STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 535036	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 10/6/2005
NAME OF PROVIDER OR SUPPLIER: SOUTH CENTRAL WY HEALTHCARE &	STREET ADDRESS, CITY, STATE, ZIP CODE: 542 16TH STREET RAWLINS, WY		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) RESIDENT ASSESSMENT

The assessment must accurately reflect the residents 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 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 the accuracy of assessments for 2 of 12 sample residents (#4, #24). The findings were:

1. Review of the 9/16/05 re-admission Minimum Data Set (MDS) assessment showed resident #24 was continent of bladder. The assessment reference date (ARD) for the assessment was 9/15/05. Review of the 9/05 flow sheet record, however, revealed the resident was incontinent of bladder on every shift from9/12/05 through the ARD of 9/15/05. During an interview on 10/6/05 at 10:30 AM, the director of nursing (DON) stated the assessment was inaccurate.

2. Review of the 7/25/05 MDS annual assessment for resident #4 revealed the R2b date indicating completion of the MDS process was 7/25/05. However, the comprehensive assessment process (VB2) and the Resident Assessment Protocols (RAPs) completed on the triggered areas of cognitive loss, ADL (activities of daily living) function, psychosocial well-being, mood state, behavioral symptoms, falls, nutritional status, and dehydration were dated 7/15/05.

Interview with the medical records' director on 10/5/05 at 2 PM confirmed the VB2 date was prior to the Rb2 date.

According to the "Center for Medical and Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual" version 2.0, revised May 2005, page 1-2, the order of the Resident

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 535036	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 10/6/2005
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	Continued From Page 1 Assessment Instrument is completion of the MDS (R2b) and then completion of the RAPs (VB2).

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 _____	10/06/2005

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 PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246 SS=D	483.15(e)(1), 483.70(c)(1), 483.70(d)(2) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. The facility must provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care. The facility must provide each resident with a separate bed of proper size and height for the convenience of the resident; a clean, comfortable mattress; bedding appropriate to the weather and climate; and functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview, the facility failed to accommodate individual food preferences for 1 (#4) of 11 sample residents during 2 of 2 meal observations.	F 246	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law" F-246 1.) Facility will accommodate individual food preferences. 2.) All Residents have the potential to be affected. 3.) Resident #4 and all residents will receive foods of preference. Resident will be interviewed and trays will be reviewed for accurate food preferences. 4.)Dietary manager will in-service dietary staff regarding the accuracy of meals served to the tray card preferences.	

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

Micki Hansen — Executive Director — 10/26/2005

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Revised on 11/2/05 @ 11am E Micki Hansen Accepted w/Changes

pg. 1, 3 & 18.

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 246	Continued From page 1 The findings were: Interview with resident #4 on 10/4/05 at 9:35 AM revealed he/she had stomach ulcers, and "I get served foods I can't eat." The resident further stated gravy was a food that upset the ulcers, but was served gravy anyway. Observation of the noon meal on 10/4/05 revealed resident #4 was served gravy on both the pork chop, and the parmesan potatoes. Subsequent observation of the evening meal on 10/4/05 at 5:58 PM revealed he/she was served gravy on both the country fried steak, and the oven browned potatoes. Review of the diet card revealed resident #4 "dislikes: fish sticks, gravy." Interview with the dietary manager on 10/5/05 at 11:15 AM revealed that she was aware resident #4 disliked gravy, and gravy should not have been served to this resident.	F 246	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law" 5.) The dietary manager or designee will conduct random weekly audits for one month then monthly audits for four months. To insure dietary preferences are being maintained. The results of these audits will be presented to the PI (Performance Improvement /Quality Improvement) committee monthly. Compliance Date: 11-9-2005	
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS 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;	F 272		

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	535036	A. BUILDING _____ B. WING _____	10/06/2005

