STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 45. The findings were: Confidential interview of seven residents on 8/28/07 at 1 PM revealed three residents were not provided the opportunity to vote in the November 2006 election. Further interview revealed these residents had a desire and interest in voting but did not have election information or absentee ballots. Interview with the activity director on 8/29/07 at 4 PM revealed she asked all new residents if they wanted to vote during the admission assessment process. She further stated when there was an upcoming election, she would again ask those residents whom she thought might have changed their minds about voting. She did not, however, routinely ask all residents or provide them with information.	F 151	**Weston County Health Services will ensure each and every resident has the right to exercise his or her rights as a resident of the facility and as a citizen of the United States.** **A) We will strive to identify those residents who feel they have been unable to vote in the past and provide adequate education to assure they are aware of their rights as a resident.** **B) Upon admission to Weston County Health Services each new resident will be asked during Activities Assessment if they are a registered voter, and if they would like to vote either by absentee ballot or by going to the poll. If they do not, this will be respected. If they are not a registered voter, they will be given the opportunity to register if they so choose. This will be documented on the original assessment form. At the time of every local, County, state and national election each resident will be re-asked if they wish to vote in the upcoming election one month prior to the election. Those who choose to vote will have the option of voting absentee or by going to the polls.** **C) Each resident's response upon re-evaluation will be noted on the original activity assessment form. It will be dated and signed by activity staff.** **D) Activities staff will ensure residents who are voting absentee will receive the ballot and have assistance with form if needed one month prior to the election. Activities staff will organize transportation to and from the polls on Election Day.**	10-1-07
F 241 SS=E	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	F 241	Activity director will monitor + Report to QA annually	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 9-24-07

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.

SEP 25 2007

Accepted with changes. Reviewed with Don Nelson and Joann Farnsworth 10/2/07 3:15 pm

Wyoming Dept of Health
Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 241	Continued From page 1 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 promote the dignity of 16 residents during one of three meal observations. The findings were: Observation on 8/27/07 at 6 PM revealed 16 residents were eating their evening meal in the main dining room. Observations revealed four contract cleaning employees entered the dining room at 6 PM and started wiping off the tables and sweeping the floor while the residents were still finishing their meal. Interview on 8/29/07 at 10:45 AM with the director of nurses revealed the facility's expectation was that cleaning of the dining room would not be done until all residents had finished their meals.	F 241	Weston County Health Services will promote care for residents in a manner and environment that maintains or enhances residents' dignity and respect in full recognition of his or her individuality by: A) Informing cleaning services that they are not allowed to begin cleaning until all residents have finished their meals B) The nursing staff will randomly observe dining room cleaning and halt the cleaning crew if any residents have not completed their meals. C) The Director of Nursing will implement a monitoring tool to record observations and report to the QA Committee. monthly	10/01/07
F 272 SS=D	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; Communication; Vision; Mood and behavior patterns;	F 272	Weston County Health Services will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of resident #10 and all other residents' functional capacity using the RAI guidelines. This will be accomplished by: A- Resident #10 will Receive paper assessment from charge nurse B) The charge nurse on the day shift will recognize the need for a change of status and report to the MDS coordinator. C) The charge nurse on the day shift will complete the assessment within 24 hours of recognition of a change of status.	10/01/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 2 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 ensure a comprehensive assessment was completed for one (#10) of five sample residents who experienced a change in pain status. The findings were: Review of the initial Minimum Data Set (MDS) assessment for resident #10 revealed the section on pain was marked as zero indicating the resident experienced no pain during that assessment period. Review of the significant change MDS assessment on 8/22/07 revealed the resident experienced pain daily. Review of the entire medical record revealed there was no evidence a comprehensive assessment for the cause of the resident's newly identified pain was performed. Interview with the director of nursing on 8/30/07 at 9:30 AM revealed the resident's change in pain status should have been assessed.	F 272	C) MDS Coordinator will monitor and report to QA Committee. monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. 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 ensure physician's orders were followed for one (#22) of eleven sample residents. In addition, the facility failed to ensure nurses followed accepted professional standards in regard to locking the medication cart. The findings were: 1. Review of the 8/07 physician's orders for resident #22 revealed an order dated 7/28/06 to examine the resident's ears for wax build up every two weeks and document the findings in the nursing notes. Review of the nursing notes revealed no evidence the check was completed from 8/6/06 to 9/10/06 (5 weeks), from 9/10/06 to 11/12/06 (9 weeks), from 11/12/06 to 4/24/07 (greater than 23 weeks), and from 4/26/07 to date, 8/30/07, (18 weeks). Interview with the director of nursing on 8/30/07 at 9:30 AM revealed she thought the nurses were just documenting the ear checks on the Medication Administration Records (MARs), however, review of the MARs for 7/07 and 8/07 revealed the checks were not performed every two weeks as ordered and there were no findings or results noted. 