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

PRINTED: 09/24/201
FORM APPROVE
OMB NO. 0938-039

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 ______	C 09/16/2010

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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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, medical record review, and staff interview, the facility failed to ensure care was provided in accordance with the written plan of care for 8 of 9 sample residents (#4, #10, #11, #14, #15, #16, #20, #33). The findings were: Refer to F311 for details on the facility's failure to provide restorative nursing care in accordance with the care plan for residents #4, #10, #11, #14, #15, #16, and #20. Refer to F318 for details on the facility's failure to	F 282	**This facility will ensure that services are provided in accordance with each resident's plan of care.** Step 1. Restorative Aides will be immediately inserviced by Director of Nursing Services regarding need to provide restorative services to residents #4, #10, #11, #14, #15, #16, #20, and #33 and restorative services will be done per written plan of care. Step 2. All resident's care plans will be reviewed by interdisciplinary team to ensure all appropriate restorative cares are being provided to all residents identified with a need for restorative services. Step 3. Restorative CNA's will be inserviced by Director of Nursing Services regarding the need to provide restorative services according to the written plan of care for each resident as appropriate.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — [signature] TITLE Administrator (X6) DATE 10/7/10

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.

Changes made by Jackie Crowder, Adm, via phone call on 10/21/10 @ 2:00pm Janelle Conn, OHLS

RECEIVED OCT 07 2010 Office of Healthcare Licensing and Surveys

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

10/21/10

PRINTED: 09/24/20
FORM APPROVE
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536019	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	305 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 282 F 311 SS=E	Continued From page 1 provide range of motion services in accordance with the care plan for residents #20 and #33. 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure 7 of 7 sample residents (#4, #10, #11, #14, #15, #16, #20) received restorative services as planned to maintain their physical abilities. The findings were: 1. Review of the 6/11/10 quarterly MDS assessment showed resident #14 was independent with transfers. Observation on 9/14/10 at 8:50 AM revealed the resident transferred independently. However, on 9/14/10 at 9:26 AM CNA #1 answered the resident's bathroom call light. The CNA then assisted the resident to transfer from the toilet to the wheelchair using a sit-to-stand mechanical lift. The CNA stated sometimes the resident needs assistance with transfers due to weakness. Review of the care plan, initiated 6/24/05 and updated 6/11/10, revealed the resident was supposed to receive restorative nursing services 3 to 6 times per week to achieve the goal of safe transfers. However, review of the 2010 restorative aide documentation revealed the resident only received services 4 times in June, 3 times in July, and 7 times in August. During the first week in	F 282 F 311	Step 4. Monitored by Director of Nursing Services through restorative care observation and documentation review and reported quarterly to QA committee. 10/25/10 **This facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her physical abilities.** 10/29/10 Step 1. Director of Nursing Services will immediately inservice all Restorative Care staff regarding the need to ensure resident #4, #10, #11, #14, #15, #16, and #20 receive restorative services in accordance with their written plan of care. Residents will have appropriate restorative services performed. A – Resident #14 will have new Restorative Assessment done by RN to ensure appropriate transfer needs are identified and care planned. CNA's will be inserviced regarding appropriate transfers, appropriate restorative services and appropriate documentation for resident #14. B – Resident #10 will have new Restorative Assessment done by RN to determine most appropriate restorative service needs to maintain current physical mobility. CNA's will be inserviced regarding appropriate restorative services for resident #10. C – Resident #20 will have new Restorative Assessment done by RN to ensure most appropriate need for restorative services. Appropriate cares will be included in the resident plan of	

