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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **53A051**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/10/2025**
NAME OF PROVIDER OR SUPPLIER **South Lincoln Nursing Center**		STREET ADDRESS, CITY, STATE, ZIP CODE **711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101**	

(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
F0000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 7/7/25 through 7/10/25. Also reviewed in the course of the survey were complaint intakes WY1902076 WY1902077and WY1902078. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant MDS: Minimum Data Set DON: Director of Nursing BIMS: Brief Interview for Mental Status Less commonly used abbreviations will be annotated in each deficiency.	F0000		07/25/2025
F0576 SS = C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail.	F0576	To address the facility's failure to ensure mail is delivered to residents everyday including on Saturday's, the facility will implement a new process where a nursing home team member is designated every Saturday to go pick up the mail from the Kemmerer Post Office and deliver it to the residents upon return to the facility. This will be added to the daily task sheet and every Saturday a nursing home team member will be identified to complete this task. This will also be added to the nurse task sheet for nurses to initial completion of on Saturdays. There will also be a sign off sheet for the designated nursing home team member and charge nurse on shift to sign indicating the date and time mail was delivered to the residents on Saturdays. The first completion of this task will occur on 08/16/2025.. The DON has communicated this new task to all staff as of 08/01/2025 to ensure that the task is completed. The DON will then follow up with the charge nurse that works on 08/16/2025 on 08/18/2025 to ensure the task was completed. This will be tracked through the Quality Assurance and Assessment (QAA) committee for monthly compliance and sustainment.	08/18/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **53A051**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/10/2025**
NAME OF PROVIDER OR SUPPLIER **South Lincoln Nursing Center**	STREET ADDRESS, CITY, STATE, ZIP CODE **711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101**		

(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
F0576 SS = C	Continued from page 1 §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interview, the facility failed to ensure mail was delivered to residents, including on Saturday. The census was 18. The findings were: 1. Interview with 8 residents during resident council on 7/8/25 at 2:08 PM revealed purchasing and receiving received all mail and was closed on the weekends. The residents revealed the closure of purchasing and receiving resulted in mail delivery not being performed on Saturdays. 2. Interview with quality assurance manager on 7/10/25 at 9:59 AM confirmed mail was not delivered on Saturdays because the facility did not have anyone available to receive it from the post office. Further interview revealed the post office added all mail received on the weekends to a box of mail which was delivered the following Monday.	F0576		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F0578	In regard to the facility’s failure to ensure the residents’ right to elect cardiopulmonary status, the facility has ensured forms are complete for both resident #16 and resident #18.	07/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Lincoln Nursing Center	711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101

(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
F0578 SS = D	Continued from page 2 §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and policy procedure review, the facility failed to ensure residents' right to elect a cardiopulmonary resuscitation (CPR) status for 2 of 12 sample residents reviewed (#16, #18) for advance directives. The findings were: 1. Review of the medical record for resident #16 showed	F0578	Continued from page 2 For resident #16, this resident's POLST and advanced directive were found following the exit of state surveyors. The resident's POLST was signed by the resident's provider and POA on 11/25/2024, and scanned into the EHR on 12/03/2024. Resident #16 also had an advanced directive on file that was found stating the choice to not prolong life. The resident's WyoPOLST form states that the resident is DNR and is signed by both the responsible party and the physician and present in the resident's EHR, along with this, it was also verified that this was documented as an order appropriately in the EHR and the resident does have a DNR order documented in the EHR. An audit was completed for all resident POLST forms to verify they were signed, fully filled out, and the appropriate order was documented in the EHR. . For resident #18 the resident representative has gone over the WyoPOLST form with the DON and a new form was filled out. The box stating the resident is DNR is now checked on the updated form and this has been signed by both the resident representative and the provider as of 07/31/2025. In regards to addressing this in the future with new admissions, a check box has been added to the admission checklist for the DON to select whether DNR or CPR is selected on the POLST, the date and time this was selected, and a date and time for the DON to sign when this has been verified that it matches with the electronic chart. All resident medical records and electronic charts have been checked for congruency as of 07/30/2025 and moving forward this will be tracked through the Quality Assurance and Assessment (QAA) committee for monthly compliance and sustainment with each new admission.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **53A051**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/10/2025**
NAME OF PROVIDER OR SUPPLIER **South Lincoln Nursing Center**	STREET ADDRESS, CITY, STATE, ZIP CODE **711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101**		