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F 272	Continued From page 2 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 staff interview, and medical record review, the facility failed to fully assess 3 (#27, #25, #43) of 12 sample residents in a variety of areas. The findings were: 1. Review of the October 2005 physician's orders for resident #27 revealed an order for Ambien (hypnotic) 5 milligrams (mg) as needed for insomnia. Review of the entire medical record revealed there was no assessment completed to determine the cause of the resident's insomnia and no evidence that non-pharmacological alternatives were tried. Interview with the director	F 272	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law" F- 272 1.) Residents # 25 will have a bladder assessment done. Resident # 27 will have an assessment done to attempt to determine the cause of insomnia. Resident #43 will have a comprehensive assessment done. 2.) All residents have the potential to be affected. all 3.) Residents will have comprehensive assessments completed upon admission and during an annual or significant change of condition and on a quarterly basis during the MDS period.	

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	535036	A. BUILDING _____ B. WING _____	10/06/2005

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F 272	Continued From page 3 of nursing (DON) on 10/6/05 at 10:30 AM confirmed she was unable to find evidence an assessment was done to determine the cause of the resident's insomnia. 2. Review of the 5/13/05 admission and 8/2/05 quarterly Minimum Data Set (MDS) assessments for resident #25 revealed he/she had an indwelling catheter. Review of the progress notes revealed the catheter was removed on 8/21/05. Further review of the progress notes revealed the resident was incontinent of urine after removal of the catheter. Interview with CNA #2 on 10/4/05 at 11:25 AM revealed the resident was incontinent of urine daily. Observation on 10/4/05 at 12:45 PM revealed the resident's incontinence brief was saturated with urine. Review of the medical record revealed there was no bladder assessment completed since removal of the catheter. Interview with the DON on 10/6/05 at 9:15 AM revealed bladder assessments were completed quarterly and the resident was not yet due for one. 3. Review of the 2/1/05 annual Resident Assessment Instrument (RAI) for resident #43 revealed no section V (Resident Assessment Protocol (RAP) summary) and no RAP summaries for triggered areas. On 10/5/05 at 2:10 PM, the medical records director stated section V and the RAP summaries were "lost." Review of the re-printed section V showed the following triggered areas lacked comprehensive assessments: cognitive loss, activities of daily living (ADL), psychosocial well-being, behavioral symptoms, falls, and psychotropic drug use.	F 272	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law" 4.) The District Director of Utilization Services or his designee will in-service the MDS team to ensure coordination of information and accuracy of care plans. 5.) Random MDS audits will be completed by the DNS or designee on a monthly basis for four months. Any MDS that is not accurate will be re-done and completed accurately. Results of there audits will be presented to the PI (Performance Improvement/ Quality Improvement)committee monthly. Compliance Date: 11-9-2005	
F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS	F 279		

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 _____	10/06/2005

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F 279	Continued From page 4 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure treatment plans were developed in a variety of areas for 3 (#24, #27, #31) of 12 sample residents. The findings were: 1. Review of the 6/7/05 admission Minimum Data	F 279	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law" F-279 1.) Resident # 24, #27, #31, will have care plans developed to meet the needs identified in the comprehensive assessments. 2.) All residents have the potential to be affected. 3.) The District Director of Utilization Services or his designee will in-service the MDS team to ensure coordination of information and accuracy of assessments. 4.) Random MDS audits will be completed by the DNS or designee on a monthly basis for four months. Any MDS that is not accurate will be re-done and completed accurately. Results of there audits will be presented to the PI (Performance Improvement/ Quality Improvement)committee monthly.	

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	535036	A. BUILDING _____ B. WING _____	10/06/2005

