

Healthcare Licensing and Surveys

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>WY0002</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>05/15/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BONNIE BLUEJACKET MEMORIAL NURSING I</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>388 SOUTH US HWY 20</b><br><b>BASIN, WY 82410</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| {S 000}                                                                         | <p><b>OPENING COMMENTS</b></p> <p>Rules and Regulations utilized for this survey are:</p> <p>Rules and Regulations for Program<br/>Administration of Nursing Care Facilities, Chapter<br/>11, effective 06/26/2000</p> <p>Rules and Regulations for Licensure of Nursing<br/>Care Facilities, Chapter 19, effective 06/26/2000</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | {S 000}                                                                                       |                                                                                                                          |                                                                    |
| {S3001}                                                                         | <p><b>Ch 11 Sec 11 (a)(i) Dietetic Services</b></p> <p>The facility shall provide dietetic services that<br/>meet the nutritional needs of residents according<br/>to the science of nutrition. The dietetic service<br/>shall operate with safe food handling practices<br/>from receipt through service in accordance with<br/>the most current edition of the FOOD CODE from<br/>the U.S. Department of Health and Human<br/>Services, Public Health Service, Food and Drug<br/>Administration.</p> <p>(a) Dietary Supervision. Overall supervisory<br/>responsibility for the dietetic service shall be<br/>assigned to a full-time qualified dietetic<br/>supervisor.</p> <p>(i) If the qualified supervisor is not a<br/>Registered Dietitian, she/he shall be a graduate<br/>of a dietetic technician program approved by the<br/>American Dietetic Association or a dietary<br/>managers' educational program approved by the<br/>Certifying Board of Dietary Managers. Training<br/>and experience in food service supervision and<br/>nutrition equivalent in content to the approved<br/>educational programs are acceptable.</p> | {S3001}                                                                                       |                                                                                                                          |                                                                    |

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Healthcare Licensing and Surveys

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| {S3001}                                                                         | Continued From page 1<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on review of written documentation, the facility failed to ensure the supervisor of dietary services was a certified dietary manager or the equivalent. The findings were:<br><br>Review of an e-mail dated 5/15/18 from the administrator revealed the dietary supervisor was enrolled in the dietary manager course and was expected to complete it in October 2018.                                                                                                                                                                                                                                                              | {S3001}                                                                                       |                                                                                                                          |                                                                    |
| {S3022}                                                                         | Ch 11 Sec 14 (a) Dental Services<br><br>(a) The facility shall have an advisory dentist who shall provide consultation, develop and participate in inservice education, and recommend policies concerning oral hygiene. Records of in-service education meetings shall be in writing.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on review of written documentation, the facility failed to ensure an agreement with a dentist was obtained. The findings were:<br><br>Review of documents submitted by the facility showed a written agreement with a dentist that was not signed by the dentist. Review of an e-mail dated 5/15/18 by the administrator revealed the agreement was not signed yet. | {S3022}                                                                                       |                                                                                                                          |                                                                    |