(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
F0578 SS = D	Continued from page 3 there was no evidence the resident had made an election for CPR status. Review of the electronic health record showed the resident was indicated as do not resuscitate (DNR). 2. Interview with the quality assurance manager on 7/10/25 at 11:49 AM confirmed there was no evidence resident #16 had elected a DNR status. 3. Review of the medical record for resident #18 showed no evidence the resident had made an election for CPR status. Further review showed a WyoPOLST dated 5/23/25 which indicated comfort focused therapy; however, the CPR and DNR boxes were left blank. Review of the electronic health record showed the resident was indicated as DNR. 4. Interview with the DON 7/10/25 at 11:40 AM revealed residents or the representative showed elect to be full code or DNR at the time of admission. She revealed the representative for resident #18 had indicated the resident was to be DNR; however, she confirmed the WyoPOLST should be completed. Further interview revealed if an election was not made, the resident would be considered full code and she confirmed resident #16 should be a full code. 5. Review of the facility policy titled "Advanced Directives" provided by the facility on 7/10/25 showed "...4. All residents will be provided a copy of the Wyoming POLST form at the time of admission. The DON and nursing center staff will work with the resident and/or their representative as well as their provider to ensure completion of this form..."	F0578		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F0600	Related to the facility's failure to protect the resident's right to be free from verbal abuse by a staff member and related to the specific allegation of abuse reviewed, for immediate actions the facility did place CNA #2 on immediate suspension which then resulted in termination for the accused CNA #2 from working at the facility. For secondary actions related to this specific tag and the facilities failure to comply, the DON will provide an abuse training to all staff on 08/01/2025 which will include the review of the facility abuse policy as well as a question and answer session on what abuse is in all forms with employees signing the policy and that the in-service was attended/reviewed, this will be completed by 08/15/2025. The DON will also conduct monthly interviews will all residents on how they feel their treatment at the facility is, this will occur for 3 months, if 100% compliance is met (all resident's feel safe and cared for in the facility), then this will	08/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER: South Lincoln Nursing Center	STREET ADDRESS, CITY, STATE, ZIP CODE: 711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101		

(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
F0600 SS = D	Continued from page 4 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, resident and staff interview, facility incident review, and policy and procedure review, the facility failed to protect the resident's right to be free from verbal abuse by a staff member for 1 of 2 sample residents (#2) reviewed with allegations of abuse. The findings were: 1. Review of the annual MDS assessment dated 4/9/25 showed resident #2 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included multiple sclerosis, depression, and manic depression. Further review showed the resident had upper and lower impairment bilaterally and required supervision and touching/steadying with eating. The following concerns were identified: a. Review of an incident report dated 4/18/24 showed the resident reported, on 4/7/24, CNA #1 was assisting the resident with eating when CNA #2 stated "What, are you going to feed [him/her] like the fucking baby [s/he] is?" Further review showed CNA #2 was placed on suspension and an investigation was initiated. The facility incident indicated CNA #2 was interviewed and denied using the "f" word and referring to the resident as a baby; however, the CNA admitted to asking the CNA #1 "Are you really going to feed [him/her]? [S/he] can feed himself." The incident report showed during the interview CNA #2 stated she refused to treat the resident different than other residents and she stated "I will not take care of [his/her] clothes for [him/her]. That's not my job. [His/her] family can do that for [him/her]. I will not go in to [sic] [his/her] room at 3:00 AM to change the channel for [him/her] because [his/her] hands are under the blanket and [s/he] doesn't want to reach for the remote. [S/He] can do that for [him/herself]. If [s/he] wants to be fed, [s/he] can go out to the dining room to be fed. [S/He] can do these things on [his/her] own/ I'm not going to do special things for [him/her]. I'm too busy." The CNA then stated "I hope you realize what you're doing to my team. I'm scheduled to work the next nine days." Review of the facility incident report showed during an interview with CNA #1, the CNA reported the resident rang for a snack and requested to be fed pudding. CNA #1 explained when pudding was placed in a bowl or on a plate, it made a mess on the resident's bedding so she agreed to feed the resident. CNA #1 reported when she began assisting the resident, CNA #2 was on the other side of the resident's bed and said "Are you seriously	F0600	Continued from page 4 occur periodically after. DON will also request she sit in on monthly resident council meetings to hear any additional concerns. These interviews and resident council concerns will be kept in a binder and the compliance (all residents feeling safe in the facility) of the interviews with be tracked through the Quality Assurance and Assessment (QAA) committee for monthly compliance and sustainment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER South Lincoln Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101	