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 279	Continued From page 5 Set (MDS) assessment for resident #27 revealed he/she triggered for comprehensive review of his/her visual function, cognitive loss, communication, and delirium. Review of the comprehensive assessments for these areas revealed the facility made a decision to proceed with care planning. However, review of the June 2005 care plan revealed these issues were not addressed. 2. During an interview on 10/4/05 at 10:05 AM, licensed practical nurse (LPN) #1 stated resident #24 had "panic attacks", and received Valium (antianxiety drug) for anxiety. On 10/4/05 at 5:40 PM, the staff development coordinator (SDC) stated the resident received Valium since 8/8/05 for anxiety. The SDC stated the resident had panic attacks. Review of the physician's orders showed the resident received Valium 2 milligrams (mg) twice per day. In addition, on 10/3/05 the physician ordered Valium 2 mg prn (as needed) every six hours for anxiety. Review of the care plan dated 9/27/05 showed anxiety was not addressed. The care plan addressed "sleep pattern disturbance," however on 10/6/05 at 12:15 PM the director of nursing (DON) stated the resident had anxiety, not sleep pattern disturbance. 3. Review of the October 2005 physician's orders for resident #31 revealed he/she was prescribed Zoloft (antidepressant) 50 mg, Wellbutrin SR (antidepressant) 150 mg, Ativan (antianxiety) 1 mg, Seroquel (antipsychotic) 100 mg, and Ambien (sedative-hypnotic) 10 mg. Review of the 1/20/05 admission MDS assessment revealed he/she triggered for comprehensive review of psychotropic drug use. Review of the 1/17/05 comprehensive assessment revealed the facility	F 279	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law" Compliance Date: 11-9-2005	

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	535036	A. BUILDING _____ B. WING _____	10/06/2005

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

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F 279	Continued From page 6 had made the decision to proceed with care planning. However, review of the April 2005 care plan for this resident revealed psychotropic drug use was not addressed.	F 279	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law"	
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff provided the necessary care to maintain good personal hygiene for one (#30) of six sample residents who were incontinent of bowel. The findings were: Review of the 8/18/05 admission Minimum Data Set (MDS) assessment for resident #30 revealed he/she was incontinent of bowel (all or almost all of the time) and required total assistance with toileting and personal hygiene. Observation on 10/4/05 at 9:40 PM revealed the resident was incontinent of bowel. Observation further revealed certified nurse aide (CNA) #1 provided perineal care for the resident. Observation of the perineal care revealed the CNA used the same area of the cleansing wipe two times, folded the wipe to a clean area, again used the same area of the wipe two times, folded the wipe to a clean area, and then used the same area of the wipe two more times to cleanse the perineum. Observation revealed the areas used were soiled with feces.	F 312	F-312 1.) Resident # 30 will receive appropriate perineal care. 2.) Residents that are incontinent have the potential to be affected. 3.) The SDC or designee will in-service nursing staff on policies and procedures regarding peri care. 4.) The SDC or designee will complete a random care audit to determine if peri care is completed according to policies and procedures. This audit will be completed once a week for four weeks then monthly for four months. Results of thee audits will be presented to the PI (Performance Improvement / Quality Improvement) committee monthly. Compliance Date: 11-9-2005	

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 _____	10/06/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 7 Interview with CNA #1 on 10/4/05 at 10:45 AM revealed each area of the wipe should only be used once. Review of the facility's policy on perineal care revealed the utilization of disposable cleansing wipes was not addressed. However, according to the authors of "Nursing Assistant," 9th edition, 2004, page 365, a clean area of the cloth (or wipe) must be used for each cleansing stroke.	F 312	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law"	
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of facility policies and procedures, the facility failed to provide care to minimize infection risk for one (#30) of one sample residents with an indwelling catheter. In addition, the facility failed to ensure staff provided	F 315	F-315 1.) Resident # 30 will receive care to minimize risk of infection. Resident # 25 assistance to restore as much bladder function as possible. 2.) All residents have the potential to be affected. 3.) The SDC of designee will in-service the nursing staff on policies and procedures for catheter care and bladder retraining.	

