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 01/13/2022

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 recertification survey was conducted by Healthcare Licensing and Surveys from 1/10/22 to 1/13/22. Also reviewed in the course of the survey was complaint intake WY00003346. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set LPN- Licensed Practical Nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care.	F 553		2/10/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/07/2022

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.

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 01/13/2022

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 553	Continued From page 1 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interview, and policy and procedure review, the facility failed to ensure resident care plan meetings facilitated the inclusion of the resident and resident representative for 1 of 15 sample residents (#13). The findings were: 1. Review of the quarterly MDS assessment dated 11/1/21 showed resident #13 had diagnoses which included cancer, diabetes mellitus, depression, and diverticulosis of the large intestine. The resident had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. The following concerns were identified: a. Interview with resident #13 on 1/11/22 at 10:09 AM revealed the resident had not attended recent care plan meetings because the resident's family members were not available on the days care plan meetings were held, and the resident wanted his/her family members to attend. The	F 553	F553 This requirement will be met as evidenced by: A.) All residents and their representative will be invited to the residents care plan meeting held each quarter. They will have the option to reschedule the meeting if they are unable to attend the designated date and time. Resident (#13) will be reviewed. The Family Care plan invitations to the meeting will be updated to include the option of alternate means of meeting days and times. The family care plan policy has been updated to include the representative calling and giving 3 alternate days or times they are able to meet. All invitations sent out will be scanned into the residents chart, Invitations will then be sent to the representative and given to the resident. Resident will accept or decline a meeting, it will be logged and initialed by resident if	

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 01/13/2022

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 553	Continued From page 2 resident stated meetings were only held on Mondays and Wednesdays when family members were working. Further interview revealed the resident requested the meetings be held on a different day so his/her family could attend, however, the facility said no to this request, and no explanation was provided. b. Interview with the administrator/social services director on 1/13/22 at 11:01 AM revealed the last scheduled care plan meeting for the resident was in November 2021 and confirmed neither the resident nor his/her family attended the meeting because they did not call or make an appointment. Further interview revealed she was not aware the resident and family wanted the care plan meeting to be held on a different day. 2. Review of the policy titled "Family Care Plan" dated 3/9/20 showed "...A. Social Services will serve as a liason between the resident, their family, and other department services. Activities will be scheduling care plan conferences with emphasis on the resident and his/her family. All other departments listed will be prepared with pertinent information about the resident...B. Family Care Plans will be held the last Wednesday of each month unless there is a [sic] interfering holiday..."	F 553	able. B.) Social services and designee were educated on 2/2/2022 for the process of inviting residents and their representatives, as well as giving options for those representatives who cannot make it on the scheduled day. This education includes, scanning the invitation that is sent to a representative and logging the resident acceptance or denial of the invitation. C.) At the beginning of each month, the care plan invitation letters will be produced and scanned by social services or designee into the electronic chart of each person who will be having a care plan that month. The care plan invitation will then be sent to representatives and given to residents. The family care plan policy will be reviewed annually for compliance as well as any changes to state or federal requirements. This process will be implemented by 2/10/22. D.) The Social Services Director will ensure compliance with all family care plan invitations being sent out, logged, and signed, utilizing the Resident Care Plan Invitation Log. Letter will be scanned into each resident□s chart. This log will be monitored monthly and reported quarterly during Nursing Home QAPI for compliance with CMS.	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family	F 565		2/10/22

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 01/13/2022

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 565	Continued From page 3 group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and review of the resident council meeting minutes, the facility failed to ensure group grievances and recommendations were acted on. The census was 26. The findings were:	F 565	F565 □ This requirement will be met as evidenced by: A.) All resident grievances and recommendations will be acted upon according to the grievance policy. Resident council complaints from the	

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 01/13/2022

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 565	Continued From page 4 1. Interview with 15 residents on 1/11/22 at 1:16 PM revealed the residents felt "Communications between administration, the staff, and residents is not consistent or smooth. The facility does not really give us answers to our requests, especially about food." 2. Review of the resident council minutes for the 1/5/22 meeting showed resident concerns included "Plates are cold, no coffee in early a.m. or towards the end of meals. They don't want leftovers." Further review showed the facility response to these concerns was "The residents not having leftovers is something I feel is not realistic and it is not a cost-effective way to offer alternatives at lunch and dinner. We have cut down the total servings of all main dishes to 32 so that will only leave about 3-10 left over after each meal (based off of amounts of alternates taken and how many hospital patients take the special which is the nursing home menu). Those 3-10 servings are then used within a day or two as the alternate for another meal so we don't waste product. I could see if we did 'no leftovers' all lunch alternates would be an assorted sandwich and canned fruit (leftover from other meals) and dinner alternates would always be soup (leftover from other dinners) and a grain." 3. Interview with the DON on 1/13/22 at 10:10 AM revealed she was not sure what the process was for handling grievances identified in resident council. 4. Interview with the administrator on 1/13/22 at 12:46 PM revealed concerns brought up in resident council were not turned into a grievance unless there was an identified resident risk. Further interview revealed resolutions to	F 565	January 5, 2022 resident council meeting will be reported as grievances and continued through the grievance policy. These grievances will be entered in the grievance log form and will then be reported to the state on the incident portal. An investigation will be done and reported to the state, the findings will then be covered in the following resident council meeting. Dietary will provide a Resident Food Preference Forms upon admission with current residents having preference forms previously completed. With the change of new menus, leftovers will no longer be used as an alternate. B.) Director of Nursing and Social Services will be re-educated about the grievance process and how they are submitted. This will be completed by 2/10/2022. C.) Social Services will accept grievances, log them, start the notification and investigation process. Any complaints either written or voiced in resident council will be addressed in accordance with the Grievance policy. The grievances for January will be logged and processed through the grievance procedures as written in the Grievance policy. This will be completed by 2/10/22 D.) The grievance policy will be reviewed and any updates will be done. A log of complaints and resolutions will be monitored monthly and reported on quarterly during QAPI for compliance with CMS.	