2. Observation on 8/28/07 at 7:45 AM through 8:20 AM revealed registered nurse (RN) #7 left the medication cart open while she administered	F 281	The facility will ensure the services provided by the facility will meet professional standards of quality by: B-Order for resident #22 ear check discontinued A) The nurses will ensure physician orders are followed for resident #22 and all other residents ~~B) The Resident Care Coordinator will monitor and report to QA Committee~~ Phy. order C) Nurses will be educated by the DON regarding the Medication Cart Policy that the "medication cart will be kept locked when unattended." D) The DON will monitor monthly and report to the QA Committee	10/01/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 4 medications to residents in the main dining room. Observation also revealed the three bottom drawers of the cart were pulled out with medications in sight. In addition, there were six medication cups of liquid medications placed on the top of the medication cart. The following concerns were identified: a. The medication cart was located in the main dining room during the observation. Observation also revealed residents were passing near the medication cart when entering or exiting the dining room for their morning meal. b. Throughout the observation, when the RN was away from the cart to administer medications, the medication cart was not within her line of vision. Interview with the director of nursing on 8/30/07 at 9:30 AM revealed the facility's expectation was that a medication cart would be locked whenever the cart was out of the nurse's sight. c. The following types of medications were accessible to residents passing by the cart: antihypertensives, antianginals, antidepressants, steroids, potassium, vitamins, narcotics, antilipidemics, iron, antiparkinson agents, insulins, diuretics, antiinfectives, antibiotics, anticoagulants, antiemetics, antidysrhythmics, skeletal muscle relaxants, laxatives, stomach medications, diabetic medications, breathing medications, anticonvulsants, antipsychotics, drugs for osteoporosis, thyroid medications, Alzheimer's disease medications, heart medications, pain medications, and an anti-gout drug. d. Review of the facility medication cart policy revised 10/03 revealed: "The medication cart will be kept locked when unattended."	F 281		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 282	Continued From page 5 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 observation, staff interview, and medical record review, the facility failed to ensure care plans were followed for three (#15, #22, #25) of eleven sample residents. The findings were: 1. Review of the 8/10/06 initial, the 4/18/07 quarterly, and the 7/11/07 annual Minimum Data Set (MDS) assessments for resident #22 revealed s/he was incontinent (two or more times a week but not daily) of urine. Furthermore, the assessment showed that the resident required extensive assistance with personal hygiene. Review of the 7/11/07 care plan revealed the resident was to be toileted upon rising, before and after meals, at bedtime, 11 PM, 1 AM, 3 AM and PRN (as needed). Observation on 8/27/07 revealed the resident was not toileted before the evening meal at 5:20 PM. Observation on 8/27/07 from 3:15 PM until 6:42 PM (3 hours 27 minutes) revealed the resident was not checked, changed, or toileted. Observation at 6:42 PM on 8/27/07 revealed the resident had been incontinent of bowel and urine. 2. Review of the 7/26/07 initial MDS assessment for resident #25 revealed s/he was frequently incontinent (daily with some control) of urine. Further review revealed s/he required extensive assistance with personal hygiene. Review of the	F 282	Weston County Health Services will provide services to our residents via qualified personnel in accordance with each resident's written plan of care by: A) Staff members will review care plans of residents #15, #22, #25 and all other residents initially and whenever updated. B) Resident Care Coordinator will post revised care plan in the Communication Book. C) Staff members will read revised care plan and initial that they have read it. D) CNA Team Leader will monitor CNA accuracy of following care plans and report to QA Committee monthly SubA Resident #15 will be repositioned per care plan Resident #22 and 25 will be toileted per care plan	10/01/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 6 8/1/07 care plan revealed staff were to assist the resident to the bathroom upon request and if the resident did not request, staff were to offer to take him/her to the bathroom. Observation on 8/27/08 from 3:15 PM until 8:45 PM (5 hours 30 minutes) revealed the resident was not taken to the toilet or asked if s/he needed to use the toilet. Observation at 8:45 PM on 8/27/07 revealed the resident was readied for bed. At that time s/he was taken to the toilet and his/her incontinence brief was observed to be saturated with urine. 3. According to the 8/8/07 quarterly MDS assessment for resident #15, the resident required extensive assistance in bed mobility, total assistance with transfers, was not ambulatory, and required total assistance with locomotion. Review of the resident's 8/9/07 care plan revealed the resident was at risk for skin breakdown. Further review of the care plan revealed interventions to prevent skin breakdown included repositioning the resident every two hours and as needed. The following concerns were noted: a. Observation on 8/28/07 from 7 AM until 4:30 PM revealed resident #15 was seated in a geriatric chair (high-backed, reclining, wheeled chair). Observation also revealed during that time, 7 hours 30 minutes, the resident was not repositioned by staff. b. Interview with certified nurse assistant (CNA) #43 on 8/28/07 at 4:30 PM revealed staff usually assisted the resident to lie down every morning. However, observation revealed that action did not occur on the morning of 8/28/07.	F 282		