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F 315	Continued From page 8 appropriate treatment to restore as much bladder function as possible for one (#25) of six sample residents who had incontinence. The findings were: 1. Review of the 8/18/05 admission Minimum Data Set (MDS) assessment for resident #30 revealed he/she required the use of a mechanical lift for transfers. Observation on 10/4/05 at 9:05 AM revealed the resident had an indwelling urinary catheter. Observation at that time revealed CNA #1 and CNA #3 transferred the resident from his/her wheelchair to the commode utilizing a mechanical lift. During the transfer, CNA #1 placed the catheter bag on the hook of the lift which was above the resident's bladder. Observation revealed urine flowed back into the tubing towards the bladder. On 10/4/05 at 9:40 AM observation revealed CNA #1 and an occupational therapist transferred the resident from the commode to his/her bed utilizing a mechanical lift. During the transfer, CNA #1 again placed the catheter bag on the hook of the lift which was above the resident's bladder. Continued observation revealed urine flowed back into the tubing towards the bladder. Interview with CNA #1 on 10/4/05 at 10:08 AM revealed a catheter bag should never be placed above the resident's bladder but with this particular resident it was too difficult to transfer him/her without placing it on the sling hook of the mechanical lift. Interview with the staff development coordinator on 10/6/05 at 10:10 AM confirmed staff were taught that catheter bags should not be placed above a resident's bladder. Review of the facility's policy on indwelling urinary catheter care dated 9/26/03 revealed positioning of the catheter bag was not addressed.	F 315	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law" 4.) The SDC or designee will complete random care audits weekly for four weeks then monthly for four months. 5.) The results of these audits will be presented to the PI (Performance Improvement/ Quality Improvement) committee monthly. Compliance Date: 11-9-2005	

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 315	Continued From page 9 According to "Skills and Techniques for The New Nursing Assistant Textbook", 7th edition by Gillogly and Conley, copyright 2004, revealed the following information. "To keep a free-flowing system going, the catheter drainage tubing and collection bag or container must be properly placed. The collection bag or container must always be below the level of the bladder to allow the urine to drain. .... Germs and bacteria grow very quickly in urine. If urine is allowed to pool or if the collection container is above the level of the bladder, these germs and bacteria can travel back into the body to cause illness." 2. Review of the 5/13/05 admission and 8/2/05 quarterly MDS assessments for resident #25 revealed he/she had an indwelling catheter. Review of the progress notes revealed the catheter was removed on 8/21/05. Further review of the progress notes revealed the resident was incontinent of urine after removal of the indwelling catheter. The following concerns were identified: a. Periodic observation on 10/4/05 revealed the resident was in bed and was not toileted or offered toileting from 9 AM to 12:45 PM (3 hours and 45 minutes). Interview with the resident's wife at 12:45 PM confirmed the resident was not toileted or offered toileting during this time period. b. Interview with CNA #2 on 10/4/05 at 11:25 AM revealed the resident was incontinent of urine daily. During the interview, she stated the resident should be toileted before and after meals, at bedtime and each time he/she was gotten up out of bed. She further stated she had not toileted the resident when she got him/her up for lunch because she was "not working that hallway today." c. Observation on 10/4/05 at 12:45 PM revealed the resident's wife asked staff to toilet	F 315	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law"	

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	535036	A. BUILDING _____ B. WING _____	10/06/2005

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 315	Continued From page 10 the resident. Further observation revealed the resident's incontinence brief was saturated with urine at that time. d. Review of the facility policy on routine toileting dated 6/27/05 revealed the following instructions: "Offer the bedpan or urinal or to take the resident to the bathroom on a routine basis. This may be: ....b. before and after meals, c. at bedtime..." e. Review of the May 2005 care plan revealed a toileting schedule was not addressed.	F 315	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law"	
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure safe utilization of a mechanical lift during one of two observations for sample resident #30. The findings were: Review of the 8/18/05 admission Minimum Data Set (MDS) assessment for resident #30 revealed he/she required the use of a mechanical lift for transfers. Observation on 10/4/05 at 9:40 AM revealed CNA #1 and an occupational therapist transferred the resident from the commode to his/her bed utilizing a mechanical lift. Observation of the mechanical lift revealed there were three hooks on each side to attach the sling. During the transfer, one of the areas where the sling was hooked to the mechanical lift slipped off on the	F 324	F-324 1.) Resident #30 will have safe lift during the utilization of a mechanical lift. 2.) All residents using lifts have the potential to be affected 3.) The SDC or designee will in-service the Certified Nursing Staff and Professional Nursing staff on the policies and procedures for using a Safe Lift. 4.)The SDC or designee will complete random audits weekly for four weeks them monthly for four months. Results of these audits will be presented to the PI Performance Improvement /Quality Improvement) committee monthly. Compliance Date: 11-9-2005	

