 10/21, and 10/22 through 10/28/06.	F 318	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* to be corrected. A) The item used to prop the housekeeping door open has been removed and the door is closed and locked when the housekeeper is not using it. The electrical outlet in the activity area will be used instead of the closet outlet. B) All medication has been removed from the resident's fridge at the back nurses' station and the fridge has been cleaned. A sign has been posted on the fridge noting "Food Fridge Only, do not place any medication in this fridge." C) A working lock has been placed on the medication fridge at the front nurses' station. **Identification of Residents with potential to be Affected** Any resident that can access the refrigerators at the nurses' station and can access the housekeeping closet has the potential to be affected. **Corrective Action to Prevent Recurrence** The housekeeping staff will be in-serviced by 01/05/07, by Administrator or designee, on the importance of keeping doors closed that contain harmful chemicals.	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

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F 318	Continued From page 33 Review of the 11/06 restorative daily record revealed the resident did not receive restorative services six times per week during the week of 11/5 through 11/11/06. Review of restorative progress notes revealed no evidence as to why services were not provided the required six times per week. Interview with the restorative nurse on 11/30/06 at 9:15 AM revealed she did not know why the resident did not receive restorative services as required.	F 318	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.*	
F 323 SS=D	483.25(h)(1) ACCIDENTS 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: Based on observation and staff interview, the facility failed to provide an environment that was free of accident hazards. The census was 43. The findings were: 1. Observation on 11/28/06 at 7:10 AM revealed the door to the housekeeping closet by the resident activity area was propped open. Observation revealed the closet contained the following hazardous materials: one jar of premium resilient tile adhesive, one half gallon of oxy bleach cleaner, and disinfectant to be used in the hazardous materials mop bucket. Review of the ECOLAB Material Safety Data Sheet revealed the following precautions for the disinfectant: "Can cause severe irritation, possible chemical [for skin and eyes]." If swallowed "Immediately call the medical emergency number ..., a poison control center or a physician." "Keep out of reach of children." Interview with the housekeeper at the	F 323	The nursing staff will be in-serviced by 01/05/07, by Administrator or designee, on the proper use of refrigerators and the importance of keeping the medication refrigerators locked. **Monitoring/Quality Assurance** An audit monitoring compliance with keeping the housekeeping closet closed and locked will be completed daily for 2 weeks, then weekly for 4 weeks. Audits will be reviewed by the Performance Improvement Committee who will then determine the need for further audits. An audit monitoring compliance with keeping the back nurses' station fridge free of medications and the front nurses' station medication fridge locked will be completed weekly for 4 weeks the monthly for 2 months. Audits will be reviewed by the Performance Improvement Committee who will then determine further need for audits. **Responsible Party** **Administrator or Designee** **Correction Date** January 14, 2006	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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SOUTH CENTRAL WY HEALTHCARE &	542 16TH STREET RAWLINS, WY 82301

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F 323	Continued From page 34 time revealed he uses the electrical outlet inside the closet while cleaning the floors and that was why it was propped open. Observation at that time, however, revealed there was an electrical outlet available for use in the activity area and the housekeeper was using that particular outlet; not the outlet in the closet. Interview with the administrator on 11/29/06 at 8:47 AM revealed the housekeeping storage room/closet should have the door closed and locked at all times. 2. Observation of the resident refrigerator located at the back nurses' station on 11/28/06 at 10:05 AM revealed it contained a medicated nasal spray for resident #43 and a box of influenza vaccine syringes. The observation revealed the refrigerator was not locked. Interview with licensed practical nurse (LPN) #28 on 11/28/06 at 10:05 AM revealed the refrigerator was for food items only and medications should be stored in the front medication refrigerator. Two residents, #31 and #16 were observed to wander the facility during the days of the survey. 3. Observation of the front nurses' station medication refrigerator on 11/28/06 from 10:18 AM to 12:55 PM revealed the medication refrigerator was unlocked. During the observation, residents gathered in the seating area near the station which was located by the front entrance. The observation revealed staff left the station unattended even though the refrigerator was unlocked and medications were not secure. Observation of the contents of the refrigerator on 11/28/06 at 10:18 AM revealed it contained injectable influenza vaccine syringes, medicated nasal sprays, and Tylenol suppositories. Interview with LPN #29 and the director of nursing at 11:13 AM on 11/28/06 revealed the medication	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* **F-329 Unnecessary Drugs** **Corrective Action for Identified Residents** Resident # 30's wound was re-cultured on 12-07-06 and Tetracycline was ordered. The MRSA (Methicillin-Resistant Staphylococcus Bacteria) is shown to be sensitive to this medication. Ditropan for Resident # 15 was discontinued on 07-14-06. **Identification of Residents with Potential to be Affected** All residents have the potential to be affected since all residents have ordered medications. **Corrective Action to Prevent Recurrence** Staff Development Coordinator (SDC) or designee will inservice by 1-10-07 the licensed nurses on: 1. After a culture and Sensitivity test comparing ordered medication to ensure that the identified organism is sensitive to the ordered medication. If not sensitive, informing the physician and	Completi on Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 35 refrigerator was left unlocked unless controlled substance medications were in the refrigerator.	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.*	
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS 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 observation, medical record review, and staff interview, the facility failed to ensure two (#30, #15) of twelve sample residents received medications to treat appropriate medical conditions and/or were effective in treating the specific medical condition. The findings were: 1. During the initial tour on 11/27/06 at 3:51 PM, interview with licensed practical nurse (LPN) #29 revealed resident #30 had a bacterial resistant infection. The LPN stated the infection was in a pressure sore area in the left gluteal (buttock) fold. On 11/28/06 at 9:28 AM, observation with LPN #28 and interview with the LPN at that time revealed the resident had a stage two pressure sore to the left gluteal fold (pelvic ischium). The LPN further stated the sore was cultured and antibiotic therapy was initiated approximately one week ago. The following concerns were noted related to the antibiotic treatment of the pressure sore: a. Review of the 11/12/06 at 11:57 AM	F 329	obtaining an order for an appropriate medication. 2. Following through with the physician as needed to address recommendations of the Consultant Pharmacist. **Monitoring/Quality Assurance** The Director of Nursing or designee will do weekly audits for 6 weeks to monitor compliance with ensuring that the appropriate medications is prescribed for any culture and sensitivity test and that the Consultant Pharmacist's recommendations are follow up on timely. At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. **Director of Nursing will be responsible for continued compliance.** Correction date: January 14, 2007	