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 01/13/2022

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 565	Continued From page 5 concerns were communicated in the meetings.	F 565		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech,	F 676		2/10/22

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 01/13/2022

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 676	Continued From page 6 (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on medical record review, and resident and staff interview, the facility failed to ensure residents received needed assistance with bathing for 1 of 3 sample residents (#13) reviewed for ADL assistance needs. The findings were: 1. Review of the quarterly MDS assessment dated 11/1/21 showed resident #13 had diagnoses which included cancer, diabetes mellitus, depression, and diverticulosis of the large intestine. The resident had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Further review showed the resident required supervision of 1 person for bathing. Review of the care plan titled "I do need staff to provide supervision with bathing" last revised on 2/4/20 showed interventions which included "...Bathing: Staff to provide supervision with showering twice weekly..." The following concerns were identified: a. Interview with the resident on 1/11/22 at 10:27 AM revealed the resident had not received showers on his/her scheduled shower days "4 times" because "there wasn't enough staff to do it." Further interview revealed the facility did not attempt to give the resident a shower at another time when scheduled showers were missed. b. Review of the bathing record for November 2021 showed the resident received a shower on 11/5/21 and the next shower was not provided until 10 days later on 11/15/21. c. Review of the bathing record for December 2021 showed the resident received a shower on 12/3/21 and the next shower was not provided	F 676	Tag F676-This Requirement will be met as evidenced by: A. All residents will be provided with the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. Resident #13 and all resident ADL documentation will be reviewed and addressed for compliance. All resident care plans will be updated with preferences and bathing schedules. A policy will be created addressing resident ADL Standards of Care. Regarding interview comments from CNA #1 and #2, we will be implementing a staffing matrix based on State of Wyoming regulations. Current recruitment efforts will continue until fully staffed. B. All resident ADL and care plans will be reviewed and updated. DON will educate nurses and CNA□s on the ADL Standards of Care as well as on proper documentation of resident ADL refusals. The Chief Talent Officer will continue active recruitment efforts for nursing staff. The staffing matrix will be utilized when considering increases in resident census. C. An auditing tool will be created in order to track the resident ADL documentation. The care plan review sheet will be signed by the Interdisciplinary Team initially and quarterly. Staff education will be documented. The Chief Talent Officer will create a minimum staffing policy and	

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 01/13/2022

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 676	Continued From page 7 until 8 days later on 12/11/21. Further review showed the resident received a shower on 12/20/21 and the next shower was not provided until 7 days later on 12/27/21. d. Review of the bathing record for January 2022 showed the resident received a shower on 1/3/22 and the next shower was not provided until 7 days later on 1/10/21. e. Interview with CNA #1 on 1/11/22 at 7:14 PM revealed there was "usually" only 1 CNA from 6 PM to 6 AM and if showers were scheduled, they did not occur because nobody else was available to answer lights or monitor residents during the shower. f. Interview with CNA #2 on 1/13/22 at 10:20 AM revealed the staff "always worked shorthanded" and it was "doubtful" if even half of the baths were being performed. g. Interview with the DON on 1/13/22 at 9:45 AM revealed residents should receive showers twice per week and she felt the reason resident #13 missed his/her showers was because the facility did not have enough staff to perform the showers. Further interview confirmed resident #13 did not refuse any showers and was not out of the facility on his/her shower days.	F 676	Monthly Schedule Check Tool. The DON and Nursing Supervisors responsible for staff scheduling will monitor the Monthly Schedule Check Tool. D. The DON will be responsible for implementing new policy on Standards of Care, ADL auditing tool, education for nursing staff on Standards of Care and proper documentation of refusals. DON and MDS Coordinator will be responsible for monitoring ADL documentation for compliance using the ADL auditing tool weekly, and report findings to QAPI quarterly. This will be complete by 2/10/2022. The Chief Talent Officer will monitor active recruitment and responses during business days and report to QAPI quarterly.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		2/10/22

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 01/13/2022

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 690	Continued From page 8 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure appropriate indwelling catheter care was performed for 1 of 1 sample residents (#25) with an indwelling catheter. The findings were: 1. Review of the quarterly MDS assessment dated 11/9/21 showed resident #25 required extensive physical assistance of 1 person for bed mobility, dressing, and personal hygiene and total physical assistance of 1 person for toileting and bathing. Further review showed the resident had	F 690	Tag F690- The Requirement will be met as evidenced by: A.) All residents requiring indwelling catheters with urine collection bags will receive appropriate care. Resident #25 urine collection bag was placed in a privacy cover and secured to hook on bedframe on 1/13/2022. A policy will be created to standardize this process. B.) All residents with urine collection bags will be assessed for proper storage and covering and will be documented on the	

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 01/13/2022

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 690	Continued From page 9 an indwelling urinary catheter. The following concerns were identified: a. Observations on 1/11/22 at 9:28 AM and again on 1/12/22 at 3:37 PM showed the urine collection bag for the indwelling catheter was lying on the floor next to the bed without a privacy cover. b. Interview with CNA #3 on 1/12/22 at 4:15 PM revealed it was unclear if there ever was a privacy cover in use. c. Interview with the Director of Nursing on 1/12/22 at 3:10 PM revealed it was the facility expectation that all catheter bags have a protective covering, and were not stored on the floor.	F 690	auditing tool. Nurses and CNA□s will be educated on this process by 2/10/2022. C.) Random audits will be performed weekly and documented on auditing tool. An auditing tool will be developed in order to ensure that all that urine collection bags are properly placed and covered. This process will be implemented by 2/10/22. D.) The DON or designee will perform the random audits weekly and will report to QAPI quarterly to ensure compliance.	
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure oxygen tubing in a common area was stored in way that ensured the tubing was clean and safe for use for 1 of 1 sample resident (#12) reviewed for oxygen use. The findings were: 1. Review of the significant change MDS assessment dated 10/6/21 showed resident #12	F 695	F695-This Requirement will be met as evidenced by: A. All nasal cannulas will be stored in a manner to ensure the tubing is clean and safe for use. Resident #12□s nasal cannula that was stored in the dining room was removed. Resident #12 will wear same nasal cannula that will be reconnected to her various oxygen	2/10/22

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 01/13/2022

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 695	Continued From page 10 had diagnoses which included heart failure. The resident had a BIMS score of 2 out of 15, which indicated the resident had severe cognitive impairment. The resident required extensive physical assistance of 1 person for bed mobility, locomotion on and off the unit, dressing, toilet use, and personal hygiene and required total physical assistance of 1 person for transfers and bathing. Further review showed the resident required the use of oxygen. Review of the care plan titled "I require oxygen" last revised on 1/2/20 showed interventions which included "Administer my oxygen therapy as ordered 2L [2 liters] via NC [nasal cannula]. Assess my respiratory status. Obtain and record my oxygen saturation levels every shift." The following concerns were identified: a. Observation on 1/10/22 at 6:01 PM showed the resident was seated at a table in the dining room, wearing a nasal cannula dated 1/2/22, which was connected to an inline wall-mounted oxygen regulator. An unidentified staff member removed the resident's nasal cannula and hung the cannula on the oxygen regulator flowmeter. A storage receptacle was not used. b. Observation on 1/11/22 at 10 AM showed the nasal cannula remained hung on the inline wall-mounted oxygen regulator's flowmeter. A storage receptacle was not used. c. Observation on 1/12/22 at 3:34 PM showed the nasal cannula remained hung on the inline wall-mounted oxygen regulator's flowmeter. A storage receptacle was not used. d. Observation on 1/13/22 at 10:02 AM showed the nasal cannula remained hung on the inline wall-mounted oxygen regulator's flowmeter. A storage receptacle was not used. e. Interview with the DON on 1/13/22 at 10:11	F 695	sources. The DON will be ordering nasal cannula storage bags in order to store oxygen tubing in a clean and safe manner in all areas where oxygen is in use. These nasal cannula storage bags will be designated for each resident who uses oxygen and replaced according to manufacturer guidelines. A policy will be created to define and standardize the expectation for storage of nasal cannulas. B. The DON will educate nurses and CNA□s on the proper use of nasal cannula storage bags by 2/10/2022. C. The DON will develop an auditing tool for documentation for monitoring of correct nasal cannula storage processes. D. The DON will implement the policy and auditing tool. The DON or designee will perform random audits on nasal cannula storage processes weekly and report to 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 01/13/2022