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	F 309		

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 7 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 observation, staff interview, and medical record review, the facility failed to ensure staff provided care and services to meet the needs of five (#4, #6, #8, #22, #25) sample residents. The findings were: 1. Review of the 5/29/06 history and physical and the 8/07 physician's orders for resident #6 revealed the resident had diagnoses including chronic obstructive pulmonary disease, probable cor pulmonale (heart failure caused by a disorder of the lungs or pulmonary vessels requiring meticulous respiratory care including oxygen), congestive heart failure, and coronary artery disease. Review of the physician's orders revealed an order dated 6/1/06 for continuous oxygen at 2 liters per nasal cannula. Observation on 8/29/07 at 1:32 PM revealed the resident returned to his/her room in the 200 hospital pod area. Observation revealed the resident removed his/her oxygen nasal cannula upon entering his/her room. At 2:15 PM licensed practical nurse (LPN) #1 entered the resident's room and stated, "....You don't have your O2 (oxygen) on," and th nurse replaced the cannula at that time. Observation revealed the resident was without his/her oxygen for 43 minutes. Observation revealed the LPN did not perform an assessment or check the resident's oxygen saturation level after being without oxygen for 43 minutes.	F 309	Weston County Health Services will 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 by: A) Resident #6 and all other residents who remove their oxygen will be assessed by the nurse for oxygen saturation and respiratory status. Appropriate action will be taken to relieve respiratory distress. B) DON will educate the nursing staff about respiratory assessment protocol and subsequent actions C) SS designee will monitor and report to QA D) Resident #8 and all residents at risk for cough and aspiration whose swallowing evaluation recommendation was to sit upright at a 90 degree angle during meals will sit upright at meals. CNA team leader will monitor and report to QA team. E) Residents # 25, #4, #22 and all residents who experience falls will be assessed according to WCHS policy. The DON will monitor fall follow-up assessments and report to the QA Committee. monthly	10/01/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 Interview with the director of nursing on 8/30/07 at 9:30 AM revealed the LPN should have assessed the resident's respiratory and cardiac status. 2. Review of the 5/20/04 fluoroscopic swallow study for resident #8 revealed s/he was at risk for cough and aspiration during meals. Review of the 6/9/04 swallow study revealed the speech therapist recommended the resident remain in a 90 degree upright position while eating. The following concerns were identified: a. Observation on 8/27/07 at 5:30 PM and on 8/29/07 at 5 PM showed the resident was seated in a geriatric chair (high-backed and reclining wheeled chair) at an approximate 110 degree angle while eating. Observation during both meals revealed the resident coughed periodically during, or shortly after, a swallow. b. An interview with the director of nursing on 8/29/07 at 2 PM revealed the resident was supposed to be placed in an upright position during meals. 3. Review of the 7/26/07 initial Minimum Data Set (MDS) assessment for resident #25 revealed s/he had experienced a fall in the past 31 to 180 days. Review of the 7/16/07 fall risk assessment revealed the resident was at high risk for falls. Review of nursing notes revealed the resident had falls on 7/14/07, 715/07, 7/17/07 (2 falls), 7/18/07, and 8/4/07. Review of the facility policy on falls revealed staff were required to monitor and assess a resident each shift for 72 hours after a fall unless told otherwise. The following concerns were identified: a. Review of the nursing notes revealed there was no monitoring or assessment of the falls on 7/14/07 (7 AM) and 7/15/07 (2 PM) and 7/18/07	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 9 (1:30 PM) except for the initial one completed at the time of the falls. b. Review of the nursing notes revealed the fall on 7/15/07 (6:15 PM) and on 7/17/07 (9:30 AM and 11:45 AM) had only three shift assessments performed instead of the required nine. c. Review of the nursing notes revealed there was no monitoring or assessment during six of the nine required shifts after the fall on 8/4/07 at 6:30 AM. d. Review of the medical record revealed there was no evidence staff were directed not to perform the shift assessments for 72 hours for the above noted falls. 4. Review of the 8/1/07 quarterly MDS assessment for resident #4 revealed s/he had fallen in the past 31 to 180 days. Review of the nursing notes revealed the resident had falls on 7/16/07, 8/23/07 and 8/25/07. Further review revealed there was no evidence the 72 hour shift assessment and monitoring was completed for any of these falls. Review also revealed there was no evidence staff were directed not to perform the assessments for 72 hours. 5. Review of the 7/11/07 annual MDS assessment for resident #22 revealed s/he had experienced a fall in the past 31 to 180 days. Review of the nursing notes revealed the resident had a fall on 8/24/07. Review of the medical record revealed the resident was not monitored and assessed the required 72 hours after his/her fall. Review also revealed there was no evidence staff were directed not to perform the assessments for 72 hours.	