

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

PRINTED: 09/29/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2020
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1124 WASHINGTON BLVD NEWCASTLE, WY 82701		
(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 focused infection prevention survey, which included a review of emergency preparedness requirements, was conducted by Healthcare Licensing and Surveys from 7/1/20 to 7/2/20. . The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant DON: Director of Nursing Less comonly used abbreviations will be annotated in each deficiency.	F 000			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		7/24/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/20/2020

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.

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

PRINTED: 09/29/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2020
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1124 WASHINGTON BLVD NEWCASTLE, WY 82701		
(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 880	Continued From page 1 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880			

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

PRINTED: 09/29/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2020
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1124 WASHINGTON BLVD NEWCASTLE, WY 82701		
(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 880	Continued From page 2 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, Weston County Health Service memo review and policy and procedure review, the facility failed to establish and maintain an effective infection prevention and control program for 1 of 2 resident areas (secure unit) within the facility. The findings were: 1. Observation on 7/1/20 at 2:25 PM in the secure unit showed 5 residents were seated in recliners in the common area. The recliners were positioned in an "L" shape and were within arm's reach of one another. None of the 5 residents were wearing face masks. The following concerns were identified: a. Interview on 7/1/20 at 2:25 PM with CNAs #1 and #2 revealed the facility was not social distancing in the unit, nor requiring the residents to wear face masks. b. Interview on 7/1/20 at 3:15 PM with the DON confirmed the residents on the secure unit were not social distancing or wearing face masks. c. Review of the "Weston County Health Services memo to residents and families dated June 29, 2020 showed ..."3. All staff and residents will be required to wear medical grade facemasks..." d. Review of policy and procedure "Methods of Implementation and Control LTC, 150.159" revised 6//2020 showed ..."COVID19 Epidemic Addendum: WCHS will follow guidance of CMS and WY dept of Health for Covid exclusions: ...No communal activities or dining will be offered at	F 880	F880 WCHS will implement appropriate infection prevention and intervention plan consistently with the requirements and this will be accomplished by: 1. WCHS will measure out 6 foot separation between recliners and dining locations. WCHS will mark locations with tape on the floor. All staff will be educated on placement of furnishings and residents. 2. All residents are provided face coverings and encouraged to wear them while in communal areas. Residents living in the secured unit will not leave secured area unless medically necessary, and will wear face coverings if they leave secured area. All staff will be educated on face coverings. 3. As identified in number 1. Dining seating spaces will be marked with 6 foot separation between residents. All staff will be educated on hand hygiene and social distancing during dining. 4. IP will contact QIO for assistance in improving infection prevention and control within the facility. 5. IP, DON, and IDT will conduct random monitoring via observation to ensure compliance and report to IP weekly and QA meetings monthly. 6. All staff will be educated on the infection control changes by July 24,		

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

PRINTED: 09/29/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2020
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1124 WASHINGTON BLVD NEWCASTLE, WY 82701		
(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 880	Continued From page 3 this time..."	F 880	2020. 7 All PRN staff and staff on leave who will not work by July 24, 2020 with be educated immediately upon starting their next scheduled shift. 8. All newly hired staff will receive education upon hire.		