PRINTED: 10/28/2009
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING ______ B. WING ______	10/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

(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 SS=D	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 and staff interview, the facility failed to ensure resident safety during care for 1 of 9 sample residents (#19). The findings were: Observation on 10/13/09 at 10 AM showed director of nursing (DON) #2 was changing a dressing for resident #19 in the bathroom adjacent to the shower room. During the observation, the resident was instructed by DON #2 to support his/her body weight using the hand washing sink in the room, and the resident complied. The hand washing sink was held to the wall by several bolts, and there was no support at the front of the sink. During an interview with DON #2 on 10/13/09 at 10:35 AM, she stated this bathroom was used to complete the resident's dressing changes when the shower room was occupied. She also stated she had instructed the resident to use this hand washing sink for weight support on other occasions during dressing changes.	F 323	F323 This facility will 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. A. All staff will use walker for support for resident #19 when providing cares which require resident to stand. B. Director of Nurses #1 will observe cares of resident #19 and all residents for proper assistive device use to ensure that all accident hazards are identified and fixed. C. All staff will be inserviced by Risk Manager to ensure understanding of accident hazards including appropriate assistive devices, which would not include a sink. D. Monitored by Quality Assurance Committee through quarterly reporting by Director of Nurses.	11-27-09
F 329 SS=D	483.25(l) 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	F 329		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 11-5-09

RECEIVED NOV 0 5 2009 Office of Healthcare Licensing and Surveys

This POC accepted c̄ agreed to change on 11/10/09 between Jackie Claudson (Administrator) and Terry Buffon 11/10/09

PRINTED: 10/28/2009
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	10/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

(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 329	Continued From page 1 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. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medication regimens for 2 of 10 sample residents (#13, #22) were free of unnecessary drugs. The findings were: 1. Review of the July 2009 physician's orders for resident #13 showed s/he was started on trazodone a sedative anti-depressant on 7/17/08. According to the psychoactive medication quarterly review, the trazodone was used to treat the diagnosis of sleep disturbance for this resident. The quarterly review form showed the medication was reviewed on 10/20/08, 1/20/09	F 329	F329 This facility will ensure resident's drug regimen is free from unnecessary drugs. Resident #13 will have a sleep assessment done by the Director of Nurses A. 1. Resident #13 will have MD review of Trazodone and Ativan for possible reduction. MD will attempt reduction or provide contraindication for reduction attempt for both medications., 2. Resident #22 will have a sleep assessment done by Director of Nurses. Results of sleep assessment will be reviewed with MD and determination of potential for dose reduction or discontinuation of Temazapam. MD will note contraindications of sleep medication found to be appropriate and necessary. B. All residents will have psychoactive medication review done by Director of Nurses. Any resident identified as not having tried dose reduction or holiday will be reviewed for contraindication notation by MD. Any resident not having reductions or noted contraindications will have appropriate assessments and review by MD to ensure appropriate psychoactive use for all residents. C. Medical Staff will be inserviced by Medical Director regarding need to attempt psychoactive drug reductions on all residents. If reduction is contraindicated, MD must note contraindications in the patient record. D. Monitored through quarterly Quality Assurance reporting of psychoactive drug reduction by Social Service Director.	11-27-09

11/10/09

PRINTED: 10/28/2009
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	10/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

(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 329	Continued From page 2 and 4/20/09. However, each time the medication was reviewed the question of gradual dose reduction being attempted was asked, and each time the answer was "No." Interview with director of nursing (DON) #2 on 10/15/09 at 9 AM revealed she was unable to find evidence of any attempt of a reduction, or any contraindication for a dose reduction since the medication was started 15 months prior. In addition, this resident was ordered Ativan (an anti-anxiety medication)1 mg to be given every eight hours routinely starting on 1/6/09. Review of the medical record showed there had been no attempt to gradually reduce this medication in the past 9 months, nor any contraindication to do so. In the 10/15/09 at 9 AM interview with DON #2 she verified a dose reduction for the Ativan was lacking. 2. Review of the October 2009 orders for resident #22 showed an order originally dated 12/11/08 for temazepam (a hypnotic medication) 15 mg to be given at bedtime for insomnia. Review of the medication administration records (MARs) for August 2009, September 2009, and October 2009 showed the resident received 15 mg of temazepam nightly with almost no exceptions. Continued record review showed no gradual dose reduction had been attempted. In an interview with DON #2 on 10/14/09 at 3 PM, she stated the facility had not assessed the resident for sleep issues. Also, the DON confirmed no gradual dose reduction had been attempted for the resident's temazepam.	F 329		
F 333 SS=E	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333		