(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
F0600 SS = D	Continued from page 5 going to fucking feed [him/her] like a baby?" CNA #1 replied to CNA #2 by saying "Yes, that is what [s/he] has asked and what is easiest for [him/her]." CNA #1 reported at that time, CNA #2 began yelling and saying things like "You're too accommodating for [him/her]. You're making day shift look bad. You treat him like a [king/queen]." b. Interview with CNA #2 on 7/10/25 at 8:29 AM confirmed she was suspended and terminated related to resident #2 alleging she him/her a "fucking baby;" however, the CNA denied the allegation. The CNA revealed she questioned another CNA for assisting the resident with eating instead of the resident eating independently. Further interview revealed the CNA had previous issues with the resident and the resident had allegedly reported other staff members. c. An attempt was made to interview CNA #1 on 7/9/25 at 5:42 PM; however, the phone number was disconnected and the staff member was no longer employed at the facility. d. Interview with resident #2 on 7/10/25 at 9:50 AM revealed s/he had only experienced problems with 1 staff member, which was CNA #2. The resident revealed on one occasion during the "graveyard" shift, a staff member was giving him/her pudding and CNA #2 stated "What are going to do, spoon feed him like a big fucking baby?" The resident revealed the comment really upset him/her and made him/her mad. The resident revealed s/he remained mad until s/he learned the CNA was no longer working at the facility. 2. Review of the facility policy titled "Abuse, Neglect, and Exploitation of Residents & Property" approved on 1/30/24 showed "...Our residents have the right to be free from abuse, neglect, misappropriation of property and exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat a resident's symptoms..."	F0600		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . .	F0605	To address the facility's failure to ensure PRN psychotropic medications were limited to 14 days, the facility has evaluated resident #18, noting that the medications have not been used since resident admission, the facility has also evaluated resident #18 noting that these medications are not needed at this time. Following this evaluation the facility has reached out to the hospice nurse to obtain orders from the hospice provider to discontinue these medications. Once the order was obtained on August 1, 2025 the facility discontinued the medications in the resident's	08/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Lincoln Nursing Center	711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101

(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
F0605 SS = D	Continued from page 6 chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §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. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F0605	Continued from page 6 electronic record and further destroyed the medications following facility protocol with two nurses verifying and witnessing the destruction and signing off on this. To prevent further occurrences like this from happening in the future the facility has updated the psychotropic medication review worksheet used for all residents reviewed during the psychotropic meeting to note whether a psychotropic medication is PRN and if so, the date it was started and the stop date, 14 days following that it will be stopped. The facility has also added a line to review the medication in 10 days from the start date, if not appropriate to have a stop date, to have the provider ensure that it is documented in the resident chart the provider's rationale for extending the medication beyond 14 days and indicate the duration of the order. If the resident taking PRN medication is admitted or started on the medication, the DON or designee will ensure this form is complete immediately following the start of the medication and that a meeting occurs with the provider in the 10-14 day window after the start date of the medication, even if this does not occur with the regularly scheduled psychotropic meeting. This will be tracked through the Quality Assurance and Assessment committee for monthly compliance and sustainment based on if there are residents taking PRN psychotropic medications or not. The DON has also educated all nurses, as of 08/19/2025, within the facility on the use of psychotropic medications and that these are to be used on a scheduled basis when needed for residents for their comfort and needs. Nurses were also educated that if psychotropic medications are ordered on a PRN basis that nurses need to ensure that these have an end date at day 14. If not, the resident needs to be evaluated by the provider at day 10 to determine an end date for the medication or how long past 14 days that the medication will be order.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Lincoln Nursing Center	**711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101**