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 695	Continued From page 11 AM revealed the facility did not have a formal practice to store nasal cannulas when not in use. Further interviewed confirmed hanging the cannula on the regulator's flowmeter in the dining room did not protect it from contamination.	F 695		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, and policy and procedure review, the facility failed to ensure bed rails were assessed for safety for 3 of 3 sample residents (#3, #10, #25) with bed rails. The findings were:	F 700	Tag 700 - This requirement will be met as evidenced by: A) Residents that utilize side rails will be assessed initially by physical therapy for appropriate use of the bed rails and	2/10/22

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 01/13/2022

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 700	Continued From page 12 1. Review of the quarterly MDS assessment dated 11/10/21 showed resident #10 had diagnoses which included cancer, spinal stenosis, and chronic low back pain. The resident had a BIMS score of 15 out of 15, which indicated s/he was cognitively intact. The resident required supervision with set-up help for bed mobility. Review of the care plan titled "Self Care Deficit" last revised on 1/4/21 showed interventions which included "...Bed Mobility: Independent and I do not use side rails..."The following concerns were identified: a. Observation on 1/11/22 at 9:11 AM showed the resident had a half side rail, in the up position, on the upper right side of the bed. The rail was designed to have 2 gaps which were the same length as the rail. Interview with the resident at that time revealed s/he used the rail for positioning. b. Review of the medical record showed no evidence the side rail was assessed for safety or entrapment risk. c. Interview with the DON on 1/13/22 at 1:30 PM confirmed the facility did not assess the rail for safety or entrapment and she confirmed the half side rail had gaps which were large enough to pose a risk for entrapment. 2. Review of the admission MDS assessment dated 10/14/21 showed resident #3 had diagnoses which included anoxic brain damage, post procedural cardiac arrest, abnormal heart beat, and abdominal pain. Further review showed the resident required total physical assistance of 1 person for bed mobility, transfers, dressing, eating, toileting, and personal hygiene. The following concerns were identified:	F 700	evaluated for an alternative method. Evaluation for use of bed rails will be completed quarterly and with a significant change of condition in accordance with MDS schedule. Bed Rail Policy was updated to reflect the manufacturers recommendations and specifications, to reflect assessment, safety concerns. Resident (#3, #10, #25) will be assessed for bed rails and implemented in the plan of care. The assessment for Evaluation for Use of Assist Rails will be scanned into electronic health record. A physician order will be obtained for use of side rails. The DON or MDS Coordinator will continue to evaluate effectiveness of bed rail use. B) Education will be provided to nursing on the process of determining the implementation of bed rails. A pamphlet for a guide to bed safety will be utilized to provide education to resident and resident representative. C) A monthly monitoring tool will be developed to ensure the completion of evaluation for bed rails use, education of risk and benefits, ensuring bed□s dimensions are appropriate for resident and manufacturer□s recommendations are followed for installing and maintaining bed rails. This will be completed as of 2/10/22 D) The DON or MDS Coordinator will ensure the compliance with the completion of assessments of Evaluations for Use of Assist Rails. Monthly audits will be completed to ensure completion and reported on quarterly at the QAPI meeting to ensure compliance with CMS.	

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 01/13/2022

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 700	Continued From page 13 a. Observation on 1/12/22 at 9:50 AM showed the resident's bed had half side rails, in the up position, on the bilateral upper portion of the bed and a circulating air mattress which periodically left space between the rails during mattress deflation phases. b. Review of the medical record for the resident showed no evidence the side rail was assessed for safety or entrapment risk and no evidence the care plan was updated related to the use of side rails. 3. Review of the quarterly MDS assessment dated 11/9/21 showed resident #25 had diagnoses which included congestive heart failure, and repeated falls. Further review showed the resident required extensive physical assistance of 1 person for bed mobility, dressing, and personal hygiene, and total physical assistance of 1 person for toileting and bathing. The following concerns were identified: a. Observation on 1/11/22 at 9:28 AM showed the resident was in bed with quarter side rails, in the up position, to the bilateral upper portion of the bed. Further observation showed the resident was able to place his/her arm between the rail and the mattress. b. Review of the medical records for the resident showed no evidence the side rail was assessed for safety or entrapment risk and no evidence the care plan was updated related to the use of side rails. 4. Interview with the MDS Coordinator on 1/12/22 at 11:22 AM revealed the facility did not use a side rail safety assessment tool and there was no policy regarding side rail usage. Further interview revealed side rails were used as needed.	F 700		

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 01/13/2022

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 700	Continued From page 14 5. Interview with the DON on 1/13/22 at 1:30 PM revealed she was aware side rails needed to be assessed for safety and entrapment risk. Further interview revealed she was unsure if the facility had an assessment for side rail use. 6. Review of the policy titled "Appropriate Use of Side Rails" dated 8/13/14 showed "...1. DON or designee will complete assist rail consent form to determine if appropriate and safe. 2. The potential benefits as well as the potential risks will be identified and benefits must outweigh the risks. 3. If determined safe and appropriate an order from the physician will be obtained. 4. Resident or DPOA must sign the consent after the benefits and risks are discussed with them. 5. Assist rail need will be reviewed by IDT quarterly and as needed or with significant change in status and determined at that time to continue with rail or discontinue."	F 700		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following	F 725		2/10/22