F 309		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 312	Continued From page 10 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, medical record review, and review of facility policy and procedure, the facility failed to ensure staff provided adequate perineal cleaning for two (#22, #25) of six sample residents who had been incontinent. The findings were: 1. Review of the 8/10/06 initial, the 4/18/07 quarterly, and the 7/11/07 annual Minimum Data Set (MDS) assessments for resident #22 revealed s/he was incontinent (two or more times a week but not daily) of urine. Further review revealed the resident required extensive assistance with personal hygiene. Observation on 8/27/07 at 6:42 PM revealed the resident's incontinence brief was wet with urine and feces. In addition the resident had feces on the buttocks and anterior perineal area. Continued observation revealed certified nurse aide (CNA) #40 provided perineal care. Observation revealed the CNA used the same area of the wipe four times with feces smeared on it. The CNA did not cleanse the resident's thighs or between his/her legs where there were feces. In addition, the CNA tried to cleanse the anterior perineal area by wiping from behind the resident and in the process the CNA smeared feces from the urethra to the anal area. In addition, while cleaning the anterior perineal area the CNA used the same area of the wipe twice, which had feces on it.	F 312	Weston County Health Services will ensure that all residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene by: A) DON will educate staff on proper technique of peri care for residents #22, ~~#40~~, #25 and all other residents. B) CNA Team Leader will ~~randomly~~ observe peri care procedures being performed by nursing staff. CNA Team Leader will educate staff whenever necessary regarding proper peri care technique. C) CNA Team Leader will record observations and report to QA Committee. monthly	10/01/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 312	Continued From page 11 2. Review of the 7/26/07 initial MDS assessment for resident #25 revealed s/he was frequently incontinent (daily with some control) of urine. Further review revealed s/he required extensive assistance with personal hygiene. Observation on 8/27/07 at 8:45 PM revealed CNA #45 assisted the resident to the toilet and his/her incontinence brief was saturated with urine. Observation revealed the CNA provided perineal care. Continued observation revealed the CNA wiped the resident twice in the anal area only. She did not cleanse the anterior perineal area, buttocks, thighs or groin. Interview with this CNA at the time revealed she was aware of the proper way to provide perineal care. 3. Review of the facility policy and procedure on perineal care, undated, revealed instructions to cleanse both the front and back of the perineal area, thighs, and buttocks.	F 312		
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, medical record review, and staff interview, the facility failed to provide	F 315	Weston County Health Services will 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 by: B A) Residents #22 and #25 and all residents who are incontinent of bladder will receive a care plan addressing their individual needs. A B) The Care plans will be posted at the nurses station and in the	10-1-07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 12 toileting for two (#22, #25) of six sample residents who were incontinent. In addition, the facility failed to provide medical justification for catheters for two (#15, #30) of four sample residents with catheters. The findings were: 1. Review of the 8/10/06 initial, the 4/18/07 quarterly, and the 7/11/07 annual Minimum Data Set (MDS) assessments for resident #22 revealed s/he was incontinent (two or more times a week but not daily) of urine. Furthermore the assessment revealed the resident required extensive assistance with personal hygiene. Review of the 7/11/07 care plan revealed the resident was to be toileted upon rising, before and after meals, at bedtime, 11 PM, 1 AM, 3 AM and PRN (as needed). Observation on 8/27/07 revealed the resident was not toileted before the evening meal at 5:20 PM. Observation on 8/27/07 from 3:15 PM until 6:42 PM (3 hours 27 minutes) revealed the resident was not checked, changed, or toileted. Observation at 6:42 PM on 8/27/07 revealed the resident was incontinent of bowel and urine 2. Review of the 7/26/07 initial MDS assessment for resident #25 revealed s/he was frequently incontinent (daily with some control) of urine. Further review revealed s/he required extensive assistance with personal hygiene. Review of the 8/1/07 care plan revealed staff were to assist the resident to the bathroom upon request and if s/he did not request staff were to offer to take him/her to the bathroom. Observation on 8/27/08 from 3:15 PM until 8:45 PM (5 hours 30 minutes) revealed the resident did not ask to be toileted, nor did staff ask the resident if s/he wanted to be toileted. Observation on 8/27/07 at 8:45 PM revealed the resident was readied for bed. At that	F 315	Communication Book. The CNA Team Leader will monitor C) catheters for residents #30 and #15; D) ~~DON will contact physician regarding possible removal of~~ The QA team will monitor catheter use and appropriateness and review at quarterly meetings. C - cont. Catheter discontinued on #15 Resident #30 Re-assed by physician and left in safety Reasons. and review at staff mtg.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 315	Continued From page 13 time s/he was taken to the toilet and his/her incontinence brief was saturated with urine. 3. Observation on 8/27/07 revealed resident #30 had an indwelling catheter. Review of the 8/8/07 care plan revealed the catheter was for constant dribbling and urinary retention. The following concerns were noted: a. Review of a physician's progress note dated 8/28/06 revealed the resident had 10cc of urinary retention when a bladder scan was performed, which was a minimal amount. The note also stated the resident wanted a catheter. b. On 10/18/06, a urologist ordered a catheter because the resident had "multiple symptom diseases and the resident was weak and could barely stand." However, review of the annual MDS assessment dated 7/3/07 revealed the resident could transfer with assistance and ambulated independently in his/her room. c. During an interview with certified nurse aide (CNA) #43 on 8/27/07 at 4:10 PM he stated the resident had a catheter because s/he wanted one. 2. Observation on 8/27/07 revealed resident #15 had an indwelling catheter. The following concerns were identified: a. Review of a urology consult on 10/18/06 revealed the catheter was inserted because of skin breakdown on the spine and adjacent skin areas. Review of the 2/21/07 annual and the 5/16/07 and 8/8/07 quarterly MDS assessments revealed the resident had no skin breakdown. Interview with the director of nursing on 8/28/07 at 1 PM revealed the resident previously had skin breakdown but none recently. She further stated the bladder scan performed showed only 45 cc of urine was retained which was minimal.	