(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
F0605 SS = D	Continued from page 7 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. 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 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.	F0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **53A051**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/10/2025**
NAME OF PROVIDER OR SUPPLIER **South Lincoln Nursing Center**	STREET ADDRESS, CITY, STATE, ZIP CODE **711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101**		

(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
F0605 SS = D	Continued from page 8 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 as needed (PRN) psychotropic medications were limited to 14 days or there was a documented rationale for 1 of 5 sample residents (#18) reviewed for unnecessary medications. The findings were: 1. Review of the admission MDS assessment dated 5/29/25 showed resident #18 had short-term and long-term memory problems and diagnoses which included Alzheimer's disease and non-Alzheimer's dementia. Further review showed the resident was taking antipsychotic, antianxiety, and antidepressant medications. The following concerns were identified: a. Review of the resident's physician orders showed the resident received lorazepam (antianxiety) 2 mg (milligrams)/1 ml (milliliter) solution 0.25-1 ml by mouth for anxiety every 4 hours as needed and haloperidol (anti-psychotic) 2 mg/1 ml solution 1 ml PRN by mouth every 4 hours for anxiety which were ordered on 5/22/25. Further review showed neither medication had a stop date indicated. Review of the medical record showed no evidence the physician had provided a rationale for the medications to be given as needed for longer than 14 days or evidence of a duration of the medications. b. Interview with the DON on 7/10/25 at 11:42 AM revealed she was not aware of a stop date policy for psychotropic medications. Further interview revealed she had requested a rationale from the physician; however, the facility had not received the rationale. 2. Review of the facility policy titled "Psychotropic Medications" last revised on 6/1/22 showed "...4. For PRN orders for psychotropic drugs, the order is limited to 14 days, unless the provider provides documentation of medical necessity beyond 14 days with an updated duration for the order. 5. Anti-psychotic medications PRN orders may not be extended beyond 14 days unless the provider evaluates the resident every 14 days to review necessity for the medications..."	F0605		
F0679 SS = E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the	F0679	Addressing the facility's failure to ensure individual activities were provided for sample residents reviewed, the facility's activities director will complete a section F from the MDS on all residents by 08/15/2025 to ensure the activities director is aware of resident preferences/likes/dislikes. The activities director will also create an activities calendar with at least	08/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER **South Lincoln Nursing Center**		STREET ADDRESS, CITY, STATE, ZIP CODE **711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101**	

(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
F0679 SS = E	Continued from page 9 comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, medical record review, and policy and procedure review, the facility failed to ensure individual activities of preference were provided to 4 of 4 sample residents (#1, #5, #7, #18) reviewed for activities. The findings were: 1. Interview with 8 residents during resident council on 7/8/25 at 2:08 PM revealed the facility had not had any activities for at least 2 weeks and they felt there should be at least a daily activities. 2. Review of the quarterly MDS assessment dated 6/9/25 showed resident #5 had a BIMS score of 9 out 15, which indicate moderate cognitive impairment, and diagnoses which included anxiety disorder, non-Alzheimer's dementia, and depression. Review of the annual MDS assessment dated 12/23/24 showed the resident indicated it was very important to listen to music, keep up with the news, do his/her favorite activity, and go outside to get fresh air when weather was good. Further review showed it was somewhat important to have books, newspapers, and magazines to read, be around animals such as pets, and do things in groups of people. The following concerns were identified: a. Observation on 7/7/25 at 4:29 PM showed the resident was in his/her room, seated in a recliner making moaning noises and watching television. Observation on 7/8/25 at 8:58 AM showed the resident was in his her room, seated in a recliner making moaning noises and watching television. Observation on 7/9/25 at 1:57 PM showed a balloon hit activity was performed in the common area; however, the resident was not offered or assisted to attend. b. Review of the activity participation from 6/1/25 through 7/9/25 showed there were no activities from 6/18/25 to 7/8/25. The resident was marked active participation for in room visit, movies/television, and talking/conversing on 7/9/25 and was marked as passive participation for exercise on 7/9/25 with a note which said "[s/he] wheeled [him/herself out to lunch." All	F0679	Continued from page 9 two activities per day by 08/15/2025, on weekends the activities director will ensure that these activities are something floor staff can assist the residents to engage in. The activities director will also ensure that the activities calendar is posted in each resident's room to ensure residents are aware of the activities that are scheduled to occur. There will also be activities log that will be created based off of the monthly calendar, and the activities director or staff on shift who conducts the activity will make note of who participated in the activity, the date, and the time. Compliance of the number of activities to occur out of the month will be tracked through the Quality Assurance and Assessment (QAA) committee monthly to ensure compliance and sustainment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Lincoln Nursing Center	711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101

