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 01/22/2020

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 A complaint survey was conducted by Healthcare Licensing and Surveys on 1/21/20 through 1/22/20. The survey was prompted by complaint intake WY00003010. Based upon the findings of the survey team, it was determined that the complaint was unsubstantiated and no deficiencies were identified pertaining to the complaint. However, deficient practice was identified during the survey in other areas. The following common abbreviations are used throughout this document: DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on review of training records and the nurse schedule, staff interview, and review of facility policy and nurse job descriptions, the facility failed to ensure nurses were trained/certified in Basic Life Support (BLS), including cardiopulmonary resuscitation (CPR) for	F 678	This requirement will be met as evidenced by: A) CPR Certification was achieved with current documentation evidence for RN #1 on January 23, 2020.	3/1/20

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

Electronically Signed | 02/13/2020

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 01/22/2020

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 678	Continued From page 1 1 of 7 nurses (RN #1) to ensure staff were present at all times to provide CPR. The findings were: 1. Review of the facility's policy "Emergency Room/Trauma" (#7013-200-4, undated) revealed it applied to all nurses within the Bonnie Bluejacket Skilled Nursing facility. The policy read "...In the absence of a physician, nurses may initiate cardiopulmonary resuscitation on patients who have sudden unexpected cardiac or respiratory arrest, unless contraindicated." 2. During an interview on 1/22/20 at 11:42 AM the DON stated nurses were required to have CPR training. 3. Review of the job description for the RN (issued 10/19/16) showed "BLS certification is required." Review of the job description for the LPN (issued 11/29/16) showed "BLS certification is required." 4. Review of the January 2020 nursing schedule showed 7 nurses worked in the facility. The training records were reviewed for evidence of BLS or CPR certification for the 7 nurses. No documentation was found for RN #1. 5. During an interview on 1/22/20 at 12:39 PM the DON stated she was unable to provide evidence of current BLS or CPR certification for RN #1.	F 678	B) Job description for CNA□s will be updated by 2/11/2020. All nursing staff, (RN, LPN, and CNA) will be required to obtain and maintain current BLS or CPR certification during time employed at Bonnie Bluejacket Nursing Home. An RN/LPN that is certified BLS or CPR will be on duty at all times until all CNA's have their CPR certification. On site CPR classes will be arranged to allow all nursing staff to obtain and recertify their CPR certificates. C) A monitoring tool will be developed in order to ensure all nursing staff have obtained and are maintaining current certification. Human Resources will conduct a review of employee certification upon hire and monthly for dates of expiration. D) Human resources and DON will be responsible for creating and monitoring a tool to accurately reflect current BLS or CPR certification as well as expiration dates for all clinical employees. Date of Completion: 3/1/2020	
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides-	F 805		2/6/20

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 01/22/2020

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 805	Continued From page 2 §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, review of the menu, staff interview, and medical record review, the facility failed to provide food in a form to meet the resident's needs for 1 of 5 sample residents (#1) with a mechanically altered diet during 1 of 1 meals observed. The findings were: 1. Review of the annual MDS assessment, with an assessment reference date of 4/15/19, showed resident #1 received a mechanically altered diet. Review of the current care plan, dated 7/10/19, showed the resident was supposed to receive a mechanical-soft diet. Review of physician's orders showed on 3/11/19 the physician ordered a mechanical-ground soft diet. The following concerns were identified: a. Observation on 1/21/20 at 5:20 PM showed the resident was served a bowl of soup and a cup of whole grapes by cook #1. b. Review of the menu for the evening meal on 1/21/20 revealed residents with a mechanical soft diet were not supposed to receive grapes. They were supposed to receive soft chopped fruit (mechanical-soft chopped diet) or mashed fruit (mechanical-soft ground diet) instead. c. During an interview on 1/22/20 at 10:19 AM cook #1 stated the resident should not have received the grapes, because he is on a mechanical-soft diet. She stated "I should have been more aware."	F 805	This requirement will be met as evidenced by: A) Review residents□ dietary order and resident care plans, including Resident #1, specifically the residents with altered texture diets. Education will be provided on specific diet orders and guidelines for each diet/texture. Care plans were updated on February 5, 2020. B) All dietary and nursing staff (RN, LPN, and CNA) received in-service training on February 6, 2020, specific dietary changes, updated guidelines for residents with mechanical soft diets. Care Plans were updated and provided to staff. C) Monitoring tool has been developed to ensure accuracy of proper diet order to residents, particularly the residents who have a mechanically altered diet. 10 Random monthly observations will be documented, and retraining will be conducted as needed. Dietary care plans will be reviewed and updated quarterly or with change of condition of resident. D) Dietary Manager and Director of Nursing are responsible for implementing the change and education of diets and care plan of residents. Dietary Manager is to complete performance improvement project (PIP) plan and report at QAPI quarterly.	

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 01/22/2020

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 805	Continued From page 3	F 805	Date of Completion: 2/6/2020	