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
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F 329	Continued From page 36 resident progress notes revealed documentation there was a "foul smell from stage III on glute [gluteal area]." On 11/14/06 at 10:30 AM "C&S [culture and sensitivity] obtained from wound to left buttock area." Then on 11/20/06 at 10 AM the nurse documented faxing the results of the C & S to the physician. b. Review of physician orders revealed on 11/21/06 the physician ordered an antibiotic, Augmentin. Review of the C & S report dated 11/17/06 revealed a positive culture for methicillin-resistant Staphylococcus aureus (MRSA which was an antibiotic resistant bacteria). Review of the antibiotic sensitivity report revealed MRSA was not sensitive to Augmentin. c. Interview and medical record review with the director of nursing (DON) on 11/28/06 at 3:33 PM revealed the DON was unaware of the Augmentin's resistance to MRSA. She confirmed the reason for the medication was to treat the infection in the left gluteal pressure sore. 2. Review of the 11/06 physician's orders for resident #15 revealed s/he was admitted with diagnoses including benign prostatic hypertrophy (BPH). Review also revealed the resident received the medication Ditropan (prevents bladder spasms) and Flomax (used to treat symptoms of BPH). Review of the 7/6/06 drug regimen review (DRR) revealed the pharmacist recommended discontinuation of the Ditropan because the drug was known to have a high risk of adverse drug reactions with the disease. In addition, the pharmacist recommendation on the 7/6/06 DRR noted the combination of the Ditropan and Flomax had potential to counteract each other. Further review of this DRR revealed the physician wrote a note to discontinue the	F 329	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* **F-331 Anti-psychotic Drugs** **Corrective Action for Identified Resident** The Physician will review all anti- psychotic medications for resident #29 and reduce if indicated, otherwise a note will be written stating the contraindication. **Identification of Residents with Potential to be Affected** All residents on anti psychotic drugs have the potential to be affected **Corrective Action to Prevent Recurrence** The Staff Development Coordinator or designee will inservice the Psychotropic Team by 1-8-07. This inservice will inform the Team that Residents who are on anti psychotic drugs need to receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Documentation of such attempts also needs to be a part of the clinical record. Current residents on anti psychotics will be reviewed by 1-14-07 for gradual dose reduction attempts and if needed such	Completion Date: Jan 14, 2007

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 _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 37 Ditropan on 7/14/06. The following concerns were identified: a. On 10/6/06, (89 days later) licensed practical nurse #33 noted the order. b. Review of the resident's Medication Administration Record (MAR) revealed the resident received the Ditropan daily throughout July, August, and September despite the fact the physician ordered the drug be discontinued on 7/14/06. c. Review of the 10/06 MAR revealed the medication was finally discontinued on 10/4/06. d. Interview with the director of nursing on 11/29/06 at 5:30 PM revealed facility practice was for nursing to transcribe the recommended order from the DRR to a telephone order and sent to the physician for signature. She further stated the medication was given in error from 7/14/06 through 10/4/06 because the nurse did not follow the facility protocol for transcribing orders.	F 329	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* reductions will be instituted and if contraindicated such documentation will be put into the clinical record **Monitoring/Quality Assurance** The Director of Nursing or designee will do monthly audits for 3 months to monitor for compliance with the gradual dose reduction attempts for residents on anti psychotics. The Director of Nursing or designee will report compliance monthly to the Performance Improvement Committee (Quality assurance). At the completion of the 3-month audits and reports the Committee will then determine the need for further audits. **Responsible Party** **The Director of Nursing will be responsible for continued compliance.** Correction date: January 14, 2007	
F 331 SS=D	483.25(l)(2)(ii) ANTIPSYCHOTIC DRUGS Based on a comprehensive assessment of a resident, the facility must ensure that residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and resident and staff interview, the facility failed to ensure dose reductions or documented clinical contraindications occurred for one (#29) of two sample residents who required antipsychotic medications. The findings were:	F 331	**F-334 Influenza and Pneumococcal Immunization** **Corrective Action for Identified Residents** Director of Nursing has educated residents #15, #23, #26, #29, #30 and #32. A late	Completion Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 331	Continued From page 38 Medical record review for resident #29 revealed physician orders which showed the resident received Seroquel (an antipsychotic medication used to treat schizophrenia) 100 mg (milligrams) every evening. Further record review failed to reveal dose reductions were attempted and there was no evidence a dose reduction was contraindication. Interview on 11/29/06 at 4:30 PM with the facility's district director of clinical operations revealed the facility was unable to find the documentation related to dose reduction history and/or documentation of clinical contraindication to a dose reduction.	F 331	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.*	
F 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the	F 334	**Identification of Residents with Potential to be Affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence** The Staff Development Coordinator or designee will inservice the licensed nurses by 1-12-07on: The requirement is that all eligible residents are to be offered the influenza immunization annually and pneumococcal immunization (per guidelines of an initial immunization with a possible second immunization in 5 years) and that there is documentation of vaccination history and of education of the resident or the resident's legal representative on the benefits and possible side effects of immunization. **Monitoring/Quality Assurance** The Director of Nursing (DNS) or designee will do an audit of facility residents to ensure all residents are offered the immunizations per regulations and that the pertinent	

entry has been completed stating vaccination history and teaching. Resident #4 has been re-offered the vaccine but continues to be ill. When resident #4 is well enough the vaccine will be re-offered.

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

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	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

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F 331	Continued From page 38 Medical record review for resident #29 revealed physician orders which showed the resident received Seroquel (an antipsychotic medication used to treat schizophrenia) 100 mg (milligrams) every evening. Further record review failed to reveal dose reductions were attempted and there was no evidence a dose reduction was contraindication. Interview on 11/29/06 at 4:30 PM with the facility's district director of clinical operations revealed the facility was unable to find the documentation related to dose reduction history and/or documentation of clinical contraindication to a dose reduction.	F 331	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* entry has been completed stating vaccination history and teaching.	
F 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the	F 334	**Identification of Residents with Potential to be Affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence** The Staff Development Coordinator or designee will inservice the licensed nurses by 1-12-07on: The requirement is that all eligible residents are to be offered the influenza immunization annually and pneumococcal immunization (per guidelines of an initial immunization with a possible second immunization in 5 years) and that there is documentation of vaccination history and of education of the resident or the resident's legal representative on the benefits and possible side effects of immunization.] **Monitoring/Quality Assurance** The Director of Nursing (DNS) or designee will do an audit of facility residents to ensure all residents are offered the immunizations per regulations and that the pertinent	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

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F 334	Continued From page 39 influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* documentation is present in their clinical record. The results of this audit will be reported to the Performance Improvement Committee (Quality Assurance) upon completion of this audit. Director of Nursing or designee will also audit weekly through March 31, 2007 for the proper immunizations, education and documentation for new admits. The Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance) monthly through March 2007. The Committee will then determine the need for further audits and reports. **Responsible Party** **The Director of Nursing will be responsible for continued compliance.** Correction date: January 14, 2007. **F-Tag 356** **Nurse Staffing** **Corrective Action for Identified Residents** No specific residents were identified.	Completion Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 386	Continued From page 50 no progress notes for the 6/28/06 visit.	F 386	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.*	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review, transport calendar review, and staff interview, the facility failed to ensure physician visits occurred for two (#30, #32) of eleven sample residents. 1. Review of the physician's progress notes for resident #30 revealed visit notes for 9/29/06, an opthomology note dated 11/18/05, and another physician visit note on 6/15/05. Interview and review of the facility transport calendar on 11/28/06 at 3:33 PM with the director of nursing (DON) revealed the resident attended an appointment at the physician's office on 6/28/06. Progress notes faxed from the physician's office documented visits on 6/28/06, 6/15/06, and 3/22/05. There were no documented visits between 11/18/05 and 6/15/06 (nearly seven months) and between 6/28/06 and 9/29/06 (approximately three months). 2. Review of the medical record for resident #32 revealed the resident had a lapse between physician visits. Review of the physician progress	F 387	**Identification of Residents with potential to be affected** Any resident has the potential to be affected. **Corrective Action to Prevent Recurrence** The Director of Nursing (DNS) has started a file for the daily postings of nursing staff information from the date of exit of the survey. 11/30/2006. The Director of Nursing (DNS) or designee will keep a file for that Staff Posting. The Director of Nursing (DNS) will assure that the posting are returned by setting up a system and in servicing the nursing staff on the system to assure that the staff posting are returned to the Director of Nurses (DNS). **Monitoring/Quality Assurance** The Director of Nurse or designee will do weekly audits of the Staff Posting file for 6 weeks to monitor compliance. At the completion of the audits the Director of Nursing will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