(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
F0679 SS = E	Continued from page 10 other activities on 7/8/25 and 7/9/25 were marked as "not paying attention/sleeping." c. Interview with the activities director on 7/10/25 at 8:54 AM revealed resident #5 did not participate in many activities. The activity director revealed the resident liked music and she tried tried to take him/her for a walks; however, s/he wanted to be in his/her recliner. 3. Review of the quarterly MDS assessment dated 5/10/25 showed resident #1 had a BIMS score of 14 out 15, which indicated the resident was cognitively intact, and had diagnoses which included anxiety disorder and depression. Review of the annual MDS assessment dated 12/9/24 showed the resident indicated it was very important to be around pets and animals, keep up with the news, do things with groups of people, do his/her favorite activities, go outside to get fresh air when the weather was good, and participate in religious services and practices. Further review showed the resident indicated it was somewhat important to listen to music s/he liked. The following concerns were identified: a. Review of the activity participation from 6/10/25 through 7/8/25 showed there were no activities from 6/18/25 to 6/23/25 and no activities between 6/25/25 and 7/8/25. 4. Review of the annual MDS assessment dated 4/30/25 showed resident #7 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included depression. Further review showed the resident indicated it was very important to listen to music s/he liked, to be around pets and animals, keep up with the news, do things with groups of people, go outside to get fresh air when the weather was good, and participate in religious services and practices. Further review showed the resident indicated it was somewhat important to do his/her favorite activities. The following concerns were identified: a. Review of the activity participation from 6/1/25 through 7/9/25 showed there were no activities from 6/18/25 to 7/8/25. 5. Review of the admission MDS assessment dated 5/29/25 showed resident #18 had short-term and long-term memory impairment and diagnoses which included Alzheimer's disease and non-Alzheimer's dementia. Further review showed the resident indicated it was somewhat important go outside to get fresh air when the weather was good	F0679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Lincoln Nursing Center	**711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101**

(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
F0679 SS = E	Continued from page 11 and participate in religious services and practices. The following concerns were identified: a. Review of the activity participation from 6/1/25 through 7/9/25 showed there were no activities from 6/18/25 to 7/8/25. 6. Review of the June 2025 activity calendar showed 34 activities which were scheduled from 6/19/25 and 6/30/25. Review of the July 2025 activity calendar showed there were 25 activities scheduled from 7/1/25 to 7/10/25 which included 12 activities scheduled during the survey. Observations during the survey from 7/7/25 through 7/1025 showed only 2 activities were performed which included manicures for residents in the common area on 7/8/25 and noodle ball on 7/9/25. 7. Interview with the activities director on 7/10/25 at 8:54 AM revealed in addition to performing activities, she was also working the floor as a CNA. She revealed she was not able to perform daily activities and confirmed the activity schedule had not been followed during the survey. She revealed she was working two days per week on the floor as a CNA and she did not work on the weekends. 8. Review of the policy titled "Resident Activities" provided by the facility on 7/10/25 showed "...C. A monthly schedule of planned activities will be posted in each resident's room. These activities will be offered daily..."	F0679		
F0680 SS = E	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities	F0680	Related to the facility failing to ensure the activities program was directed by a qualified professional, South Lincoln Hospital District will provide temporary assignment to the Activities Director to cover these initiatives through a contracted 3rd party staffing company named Inspire using licensed occupational therapists (OT) or certified occupational therapy assistants. This will allow for immediate and improved availability of the Activities Director (AD) to oversee regularly scheduled activities daily, administer the program, and ensure resident engagement until our staff member in training becomes certified to assume these responsibilities. This will be monitored through a tracking log indicating what activity occurred each day of the month and the individual completing the activity as well as the charge nurse signing off on the activity being completed. Staff will be educated on this through communication from the DON as of 08/19/2025.	08/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER: South Lincoln Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101	