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F 324	Continued From page 11 left side by the resident's shoulder. Observation revealed the resident did not fall, but stated it made him/her nervous when the hook slipped off. Interview with the administrator on 10/5/05 at 2 PM revealed staff should check the hooks for safety and proper placement prior to lifting the resident. Review of the facility policy and procedure on hydraulic lifts, dated 9/26/03, revealed instructions to "Check to be sure that all hooks are secure and evenly placed ...." Interview with the administrator on 10/5/05 at 3 PM revealed neither staff member had reported the incident so corrective action could occur.	F 324	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law" F-329 1.) Resident # 4, #5. #8, #27, #31, and #43 will be re-assessed for anti-psychotic drug use and changes will be made per the re-assessment. MDS will be updated per the MDS schedule. Interventions will be put into place. CNA behavior-tracking form will be implemented to monitor behaviors. 2.) All Residents have the potential to be affected.	
F 329 SS=E	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 medical record review and staff interview, the facility failed to assure the drug regimen was free of unnecessary drugs for six of nine sample residents who received psychoactive medications (#4, #5, #8, #27, #31, #43). The	F 329		

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F 329	Continued From page 12 findings were: 1. Review of physician's orders showed resident #43 had received BuSpar 10 milligrams (mg) everyday since 3/4/04. According to the 2005 PDR Nurse's Drug Handbook, BuSpar is an anxiety drug for "...short-term use to relieve symptoms of anxiety due to motor tension, apprehension, autonomic hyperactivity, or hyper-attentiveness." Review of the medical record revealed no attempt at a dose reduction, nor documentation as to why a dose reduction would be contraindicated. Review of behavior monitoring sheets showed the facility monitored the resident for "angry outbursts" in relation to the BuSpar. Review of the behavior monitoring sheets for June, July, August and September 2005 showed the resident did not have any angry outbursts. During an interview on 10/6/05 at 10:30 AM, the director of nursing (DON), the administrator , and the corporate consultant all confirmed a dose reduction had not been attempted. The DON and corporate consultant stated the pharmacist thought a dose reduction was not required because the medication was not a benzodiazepine. 2. Review of the October 2005 physician's orders for resident #27 revealed an order for Ambien (sedative-hypnotic) 5 mg at bedtime as needed, but not to exceed nine consecutive nights, for insomnia. According to the 2005 PDR Nurse's Drug Handbook, page 1333, Ambien is a drug used for the short term treatment of insomnia. Review of the Medication Administration Records (MAR)s revealed the resident received Ambien every night for 22 consecutive nights in September 2005 (9/1 through 9/22). Review of	F 329	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law" 3.) The facility will establish protocol for prescribing anti-psychotic medication. New CNA behavior-tracking and monitoring will be put into place. Psychopharmacological drug summary sheet will be used to track increases or decreases in behaviors and to monitor the need to adjust medications or change interventions. Information used will be from assessments and tracking records including the MAR and the CNA flow sheets. Pharmacological Drug Gradual Dose reduction (GDR) will be reviewed monthly by the psychotropic committee. Changes will be made per recommendations. 4.) The SDC or designee will in-service staff on the Anti-psychotic protocols.	