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F 387	Continued From page 51 notes revealed the physician wrote progress notes during a visit on 3/2/06 and then, on 7/25/06 (three and a half months later.) Interview and review of the facility transport calendar on 11/28/06 at 3:33 PM with the DON revealed the calendar only documented transport activity, including transport to physician office appointments, back to July 2006.	F 387	~~This Plan of Correction is the center's credible allegation of compliance.~~ *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 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.* audits/reports.	
F 428 SS=D	483.60(c)(1) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to assure the drug regimen was reviewed at least monthly by a pharmacist for two (#20, #26) of 12 sample residents. The findings were: 1. Review of the face sheet showed resident #26 was re-admitted on 8/25/06 (3 months ago). Review of the medical record revealed no monthly pharmacist review sheet. On 11/28/06 at 5:53 PM, when questioned about it, the director of nursing (DON) provided a pharmacist recommendation for the resident dated 10/6/06. On 11/30/06 at 9:25 AM, the DON stated the medical record should contain a yellow pharmacy review sheet, but did not. The DON stated there was no evidence to show the resident's drug regimen was reviewed other than the one time in October. 2. Review of the drug regimen review pharmacist signature log for resident #20 revealed there was	F 428	**Responsible Party** **The Director of Nursing will be responsible for continued compliance.** **Correction Date** January 14, 2007 **F-Tag 368** **Frequency of Meal** **Corrective Action for Identified Residents** No specific residents were identified. **Identification of Residents with potential to be affected** Any resident has the potential to be affected. **Corrective Action to Prevent Recurrence** The Staff Development Coordinator (SDC) will inservice the nursing staff on nightly offering and distribution of HS snacks and the documentation of the offering and distribution of snacks by 1/14/2007.	Completi on Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 334	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure one (#4) of seven residents who were eligible for flu vaccination was offered the vaccination. In addition the facility failed to document vaccination history and/or teaching for six (#15, #23, #26, #29, #30, and #32) of seven sample residents. The findings were: 1. Review of the immunization record in the medical record showed no evidence resident #4 received the influenza vaccine in 2006. Review of nursing notes showed no documentation why the resident did not receive the vaccine. During an interview on 11/29/06 at 8:55 AM, the director of nursing (DON) stated the resident did not receive the flu shot because s/he was ill. The DON stated the medical record did not contain documentation regarding why the resident did not receive the vaccine. 2. Review of the immunization record in the medical record showed no documentation resident #26 had received the pneumococcal vaccine. During an interview on 11/29/06 at 8:55 AM, the DON stated upon admission, the resident's family stated the resident had already received the pneumococcal vaccine. The DON confirmed the medical record lacked documentation of the pneumococcal vaccination status of the resident. 3. Review of the resident medical records revealed the following concerns related to lack of documentation for vaccination history and/or vaccination teaching for individual residents:	F 334	*~~This Plan of Correction is the center's credible allegation of compliance.~~* *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 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.* **Monitoring/Quality Assurance** The Director of Nurse or designee will do weekly audits of the Individual Resident Meal Intake Record sheet for 6 weeks to monitor compliance. At the completion of the audits the Director of Nursing will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. **Responsible Party** **The Director of Nursing will be responsible for continued compliance.** **Correction Date** January 14, 2007 **F-Tag 371** **Sanitary Conditions – Food Prep & Service** **Corrective Action for Identified Residents** No specific residents were identified. Sausages were removed from the microwave and the microwave was cleaned during	Completion Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 334	Continued From page 41	F 334	*This Plan of Correction is the center's credible allegation of compliance.*	

a. Review of the immunization records for resident #20 revealed s/he refused the vaccine. However, review of the entire medical record revealed there was no evidence education was provided for the resident regarding the risks and benefits.

b. Review of the immunization records for resident #15 revealed s/he received a flu vaccine on 10/24/06. However, review of the entire medical record revealed there was no evidence education was provided for the resident regarding the risks and benefits.

c. Review of the medical record for resident #29 revealed a vaccination sheet which documented the resident received flu vaccination on 10/21/06. Further review of the medical record failed to revealed documentation of teaching done.

d. Review of the medical record for resident #30 revealed resident progress notes dated 10/24/06 which documented the resident received flu vaccination on 10/24/06. Further review of the medical record failed to revealed documentation of teaching done.

e. Review of the medical record for resident #32 revealed a vaccination sheet which documented the resident received flu vaccination on 10/6/06. Further review of the medical record failed to revealed documentation of teaching done.

Interview with the DON on 11/28/06 at 3:33 PM revealed the facility administered vaccinations as ordered by physicians. She stated only cognitive residents received verbal teaching and the teaching was not documented.

4. Review of the facility's policy titled, "Pneumococcal Vaccination", #PRO 68010-01 and "Influenza Program," #PRO 56010, included

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survey. The uncovered/unlabeled milkshakes were thrown out during survey. Popcorn machine has been taken apart and cleaned on 12/4/2006. The refrigerators at the nurse's have been cleaned out during survey.

Identification of Residents with potential to be affected

Any resident has the potential to be affected.

Corrective Action to Prevent Recurrence

The Dietary Manager has developed and implemented a cleaning schedule to address the microwave. The Dietary Manager had re-inserviced the dietary staff on the Policy of covering/labeling of items in the Refrigerators in the dietary department.

The Activities Director had developed and implemented a cleaning schedule for the popcorn machine after each use.

Then Director of Nursing (DNS) has developed and implemented a cleaning schedule for the refrigerators at the nurses station and the Staff Development Coordinator (SDC) will inservice the staff cleaning of the nurse station refrigerators.