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 01/13/2022

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 725	Continued From page 15 types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, medical record review, review of resident council meeting minutes, review of the facility assessment for 2021, and review of the staff schedule, the facility failed to ensure there was sufficient qualified nursing staff available at all times to provide nursing and related services to meet resident needs. The census was 26. The findings were: 1. Review of the Facility Annual Assessment for 2021 dated 1/29/21 showed the facility had determined a nurse staffing of 1 licensed nurse and 3 CNAs was required for day shift, and 1 licensed nurse and 2 CNAs was required for night shift to meet the needs of an average daily census of 18 residents. The census at the time of survey was 26 residents. 2. Review of the nursing staffing schedule and the daily direct care staff posting showed the facility met the required staffing rates on only 43% of night shifts, and only 3% of day shifts for the months of November and December 2021. 3. Interview with CNA #1 on 1/11/22 at 7:14 PM	F 725	F725- This requirement will be met as evidenced by: A) The Facility shall have sufficient nursing staff to meet the needs of the resident. The plan to address the nursing staff deficiency will include creating a policy addressing minimum staffing requirements for the nursing home based on Wyoming Administrative Statutes, Ch. 11, Section 9. The Facility Assessment will be updated to reflect minimum staffing requirements based on the Minimum Staffing Policy. Each month the nurse and C.N.A schedule will be created based on the Minimum Staffing Policy and resident census. The nurse and C.N.A. schedule will reflect the appropriate number of staff members schedule each shift. B) Key stakeholders will receive training and will attest to reading, acknowledging, and abiding by the Minimum Staffing Policy. C) The procedure for implementing the plan of correction for staffing deficiency will involve a Monthly Schedule	

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 01/13/2022

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 725	Continued From page 16 revealed the facility only had 2 CNAs who worked night shift and the facility staffed one each night to care for 26 residents. The CNA revealed she had to assist the residents to bed after dinner and did not have enough time to perform other duties like showers. Further interview revealed if she were to perform showers, there would not be anyone available to monitor residents or answer call lights as the nurse had to complete medication administration and treatments. 4. Interview with CNA #2 on 1/13/22 at 10:20 AM revealed the staff always worked shorthanded and it was "doubtful" if even half of the baths were being performed. 5. Review of the Resident Council meeting minutes dated 11/7/21 showed concerns were voiced by the resident council about the staffing shortage. 6. Interview with resident #10 on 1/11/22 at 9:01 AM revealed the facility "could use more staff." 7. Interview with resident #76 on 1/11/22 at 4:35 PM revealed "staff work long hours" and it felt like the there was "low staffing." 8. Interview with the DON on 1/12/22 at 3:10 PM revealed it was "impossible" for the facility to provide the required staff on each shift. The DON revealed there were 6 open CNA positions that could not be filled at that time. Further interview revealed a job posting had been made locally and the facility had been attempting to obtain contracted agency staff since 12/26/21; however, they had not been successful with getting contracted agency CNAs.	F 725	Check Tool. The Monthly Schedule Check Tool will compare the nursing home nurse staff schedule and C.N.A. staff schedule against the minimum staffing requirements per policy prior to publication of the schedule. The monthly schedule check will ensure that the plan of correction is effective, and the specific deficiency of sufficiently staffing each shift,remains corrected. D) The Chief Talent Officer will be responsible for the creation, implementation and education on the Minimum Staffing Policy and will be responsible for updating the staffing portion of the Facility Assessment. The creation of the Minimum Staffing Policy will be completed by February 10th, 2022. Education on the minimum staff policy will be accomplished by February 10th, 2022. The Facility Assessment will be updated with the staffing requirements by February 10th, 2022. The Director of Nursing will be responsible for the Monthly Schedule Check Tool. The monitoring tool will be completed monthly and reported on quarterly at the QAPI meeting to ensure sufficient staffing based on resident census.	

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 01/13/2022

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 758	Continued From page 17	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		2/3/22

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 01/13/2022

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 758	Continued From page 18 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure psychotropic medications monitored for effectiveness for 2 of 5 sample residents (#21, #22) reviewed for unnecessary medication use. The findings were: 1. Review of the quarterly MDS assessment dated 1/3/22 showed resident #21 had diagnoses which included depression and no behavior symptoms were coded. Further review showed the resident had a BIMS score of 4 out of 15, which indicated the resident had severe cognitive impairment, and a patient health questionnaire 9 (PHQ-9) score of 00, which indicated no depression symptoms were present. Review of the medication orders showed the resident received mirtazapine (antidepressant) 15 mg by mouth every day at bedtime (order dated 4/1/21) and Zyprexa (antipsychotic) 5 mg by mouth at bedtime (order dated 9/8/21). Review of the psychoactive medication consent for mirtazapine dated September 2021 showed "...Medication Target Behavior...Anxiety, agitation, confusion, depression, delirium, further weight loss..." Review of the psychoactive medication consent	F 758	F758 □ This requirement will be met as evidenced by: Bonnie Bluejacket Memorial Nursing Home (BBMNH) and the Pharmacy Department and Psychotropic Committee acknowledge that nursing home residents, including residents #21 and #22, should be free from unnecessary psychotropic meds. This will be evidenced by all psychotropic medications being reviewed for possible inclusion, when clinically appropriate, and every 6 months (twice yearly in January and July) at a minimum. Front line nursing personnel (Care Plan coordinator, nurses and CNAs) will be educated and provided a Psychotropic Charting Aid, as to reason for psychotropic use, target symptoms, treated conditions symptoms, and potential adverse reactions to the medication being used so that their psychotropic and behavior charting is correct and appropriate for use by the Medical Director, Consultant Pharmacist	

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 01/13/2022

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 758	Continued From page 19 for Zyprexa dated October 2021 showed "...Medication Target Behavior...Hallucinations, anger, agitation, unhappiness with surroundings or food due to perceived conditions..." The following concerns were identified: a. Review of the care plan titled "I am taking an antidepressant/antipsychotic medication daily" last revised on 12/21/21 showed interventions which included "monitor my behavior and document every shift. Report any negative observations to physician...I had been seeing worms in my food and not eating well. I was placed on Zyprexa and my appetite has increased..." There were no identified target symptoms for the use of mirtazapine and no additional target symptoms for the use of Zyprexa. b. Review of the medical record showed no evidence of routine monitoring for the identified target symptoms. 2. Review of the quarterly MDS assessment dated 12/20/21 showed resident #22 had diagnoses which included non-Alzheimer's dementia and had a BIMS score of 0 out 15, which indicated the resident was severely cognitively impaired. Further review showed the resident had verbal behavior symptoms directed at others and other behaviors not directed at others. No PHQ-9 assessment had been performed. Review of the physician orders showed the resident received mirtazapine (antidepressant) 15 mg by mouth daily at bedtime (order dated 1/12/22). Review of the psychoactive medication consent for mirtazapine dated May 2021 showed "...Medication Target Behavior...Talking negatively or fatalistically, unhappiness, decreased appetite, refusing to take medications..." The following concerns were	F 758	and the Psychotropic Committee in deciding appropriateness of the medication and its possible gradual dosage reduction. These actions will be accomplished by February 3, 2022. The Consultant Pharmacist will take responsibility for seeing these corrections are done and that the system continues to stay up to date and functioning in continuity. This information will be presented to the Resident Care Council and the Psychotropic Committee and potential Quality issues will be reported to the QAPI program. POC Components: -Psych policy updated to include mechanism to accomplish above corrections. Completed and returning to P&T for Acceptance. -Update of Consent Statements for each resident, and communication technique to pass information from this sheet to the front-line staff responsible for behavior notes. To be finished and communicated to the Director of Nursing and the Care Plan Coordinator on 2/3/22 January GDR statements forwarded to Medical Director. Completed with communication of Jan 2022 DRR.	