11/10/09

PRINTED: 10/28/2009
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	10/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

(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 333	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 2 of 3 sample residents (#11, #21) who were identified with drug allergies were not administered medications they were possibly allergic to. The findings were: 1. Review of the medical record for resident #21 showed a sticker on the front cover that listed several medication allergies for this resident. Among those listed were sulfa drugs (sulfonamide-based groups of drugs). The record review showed that on 9/5/09 the resident's physician ordered Bactrim DS (a brand name for sulfamethoxazole, a sulfonamide based antibiotic) twice a day for ten days to treat a urinary tract infection (UTI). According to a notification to the physician dated 9/10/09, a nurse noticed the resident was being given a sulfa drug, and asked that the Bactrim be discontinued. On 9/11/09 the physician changed the antibiotic to one the resident was not allergic to. Review of the September 2009 medication administration record (MAR) showed the resident received seven doses of the medication before it was discontinued. Review of nursing notes during that time frame revealed the resident did not show any adverse effects to the antibiotic treatment. Interview with director of nursing (DON) #1 on 10/14/09 at 3:05 PM confirmed nursing should have checked for allergies when the medication was first ordered, and it should not have been administered without clarification from the physician. 2. Review of the medical record for resident #11 showed a sticker on the front cover that listed	F 333	F333 This facility must ensure that residents are free of any significant medication errors. A. 1) Resident #21 will have allergies highlighted on MAR. All nurses will be notified of residents allergy to Sulfa drugs. 2) Resident #11 will have allergies highlighted on MAR. All nurses will be notified of resident allergy to Cipro. B. All residents records will be reviewed by Director of Nurses to identify allergies and ensure all allergies are clearly marked on resident chart and MAR. C. Director of Nurses will inservice all Licensed Nursing staff regarding need to identify resident allergies prior to giving any medication or starting any new medications. Pharmacist will provide a list of common base medications and their derivatives to ensure identification of all possible medications containing problematic base medications, (i.e. Sulfa-Bactrim). D. Monitored through quarterly quality assurance reporting of medication allergies by Director of Nurses.	11-27-09

11/10/09 AM

PRINTED: 10/28/2009
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	10/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

(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 333	Continued From page 4 "Cipro" (ciprofloxacin, an antibiotic) as an allergy. During a review of the medical record, it was noted that the physician ordered ciprofloxacin on 7/21/09 to treat a UTI. Further review showed on the MAR for July 2009 the Cipro was administered for the full course (twice a day for seven days). Interview with director of nursing #1 on 10/14/09 at 2:10 PM revealed after reviewing the record, there was not any reaction to the antibiotic, and it may not have been a true "allergy." However, she stated it should have been clarified when ordered, and a nurse was responsible to check for allergies.	F 333		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 3 of 9 sample residents (#2, #11, #22) were seen by physicians at the required intervals. The findings were: 1. Review of the medical record for resident #2 showed s/he had no physician visits after 2/17/09 until 5/26/09 (98 days). In an interview with director of nursing (DON) #1 on 10/14/09 at 1:30 PM, she stated there was no information to	F 387	F387 This facility will ensure residents are seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A. Resident record #2, #11, #22 will be reviewed by MD's to ensure understanding of timely physician visits for the residents. B. All resident records will be reviewed by Director of Nurses for appropriate and timely physician visits. Any records identified to be missing visits will result in MD notification of appropriate and timely visits. C. Medical Director will inservice medical Staff regarding need for timely (every 30 days for the first 90 days after admission, and at least once every 60 days thereafter) D. Monitored by Medical Director through quarterly review reporting of timely resident visits through Quality Assurance Committee.	11-27-09