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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			This Plan of Correction is the center's credible allegation of compliance.	
F 334	Continued From page 42 interventions such as screening residents for eligibility, side effects and benefit teaching, documentation, and administration. The policies included teaching to residents and/or authorized persons.	F 334	*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 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.*	
F 356 SS=C	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 356	**Monitoring/Quality Assurance** The Director of Nurse or designee will do weekly audits of the nurses station refrigerators for 6 weeks to monitor compliance. At the completion of the audits the Director of Nursing will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. The Activity Director will do weekly audits on the popcorn machines and after each use fore 6 weeks to monitor compliance. At the completion of the audits the Activity Director will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. The Dietary Manager will do weekly audits of the microwave and the refrigerator for 6 weeks to monitor compliance. At the completion of the audits the Dietary Manger will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports.	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

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F 356	Continued From page 43 by: Based on observation, staff interview, resident interview, and review of policy and procedure, the facility failed to ensure records of nurse staffing information posted for each shift were kept the required eighteen months. The findings were: Observation of the facility revealed the number of staff was posted for each day of the survey. However, interview with the director of nursing on 11/30/06 at 8:40 AM revealed she did not keep the postings. She further stated she had no record of postings from the past eighteen months as required.	F 356	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* **Responsible Party** **The Administrator or Designee will be responsible for continued compliance.** **Correction Date** January 14, 2007	
F 368 SS=E	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and policy and procedure review, the facility failed to assure	F 368	**F-Tag 386 Doctor Progress Notes** **Corrective Action for Identified Residents** Resident #29's medical record has been updated to reflect a current physician's progress note. Resident # 30's medical record has been updated to reflect a current physician's progress note. Progress notes were received from doctor's office for visit on 6/28/06. Identification of Residents with potential to be Affected All residents have the potential to be affected. **Corrective Action to Prevent Recurrence** A system will be set up by the Director of Nursing or designee to track doctor's	Completion Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

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F 368	Continued From page 44 each resident was offered a bedtime snack. The facility census was 43. The findings were: 1. During confidential interview of ten residents on 11/28/06 at 1:30 PM, residents stated they did not receive bedtime snacks routinely. They stated an overhead announcement was made around 7 PM that snacks were available and they could go get what they wanted but that staff did not personally offer snacks to each resident. Concern for those residents unable to hear the announcement or who were unable to go to the front to obtain their snacks was verbalized by residents. 2. During an interview on 11/29/06 at 9:10 AM, the dietary manager stated all residents should receive bedtime snacks. The dietary manager stated the kitchen provided nursing staff with snacks for residents. 3. During an interview on 11/29/06 at 1:15 AM with certified nurse aide (CNA) #14, she stated she worked both evenings and nights and that bedtime snacks were brought on a tray from dietary around 7 PM in the evening. She stated an overhead announcement was made that snacks were available and residents would then go to the snack tray and get what they wanted. The CNA further stated that if staff had time they would take the tray to each room to offer a snack but that rarely happened because staff were too busy. 4. During an interview on 11/30/06 at 8:36 AM, resident #4 stated the facility did not provide snacks in the evening. The resident added "well, if they do they don't come in here." The resident stated he/she would eat a snack if it was offered.	F 368	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* appointments and the receiving of progress notes from those appointments. The Director of Nursing (DON) will in-service the licensed staff by 01/05/06, on the timely receiving of progress notes for residents who go out to see their physicians as well as ensuring that progress notes are completed when physician comes into see a resident. This in-service will also include the information regarding how the system for tracking doctor's appointments will work. **Monitoring/Quality Assurance** An audit tool will be developed to monitor the system for tracking appointments and receiving of progress notes. Audits will be completed weekly for 4 weeks and then monthly for 2 months. Results of the audits will be reported to the Performance Improvement Committee (Quality Assurance) and they will determine continued need for monitoring. **Responsible Party** **Director of Nursing or Designee** **Correction Date** January 14, 2006	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

(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 368	Continued From page 45 5. In addition, during an interview with resident #20 on 11/30/06 at 8:40 AM, s/he stated snacks were not offered to him/her at bedtime on a routine basis.	F 368	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.*	
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE 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 and procedures, the facility failed to ensure expired and/or undated foods were not available for use, and that equipment was maintained clean. The resident census was 43. The findings were: 1. Observation during the initial tour of the kitchen on 11/27/06 at 3:43 PM revealed the inside of the microwave oven had splatters of dried food debris on the top and all sides. A plate of uncovered sausage links was located inside the microwave oven. Observation of the microwave oven on 11/28/06 at 7:25 AM revealed the top and sides remained splattered with dried food debris. During an interview on 11/28/06 at 10 AM, the dietary manager stated the microwave oven should be cleaned out daily. According to Food Code 2005, U.S. Public Health Service, 4-60.11: "...(B) The food-contact surfaces of cooking equipment and pans shall be free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food	F 371	**F-Tag 387 Doctor Visits** **Corrective Action for Identified Resident** Resident #30 has an appointment to see the physician on Dec 27th 2006. Resident #32 has an appointment to see the physician on Jan 3rd 2006. **Identification of Residents with potential to be affected** All residents have the potential to be affected by untimely doctor visits. **Corrective Action to Prevent Recurrence** A system for monitoring when doctor's visits are needed will be developed by the Director of Nursing or designee by 12/30/06. The Director of Nursing will in-service the licensed staff and medical records on the system for monitoring and importance of timely doctors visits for residents, by 01/05/06. **Monitoring/Quality Assurance** Audits monitoring the system will be completed weekly for 4 weeks then monthly for 2 months to ensure efficacy of the	Completion Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 46 residue, and other debris." 2. Observation of the reach-in freezer inside the kitchen on 11/27/06 at 3:43 PM revealed two uncovered, unlabeled cups containing a white frozen liquid. Observation on 11/28/06 at 7:25 AM revealed the uncovered and unlabeled cups remained. On 11/28/06 at 1:45 PM, the dietary manager stated the cups contained homemade milkshakes, and she threw them out when she noticed them. 3. Review of the facility's policy "Food Storage Guide" (TL 6829, 10/31/06) revealed "...Discard leftover foods that have not been used within three (3) days of preparation of soon if indicated on the food storage guide. Leftover food is stored in an appropriate food storage container, labeled, and dated..." 4. According to Food Code 2005, U.S. Public Health Service 3-501.17: Date Marking. ...Refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified below. The day of preparation shall be counted as Day 1. (1) 5°C (41°F) or less for a maximum of 7 days; 5. According to Food Code 2005, U.S. Public Health Service, 4-60.11: "...(B) The food-contact surfaces of cooking equipment and pans shall be free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of	F 371	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* system. Reports will be given to the Performance Improvement Committee (Quality Assurance) and further monitoring will be determined by the Performance Improvement Committee (Quality Assurance). **Responsible Party** **Director of Nursing or Designee** **Correction Date** January 14, 2006 **F-Tag 428 Pharmacy Review** **Corrective Action for Identified Residents** Resident #20 had a drug regime review completed on 12/4/06. Resident #26 had a drug regime review completed on 12/4/06. **Identification of Residents with potential to be Affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence**	Completion Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

