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 07/11/2024

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

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 7/8/24 to 7/11/24. Also reviewed in the course of the survey were complaint intakes WY000003906 and WY000003910. The following common abbreviations are used throughout this document: CEO: Chief executive officer DON: Director of nursing LPN: Licensed practical nurse QAPI: Quality assurance and performance improvement Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 837 SS=F	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by:	F 837		8/25/24

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

Electronically Signed | 08/02/2024

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F 837	Continued From page 1 Based on observation, QAPI minutes review, and staff interview, the facility failed to ensure a qualified administrator was able to manage the facility and report to the governing body. The census was 38. The findings were: 1. Observation on 7/10/24 at 9:45 AM of the current open positions showed the nursing home administrator position was included. Further, observations throughout the survey showed no administrator was in the facility. 2. Review of the 5/9/24 and 6/13/24 QAPI committee attendance sign in sheet showed the administrator was not present. 3. Interview with the CEO on 7/8/24 at 1:20 PM revealed the administrator was put on leave. Further, she stated the facility did not have a delegated administrator, and it was a problem and it was something the facility was working on. 4. Interview with the DON on 7/10/24 at 10:09 AM revealed the administrator had been on leave for the last 3 months. 5. Interview with the administrator on leave on 7/10/24 at 3:12 PM revealed the former CEO put her on leave on 4/23/24 and she was told not to enter the building. She stated it was impossible to do the overall management for the facility since she was unable to enter the building or be in contact with staff.	F 837	1. WCHS governing board is responsible to hire and maintain a full time on site administrator. 2. WCHS governing board has recently hired an interim CEO. Interim CEO has identified our need for a full time on site administrator and had recruited and interviewed a candidate for this position. 3. Interim CEO has offered a contract to this candidate and they will start the week of 8/5/2024. 4. WCHS will ensure that the facility maintains a full time on site administrator to over see day to day operations and management of the facility. 5. QAPI committee will review administrator license to ensure compliance quarterly or until substantial compliance is met and achieved.	
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform	F 851		8/25/24

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F 851	Continued From page 2 format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).	F 851		

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F 851	Continued From page 3 §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the Payroll Based Journal (PBJ), the facility failed to ensure the mandatory submission of staffing was submitted to CMS for 1 of 4 quarters reviewed (10/1/23 through 12/31/23). The census was 38. The findings were: 1. Interview with the DON on 7/10/24 at 4:32 PM revealed the staffing was not submitted for the 10/1/23 through 12/31/24 quarter. She stated the data did not get submitted in time so it was missed. 2. Review of the PBJ for 10/1/23 through 12/31/23 showed the facility failed to submit data for the quarter.	F 851	1. QAPI committee will review PBJ submission quarterly to ensure compliance or until substantial completion is met and achieved. 2. DON or designee will submit PBJ quarterly. 3. Administrator will educate QAPI committee and governing body on PBJ submission requirements.	
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	F 868		8/25/24

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F 868	Continued From page 4 §483.75(g) Quality assessment and assurance. §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; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on observation, QAPI minutes review, job posting review, and staff interview, the facility	F 868	1. WCHS governing board is responsible to hire and maintain a full time on site	

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F 868	Continued From page 5 failed to ensure the QAPI committee included a qualified administrator who attended meetings. The census was 38. The findings were: 1. Observation on 7/10/24 at 9:45 AM of the current open positions showed the nursing home administrator position was included. Further, observations throughout the survey showed no administrator was in the facility. 2. Review of the 5/9/24 and 6/13/24 QA committee attendance sign in sheet showed the administrator was not present. 3. Interview with the CEO on 7/8/24 at 1:20 PM revealed the administrator was put on leave. Further, she stated the facility did not have a delegated administrator, and it was a problem and it was something the facility was working on. 4. Interview with the DON on 7/10/24 at 10:09 AM revealed the administrator had been on leave for the last 3 months. Further interview with the DON on 7/11/24 at 11:29 AM revealed the facility met monthly for QAPI, with all attendees, for facility improvement and to increase communication. 5. Interview with the administrator on leave on 7/10/24 at 3:12 PM revealed the former CEO put her on leave on 4/23/24 and she was told not to enter the building. She stated it was impossible to do the overall management for the facility since she was unable to enter the building or be in contact with staff.	F 868	administrator. 2. WCHS governing board has recently hired an interim CEO. Interim CEO has identified our need for a full time on site administrator and had recruited and interviewed a candidate for this position. 3. Interim CEO has offered a contract to this candidate and they will start the week of 8/5/2024. 4. WCHS will ensure that the facility maintains a full time on site administrator to over see day to day operations and management of the facility. 5. QAPI committee will review administrator license to ensure compliance quarterly or until substantial compliance is met and achieved. 6. Administrator will attend QAPI meetings quarterly. 7. QAPI committee was given education on administrator attendance requirements.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		8/25/24

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F 880	Continued From page 6 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following 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	F 880		

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F 880	Continued From page 7 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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, and policy review the facility failed to ensure clean dressing changes were kept clean for 1 of 1 wound care observation (resident #8). The findings were: 1. Observation on 7/9/24 at 10:12 AM of resident #8 wound care with LPN #1 and LPN #2 showed they performed hand hygiene, and donned gloves and gowns. LPN #2 then closed the curtains, turned on the lights, pulled the supplies out of the storage bag, and opened the dressing packages, and dated the dressing. She then moved the extra gloves twice. The nurses turned the	F 880	1. Reviewed "Hand Hygiene" policy and procedure with LPN #1 and LPN #2 with repeat back demonstration of proper hand washing. 2. All staff will be educated on proper handwashing and procedure for donning and doffing gloves. 3. Infection control nurse, DON or designee will conduct random handwashing audits 3x weekly for 6 weeks and randomly monthly thereafter to	

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F 880	Continued From page 8 resident to his/her side. LPN #2 removed the old dressing, and cleaned the wound. She then doffed her gloves and donned the gloves she had moved earlier, without performing hand hygiene. 2. Interview with the LPN #2 on 7/9/24 at 10:28 AM revealed the procedure performed was her normal routine when doing a dressing change. She stated she should have used hand sanitizer between dirty and clean. 3. Interview with DON on 7/9/24 at 2:22 PM revealed it is the facility's expectation for staff to do hand hygiene, put on gloves, and complete hand hygiene when they remove their gloves. 4. Review of policy "Hand Hygiene" revised 1/2024 showed "...1. Indications for hand washing and hand antisepsis. ...I. Decontaminate hands after removing gloves..." 6. Other aspects of hand hygiene... D... Gloves do not replace hand hygiene, decontaminate hands after removal of gloves. E. Change gloves during patient care if moving from a contaminated-body site to a clean-body site.	F 880	ensure understanding of education provided or until 100% compliance is achieved and met. 4. QAPI committee will review all audits monthly until substantial compliance is met and achieved.	