11/10/09

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

PRINTED: 10/28/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	10/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

(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 387	Continued From page 5 confirm a physician visit between these dates. 2. Review of the physician's notes for resident #11 revealed the resident was seen by the physician on 2/17/09, on 6/2/09 (105 days between visits) and again on 9/16/09 (106 days between visits). Interview with DON #1 on 10/14/09 at 3:05 PM revealed she was unable to find any additional physician visits during that time frame for the resident. 3. Review of the medical record for resident #22 showed s/he had no physician visits after 2/23/09 until 5/11/09 (77 days). DON #2 was interviewed on 10/14/09 at 3 PM. She stated there was no information to confirm there had been a physician visit between those dates.	F 387		
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 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 medical record review, observation, staff interview, and facility policy and procedure review, the facility failed to assure transmission based precautions were consistently followed for 1 of 1 resident (#19) with contact precautions in	F 441	F441 This facility will establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of disease and infection. A. 1) Recliner in sunshine room will be designated as "reserved" to ensure use by resident #19 only. Staff will be observed by Director of Nurses and immediately instructed to sanitize electric chair control upon resident transfer. All CNA's will be observed by Director of Nurses and will immediately intervene and inservice regarding appropriate infection control procedures for transfer for resident #19.	

11/10/09

PRINTED: 10/28/2009
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	10/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

(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 6 place. The findings were: Review of the history and physical dated 5/1/07 for resident #19 showed the resident was admitted to the facility on 5/1/07 with diagnoses that included Staphylococcus aureus septicemia. In addition, the resident had a history of infections that included: Staph aureus in December 2006 and Jan 2007, and methicillin sensitive staph aureus in March 2007. Further review of a 7/12/09 microbiology report showed the resident had an infection of Staphylococcus epidermis in a wound on the buttocks. According to the 7/16/09 physician's progress note, the resident habitually picked at the wound, and it had been a problem for the past three years despite many attempted interventions. Review of nursing notes dated 6/29/09, 7/1/09, 7/19/09, 8/3/09, 8/30/09, 9/8/09, 9/12/09, and 9/22/09 showed the resident continued to scratch at his/her wound. A review of the resident's 8/31/09 laboratory service report showed the buttocks wound was cultured and Pseudomonas aeruginosa was identified. The treatment for the Pseudomonas infection included "contact precautions." According to the sign posted outside the resident's room during the days of survey (10/12 - 10/15/09), staff were instructed to follow these contact precautions: "Wear gloves when entering the room ...Wash with an antimicrobial agent immediately after glove removal ...Wear a gown when entering patient room if you anticipate that your clothing will have substantial contact with the patient, environmental surfaces, or items in the patient's room, or if the patient has...wound drainage not contained by a dressing. Remove gown before leaving the patient's environment and ensure that clothing does not contact potentially contaminated environmental surfaces	F 441	2) LN's will be observed by Infection Control Coordinator during dressing changes and transfer of resident #19. Infection Control Coordinator will immediately intervene to inservice LN's regarding appropriate infection control procedures, including gloves and gown, during wound care for resident #19. Director of Nursing #1 will observe LN staff during resident #19 cares and ensure LN's and all staff understand the need to sanitize resident #19's chair and chair controls upon any transfer. 3) All CNA's will be observed by Director of Nurses during transfers of resident #19. CNA's will be immediately instructed to don gloves, gowns as appropriate and sanitize all equipment following transfer. 4) Director of Nurses will observe all staff during cares for resident #19. Staff will immediately be instructed by Director of Nurses regarding appropriate infection control procedures, including gloves and gowns, appropriate protection and sanitization of resident #19 chair, sanitization of controls and equipment and resident #19 hand washing. B. All residents with identified infections requiring isolation precautions will have staff observation done by Director of Nurses and ensure appropriate infection control procedures are being followed. C. Infection Control Coordinator will inservice all nursing staff regarding the need to observe all infection control procedures as posted, sanitization of all surfaces touched by resident #19 following any transfer, need to wash resident #19 hands between all activities. D. Monitored by Director of Nurses through quarterly Quality Assurance reporting	11-27-09

