STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	R 10/27/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES	BOX 517 SUNDANCE, WY 82729

(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 444} SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure staff followed appropriate hand hygiene practices for 2 of 2 residents following personal care. The findings were: 1. Observation on 10/27/06 at 10:30 AM showed certified nurse aide (CNA) #1 provided personal care for resident #18, cleansing the anal and perineal areas following bowel movement and urination. While still wearing the gloves used when cleaning urine and feces from the resident, the CNA was observed to touch the hoyer lift, the resident's bare left leg, sweater, shoulders, arms, and wheelchair. After removing his gloves, the CNA placed the incontinence brief on the resident, handled the lift sling, lift, wheelchair, and the resident's clothing without washing or sanitizing his hands. Interview with CNA #1 at 11:14 AM revealed he thought he should wait until the entire process of cleansing and placing the incontinence pad on the resident was completed prior to changing gloves. Interview with the director of nursing at 11:20 AM revealed he should have removed his gloves after cleansing the anal and perineal areas, washed his hands, and then put on a new pair of gloves prior to pushing the hoyer lift from the bathroom to finish dressing the resident.	{F 444}	F444 All facility staff will wash their hands after each direct resident contact for which hand washing is indicated by accepted professional standards. This will be evidenced by mandatory inservice of all staff on accepted professional standards of hand hygiene and facility policies have been completed. Hand hygiene will be monitored for monthly QI and reported quarterly to the QI committee.	11/21/06

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

CEO — 11-22-06

NOV 24 2006

WYOMING DEPT OF HEALTH
HEALTH FACILITIES

11-22-06 Error corrected 11/27

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	R 10/27/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES	BOX 517 SUNDANCE, WY 82729

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{F 444}	Continued From page 1 2. On 10/27/06 at 11:00 AM, observation revealed CNA #2 provided personal care for resident #14. The following concerns were identified: a. After completing perineal care, the CNA removed his gloves and put on a new pair of gloves without washing or sanitizing his hands between glovings. b. After placing the new gloves on his hands, the CNA picked up the urinary catheter drainage bag and emptied the contents into the toilet. He then reached into his left pocket to obtain an alcohol wipe to cleanse the drainage bag tip while still wearing the soiled gloves. Observation revealed the pocket contained additional clean gloves to be used for this resident and others as well. Review of the facility policy entitled, "Handwashing and Hygiene," dated 10/11/06, revealed instructions to "Decontaminate hands after contact with body fluids or excretions, ..." and "Decontaminate hands if moving from a contaminated-body site to a clean-body site during patient care." Review of the facility policy entitled, "Female Perineal Care," reviewed 2/04, revealed instructions to "Dispose of your gloves and wash your hands and put on clean gloves." after cleansing the perineal area.	{F 444}		

Department of Health and Human Services
Centers For Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535029	A. Building B. Wing	10/27/2006

Name of Facility	Street Address, City, State, Zip Code
CROOK COUNTY MEDICAL SERVICES	BOX 517 SUNDANCE, WY 82729

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

Upload 11/28/06 D. 53-121407

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0253 Reg. # 483.15(h)(2) LSC	Correction Completed 10/26/2006	ID Prefix F0272 Reg. # 483.20, 483.20(b) LSC	Correction Completed 10/26/2006	ID Prefix F0274 Reg. # 483.20(b)(2)(ii) LSC	Correction Completed 10/26/2006
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 10/26/2006	ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC	Correction Completed 10/26/2006	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 10/26/2006
ID Prefix F0329 Reg. # 483.25(l)(1) LSC	Correction Completed 10/26/2006	ID Prefix F0364 Reg. # 483.35(d)(1)-(2) LSC	Correction Completed 10/26/2006	ID Prefix F0371 Reg. # 483.35(i)(2) LSC	Correction Completed 10/26/2006
ID Prefix F0386 Reg. # 483.40(b) LSC	Correction Completed 10/26/2006	ID Prefix F0442 Reg. # 483.65(b)(1) LSC	Correction Completed 10/26/2006	ID Prefix F0454 Reg. # 483.70 LSC	Correction Completed 10/26/2006
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:		Date:
	TS	11/14/06	Linda Brown	RN Surveyor	11/1/06
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**		

Followup to Survey Completed on: ___

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