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 01/13/2022

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 758	Continued From page 20 identified: a. Review of the care plan last revised on 11/30/21 showed no evidence of psychotropic medication use or identified target symptoms. b. Review of the medical record showed no evidence of routine monitoring for identified target symptoms. 3. Interview with pharmacist #1 on 1/13/22 at 8:21 AM revealed the interdisciplinary team reviewed psychotropic medication use to determine if continued use was necessary. The team identified target symptoms for use on the consent form; however, he was unsure how the facility monitored and documented the symptoms or how the facility communicated target symptoms with floor staff. 4. Review of the policy titled "BBJNH LTCF Policy and Procedure for Prescribing Psychotropics and Antipsychotics" provided by the facility on 1/13/22 showed "...To assure the psychotropic medication, especially antipsychotics, are prescribed, administered, monitored by approved current evidence-based medical practices and regulatory statutes; and limited to the lowest effective dose for approved clinical diagnoses and/or conditions causing distress and potential mental or psychological harm, and for the minimum appropriate duration of use and therefore will be used with rigorous monitoring aimed at protecting the resident while still meeting their psychiatric needs..."	F 758		
F 806 SS=F	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides-	F 806		2/1/22

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 01/13/2022

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 806	Continued From page 21 §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, resident, resident group, and staff interview, medical record review, review of resident council meeting minutes, and review of the facility meal menu, the facility failed to ensure meals accommodated resident allergies, intolerances, and preferences. The census was 26. The findings were: 1. Review of the quarterly MDS assessment dated 11/1/21 showed resident #13 had diagnoses which included cancer, diabetes mellitus, depression, and diverticulosis of the large intestine. The resident had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of the care plan titled "I am over ideal body weight and BMI" last revised 11/11/21 showed interventions which included "I will follow physician diet ordered of LCS [low concentrated sweets]/lactose interance [sic]...Maintain my current listing of food likes and dislikes..." Review of the "Food Preference Form" provided by the facility on 1/13/22 showed the resident was on a low concentrated sweets diet and food allergies indicated the resident was lactose intolerant. a. Interview with the resident on 1/11/22 at 10:13 AM revealed the s/he felt the food was "horrible" and when s/he told the facility they said there wasn't anything they could do about it. The	F 806	F806- This requirement will be met as evidenced by: A) Individual residents preference and/or restrictions will be assessed and documented on the Resident Food Preferences Form upon admission or with a change in condition. Resident restrictions are obtained from the Physician signed order. Orders are then printed out and placed in the Resident Diet Binder that is accessible to all dietary staff. All Registered Dietician approved resident menus will include two entr¿es of different protein sources with at least one being lactose free for resident #13 (Completed 1/26/2022). Leftovers have been eliminated from alternate meal use (Completed 1/31/2022). Updated menus will be assessed for nutritional value and approved by the Registered Dietician on an ongoing basis as menus are updated. Lactose free items on the menu calendar and the resident order form will have items containing lactose clearly identified. New Alternate Entr¿e menu, approved by the Registered Dietician, is available for quick order daily. The lactose identifying menu was updated to make lactose	

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 01/13/2022

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 806	Continued From page 22 resident revealed she was lactose intolerant and when s/he ate dairy products, it caused diarrhea; however, the resident still received dairy products on his/her meal trays. The resident revealed the facility provided a weekly menu for her to review; however, the menu did not identify items with dairy, did not identify alternative options, and sometimes had names of food that s/he had never heard of. The resident revealed the usual alternative options were a tuna fish sandwich, a peanut butter and jelly sandwich, or a salad. S/he revealed s/he ate "a lot of salad" since s/he did not like tuna fish or peanut butter and jelly. Further interview revealed the facility "keep saying it is our home, but they do not want us to complain." b. Review of a progress note dated 8/25/21 and timed 5:31 PM showed "IDT met with [resident name] to discuss [his/her] plan of care. [S/he] had no concerns at this time. [His/her] cares have not changed and no concerns with mood/behavior. [S/he] did wonder if dietary could add if items on the menu contained milk or cheese and we would take it to [name] dietary manager..." 2. Interview with resident #76 on 1/11/22 at 4:36 PM revealed the facility served tuna salad sandwich and macaroni and cheese "several nights in a row" and the alternate option was a peanut butter and jelly sandwich with fruit salad. The resident revealed alternates were "not filling" and "4 days out of the last week" residents had sandwiches for dinner. 3. Interview with resident #18 on 1/11/22 at 10:39 AM revealed "Because I am listed as independent they don't pay much attention to me." Further interview revealed the resident frequently did not	F 806	containing foods more visible on menu (completed 2/1/2022). Leftover hot food will be disposed after meals. B) Dietary staff was trained on how to complete the alternate resident order form. Menus will be updated on a 6-month rotation by the Certified Dietary Manager, or sooner if needed, and approved by the Registered Dietician. A signed nutritional statement will be placed in the front of each weekly recipe book to attest to the approval of the weekly cycle menu by the Registered Dietician. C) All updates and changes will be monitored by the Certified Dietary Manager and approved by the Registered Dietician. Alternate entr¿e (special orders) will be documented on The Alternate Resident Order Form. The Alternate Resident Order Form audit tool will be used in conjunction with information from Resident Council meetings to make changes to menus. Using the Alternate Resident Order Form (Created 1/26/2022), the dietary department will track individual resident requests and substitutions. Those will then be used to help build the semi-annually updated resident cycle menus. This process was completed on 2/1/2022. D) Menus are meeting the nutritional needs of the residents as evidenced by Registered Dietician evaluation, statement of fact, and the Registered Dietician signature. The completed Alternate Resident Order Form will be evaluated quarterly with menu updating semi-annually, at a minimum, and	