11/10/09

PRINTED: 10/28/2009
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	10/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

(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 7 to avoid transfer of microorganisms to other patients or environments... Limit transport of patient to essential purposes only...Dedicate the use of noncritical patient-care equipment to a single patient. If common equipment is used, clean and disinfect between patients." The following concerns were identified related to following these precautions: a. Observation on 10/13/09 at 8:40 AM showed resident #19 was sitting in the sun room in a recliner chair by the wall. The resident independently used the electric chair control to position the seat. Observation during the days of survey showed the area was a public room used by several residents and visitors. Later that morning at 9:25 AM certified nurse aide (CNA) #1 was observed bringing the resident back into the sun room, and she transferred the resident from a wheelchair to a recliner located next to the wall. During the transfer, the aide had physical contact with the resident and was not wearing gloves or a gown. b. Interview with director of nursing (DON) #2 on 10/13/09 at 9:45 AM revealed the resident's wound had saturated through the current dressing, and she was preparing to change the dressing. Observation on 10/13/09 at 10 AM showed DON #2 transferred the resident from the recliner to his/her wheelchair. During the transfer, the DON did not wear gloves or a gown, and did not sanitize the chair or electric chair control. The DON transferred the resident to a bathroom next to the shower room up the hall. The observation also showed the nurse put on gloves and changed the resident's dressings, which consisted of two abdominal (ABD) pads. The pads were located over the upper right and left buttocks and were contaminated with clear and odiferous drainage that had soaked through both	F 441		

11/10/09

PRINTED: 10/28/2009
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	10/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

(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 8 ABD pads and onto the resident's pajamas. The nurse did not wear a covering over her clothing (gown) during the dressing change. During an interview immediately after the dressing change, the DON said the resident's dressing could not be secured with tape due to the sensitivity of the resident's skin, so the dressing would often slip. The nurse stated she did not know what organisms were in the resident's wound drainage, or what organisms were identified as a result of any laboratory work completed for the resident. c. During an observation on 10/14/09 at 12:30 PM, CNA #2 did not wear gloves while she transferred the resident to his/her room pushing the wheelchair. Continued observation showed the CNA did not wear gloves or put on a gown when she entered the resident's room and transferred him/her into bed. During an interview on 10/14/09 at 1:10 PM, CNA #2 stated she was aware that the resident was on contact precautions. However, she only used gloves if she thought contact with secretions from the resident's wound was likely, and she did not use gowns. d. During an interview with the infection control coordinator (ICC) on 10/14/09 at 10 AM, she revealed resident #19 was the only resident in the facility with a Pseudomonas infection. This resident was also the only resident on transmission- based precautions. The ICC stated the resident had been on precautions for a long period of time, and she had provided random staff education. Some of the education she remembered providing included sanitizing equipment used by the resident, keeping the resident's hands cleaned as s/he had a habit of scratching at the draining wound, and wearing gloves and gowns as instructed by the contact precaution guidelines. She was also aware the	F 441		

11/10/09

PRINTED: 10/28/2009
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	10/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

(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 9 recliner chair by the wall in the sun room was used by the resident; however, it was not designated only for the resident. The ICC further stated staff knew this was his/her seat, and she would expect staff to keep other residents from using the chair. She was not aware of staff ever sanitizing the chair or the electric chair control after use by the resident. She stated the contact precautions for this resident should be followed. During a review of the facility policy and procedure for contact precautions, the following information was noted, "Healthcare personnel caring for patients on contact precautions should wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment."	F 441		

11/4/09 GM