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F 329	Continued From page 13 the medical record revealed there was no evidence of monitoring and no evidence non-pharmacological interventions were attempted to address the resident's insomnia. In addition, there was no evidence an assessment was done to determine the cause of the resident's insomnia. Interview with the DON on 10/6/05 at 10:30 AM confirmed no monitoring and no assessment was done, and no non-pharmacological interventions were attempted. 3. Review of the October 2005 physician's orders for resident #31 revealed an order for Ativan (antianxiety) 1 mg as needed for anxiety, exhibited by shaky behaviors, related to health concerns. The following concerns were identified: a. Review of the August 2005 MAR revealed the resident received Ativan every day except 8/6/05 and 8/7/05. b. Review of the September 2005 MAR revealed the resident received Ativan every day except 9/9/05. c. Review of the behavior monitoring flow sheets for August and September 2005 revealed the resident had no shaky behaviors (tremors) during these months. d. Interview with the DON on 10/6/05 at 10:30 AM revealed there was no evidence to indicate the resident's need for almost daily utilization of the Ativan. 4. Review of the October 2005 physician orders showed that on 12/1/04 resident #4 was started on Ambien (a sleep aide) 5 milligrams by mouth at bedtime PRN (as necessary) for insomnia. The following concerns were noted: a. Review of the July 2005 MAR (medication administration record) showed that Ambien was	F 329	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law" 5.)The DNS or designee will do random audits weekly for four weeks then monthly for four months. Results of these audits will be presented to the PI (Performance Improvement/ Quality Improvement) committee monthly. Compliance Date: 11-9-2005	

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F 329	Continued From page 14 given nightly for the entire month. b. Review of the August 2005 MAR showed that Ambien was given nightly except 8/3, and 8/28. c. Review of the September 2005 MAR showed that Ambien was given nightly for the entire month. d. Review of the September 2005 behavior/intervention flow record showed the number of hours slept at night, but did not show evidence that other interventions were tried before the medication was given. Interview with the DON on 10/6/05 at 10:30 AM revealed that the resident requested the medication nightly, and was given it when requested, without trying any other interventions. 5. Review of the October 2005 physician orders showed that on 7/5/05 resident #5 was started on Ambien (a sleep aide) 5 milligrams by mouth at bedtime PRN (as necessary) for insomnia. The following concerns were noted: a. Review of the July 2005 MAR (medication administration record) showed that Ambien was given nightly from 7/5 through 7/31 except on 7/13. b. Review of the August 2005 MAR showed that Ambien was given nightly except 8/10, 8/11 and 8/28. c. Review of the September 2005 MAR showed that Ambien was given nightly except 9/11, 9/12, 9/15, 9/19, 9/20, 9/21. d. Review of the September 2005 behavior/intervention flow record revealed no evidence that any alternative interventions were tried before the medication was given. Interview with the DON on 10/6/05 at 10:30 AM	F 329	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law"	

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F 329	Continued From page 15 revealed that the monitoring sheet included the hours slept after the medication was given. There was no evidence other interventions were tried. 6. Review of the October 2005 physician's orders for resident #8 showed a 5/12/05 order for Haldol (an antipsychotic medication) 2 milligrams by mouth every six hours PRN (as necessary) for agitation. The following concerns were noted: a. Review of the June 2005 MAR (medication administration record) showed that Haldol was given all but 6 days (6/7, 6/7, 6/20, 6/21, 6/27, 6/28) and included every Friday, Saturday and Sunday morning at approximately 8 AM. b. Review of the July 2005 MAR showed that Haldol was given all but 10 days (7/2, 7/3, 7/4, 7/6, 7/11, 7/18, 7/19, 7/25, 7/27, 7/31) and included every Friday, Saturday and Sunday except: 7/2, 7/3, and 7/31. c. Review of the August 2005 MAR showed that Haldol was given on 8/4, and on every Friday, Saturday and Sunday at approximately 8 AM with the exception of Friday 8/5 and Saturday 8/6 when it was not administered. d. Review of the September 2005 MAR showed Haldol was given 9/12, 9/14, 9/15, 9/19, and every Friday, Saturday and Sunday at approximately 8 AM with the exception of Friday 9/5, and Saturday 9/6 when it was not administered. e. Further review of the June, July, August and September 2005 MARs revealed that RN #1 administered all the above mentioned weekend dates except: 7/1, 7/29, 7/30, 8/7, and 9/30. Interview with RN #1 on 10/6/05 at 11:10 AM revealed she works Fridays, Saturdays, and Sundays, and gives resident #8 the Haldol "first thing in the morning" because she anticipates the	F 329	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law"	