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 315	Continued From page 14 b. Review of the 10/27/06 physician's progress note revealed the resident had a recent urinary tract infection (UTI). In addition, review of the physician's orders revealed the resident had UTIs on 12/30/06, 5/17/07, and 8/15/07. Review of the 8/19/07 physician's progress notes revealed the resident possibly had urosepsis. c. According to "Taber's Cyclopedic Medical Dictionary," 20th edition, 2005, page 2273: UTIs commonly occur in otherwise healthy men and women who have indwelling catheters.	F 315		~~10/15/07~~
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 a safe environment for residents in one of one shower room and one of one exam room. The findings were: 1. Review of the 6/1/07 initial and the 8/22/07 significant change Minimum Data Set (MDS) assessments for resident #10 revealed s/he had memory problems and was moderately impaired in decision making abilities. Observation on 8/27/07 at 3:15 PM revealed the resident resided in the special care unit (SCU). The following concerns were identified: a. Per interview with the director of nursing	F 323	Weston County Health Services will Ensure that the residents' environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents by: A) Changing the lock on the SCU shower room to locks that will remain locked at all times. B) DON will post signs on shower room cupboard, SCU doors leading into the shower room, and Exam Room cart to remind staff to keep them locked at all times. Available to ~~pt~~ may will be kept on locked med Room. C) DON will monitor locks on bathing suite cupboard, SCU doors, and Exam Room cart for safety and report to the QA Committee. monthly Resident #10 will not be able to enter shower room because will be locked @ all time.	10-15-07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 323	Continued From page 15 (DON) on 8/27/07 at 2:25 PM, the SCU shared a shower room with another resident unit. Observation revealed the shower room was located between the two units and could be entered from either side. The DON stated the shower room door was supposed to be locked at all times. However, observation at 3:45 PM on 8/27/07 revealed the resident went into the shower room which was unlocked. At 3:48 PM the resident was assisted out of the shower room by a staff member from the resident unit that shares the shower room with the SCU. Observation revealed certified nurse aide (CNA) #22 on the SCU was unaware the resident had gone into the unlocked shower room, because she was assisting another resident behind closed doors. b. Observation on 8/30/07 at 10 AM revealed the door to the shower room was again unlocked, and no staff members were present. Observation revealed the following items were accessible to residents: (1) One open and one closed one gallon jugs of Omega detergent/disinfectant. Review of the Material Safety Data Sheet (MSDS) revealed if the liquid got into the eyes, a physician was to be called immediately, and if the product was swallowed, 911, the poison control center, or a physician should be called immediately (2) Colgate shaving cream with the labeled warning: "Keep out of the reach of children." (3) Seven razor blade refills. (4) One container of Sensicore with the warning: "Keep out of the reach of children." The label said if the product was swallowed one should "get medical help or consult the poison control center right away." (5) Two aerosol cans of Secret	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 323	Continued From page 16 Deodorant with the warning: "Keep out of the reach of children. The label noted that if the product was swallowed one should get medical help or consult the poison control center right away. Periodic observations from 8/27/07 through 8/30/07 revealed the door to the resident exam room across the hall from the nurses' station was never closed or locked. An unlocked medical cart was present in the room during each observation. Observation on 8/29/07 at 2:48 PM revealed the following hazardous items were accessible to residents: a. A box of 10 disposable scalpels, a pair of sharp nosed scissors, and an 8 fluid ounce tube of aloe vera skin conditioner labeled "for external use only" were observed in the second drawer. b. A tray containing a medicated cream, as well as another pair of scissors were noted on top of the cart. c. Two 30 gram tubes of hydrostatic gel, a container of isosorb labeled "not for internal use," and several envelopes of Calmoseptine ointment were seen in the first drawer.	F 323		
F 334 SS=C	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	F 334	Weston County Health Services will develop policies and procedures that ensure that each resident is offered the influenza immunization and receives education regarding the benefits and potential side effects of the immunization by: Residents #4, 15, 16, 22, 30 38, 44 & 46 and A) All residents, or the residents' legal guardians will be given education	10/15/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 334	Continued From page 17 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 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	F 334	regarding the benefits and potential side effects of the immunization. B) Each resident will be offered an influenza immunization annually October 1 through March 31, unless the immunization is medically contraindicated or the resident has already been immunized during this time period. The resident or their legal guardian will have the opportunity to refuse immunization. The residents' medical records will include documentation indicating that education was provided regarding the benefits and potential side effects of influenza immunization; and that the resident either received