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

10/21/10

PRINTED: 09/24/201
FORM APPROVE
OMB NO. 0938-036

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536019	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	390 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 311	Continued From page 2 September, the resident only received services twice. A note on 9/3/10 read "Resident was in bowling." There lacked evidence the restorative aide tried to re-schedule for another time, or another day. 2. Review of the 8/11/10 quarterly MDS assessment revealed resident #10 was independent with ambulation and transfers. According to the care plan, initiated 5/16/06 and updated 8/11/10, the resident was supposed to receive restorative services 3 to 5 times per week to maintain his/her current physical mobility. However, review of the 2010 restorative aide documentation revealed the resident only received services 3 times in June, once in July, and 4 times in August. As of 9/15/10, the resident received services 4 times in September. 3. Review of the 7/21/10 significant change MDS assessment revealed resident #20 needed assistance with transfers, bed mobility, dressing, bathing and toileting. The resident's care plan revealed the resident was to receive restorative services three days a week for shoulder pain, weakness, and decreased endurance. The care plan was initiated on 3/1/07 and last updated on 7/21/10. Review of the restorative aide treatment sheets showed the resident received services three times and refused three time in July 2010. Further review showed the resident received restorative services only three times a month in August and September 2010. 4. Review of the care plan showed resident #11 was to receive restorative services three days a	F 311	care and CNA's will be inserviced regarding appropriate restorative services for resident #20 D – Resident #11 will have new Restorative Assessment done to determine resident's physical needs. Appropriate restorative services will be written in the resident plan of care. CNA's will be inserviced regarding appropriate restorative services necessary for resident #11. E – Resident #15 will have new restorative assessment done to determine appropriate restorative interventions. Interventions will be included in the resident care plan. CNA's will be inserviced regarding need to follow restorative plan for resident #15. F – Resident #16 will have new restorative assessment done to determine most appropriate restorative needs. Needs will be included in the written care plan and CNA's will be inserviced regarding need to follow restorative plan for resident #16 G – Resident #4 will have new restorative assessment done to review restorative needs. Restorative needs will be included in resident care plan. CNA's will be inserviced regarding need to follow restorative plan for resident #4. H – CNA's will be inserviced regarding restorative CNA scheduling. Step 2. All residents care plans will be reviewed by Interdisciplinary Team to identify appropriate restorative care. All	

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

10/21/10

PRINTED: 09/24/2010
FORM APPROVED
OMB NO. 0938-039

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 _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	308 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 311	Continued From page 3 week for weakness. The care plan was initiated on 10/29/09 and last updated on 6/24/10. Review of the restorative aide treatment sheets showed the resident did not receive any restorative services in June 2010 and received services once in July 2010. The resident did not receive any restorative services from August 1 through August 30, 2010, then refused services on August 31st due to pain. The first 14 days of September 2010 showed restorative was only offered two days; both times the resident was out of the facility with activities. 6. Review of the care plan for resident #15 revealed the resident was to receive restorative services three to five days a week for traumatic brain injury and spasticity. The care plan was initiated on 7/24/09 and last updated on 8/2/10. Review of the restorative aide treatment sheets showed the resident received restorative services three times in June 2010, six times in July 2010, and four times in August 2010. 5. Review of the care plan revealed resident #16 was to receive restorative services five days a week for weak hips. The care plan was initiated on 8/13/09 and last updated on 8/19/10. Review of the restorative aide treatment sheets for June 2010 showed the resident was only offered services twice the whole month. No restorative services were offered the resident in July 2010. The resident did receive services six times in August 2010 and three times the first 14 days of September 2010. 7. Review of the care plan for resident #4 revealed the resident was to receive restorative services 6 days a week for generalized weakness. The care plan was initiated on 7/28/09	F 311	residents identified will have appropriate cares provided. Step 3. Director of Nursing Services will inservice all restorative staff regarding the need to provide appropriate restorative care to residents as per written plan of care to ensure each resident maintains or improves their physical abilities. Step 4. Monitored by Director of Nursing Services through daily observation of restorative cares and review of documentation and reported to QA committee quarterly.	~~10/25/10~~ 10/29/10

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

10/7/10

PRINTED: 09/24/20
FORM APPROVE
OMB NO. 0938-03

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 _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	888 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 311	Continued From page 4 and last updated on 8/5/10. Review of the restorative aide treatment sheets showed the resident received restorative services five times in June 2010, twice in July 2010, four times in August 2010, and twice the first 14 days in September 2010 8. During an interview on 9/15/10 at 3:30 PM, CNA #1 stated she was the restorative aide for that day. When asked about the restorative documentation, the CNA stated "it's tough...don't have a regular restorative person, so it usually goes to the 12 hour person [CNA working a 12 hour shift]...days can be really crazy." The CNA also stated, "I know if not documented, it didn't happen." On 9/15/10 at 4:30 PM, the DON stated all CNAs were responsible for restorative services; there was not a designated restorative aide. The DON stated she believed part of the restorative documentation was accurate, but she also believed there was a documentation problem.	F 311		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide	F 318	**This facility will ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.** Step 1. CNA's will be immediately inserviced regarding need to provide Range of Motion services to resident #20 and #33.	