(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	Continued From page 47 equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 6. Observation of the activity area on 11/27/06 at 4:09 PM revealed there was a tabletop popcorn popper located in the activity lounge area. The machine had a thick coating of grease on the popper portion and the interior of the popper had popcorn hulls and pieces of popped corn. The sides of the machine had a grease film. The popcorn scoop was lying in the bottom of the machine, coated with popcorn pieces and grease film. Popcorn, un-popped kernels and hull pieces remained in the bottom of the machine. Observation of the machine on 11/28/06 at 7:08 AM and 11/29/06 at 9:27 AM revealed the condition of the machine remained unchanged. 7. Interview with the activity director on 11/28/06 at 4:06 PM revealed the last time the popcorn machine was used occurred on 11/24/06. The director stated activity personnel were responsible for cleaning the machine and she had not had time to clean it. 8. Observation of the back nurses' station refrigerator on 11/28/06 at 10:05 AM revealed it contained the following: medicated nasal spray for resident #43, influenza vaccine, a container of partially consumed baked chicken boxed in a container from a deli/grocery store (no resident label and no date), a partial bottle of mayonnaise (no resident label or 'open' date), four supplemental health shakes, a bottle with a manufacturers's label "Coffee Mate" (no resident label or 'open' date), and a 20 oz partially consumed bottle of Pepsi (no resident label or 'open' date). Interview with a licensed practical nurse (LPN) on 11/28/06 at 10:05 AM revealed	F 371	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* The Administrator and Director of Nursing will meet with the pharmacy consultant and review survey findings. As a result of this meeting a plan will be put in place to ensure that: 1) All residents have their drug regime reviewed monthly. 2) Pharmacy consultant will write a comment, check mark, or recommendations along with her signature to indicate that review was completed. Director of Nursing will in-service licensed staff by 1/5/07, on the importance of drug regime review and follow-up on recommendations. Director of Nursing or designee will review pharmacy reports monthly to ensure every resident was reviewed by the pharmacy consultant. **Monitoring/Quality Assurance** An audit will be completed monthly for 3 months to ensure that pharmacy reviews are being completed as discussed, and in compliance with state and federal regulation. Monthly reports will be given to the Performance Improvement Committee (Quality Assurance) for review and	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

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F 371	Continued From page 48 she identified the refrigerator as a storage area for resident food. The LPN stated the medications were incorrectly stored in the refrigerator and all food items should be labeled and dated as to which resident they belong to. Observation of the front nurses' station refrigerator on 11/28/06 at 10:18 AM revealed it was labeled "For resident snacks only" and it contained the following: various bottles of soda partially consumed (no names or dates), Gatorade 20 oz. partially consumed (no resident name or date), apple sauce in a disposable container without a label or date, a defrosted "Banquet" brand fried rice and chicken egg roll dinner without a label or date, and with manufacture printing which stated "Keep Frozen", and a deli sandwich in deli packaging dated 11/18/06 without a name. Interview with the dietary manager on 11/28/06 at 10:28 AM revealed nursing staff cleaned and cared for the unit refrigerators which held resident snacks. Interview with the director of nursing on 11/28/06 at 11:13 AM revealed all resident food should be labeled and dated when placed in the refrigerators.	F 371	~~This Plan of Correction is the center's credible allegation of compliance.~~ *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 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.* continued monitoring will be determined by the Performance Improvement Committee (Quality Assurance). **Responsible Party** **Director of Nursing or Designee** **Correction Date** January 14, 2006 **F-Tag 432 Locked Medications** **Corrective Action for Identified Residents** All medication has been removed from the resident's fridge at the back nurses' station and the fridge has been cleaned. A sign has been posted on the fridge noting "Food Fridge Only, do not place any medication in this fridge." A working lock has been placed on the medication fridge at the front nurses' station. **Identification of Residents with potential to be Affected** Any resident that can access the refrigerators at the nurses' station and can access the housekeeping closet has the potential to be affected.	Completion Date: Jan 14, 2007
F 386 SS=D	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced	F 386		

51

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

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F 386	Continued From page 49	F 386	*This Plan of Correction is the center's credible allegation of compliance.*	

by:
Based on observation, medical record review, facility transport calendar review, and staff interview, the facility failed to ensure physician wrote, signed, and dated progress notes during all physician visits. Two (#29, #30) of 11 sample residents did not have progress notes written for each physician visit. The findings were:

1. Review of the medical record for resident #29 revealed physician progress notes dated 9/29/06, 8/30/06, and 5/11/06. Interview and review of the facility transport calendar on 11/28/06 at 3:33 PM with the director of nursing (DON) revealed the resident had physician visits as often as weekly and at least monthly since July 2006. Yet, no documented progress notes other than the aforementioned were found.

2. Observation of resident #30 on 11/28/06 at 9:28 AM with licensed practical nurse (LPN) #28 revealed the resident had a gluteal fold (pelvic ischium) pressure sore. The LPN, at that time, stated that the sore was cultured and an antibiotic was initiated approximately one week ago. Review of the resident's medical record revealed resident progress notes dated 4/6/06 (no time) which documented the initial finding of the pressure sore area by notification to a nurse from a certified nurse aide of a "4 cm [centimeter] diameter open area to gluteal fold. MD [physician] called...." Review of physician progress notes revealed notes for 9/29/06, an opthomology note dated 11/18/05, and a physician visit on 6/15/05. Interview and review of the facility transport calendar on 11/28/06 at 3:33 PM with the DON revealed the resident attended an appointment at the physician's office on 6/28/06. Review of the medical record with the DON at that time revealed

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Corrective Action to Prevent Recurrence

The nursing staff will be in-serviced by 01/05/07, by Administrator or designee, on the proper use of refrigerators and the importance of keeping the medication refrigerators locked.

Monitoring/Quality Assurance

An audit monitoring compliance with keeping the back nurses' station fridge free of medications and the front nurses' station medication fridge locked will be completed weekly for 4 weeks the monthly for 2 months. Audits will be reviewed by the Performance Improvement Committee (Quality Assurance) who will then determine further need for audits.

Responsible Party
Director of Nursing or Designee

Correction Date
January 14, 2006

F-Tag 441
Infection Control

Corrective Action for Identified Residents

Completion Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

(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 428	Continued From page 52 only the pharmacist's signature and date for the months of 8/06, 9/06, 10/06, and 11/06. There were no comments or check marks indicating what the review consisted of or if there were recommendations. Interview with the director of nursing on 11/29/06 at 5:20 PM revealed some evidence of review should have been documented other that just the pharmacist's signature. She further confirmed there was no evidence the reviews were performed.	F 428	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.*	
F 432 SS=D	483.60(e) STORAGE OF DRUGS AND BIOLOGICALS In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure appropriate, locked storage of medications during two random observations. The findings were: Observation of the resident refrigerator located at the back nurses' station on 11/28/06 at 10:05 AM	F 432	Resident # 30's wound was re-cultured on 12/07/2006 and Tetracycline was ordered. The MRSA (Methicillin-Resistant Staphylococcus Bacteria) is shown to be sensitive to this medication. The facility has audited all current employee health records. All TB tests will be completed by 12/19/2006 and the three (3) other staff members will be scheduled for a chest X-ray by 1/14/2007. **Identification of Residents with potential to be Affected** Any resident has the potential to be affected. **Corrective Action to Prevent Recurrence** The Director of Nurses and the Infection Control Nurse will re-implement the infection control program per the policy of the facility by 1/14/2007 All infections will be tracked on a weekly bases on the infection control logs by the Infection Control Nurse.	