or did not receive the influenza immunization due to medical contraindications or refusal C) The Resident Care Coordinator will monitor and report at end of immunization season. to QA committee Weston County Health Services will develop policies and procedures that ensure that each resident is offered the pneumoccocol immunization and receives education regarding the benefits and potential side effects of the immunization by:	10-15-07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 334	Continued From page 18 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to provide education on the influenza vaccine for seven (#4, #15, #16, #22, #30, #38, #46) of eight sample residents who qualified for the influenza vaccine. The findings were: Review of the medical records for residents #4, #15, #16, #22, #30, #38, and #46 revealed each received the influenza vaccine on 11/1/06. However, the medical records revealed there was no evidence that education regarding the influenza vaccine was provided to residents or their families. Interview with the director of nursing on 8/29/07 at 10:45 AM revealed no resident education had been completed and that she was unaware of the requirement to provide education.	F 334	A) All residents or the residents' legal guardians will be given education regarding the benefits and potential side effects of the immunization. B) Each resident will be offered the pneumococcol immunization, unless the immunization is medically contraindicated or the resident has already been immunized during this time period. The resident or their legal guardian will have the opportunity to refuse immunization. The residents' medical records will include documentation indicating that education was provided regarding the benefits and potential side effects of pneumococcol immunization; and that the resident either received or did not receive the immunization due to medical contraindications or refusal. C) The Resident Care Coordinator will monitor and report to QA Committee quarterly	~~10/01/07~~
F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental,	F 353	Weston County Health Services will have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident	10/01/07

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 19 and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure there was enough staff to provide the needed care and services and to keep residents safe in two (special care unit, hospital pods) of three resident living areas. The findings were: 1. Observation on 8/27/07 at 4:12 PM revealed resident #25 and resident #22 were both in the special care unit (SCU) living room area. Continued observation revealed the residents had an episode of hitting and slapping at each other and a verbal altercation that lasted approximately three minutes. Observation revealed the certified nurse aide (CNA) # 23 assigned to the SCU was in another resident's room with the door closed and was unable to	F 353	assessment and individual plans of care by: A) A recruitment bonus and a sign-on bonus will be offered to attract potential CNA candidates. B) Bonus pay will be offered to existing staff as incentive to work more often. C) The DON, Resident Care Coordinator and staff nurses will fill in as CNA staff when necessary. D) The CNA assigned to the SCU will be educated by the DON about calling for help when needed. E) The CNA assigned to Hall 1 will check with the SCU every 2 hours to assist when needed. F) Two CNAs will be assigned to the hospital pods. ~~The assist Resident #22~~ other Residents. G) D.O.N. will monitor staffing patterns and report findings to the QA Committee and to the Administrator. monthly Resident #22 #25 will be assess by a nurse and a Care plan implemented to avoid inter-personal conflict	

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 353	Continued From page 20 monitor the residents. Interview with CNA #23 at 8:14 PM revealed there was normally only one CNA in the SCU to watch and provide care and services for all eight residents. Observation at the following times revealed there was no staff available to supervise residents because they were assisting another resident behind closed doors: a. 3:55 PM to 4 PM (5 minutes) b. 4:06 PM to 4:17 PM (11 minutes) c. 4:30 PM to 4:35 PM (5 minutes) d. 4:37 PM to 4:45 PM (8 minutes) e. 7:08 PM to 7:13 PM (5 minutes) f. 7:35 PM to 7:37 PM (2 minutes) g. 7:50 PM to 7:53 PM (3 minutes) h. 8:07 PM top 8:14 PM (7 minutes) i. 8:45 PM to 8:52 PM (7 minutes) 2. Review of the 8/10/06 initial, the 4/18/07 quarterly, and the 7/11/07 annual Minimum Data Set (MDS) assessments for resident #22 revealed s/he was incontinent (two or more times a week but not daily) of urine. Further review revealed the resident required extensive assistance with personal hygiene. Review of the 7/11/07 care plan revealed the resident should be toileted upon rising, before and after meals, at bedtime, 11 PM, 1 AM, 3 AM and PRN (as needed). Observation on 8/27/07 revealed the resident was not toileted before the evening meal at 5:20 PM. Observation on 8/27/07 from 3:15 PM until 6:42 PM (3 hours 27 minutes) revealed the resident was not checked, changed, or toileted. Observation at 6:42 PM on 8/27/07 revealed the resident was incontinent of bowel and urine 3. Review of the 7/26/07 initial MDS assessment for resident #25 revealed s/he was frequently	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 21 incontinent (daily with some control) of urine. Further review revealed s/he required extensive assistance with personal hygiene. Review of the 8/1/07 care plan revealed staff were to assist the resident to the bathroom upon request and if s/he did not request staff were to offer to take him/her to the bathroom. Observation on 8/27/08 from 3:15 PM until 8:45 PM (five hours 30 minutes) revealed the resident was not offered toileting and did not request to be toileted. Observation on 8/27/07 at 8:45 PM revealed the resident was readied for bed. At that time s/he was taken to the toilet and his/her incontinence brief was saturated with urine. 