STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON COUNTY HEALTH SERVICES	**1124 WASHINGTON BLVD NEWCASTLE, WY 82701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 3/7/22 to 3/10/22. Also reviewed in the course of the survey was complaint intake WY00003370. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 553 SS=E	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. (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.	F 553		3/31/22

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

Electronically Signed | 03/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON COUNTY HEALTH SERVICES	**1124 WASHINGTON BLVD NEWCASTLE, WY 82701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 1 §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 representative and staff interview, and review of the facility newsletter, the facility failed to facilitate the inclusion of the residents' representative in the care planning process for 3 of 4 sample residents (#7, #20, #27) reviewed for the care planning process. The findings were: 1. Review of the 12/14/21 annual MDS assessment showed resident #7 was admitted to the facility on 4/4/19 and was coded as having severe cognitive impairment. Review of the medical record showed the resident had a family member named as his/her representative. The following concerns were identified: a. Review of the Interdisciplinary Team Care Plan Review document showed care conferences were held on 4/21/21, 7/7/21, 9/29/21, and 12/21/21 with only staff members in attendance. There was no evidence the resident's representative had been contacted prior to the care conference. b. Interview with the resident's representative on 3/7/22 at 8:05 PM revealed the facility called to notify her of any changes, however she did not recall having a "sit-down" meeting.	F 553	The Care Conference Process was updated for residents #7, #20, and #27 and all residents in the facility starting on 03/18/2022. The Care Conference Process was updated to include personalized invitations be sent out prior to the care conference date, to ensure adequate notice and time for scheduling. This will be accomplished by Social Services and Activities staff. Training was completed with managers and IDT on 03/18/2022. Training with manor staff will be completed on 03/31/2022. An audit, using and audit tool, will be performed by the Director of LTC or designee, weekly for 6 weeks on 100% of residents who have a care conference to ensure compliance with the updated process. The audit findings will be reported during the QAPI committee monthly meeting. Compliance will be assessed by the QAPI committee at the end of the 6-week audit period to ensure compliance with F553. This updated process was started on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON COUNTY HEALTH SERVICES	**1124 WASHINGTON BLVD NEWCASTLE, WY 82701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 2 2. Review of the 1/18/22 annual MDS assessment showed resident #20 was admitted to the facility on 2/17/21 and had a BIMS score of 3 out of 15 (severe cognitive impairment). Review of the medical record showed the resident had a family member named as his/her representative. The following concerns were identified: a. Review of the Interdisciplinary Team Care Plan Review document showed care conferences were held on 5/26/21, 8/18/21, 10/27/21, and 1/26/22 with only staff members in attendance. There was no evidence the resident's representative had been contacted prior to the care conference. 3. Review of the 2/8/22 annual MDS assessment showed resident #27 was admitted to the facility on 4/18/18 and had a BIMS score of 9 out of 15 (moderate cognitive impairment). Review of the medical record showed the resident had a family member named as his/her representative. The following concerns were identified: a. Review of the Interdisciplinary Team Care Plan Review document showed care conferences were held on 6/16/21, 8/25/21, 11/17/21, and 2/16/22 with only staff members in attendance. There was no evidence the resident's representative had been contacted prior to the care conference. 4. Interview with the social services director on 3/9/22 at 4:32 PM revealed the facility sent out a monthly newsletter which contained the names of the residents and the date the resident's care conference was scheduled. 5. Review of the facility's March newsletter showed each Wednesday of the month had 1 to 4	F 553	03/18/22.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON COUNTY HEALTH SERVICES	**1124 WASHINGTON BLVD NEWCASTLE, WY 82701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 3 residents scheduled for a care conference. In addition, the newsletter stated "Please take note of your family member's Care Conference. If you would like to attend in person or via phone, please contact [the social service director and phone number]." 6. Interview with the social services director on 3/10/22 at 10:20 AM revealed the residents' representatives were expected to call the facility if they wanted to be included in the care conference. Further, the facility did not have a process in place to contact the family members that had not responded to the notice in the newsletter. The social service director confirmed the process could be better to ensure residents' representatives were notified of a pending care conference.	F 553		