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
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F 432	Continued From page 53 revealed it contained a medicated nasal spray for resident #43 and a box of influenza vaccine syringes. Observation revealed the refrigerator was unlocked and contained resident food items and beverages. Interview with licensed practical nurse (LPN) #28 on 11/28/06 at 10:05 AM revealed the refrigerator was for food items only. She stated medications should be stored in the front medication refrigerator. Observation of the front nurses' station medication refrigerator on 11/28/06 from 10:18 AM to 12:55 PM revealed the medication refrigerator was unlocked. During the observation, residents gathered in the seating area near the station which was located by the front entrance. The observation revealed staff left the station unattended even though the refrigerator was unlocked and medications were not secure. Observation of the contents of the refrigerator on 11/28/06 at 10:18 AM revealed it contained injectable influenza vaccine syringes, medicated nasal sprays, and Tylenol suppositories. Interview with LPN #29 and the director of nursing at 11:13 AM on 11/28/06 revealed the medication refrigerator was left unlocked unless controlled substance medications were in the refrigerator.	F 432	~~This Plan of Correction is the center's credible allegation of compliance.~~ *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 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.* All staff will be screened for TB on Hire and annual for bases and will be tracked by the Infection Control Nurses. Staff Development Coordinator (SDC) or Designee will inservice by 1-10-07 the licensed nurses on: 2. After a Culture and Sensitivity test is ordered, Licensed Nurse will ensure medication identified organism is sensitive to the ordered medication. If not sensitive, the Licensed Nurse will inform the physician and obtain an order for an appropriate medication.	
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and	F 441	2. The Staff Development Coordinator in-serviced the current nursing staff on the proper hand washing techniques. The Director of Nursing or designee will observe current nursing personnel performing a return demonstration of hand washing techniques. The Director of Nursing or designee, will re-inservice and /or counsel any employee identified as not performing hand washing as delineated by the facility policy and procedures. The Staff Development Coordinator will provide instruction on proper hand washing techniques new personnel during orientation.	

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 _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 54 corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, review of infection control policies and procedures, review of infection tracking and surveillance, staff interview, and medical record review, the facility failed to ensure a systematic approach related to maintenance of an infection control program, prevention of disease transmission, investigation and surveillance of resident infections, and monitoring of staff illness. The facility census was 43. The findings were: Interview with the infection control (IC) nurse on 11/30/06 at 8:59 AM revealed the registered nurse entered the position less than a month ago. Further interview revealed she was unfamiliar with, and unable to answer questions related to infection control tracking, surveillance, antibiotic use, culture and sensitivity reporting, and monitoring of illness for residents and staff. The following concerns were identified related to the overall infection control program: a. Review of the infection control log for tracking and surveillance revealed no tracking and/or surveillance for October and November 2006. The infection control log for tracking and surveillance was reviewed with the director of nursing (DON) on 11/30/06 at 9:42 AM. The DON confirmed no data was available for those months. The DON stated she and the Minimum Data Set assessment coordinator were responsible for the program until the IC nurse attended training. b. During the initial tour on 11/27/06 at 3:51 PM, interview with licensed practical nurse (LPN)	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* **Monitoring/Quality Assurance** The Director of Nursing (DNS) or designee will do weekly audits for 6 weeks to monitor compliance with ensuring that the appropriate medications is prescribed for any culture and sensitivity test. At the completion of the audits the Director of Nursing will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. The Director of Nurse or designee will monitor through direct observation audit of nursing staff performing hand-washing techniques while proving care, at least monthly for (3) months. At the completion of the audits the Director of Nursing will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. The Director of Nursing (DNS) or designee will do audits for of all new staff members health record before starting work to assure that the result of the TB testing is completed before starting work. At the completion of	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 55 #29 revealed resident #30 had a bacterial resistant infection. Review of physician orders revealed on 11/21/06 the physician ordered an antibiotic, Augmentin. Review of the culture and sensitivity (C & S) report dated 11/17/06 revealed a positive culture for methicillin-resistant Staphylococcus aureus (MRSA which was an antibiotic resistant bacteria). Review of the antibiotic sensitivity report revealed MRSA was not sensitive to Augmentin. Interview and medical record review with the DON on 11/28/06 at 3:33 PM revealed the she was unaware of the Augmentin's resistance to MRSA. She confirmed the reason for the medication was to treat the infection in the left gluteal pressure sore. When interviewed on 11/30/06 at 9:42 AM the DON identified floor nursing staff as responsible for antibiotic review to ensure appropriate treatment. c. Further interview with the DON on 11/30/06 at 9:42 AM revealed the facility's proactive action program included resident immunization and staff inservicing. When asked if proactive actions included random observations of handwashing, perineal care, or monitoring of employee illness, the DON stated the facility did not do those things. Random observations on 11/27/06 during the evening meal revealed one staff member wiping residents' faces and feeding residents without using hand sanitizer or hand washing as she went from resident to resident. A random observation during medication pass on 11/28/06 at 7:17 AM revealed a licensed practical nurse (LPN) coughed into her right hand, touched a tablet with her right forefinger, and without using hand washing or hand sanitizer, passed medications to resident #34. d. Review of the facility's policy titled, "Infection Control Program," #POL 628, the policy guide included compliance actions such as: recording	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* the audits the Director of Nursing will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. **Responsible Party** **The Director of Nursing will be responsible for continued compliance.** **Correction Date** January 14, 2007 **F -Tag 443** **Preventing Spread of infection** **Corrective Action for Identified Residents** No specific residents were identified. **Identification of Residents with potential to be Affected** Any resident has the potential to be affected. **Corrective Action to Prevent Recurrence** The facility has audited all current employee	Completi on Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 56 incidents and corrective actions related to infections, investigation, control and prevention of infections, a surveillance system to include monitoring and investigation of causes for nosocomial (facility acquired) and community acquired infections, screening employees for communicable disease or infection. Interview with the IC nurse on 11/30/06 at 8:59 AM revealed she was unaware of her role in infection control and referred the surveyor to the DON. On 11/30/06 at 9:42 AM when asked by the surveyor with whom the surveyor could review the infection control program, the DON referred the surveyor to the IC nurse. e. Review of the facility's policy and procedure titled, "Infection Control Program," #POL 628, the policy guide included compliance actions such as "6. The Employee Health Program provides: a. Tuberculosis Exposure Control Plan.... 7. Employees with a communicable disease or infected skin lesions are prohibited from direct contact with residents or their food,..." However, review of employee files revealed the following concerns: a. Review of the personnel file for employee #36 revealed s/he had a TB test administered on 11/2/06 but the results of the test were never read. b. 2. Review of the personnel file for employee #13 revealed s/he had completed the health questionnaire on 8/24/06 indicating s/he had never had a TB test or chest x-ray. There was no evidence the employee received any testing for tuberculosis prior to resident contact. c. Review of the personnel file for employee #27 revealed s/he had completed the health questionnaire on 10/31/06. Review revealed the employee indicated s/he had a negative TB test in 8/06 but there was no written evidence of the	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* health records. All TB tests will be completed by 12/19/2006 and the three (3) other staff members will be scheduled for a chest X-ray by 1/14/2007. All staff will be screen for TB on Hirer and annual for bases and will be tracked by the Infection Control Nurses. The facility will develop a screening system by using the Work Restrictions by Infection Disease (Recommendation Categories---- Centers for Disease Control and Prevention. HICPAC guideline for infection control in healthcare personnel AJIC 1998;26(3):289-354.) **Monitoring/Quality Assurance** The Director of Nursing (DNS) or designee will do audits for of all new staff members health record before starting work to assure that the result of the TB testing is completed before starting work . The Director of Nursing (DNS) or designee will audit all call of and the work restriction by infectious disease log weekly for 6 weeks. At the completion of the audits the Director of Nursing will report compliance to the	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 441	Continued From page 57 negative test results. d. Review of the personnel file for employee #30 revealed s/he had completed the health questionnaire indicating s/he had a TB test administered that was negative. However, there was no written evidence the employee had a negative TB test prior to resident contact. During the exit interview on 11/30/06 at 3 PM the administrator and director of nursing agreed employees should TB testing prior to resident contact.	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports.	
F 443 SS=E	483.65(b)(2) PREVENTING SPREAD OF INFECTION The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. This REQUIREMENT is not met as evidenced by: Based on review of employee records, staff interview, and review of the infection control log and policies and procedures, the facility failed to ensure employees were screened and monitored for communicable disease. The resident census was 43. The findings were: 1. Review of the facility's policy and procedure titled, "Infection Control Program," #POL 628, the policy guide included compliance actions such as "6. The Employee Health Program provides: a. Tuberculosis Exposure Control Plan.... 7. Employees with a communicable disease or infected skin lesions are prohibited from direct contact with residents or their food,..." and the policy referred staff to a work restrictions policy.	F 443	**Responsible Party** **The Director of Nursing will be responsible for continued compliance.** **Correction Date** January 14, 2007 **F -Tag 444** **Preventing Spread of Infection** **Corrective Action for Identified Residents** Resident #34 was not listed on the CMS 2567 that was received on 12/18/2006. **Identification of Residents with potential to be affected** Any resident has the potential to be affected. **Corrective Action to Prevent Recurrence** The Staff Development Coordinator in-serviced the current nursing staff on the	Completion Date: Jan 14, 2007