10/21/10

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

PRINTED: 09/24/201
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	556019	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	399 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 318	Continued From page 5 range of motion (ROM) services to prevent further decline for 2 of 2 sample residents (#20, #33) with a decrease in ROM. The findings were: 1. Review of the 1/21/10 annual and 7/7/10 quarterly MDS assessments revealed resident #33 had ROM limitations to his/her left hand, arm, leg, and foot. Observation on 9/14/10 at 7:15 AM revealed CNA #1 removed a splint from the resident's left hand/wrist. The resident had flexion contractures to the hand and wrist. According to the care plan, initiated 10/28/09 and updated 7/7/10, the resident was supposed to receive restorative services for ROM to the left upper extremity 7 days a week. However, review of the 2010 restorative aide documentation revealed the resident only received services three times in June, once in July, and three times in August. As of 9/16/10, the resident received services 5 times in September. 2. Medical record review for resident #20 showed a significant change MDS assessment dated 7/21/10. The MDS assessment revealed the resident had decreased range of motion in one leg, one foot, and one arm. Review of resident's care plan last updated on 7/21/10 showed the resident was to receive restorative services three times a week for shoulder pain and partial loss of range of motion. Review of the restorative aide treatment sheets showed the resident received services three times and refused services three times in July 2010. Further review showed the resident only received restorative services three times a month in August and September 2010. 3. During an interview on 9/15/10 at 3:30 PM,	F 318	A – Resident #33 will have new restorative assessment done by DNS to ensure ROM needs are appropriate identified. Written plan of care will be reviewed and implemented as appropriate based on assessment. CNA's will be inserviced regarding need to follow written plan of care for resident #33. B – Resident #20 will have new restorative assessment done by DNS to ensure appropriate restorative interventions are care planned. CNA's will be inserviced regarding need to follow written plan of care for resident #20. Step 2. All residents will have restorative care plan review done by interdisciplinary team. CNA's will be immediately inserviced by DNS regarding need to follow the written plan of care for every resident. Step 3. All CNA's will be inserviced by DNS regarding need to provide appropriate restorative cares to residents as written in the plan of care to ensure their ability to maintain or improve physical condition. CNA's will be inserviced regarding restorative scheduling. Step 4. DNS will observe restorative cares provided to residents through care observation and documentation review. Reported to QA committee quarterly.	~~10/23/10~~ 10/29/10

JC 10/21/10

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

PRINTED: 09/24/201
FORM APPROVE
OMB NO. 0938-039

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 _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	350 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 318	Continued From page 6 CNA #1 stated she was the restorative aide for that day. When asked about the restorative documentation, the CNA stated "it's tough...don't have a regular restorative person, so it usually goes to the 12 hour person [CNA working a 12 hour shift]...days can be really crazy." The CNA also stated, "I know if not documented, it didn't happen." On 9/15/10 at 4:30 PM, the DON stated all CNAs were responsible for restorative services; there was not a designated restorative aide. The DON stated she believed part of the restorative documentation was accurate, but she also believed there was a documentation problem.	F 318		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy and procedure, the facility failed to ensure proper procedure was followed during the administration of a gastrostomy tube feeding for 1 of 1 (#16) sample resident with tube feeding. The findings were: Review of the facility's policy and procedure for tube feedings showed step #7 to be: "Using a	F 322	**This facility will ensure that a resident who is fed by a naso-gastric or gastronomy tube receives appropriate treatment and services.** Step 1. Director of Nursing Service will observe all LN's providing tube feedings to resident #7. DNS will ensure all LN's follow step #7 in the Tube Feeding Policy & Procedure regarding injecting 20-30cc of air while listening with a stethoscope positioned at the epigastric are to confirm proper tube placement. Step 2. All residents will be reviewed for tube feeding needs. Step 3. Director of Nursing Services will inservice all LN's on Tube Feeding Policy & Procedure. All steps will be reviewed with emphasis on ensuring understanding of need for injection of air and confirmation of proper tube placement addressed in step #7.	