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 01/13/2022

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 806	Continued From page 23 eat because the only alternative to the meal was sandwiches. 4. Interview with group of 15 residents on 1/11/22 at 1:16 PM revealed alternatives to the scheduled menu consisted of only tuna fish sandwich, peanut butter and jelly sandwich, or macaroni and cheese. Further interview revealed a concern that leftovers were used every day until they were gone, with one resident stating, "If you don't eat it today, you will for the next three." 5. Review of the resident council minutes dated 1/5/22 showed a concern was made related to the use of leftovers as alternates and the response was "The residents not having leftovers is something I feel is not realistic, and it is not a cost-effective way to offer alternatives at lunch and dinner...based off of amounts of alternates taken and how many hospital patients take the special which is the nursing home menu...Those 3-10 servings are then used within a day or two as the alternate for another meal so we don't waste product." 6. Observation of the evening meal on 12/10/22 at 5:27 PM showed the planned meal was "tuna salad sandwiches" and chicken noodle soup. The only alternative provided was peanut butter and jelly sandwiches. 7. Review of the facility menu from 1/10/22 through 1/15/22 showed no alternative meal items were identified. In addition, sandwiches were the main course for the dinner meal on 1/10/22, 1/12/22, 1/14/22, and 1/16/22. 8. Interview with cook #1 on 1/12/22 at 10:52 AM revealed she was unsure why the dinner meal	F 806	reported by the Certified Dietary Manager at QAPI meetings quarterly to ensure that resident requests are being completed.	

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 01/13/2022

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 806	Continued From page 24 was a lighter meal and the alternative was always "whatever we have left over." Further interview revealed the residents could always have a tuna fish sandwich or a peanut butter and jelly sandwich if they did not like the meal choices. 9. Interview with the dietary manager on 1/13/22 at 11:27 AM revealed the preparation of the alternative meals was based on the cook's preference to serve left-overs the way they were originally prepared or to use the left-overs prepared in a new manner. The dietary manager confirmed when left-overs were used to prepare a new meal item, it was not reviewed or approved by a dietitian. Further interview confirmed since the facility utilized left-over meals as the alternative option, some resident allergies, intolerances, or preferences may be unaddressed in both meal options. 10. Review of the policy titled "Resident Menus" dated 3/1/21 showed "...B. Menus will be approved by the Registered Dietician (RD). C. Menus shall include meals which are nutritionally adequate and be planned within a budget. D. Modifications to diets will be available in accordance with approved extensions in the menu program..."	F 806		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced	F 810		1/31/22

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 01/13/2022

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 810	Continued From page 25 by: Based on observation, medical record review, and staff interview, the facility failed to ensure special eating equipment was available for 1 of 1 sample residents (#9) reviewed for use of assistive devices. The findings were: 1. Review of the quarterly MDS assessment dated 1/18/21 showed resident #9 had a BIMS score of 14 out 15, which indicated the resident was cognitively intact, and diagnoses which included cerebrovascular accident. Further review showed the resident required supervision with set-up help for eating. Review of the care plan titled "Difficulty with self feeding related to hand contractures" dated 11/6/19 showed interventions which included "Use adaptive equipment as recommended by OT [occupational therapy]: high sided divided plate and large handled weighted silverware. The following concerns were identified: a. Observation on 1/10/22 at 5:27 PM showed the resident was provided a weighted knife and weighted fork. The resident asked staff about his/her weighted spoon and was told "We don't know where the spoon is." An unidentified staff member stated the missing spoon was "an issue over the weekend." 2. Interview with the dietary manager on 1/13/22 at 11:27 PM revealed she was not aware the residents weighted utensils were not available. She confirmed the facility did not have extra weighted utensils at the weight the resident used.	F 810	Tag #810- This requirement will be met as evidenced by: A) Occupational Therapy will evaluate a residents need for special eating equipment and utensils when an order is placed by the Physician. Dietary will ensure compliance when special eating equipment and utensils are ordered. Occupational Therapy evaluated resident #9 on 1/31/2022 to ensure correct weight for his/her utensils. Special eating equipment and utensils are accessible to all dietary staff members to complete an order by Occupational Therapy. B) All training for special eating equipment and utensils will be completed by Occupational Therapy. Training for dietary staff will include the process for staff of notifying the Certified Dietary Manager of lost or unavailable equipment or utensils. Missing equipment and utensils will be documented on the Special Eating Equipment and Utensils monitoring tool along with completion of notification to the Certified Dietary Manager. C) Occupational Therapy will perform an evaluation of residents with special eating equipment and utensils quarterly based on the MDS schedule. Dietary will report results of that evaluation to the IDT team at the next quarterly care plan. An audit at random meals will be performed two times per week to ensure proper special eating equipment and utensil are being used and document findings on the Special Eating Equipment and Utensils	

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 01/13/2022

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 810	Continued From page 26	F 810	Audit Tool. Corrective action will be documented on audit tool, if needed. D) Certified Dietary Manager and/or the Dietary Staff will be responsible for twice weekly auditing of special eating equipment and utensils during mealtimes. The Certified Dietary Manager will report quarterly to QAPI for compliance with CMS.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the food code, the facility failed to ensure food was stored, prepared, ensure appropriate hand hygiene as performed while serving meals or assisting residents with eating for 3 random	F 812	Tag #812- This requirement will be met as evidenced by: A) All items in the refrigerator are to be stored in labeled covered containers or	2/1/22

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 01/13/2022

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 812	Continued From page 27 observations. Further, the facility failed to ensure food was stored and prepared under sanitary conditions in 1 of 1 kitchen (Main). The census was 26. The findings were: Regarding hand hygiene: 1. Observation on 1/10/22 at 5:28 PM showed CNA #4 was talking with a resident and placed her hand on the resident's shoulder. Following the interaction, the CNA obtained a tray from the cook and delivered the tray to a different resident. No hand hygiene was performed after resident contact. 2. Observation on 1/10/22 at 5:31 PM showed CNA #5 performed hand hygiene, then used her hands to brush back her own hair, rested her arms on her torso, obtained a tray from the cook, and delivered the tray to a resident. 3. Observation on 1/10/22 at 5:34 PM showed CNA #2 was assisting a resident to eat using her right hand. Another staff member approached the table and said she would assist that resident. CNA #2 turned to her left and began assisting another resident, using her right hand. No hand hygiene was performed between residents. 4. Interview with the DON on 1/13/22 at 12:26 PM revealed staff were expected to perform hand hygiene after coming in contact with a dirty surface such as clothing, residents' bodies, hair, or other surfaces that may be contaminated, prior to passing meal trays or assisting residents. Further interview confirmed hand hygiene should be performed after assisting one resident and prior to assisting another.	F 812	labeled closed bags. The table and chairs were removed from the storage room and staff no longer utilizes the store room during break time (Completed 1/17/2022). All cleaning and sanitizing items were added to the Weekly Cook/Aide Cleaning Schedule forms (Completed 1/25/2022). The cleaning schedule has been updated to include verification of storeroom cleanliness, closed and labeled containers in the refrigerator, and cleaning of the knife block (Completed 1/25/2022). All staff who participate in food preparation and serving will ensure appropriate hand hygiene is performed while serving meals or assisting residents with eating. Facility hand hygiene policy will be updated. B) All staff who participate in food preparation and serving will be re-educated on appropriate hand hygiene processes. Training of proper storage of personal items was completed and documented on 1/17/2022. C) Dietary staff will complete all assigned daily and weekly tasks on the Cook/Aide Cleaning Schedules. The Certified Dietary Manager created the Cleaning Audit Tool that will be used to verify the weekly responsibilities are completed (Completed 2/1/2022). The DON will develop and implement a hand hygiene auditing tool. The DON or designee will perform weekly random audits of hand hygiene practices during meal times and document these findings on the hand hygiene auditing tool. D) The Certified Dietary Manager and/or an assigned dietary staff member will complete a random cleaning assignment	