4. On 8/29/07 at 2:45 PM, observation revealed CNA #22 discontinued a nebulizer treatment on non sample resident #2. Interview with licensed practical nurse (LPN) #4 on 8/29/07 at 2:50 PM revealed CNAs were allowed to discontinue nebulizer treatments for residents in the hospital pods because all the nurses were over at the manor (nursing home) and could not make the long distance from the manor to the pods. She stated on the manor side, the CNAs did not discontinue nebulizer treatments. Finally, she stated the nurses were just too busy on the manor side to spend much time on the hospital pods. Review of the room roster revealed there were 12 residents living on the two hospital pods. 5. Observation on 8/29/07 at 1:32 PM revealed resident #6 returned to his/her room in the 200 hospital pod area. Observation revealed the resident removed his/her oxygen nasal cannula upon entering his/her room. At 2:15 PM licensed practical nurse #1 entered the resident's room and stated, "...you don't have your O2 (oxygen) on," and she replaced it at that time. Observation	F 353		

NAME OF PROVIDER OR SUPPLIER
WESTON COUNTY HEALTH SERVICES

STREET ADDRESS, CITY, STATE, ZIP CODE
1124 WASHINGTON BLVD
NEWCASTLE, WY 82701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 22 revealed the resident was without his/her oxygen for 43 minutes before staff checked on the resident. 6. Review of the 8/1/07 care plan for resident #25 revealed s/he had the potential for falls. Review of the nursing notes revealed the resident had falls on 7/14/07, 7/1507, 7/17/07 (2 falls), 7/18/07, and 8/4/07. Review of the 8/1/07 care plan revealed staff were to provide 1:1 interventions during periods of restlessness as "staffing allows." Review of the 7/15/07 late entry nursing notes regarding the fall at 6:15 PM revealed instructions to continue to monitor and to try to give more 1:1 care "if staff available." 8. Refer to F323 for further information regarding resident #10 who was able to enter a shower room without the knowledge of staff that was supposed to be locked.	F 353		
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 the Food Code, the facility failed to ensure foods were not stored beyond their expiration dates in two of five refrigerators. In addition, they failed to prepare food in a sanitary manner during one of two observations. The findings were: 1. Observation on 8/28/07 at 3:30 PM revealed	F 371	Weston County Health Services will ensure that food will be stored, prepared, distributed, and served under sanitary conditions: A) Dietary Manager and food service employees will utilize single use gloves to prepare food and will discard all food items in refrigerator that are 5 days beyond the labeled date they were placed in the refrigerator. B) The Dietary Manager will write a policy stating the proper use of gloves during food preparation and provide additional education to staff on food preparation and the proper storage of food.	9/28/07

NAME OF PROVIDER OR SUPPLIER: WESTON COUNTY HEALTH SERVICES

STREET ADDRESS, CITY, STATE, ZIP CODE: 1124 WASHINGTON BLVD NEWCASTLE, WY 82701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 23 the dietary manager and a dietary aide were tearing croissants into small pieces with their bare hands for puree. Interview on 8/29/07 at 11 AM with the dietary manager revealed the facility had no policy on handling food with ungloved hands. She further stated she believed it was acceptable to handle food with their bare hands if the employee had washed his or her hands, and the food was going to be pureed. 2. According to Food Code 2005, U.S. Public Health Service, 3-301.11 (B), "...Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment..." 3. Interview on 8/27/07 at 2 PM with the dietary manager revealed the dates on items in the refrigerators were the dates the items were placed in the refrigerators and they would be considered outdated five days later. The following concerns were noted: a. Observation on 8/27/07 at 2 PM revealed the following items in the refrigerator in the back of the kitchen: A one gallon container labeled potato salad dated 7/27/07 (outdated 27 days), a two quart container labeled strawberry topping dated 7/25/07 (outdated 29 days), and a one quart container of which the contents were not identified dated 7/30/07 (outdated 24 days). b. Observation on 8/30/07 at 10 AM revealed twelve thawed 4 ounce Mighty Shakes, undated, located in the refrigerator on the special care unit.	F 371	C) The pm cook will be responsible for checking the refrigerators daily and discarding any labeled food that is five days or more beyond label date. D) The Dietary Manager will initiate a performance improvement indicator to track the proper → utilization of gloves discarding of food. The manager will monitor this data and take the appropriate corrective action as required. manager will Report to QA comm. monthly	
F 441 SS=D	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	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 24 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 corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policies and procedures, the facility failed to ensure infection control practices were followed while caring for two (#15, #30) of two sample residents with a catheter. The findings were: 1. Observation on 8/27/07 revealed certified nurse assistant (CNA) #43 and CNA #29 assisted resident #15 with dressing. CNA #43 placed the resident's catheter drainage bag on the floor while CNA #29 assisted the resident to put on his/her pants. 2. Observation on 8/27/07 at 4:10 PM revealed CNA #43 assisted resident #30 with a transfer from his/her bed to the chair. Observation revealed the CNA placed the resident's catheter drainage bag on the floor.	F 441	Weston County Health Services will establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment 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 when procedures, such as isolation should be applied to an individual resident; and maintain a record of incidents and corrective actions related to infections by: A) Foley catheters of residents #15 and #30 and all other residents with foley catheters will be handled in such a way that the drainage bags do not touch the floor. B) DON will educate staff to not allow catheter collection bags or tubing to touch the floor at any time.. C) DON will randomly monitor care of catheter drainage bags and report to the QA Committee monthly	10/15/07