10/27/10

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

PRINTED: 09/24/20
FORM APPROVE
OMB NO. 0938-03

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 _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	368 SOUTH 09 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 322	Continued From page 7 catheter-tipped syringe, inject 20-30 cc of air while listening with a stethoscope positioned at the epigastric area." The rationale for this step was, "...confirmation of proper tube placement." The following concerns were noted: Observation on 9/14/10 at 8 AM showed LPN #1 administered a tube feeding to resident #15 without checking the placement of the tube. Interview on 9/14/10 at 9:15 AM with the LPN revealed she did not check tube placement with every feeding. Interview on 9/15/10 at 4:35 PM with the DON revealed her expectation was the tube placement would be checked with every feeding because the resident was very active and s/he could dislodge the tube.	F 322	Step 4. DNS will random LN observation of proper Tube Feeding procedures and will report results to QA Committee quarterly. 10/25/11 10/29/10	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	**This facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.** Step 1. Policy will be developed by Infection Control Manager regarding glucometer cleaning between each resident. Policy will be developed regarding appropriate clean linen storage. Clean linen room will be rearranged to allow for appropriate linen storage. Step 2. All residents with blood sugar check needs will be identified. Cleaning documentation will be added to glucose testing procedures. Linen room will be observed on each laundry day for two weeks to ensure adherence to new facility clean linen policy.	

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

PRINTED: 09/24/201
FORM APPROVE
OMB NO. 0938-039

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 _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	390 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 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens 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 review of the Centers for Disease Control recommendations, the facility failed to ensure staff cleaned the glucometer between residents during 1 of 1 observation of glucose testing. In addition, linen was not stored in a manner to prevent contamination during one random observation. The findings were: 1. Random observation on 9/14/10 at 11:45 AM revealed LPN #1 performed a blood sugar check on resident #18 with a "One Touch" glucometer. Interview with the LPN at that time revealed the facility had only one glucometer that was used for all residents who needed blood sugar checks. She went on to say she did not clean the glucometer before or after resident use, but she thought the glucometer was cleaned once a month by the night shift. Interview on 9/16/10 at 7:30 AM with the Infection Control Coordinator revealed the facility did not have a policy on	F 441	Step 3. All LN's will be inserviced by Infection Control Manager regarding appropriate cleaning procedures for the glucometer between resident use. Laundry Staff will be inserviced by Infection Control Manager regarding appropriate storage of clean linens. Step 4. Monitored by Infection Control Manager through LN glucose procedure observation and documentation review and clean linen room observation. Reported to QA committee quarterly. ~~10/25/10~~ 10/29/10	

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

PRINTED: 09/24/20
FORM APPROVI
OMB NO. 0938-03

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 _____	C 09/16/2010

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) COMPLETIC DATE
F 441	Continued From page 9 cleaning the glucometer and she did not know if it should be cleaned between resident use. Interview on 9/16/10 at 10:05 AM with LPN #2 revealed the glucometer was used for eight residents. According to the Centers for Disease Control recommendations, "Glucometers should be assigned to individual patients. If a glucometer that has been used for one patient be reused for another patient, the device must be cleaned and disinfected." Recommended infection-control and safe injection practices to prevent patient-to-patient transmission of bloodborne pathogens. Centers for Disease Control website. 2005. Available at: www.cdc.gov/hepatitis/Resources/OrderPubs/HealthProf/PrevP-to-PtransHandout_Eng.pdf. Accessed September 24, 2010. 2. Random observation of the clean linen room on 9/15/10 at 2:55 PM revealed one bundle of clean blankets, four bundles of clean mattress pads, and 6 bundles of clean incontinent pads were lying on the floor. The bundles were secured with a clear wrap, but there were openings in the wraps. A second observation on 9/16/10 at 7:30 AM with the Infection Control Coordinator confirmed clean linen was stacked on the floor of the clean linen room. Interview at that time with the Infection Control Coordinator revealed clean linen should be stacked on shelves or placed in bins in the clean linen room, not on the floor.	F 441		