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 01/13/2022

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 812	Continued From page 28 Regarding food storage and preparation: 1. Observation of the walk-in refrigerator on 1/10/22 at 4:44 PM showed a metal pan labeled "grilled chicken 1/8-1/11" had half the pan covered with aluminum foil and the remainder of the pan was uncovered and open to air. 2. Observation of the "True" refrigerator on 1/10/22 at 4:54 PM showed a styrofoam container, filled with what appeared to be shredded beef, which was not labeled or dated. 3. Observation of the walk-in refrigerator on 1/12/22 at 10:17 AM showed a metal pan labeled "Lemon Pepper Chicken Drum made 1/11 exp 1/14" and a metal pan labeled "Hot Dog made 1/11 exp 1/14" had half the pans covered with foil and the remainder of the pan was uncovered and open to air. The hot dog pan had hot dogs which were floating in a liquid with a white residue on the top of the liquid. Further observation showed a bag labeled "Bacon and Sausage 1/12/22 exp 1/15/22" and a bag labeled "Biscuits with butter 1/11-1/18" which were open to air. 4. Observation of the dry storage room on 1/12/22 at 10:21 AM showed a table placed next to a storage rack which contained canned vegetables and boxed mixes. Laying on top of the canned vegetables was a used facemask and a cell phone. Next to boxed mixes was a metal drink tumbler with a straw coming out of it. Interview with a staff member seated at the table at that time revealed she was on break. 5. Observation of a stainless steel table next to the flat top stove on 1/12/22 at 10:36 AM showed a knife holder secured to the end of the table.	F 812	audit on a weekly basis and document findings on the Cleaning Audit Tool. The Certified Dietary Manager or assigned Dietary staff will report quarterly at the QAPI meeting to ensure compliance of assigned cleaning duties. The DON will report quarterly at QAPI to ensure compliance of hand hygiene.	

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 01/13/2022

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 812	Continued From page 29	F 812		

The top of the knife holder had visible crumbs and debris where knives were inserted into the holder. Observation 1/12/22 at 11:27 AM showed the cook removed a knife from the dirty knife holder and began cutting ham for a chef salad. The knife was not cleaned or sanitized before use.

6. Interview with the dietary manager on 1/13/22 at 11:27 AM revealed open items should be stored in a closed container with a label and date. Leftover food should also include the date prepared and a use by date. She revealed cooked items should be fully covered and not open to air after they were cooled. Further interview revealed staff should not store personal items on food racks and all food in the kitchen was available for resident consumption.

7. According to Food Code 2017, U.S. Public Health Service: 4-601.11 "...Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch..."

8. According to Food Code 2017, U.S. Public Health Service: 3-305.11 "...Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor..."

9. According to Food Code 2017, U.S. Public Health Service: 3-305.12 "...Food Storage, Prohibited Areas. FOOD may not be stored: (A) In locker rooms; (B) In toilet rooms; (C) In dressing

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 01/13/2022

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 812	Continued From page 30 rooms; (D) In garbage rooms; (E) In mechanical rooms; (F) Under sewer lines that are not shielded to intercept potential drips; (G) Under leaking water lines, including leaking automatic fire sprinkler heads, or under lines on which water has condensed; (H) Under open stairwells; or (I) Under other sources of contamination..."	F 812		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, QAPI meeting review, and review of the QAPI plan, the facility failed to ensure the quality assessment and assurance committee met at least quarterly and identified quality issues requiring performance improvement. The facility census was 26. The findings were: 1. Review of the QAPI meeting minutes showed	F 868	F868-This Requirement will be met as evidenced by: A. The facility will ensure it has a QAPI Plan and a committee consisting of, the DON, The Medical Director and at least 3 other members of the Nursing Home staff. Meetings will be held at least quarterly and will identify quality issues requiring performance improvement. Report	2/10/22

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 01/13/2022

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 868	Continued From page 31 the most recent meeting was held on 6/22/21. 2. Interview with the DON on 1/13/22 at 2:06 PM confirmed the last formal meeting was held on 6/22/21 and revealed she was aware of the requirement to meet at least quarterly. She further revealed the facility was not working on any performance improvement plans or monitoring the performance of individual departments. 3. Review of the "Quality Assurance and Performance Improvement (QAPI) Plan" provided by the facility on 1/13/22 showed "...Quality Assurance (QA) is a process of meeting quality standards and assuring that care reaches an acceptable level to improve, maintain, or minimize the deterioration of health or quality of life...Guideline for Leadership...G. The monthly Quality Committee meetings will be the formal forum for communication and coordination and documentation of QAPI activities...:	F 868	progress to the Quality committee quarterly. The Nursing Home QAPI program will meet at least quarterly, with first scheduled on 2/9/2022. All participants are to perform their own performance improvement projects, report their progress to the Nursing Home QAPI program, and provide written copies of their performance improvement projects or monitoring they are performing, to the DON. B. The Quality committee will be trained on the process and requirements for QAPI projects. The Nursing Home Administrator will retain attendance and meeting minutes documentation. C. The minutes of the meeting will verify attendance and active performance improvement projects. Meeting attendance and meeting minutes will be documented for all Nursing Home QAPI program meetings. D. Nursing Home Administrator or designee will report to the Quality Committee on a quarterly basis. QAPI plan will be in affect by 2/10/2022.	
F 880 SS=K	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	F 880		1/13/22

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 01/13/2022

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 880	Continued From page 32	F 880		

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 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