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F 329	Continued From page 16 resident will have aggressive behaviors, especially if provided a bath or shave. However, interview with the DON on 10/6/05 at 11:15 AM revealed resident #8 was scheduled for baths and shaves on Tuesdays and Fridays in the evening. In addition, review of the September 2005 behavior/intervention flow record revealed Friday 9/2/05 was the only time during the month that medication (Haldol) was given as an intervention for an episode of aggressive behavior Interview with the DON and administrator on 10/6/05 at 11 AM revealed they were unable to find evidence of behavior tracking for June, July and August 2005. Further, they confirmed the behavior/intervention flow sheet for September 2005 showed no evidence to support the use of Haldol.	F 329	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law" F- 406 1.) Resident # 43 has been reviewed and rehabilitation services are being provided by Occupational therapy. 2.) All residents have the potential to be affected 3.) The rehabilitation services director or designee will in-service the director of nursing and the rehabilitation staff on the communication plan with physicians of potential referrals. All orders will be addressed in a timely fashion by skilled individuals.	
F 406 SS=D	483.45(a) SPECIALIZED REHABILITATIVE SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by:	F 406		

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F 406	Continued From page 17 Based on medical record review and staff interview, the facility failed to assure a physical therapy evaluation was completed for one of two sample residents (#43) with physician's orders for physical therapy. The findings were: Medical record review for resident #43 showed a physician's order dated 9/26/05 for "PT [physical therapy] to eval [evaluate]- ambulation." Review of the medical record revealed no physical therapy evaluation. On 10/5/05 at 5:30 PM, the director of nursing (DON) stated no physical therapy evaluation was done. The DON stated the facility did not currently have a physical therapist. Review of nursing notes showed that on 10/3/05, the resident fell while ambulating.	F 406	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law" 4.) The rehabilitation director or designee will conduct random audits monthly for four months to insure timely evaluations and treatments are done. The results of these audits will be presented to the PI (Performance Improvement/ Quality Improvement)committee monthly. Compliance Date: 11-9-2005	
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 review of facility policies and procedures, the facility failed to ensure staff followed handwashing protocols during one of four observations of personal care. The findings were: On 10/4/05 at 9:05 AM, certified nurse aide (CNA) #3 was observed assisting CNA #1 transfer resident #30 from his/her wheelchair to the	F 444	F-444 1.) The facility will insure the policies and procedures for hand washing protocol will be followed during care of Resident #30, and all Residents. 2) All residents have the potential to be affected.	

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F 444	Continued From page 18 commode. Observation revealed CNA #3 handled the seat of the commode with gloved hands while positioning the resident on it. Further observation revealed CNA #3 then placed the oxygen cannula on the resident without removing her gloves or washing her hands. Continued observation revealed CNA #3 left the resident's room and entered resident room #22, picked up their water glasses and proceeded to pass ice water to residents in that hallway without ever washing her hands. During an interview with CNA #3 on 10/4/05 at 10:50 AM, she stated hands should be washed before and after resident care, meals, and serving water. Interview with the staff development coordinator on 10/6/05 at 11 AM confirmed staff were taught to wash their hands before and after resident care. Review of the facility policy and procedure on handwashing dated 4/9/04 revealed the following instructions. "Handwashing is the single most important procedure for preventing the spread of infection. The hands are to be washed: ...after assisting others w/ toileting or after personal grooming, ... between tasks and procedures on the same resident, ...after handling soiled equipment or utensils, ... after removal of medical/surgical or utility gloves...." JANELLE CONLIN, OCCUPATIONAL THERAPI LINDA BROWN, REGISTERED NURSE LORI RUESS, NUTRITION/DIETICIAN	F 444	"Preparation and / or execution of this plan of correction does not constitute admission or agreement be the provider of truth of the facts alleged of conclusions set fourth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law" 3.) The SDC or designee will in-service the staff on the policies and procedures for hand washing 4.) The SDC or designee will complete a random audit for hand washing. This audit will be completed once per week for four weeks then monthly for for four months. Results of these audits will be presented to the PI (performance Improvement/ Quality Improvement) committee monthly. Compliance Date: 11-9-2005	