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

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

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F 443	Continued From page 58 Review of the infection control log revealed information "TL 5628-05" dated 4/28/06 which instructed individuals handling food to report to their supervisor information about their health. It further instructed that reported information should include the date of onset, symptoms, and illness. The information included reporting by the employee of symptoms such as vomiting, diarrhea, jaundice and others, as well as, a history of exposure to "Norovirus... Enterohemorrhagic or Shiga toxin-producing E. coli... with in the past 3 days...." In addition, the infection control log book listed work restrictions by infectious disease and was referenced as "TL 5608 (04/28/06)R". The reference included screening employees for symptoms, work restrictions, and when the employee could return to work. Interview with the director of nursing on 11/30/06 at 9:42 AM revealed the facility's infection control program did not include screening ill employees' symptoms to assess when the employee could return to work. 2. Review of personnel files revealed the following concerns in regard to infection control monitoring: a. Review of the personnel file for employee #36 revealed s/he had a TB test administered on 11/2/06 but the results of the test were never read. b. Review of the personnel file for employee #13 revealed s/he had completed the health questionnaire on 8/24/06 indicating s/he had never had a TB test or chest x-ray. There was no evidence the employee received any testing for tuberculosis prior to resident contact. c. Review of the personnel file for employee #27 revealed s/he had completed the health	F 443	~~*This Plan of Correction is the center's credible allegation of compliance.*~~ *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 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.* proper hand washing techniques. The Director of Nursing or designee will observe current nursing personnel performing a return demonstration of hand washing techniques. The Director of Nursing or designee, will re-in-service and /or counsel any employee identified as not performing hand washing as delineated by the facility policy and procedures. The Staff Development Coordinator will provide instruction on proper hand washing techniques new personnel during orientation. **Monitoring/Quality Assurance** The Director of Nurse or designee will monitor through direct observation audit of nursing staff performing hand-washing techniques while providing care, at least monthly for (3) months. At the completion of the audits the Director of Nursing will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. **Responsible Party** **The Director of Nursing will be responsible for continued compliance.**	

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
	535036	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 443	Continued From page 59 questionnaire on 10/31/06. Review revealed the employee indicated s/he had a negative TB test in 8/06 but there was no written evidence of the negative test results. d. Review of the personnel file for employee #30 revealed s/he had completed the health questionnaire indicating s/he had a TB test administered that was negative. However, there was no written evidence the employee had a negative TB test prior to resident contact. During the exit interview on 11/30/06 at 3 PM the administrator and director of nursing agreed employees should TB testing prior to resident contact.	F 443	*~~This Plan of Correction is the center's credible allegation of compliance.~~* *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 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.* **Correction Date** January 14, 2007	
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure employees utilized appropriate hand hygiene during two random observations. The findings were: 1. A random observation during medication pass on 11/28/06 at 7:17 AM revealed a licensed practical nurse (LPN) coughed into her right hand, touched a tablet with her right forefinger, and without using hand washing or hand sanitizer, passed the medications, including the pill she touched, to resident #34.	F 444	**<u>F-Tag 454 Emergency Exit</u>** **Corrective Action for Identified Residents** No residents were identified however the following corrective action will been taken for area of concern: Gate will have bolt like lock removed and a spring closer and latch will be installed on the gate. Allowing exit and entrance to the courtyard. **Identification of Residents with potential to be affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence** Gate will be checked regularly to ensure it is working properly. The Administrator or designee will in-service facility staff by 1/5/07, on the changes made regarding the gate.	Completion Date: Jan 14, 2007

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

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F 444	Continued From page 60 Interview with the director of nursing on 11/3/0/06 at 9:42 AM revealed staff were expected to perform hand hygiene when going between residents, or if the staff member touches their hair, face, or cough. Review of the facility policy, "Handwashing," dated 10/31/06 instructed staff to perform handwashing after "...touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn;...After coughing, sneezing, or blowing the nose;..." 2. Observation on 11/27/06 from 5:40 PM until 6:12 PM revealed certified nurse aide (CNA) #7 assisted seven residents with their meals in the assisted dining room. Observation revealed the CNA wiped food off the mouth of non-sample resident #36. The CNA then went directly to assist non-sample resident #38 with eating; the CNA did not wash or sanitize her hands between resident contacts. Observation at 6:10 PM revealed the CNA placed a nasal oxygen cannula into the nose of resident #38 then continued to assist him with eating without washing or sanitizing her hands. The CNA continued to assist non-sample residents #38, #36, #12, #1, #32, #31, and #30 with their meals, touching their eating utensils, their food and their bodies during the 32 minute observation period.	F 444	*~~This Plan of Correction is the center's credible allegation of compliance.~~* *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 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.* **Monitoring/Quality Assurance** An audit will be completed weekly for 4 weeks the monthly for 2 months to monitor for compliance with keeping exit clear and gate unlocked. **Responsible Party** **Administrator or Designee** **Correction Date** January 14, 2006	
F 454 SS=E	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 454	**F -Tag 465 Environment** **Corrective Action for Identified Residents** No residents were identified however the following areas of concern have been or are being corrected. A) The metal bed frame, two wheelchairs, two rolling carts with drawers, the blue floor pad, and seven wooden pallets were cleared from the outside area of entry door labeled #7. B) The dirty utility room is being spackled and painted and will be completed by 12/29/06. The container holding the unknown liquid has been removed. C) The cement wall in the basement	Completion Date: Jan 14, 2007