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 01/13/2022

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 880	Continued From page 33 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. §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, review of professional standards, review of manufacturer recommendations, and policy and procedure review, the facility failed to ensure appropriate infection control techniques were implemented. Specifically, the facility failed to ensure blood glucose monitors were disinfected between uses during 1 of 1 observation which affected 5 residents (#3, #12, #14, #20, #24). This failure resulted in an unacceptable risk to resident health and a determination of immediate jeopardy. The findings were: 1. Observation on 1/11/22 at 2:54 PM showed RN #1 obtained a glucometer from the nursing cart, wiped the glucometer with an alcohol pad, entered the room of resident #3, inserted a blood glucose strip, and obtained a blood glucose reading. The RN left the resident's room and returned to the nursing cart where she wiped the glucometer down with an alcohol pad. Interview	F 880	F880- This requirement will be met as evidenced by: A. All glucometers will be wiped down between uses as well as between all residents for blood glucose testing. Nursing will be using the manufacturers for cleaning procedure as written in the instruction manual. The Glucometer Policy will be updated with the correct information. The instruction for proper procedure will be on the med cart and the glucometer docking station at all times for reference. This process will be completed by January 13, 2022. B. RN□S/LPN□s will be educated as immediately as possible before their shifts on the updated policy and proper procedure of cleaning the Glucometer. RN□s/LPN□s will sign off that they have been properly educated on the procedure for cleaning the meter. All new	

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 01/13/2022

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 880	Continued From page 34 with the RN at that time revealed the facility only had alcohol pads to disinfect the glucometer and that was how she always cleaned it. Further interview confirmed the glucometer was the only glucometer, and it was used for multiple residents. 2. Interview with the DON and MDS coordinator on 1/11/22 at 3:01 PM revealed staff were expected to wipe down the glucometer with a "purple sani-wipe" after each use. 3. Interview with the MDS coordinator on 1/11/22 at 3:40 PM, revealed there were 5 residents who required blood glucose checks, later identifed as residents #3, #12, #14, #20 and #24. 4. Review of the staffing schedule for 1/11/22 showed RN #1 was the only licensed nurse assigned to provide direct resident care that day shift. 5. Review of the "Instructions for Use Manual" for the "Stat Strip Glucose Hospital Meter system" page 6-4 provided by the facility on 1/11/22 showed "...Acceptable Cleaning and Disinfecting Materials...Nova Biomedical recommends the use of Clorox Healthcare Bleach Germicidal Wipes, EPA Registration #67619-12, or any disinfectant product with EPA Registration #67619-12 may be used...Meter Cleaning and Disinfection Procedure...Clean and disinfect after each patient use by following this protocol to help ensure effective cleaning and disinfecting..." 6. Review of the policy titled "Glucometer Point of Care Testing Nova Statstrip System" last reviewed on 10/4/21 showed "...K. Clean the instrument after each use before leaving the	F 880	RN□s/LPN□s will be educated upon hire and will need to check off on competency for proper cleaning procedures for the blood glucometer. DON will update the bloodborne pathogen policy and educate all nursing staff procedures to prevent the spread of bloodborne pathogens. The Director of Nursing will ensure competency with proper education for the cleaning of the Glucometer. C. DON will be responsible for educating and signing off all RN□s/LPN□s after education on the processes. Check off sheet and random auditing tool will be completed monthly, as part of the performance improvement plan, D. CNO will be responsible for updating the Policy with the corrected information. DON will be responsible for doing random audits and education, will also report quarterly at the QAPI meeting to ensure compliance with CMS.	

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 01/13/2022

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 880	Continued From page 35 patient room:...ii. Gently wipe the meter's surface using a Super Sani-cloth germicidal disposable cloth...vi. Allow surface of meter to remain damp with germicidal solution for 2 minutes before drying completely..." 7. Review of the CDC's "Frequently Asked Questions (FAQs) regarding Assisted Blood Glucose Monitoring and Insulin Administration"(found at https://www.cdc.gov/injectionsafety/providers/blood-gluecose-monitoring_faqs.html and retrieved on 1/19/22) showed "...Blood Glucose Meters...Infectious agents, such as HBV, can be transmitted through indirect contact transmission, even in the absence of visible blood [4]. Indirect contact transmission is defined as the transfer of an infectious agent (e.g., HBV) from one patient to another through a contaminated intermediate object (e.g., blood glucose meter) or person (e.g., healthcare personnel hands) [12].With some blood glucose meters that require pre-loading of the test strip, the device may come into direct or close contact with the patient's finger stick wound. If blood is transferred from the patient to the meter, and the meter is not cleaned and disinfected after use, subsequent patients can be exposed to this blood when the meter is used on them. Indirect contact transmission can also occur even if the patient never directly contacts the meter. Healthcare personnel's hands can become contaminated with blood at various points while performing assisted blood glucose monitoring including pricking the patient's finger or handling the test strip. Blood can then be transferred to the meter when healthcare personnel handle the meter to obtain the reading. If the meter is not cleaned and disinfected after use, the blood remaining on the meter can be	F 880		

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 01/13/2022

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 880	Continued From page 36	F 880		

transferred to subsequent patients via healthcare personnel hands when they handle the meter and then assist with fingerstick procedures. Numerous outbreaks have implicated this mechanism in the spread of HBV infections [3, 4]. Contamination of equipment and transmission of HBV can also occur if healthcare personnel fail to change their gloves and perform hand hygiene between patients. For these reasons, blood glucose meters should be cleaned and disinfected after each use, unless they are dedicated to a single patient and appropriately stored to prevent inadvertent contamination..."

On 1/11/22 at 3:58 PM the administrator and DON were informed of an immediate jeopardy situation in the area of infection control related to a failure to disinfect blood glucometers between resident uses.

The facility submitted an action plan which included the following immediate changes:

1. The glucometer was immediately wiped down using the proper cleaning procedures as written in the instruction manual from the manufacturer. The instruction for proper procedure was placed on the med cart and the glucometer docking station for reference. The glucometer policy #7018-17 was updated with the correct information.

2. RN #1 was educated immediately following the notification of the F880 Immediate Jeopardy tag. The RN signed off that they have been properly educated on the procedure for cleaning the glucometer. Five RNs/LPNs were educated on cleaning procedures of the glucometer and 4 RNS/LPNs will be educated by the DON as they

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 01/13/2022

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 880	Continued From page 37 come on shift. All new hires will be educated on the procedure for cleaning the glucometer and will be checked off on competency for proper cleaning procedures. 3. The DON has educated and signed off the RN on duty. The CNO has updated the policy with the corrected information. A check off sheet will be kept for proof of education on all current RNs/LPNs as well as new hires. One random accu-check will be audited per shift by the DON or designee on duty until POCs are accepted and a long term QAPI/PIP can be put in place. The action plan was accepted on 1/12/22 at 4:41 PM. The implementation of the action plan was verified on 1/12/22 at 7:28 PM; however, deficient practice remained at a scope and severity of "E."	F 880		