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.	F 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 444	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of facility policy and procedure, the facility failed to ensure staff followed the handwashing and gloving practices of the facility during one of two observations of perineal care. The findings were: Review of the 7/26/07 initial MDS assessment for resident #25 revealed s/he was frequently incontinent (daily with some control) of urine. Further review revealed s/he required extensive assistance with personal hygiene. Observation on 8/27/07 at 8:45 PM revealed CNA #45 assisted the resident to the toilet and his/her incontinence brief was saturated with urine. Observation revealed the CNA provided perineal care. Continued observation revealed the CNA wiped the resident twice in the anal area. Observation revealed the CNA transferred the resident back to the wheelchair and assisted him/her to bed. Observation revealed the CNA touched the resident, the resident's clothing, the wheelchair handles, the door handle on the bathroom, the light string, the bed, the blanket and the privacy curtains while she still had on the soiled gloves utilized when she provided perineal care. When the CNA did take the gloves off, she did not wash his/her hands. Interview with the director of nursing on 8/30/07 at 9:30 AM revealed the CNA should have removed her gloves immediately after providing perineal care and then washed her hands before proceeding with other duties. Review of the facility undated policy on using gloves revealed instructions to remove gloves after procedures were completed.	F 444	Weston County Health Services will require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. This requirement will be met by: A) Nursing staff will wash hands and remove gloves after providing peri care for resident #25 and all other residents. B) DON will educate staff on proper procedures for hand washing and gloving. C) CNA Team Leader will perform competencies with all CNAs for hand washing and gloving procedures and provide written reports to the DON. D) CNA Team Leader will randomly monitor hand washing and gloving practices and report to the QA committee monthly	10/01/07
F 445 SS=D	483.65(c) INFECTION CONTROL - LINENS	F 445		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 445	Continued From page 26 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff followed infection control guidelines for handling and transporting linen to prevent the spread of infection during one of two random observations. The findings were: Review of the 7/26/07 initial MDS assessment for resident #25 revealed s/he was frequently incontinent (daily with some control) of urine. Further review revealed s/he required extensive assistance with personal hygiene. Observation on 8/27/07 at 8:45 PM revealed CNA #45 assisted the resident to the toilet and his/her incontinence brief was saturated with urine. Observation revealed the CNA provided perineal care. Continued observation revealed the CNA wiped the resident twice in the anal area. Observation revealed the CNA transferred the resident back to the wheelchair and assisted him/her to bed. The CNA then carried the resident's soiled, contaminated clothing bare handed against her uniform. Interview with the director of nursing on 8/30/07 at 9:30 AM revealed the facility did not teach staff to transport in that manner.	F 445	Weston County Health Services' personnel will handle, store, process, and transport linens so as to prevent the spread of infection. This will be accomplished by: A) Soiled linens of resident #25 and all other residents will be handled so as not to touch the clothing of the staff members. B) DON will educate staff on proper procedures for handling of soiled linens. C) CNA Team Leader will perform competencies with all CNAs for handling of soiled linens and provide written reports to the DON. D) CNA Team Leader will randomly monitor performance and report to the QA committee monthly	10/01/07
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles	F 492	Weston County Health Services will operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and	10/01/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 08/30/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE 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 492	Continued From page 27 that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure certified nurse aides (CNAs) did not provide care outside their scope of practice during one of two observations of nebulizer treatments. The findings were: On 8/29/07 at 2:45 PM, observation revealed CNA #22 discontinued a nebulizer treatment on non sample resident #2. Interview with licensed practical nurse #4 on 8/29/07 at 2:50 PM revealed CNAs were allowed to discontinue nebulizer treatments for residents in the hospital pods because all the nurses were over at the manor (nursing home) and could not make the long distance from the manor to the pods. She stated on the manor side, the nurses discontinued the nebulizer treatments. Finally, she stated nurses were just too busy on the manor side to spend much time on the hospital pods. Review of the Nursing Practice Act, July 2005 and Administrative Rules and Regulations, November 2003 by the Wyoming State Board of Nursing, chapter VII, section 8, pages 7-5 through 7-8 revealed discontinuation of medication treatments was not listed as part of the basic nursing functions, tasks, and skills that may be delegated to a CNA.	F 492	Principles that apply to professionals providing services in such a facility. This requirement will be med by: A) CNAs will not discontinue nebulizer treatments for resident #2 or any other resident. B) Nursing staff will be educated on procedures for administration of nebulizer treatments C) DON will educate nursing staff about the scope of practice for CNAs vs. LPNs and RNs. D) DON will monitor the nursing staff to assure that only licensed nurses are discontinuing nebulizer treatments. and Report to QA monthly	

10/01/07