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

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F 454	Continued From page 61 facility failed to ensure one emergency area of egress was unimpeded. The findings were: 1. On 11/27/06 at 4:09 PM observation of the activity lounge area revealed the area exited into a fenced courtyard. Lighted emergency egress signs in the lounge directed residents and the general public to use the exit in case of emergency. Observation of the courtyard area revealed it was enclosed by a wooden eight foot high fence with a gate for exit. The gate was approximately 30 feet from the building exit. The observation of the gate revealed it was locked by a bolt type lock which required a key. Interview with the administrator on 11/27/06 at 4:46 PM revealed a key to the gate lock was located near the gate. Observation on 11/27/06 at 4:51 PM revealed a key tethered to a wooden window near the gate. A second interview with the administrator on 11/28/06 at 5:42 PM revealed, other than the maintenance department, the administrator had no knowledge of anyone else with a key to the gate. Interview with both staff nurses on duty at 5:44 PM on 11/28/06 revealed neither nurse knew the gate required a key to exit the area. Each stated they did not have a key to the area. 2. According to the Life Safety Code regulations, the following must exist: Exit access is arraigned so that exits are readily accessible at all times in accordance with NFPA 101 Section 7.1. 19.2.1 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. *Appendix A.7.1.10.1 A proper means of egress allows unobstructed travel at all times.	F 454	~~This Plan of Correction is the center's credible allegation of compliance.~~ *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 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.* laundry area will be painted by 1/14/07. D) The corner wall surface at the bottom of the basement steps where it was observed to have large chips of paint flaking will be sanded and repainted by 1/14/07. E) The staff bathroom has been cleaned. The dirty rag hanging from the pipe has been removed. **Identification of Residents with potential to be affected** Any resident may have the potential to be affected by an unclean environment. **Corrective Action to Prevent Recurrence** The outside of door #7 will be added to the weekly rounds that will be completed by the Administrator or designee. The facility staff will be in-serviced by the Administrator of designee, by 1/5/07 on cleanliness of the building and what they can do as employees to maintain a clean environment for the residents. **Monitoring/Quality Assurance** An audit tool will be developed to monitor the areas of concern listed above. Audits	

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

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F 454	Continued From page 62 Any type of barriers including, but not limited to, the accumulations of snow and ice in those climates subject to such accumulations is an impediment to free movement in the means of egress. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.	F 454	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* will be completed weekly for 4 weeks. Audits will be reviewed by the Performance Improvement Committee (Quality Assurance) and need for further audits will be determined by the Performance Improvement Committee. **Responsible Party** **Administrator or Designee** **Correction Date** January 14, 2006	
F 465 SS=D	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure safety of one entry way and that all areas used by residents, staff and the public remained sanitary and clean during random observations. The finding were: 1. Observation of entry door labeled "7" during the initial tour on 11/27/06 at 3:51 PM revealed facility items stored outside the door. The items included a metal bed frame, two wheelchairs, two rolling carts with drawers, a blue floor pad, and seven wooden pallets. Observation on 11/28/06 at 7:12 AM revealed the area outside the door was unchanged. The observation also revealed a staff member entered through the door. Observation and interview with the administrator at 8:47 AM on 11/29/06 revealed the only change to the area was that a piece of therapy equipment was added	F 465	**F Tag 514** **Clinical Records** Corrective Action for Identified Residents Resident #20 physician order for CPR have been updated and are accurate with the resident's CPR form and wishes. **Identification of Residents with potential to be affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence**	Completion Date: Jan 14, 2007

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

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F 465	Continued From page 63 to the pile. When interviewed, the administrator stated the area held equipment until it was transferred to off-site storage units. 2. Observation of the dirty utility room next to room #23 during the initial tour on 11/27/06 at 4:33 PM revealed the interior room walls were constructed of unpainted dry wall which left an uncleanable surface. The observation also revealed a basin of fluid in the corner of the room with a washcloth in it. Observation on 11/28/06 at 9:45 AM and again on 11/29/06 at 8:47 AM revealed the room and basin of fluid remained unchanged. When interviewed during the observation on 11/29/06 at 8:47 AM, the administrator stated the room had unpainted walls since his employment at the facility which was approximately two months. The administrator stated he was unaware why the basin was in the corner. 3. Observation on 11/30/06 at 8:09 AM of the basement areas utilized by staff revealed an area used as a dirty laundry holding area. The window in the area had an exposed unpainted cement wall which made the surface uncleanable. Outside the room a corner wall surface at the bottom of the basement steps was flaking large chips of paint. Observation of a staff bathroom in the area revealed dirt build up on the floor tiles, a stained sink surface, and a visibly soiled rag hanging on the piping below the sink. During an interview with a laundry technician on 11/30/06 at 8:12 AM, she stated the basement window area re-occurred even after the facility attempted to place a moisture seal on the area approximately a year ago. The staff member was unaware of the corner with flaking paint. The staff member described the bathroom as "gross" and stated	F 465	*This Plan of Correction is the center's credible allegation of compliance.* *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 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.* An audit has been done by Medical Records Director of all CPR orders to assure that the residents request are being adhered to. That the physician order matches the CPR form that reveals the residents desires. All orders that have been correct and clarified with the resident/responsible party to assure that the resident's wishes are meet. **Monitoring/Quality Assurance** The Medical Records Director or designee will audit the clinical records 48 to 72 hours after each admission for CPR orders and CPR form match to assure that the residents desires are meet. At the completion of the audits the Medical Records Director will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. **Responsible Party** **The Director of Nursing will be responsible for continued compliance.** **Correction Date** January 14, 2007	

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F 465	Continued From page 64	F 465	*This Plan of Correction is the center's credible allegation of compliance.*	
F 514 SS=D	she used the one on the main level of the facility. 483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure accurate information was available to staff in regard to the resuscitation status for one (#20) of eleven sample residents. The findings were: Review of the 11/06 physician's orders for resident #20 revealed a 6/25/06 order for a full code (staff to do cardiopulmonary resuscitation (CPR) if the resident experienced a cardiac or respiratory emergency and stopped breathing). However, review of the CPR form dated 6/22/06 revealed the resident did not desire CPR. Interview with the director of nursing on 11/29/06 at 5:10 PM revealed the resident did not desire CPR and the physician's orders were incorrect.	F 514	*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 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.*	