(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
F0680 SS = E	Continued from page 12 program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interview, the facility failed to ensure the activities program was directed by a qualified professional. The census was 18. The findings were: 1. Interview with 8 residents during resident council on 7/8/25 at 2:08 PM revealed activities had not been performed for "at least 2 weeks" and the activity director was being pulled to cover as a CNA. Further interview revealed the residents felt there should be daily activities. 2. Interview with the activities director on 7/9/25 at 2:55 PM confirmed she was a CNA and did not have a background in recreation or activities. Further interview revealed she was taking an activities class at that time. 3. Interview with the activities director on 7/10/25 at 8:54 AM revealed she was not able to perform activities daily and she did work the floor as a CNA.	F0680		
F0729 SS = C	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(e)(4)-(6) §483.35(e)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes	F0729	Facility's Plan of Correction for Tag F0729 Nurse Aide Registry Verification (by August 15, 2025) 1) The facility will conduct registry audits with the State of Wyoming CNA abuse registry for all current CNA team members. (by August 15, 2025) 2) The facility will take immediate action to implement a standardized checklist for HR and hiring managers to verify nurse aide registry status using the state's official registry portal prior to hire. The facility will maintain documentation, through printed or digital verification records, in each employee's personnel file. 3) An audit protocol for CNA abuse registry audits will be put in place. HR will conduct quarterly audits of new hires and current employees. HR will keep a log of the completed audits to ensure compliance.	08/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Lincoln Nursing Center	**711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101**

(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
F0729 SS = C	Continued from page 13 registered. §483.35(e)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(e)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is NOT MET as evidenced by: Based on employee file review, staff interview, abuse registry review, and policy and procedure review, the facility failed to ensure abuse registry verification for 1 of 3 sample CNAs #3 prior to resident contact. The census was 18. The findings were: 1. Review of the employee file for CNA #3 showed the CNA had an active license and had a start date of 2/10/25. Further review showed no evidence the CNA abuse registry was checked prior to resident contact. Review of the Wyoming CNA registry at that time showed no evidence the CNA had been added to the registry for verification. 2. Interview with the human resources business partner on 7/10/25 at 11:04 AM confirmed there was no evidence of abuse registry verification for the CNA. 3. Review of the facility policy titled "Abuse Prohibition" last reviewed December 2019 showed "...Screening 1. Initial: The Human Resources Department will screen potential employees for a history of abuse, neglect, or mistreating patients/residents by : attempting to obtain information from previous employers and/or current employers; checking with the appropriate licensing boards; checking with the appropriate registries, including legal background check..."	F0729	Continued from page 13 4) The facility will implement a policy revision of the hiring procedures to ensure the verification of registry status in all states where the aide has previously worked. Reciprocity will be reviewed to ensure aides meet the host state's competency standards before employment. 5) Registry and verification will be monitored for compliance by the HR Business Partner and Director of Nursing. 6) Quarterly compliance reviews will occur for the newly instituted Nurse Aide Registry Verification processes. An audit log will be accurately kept and available for Facility administration and State officials to review.	
F0837 SS = F	Governing Body	F0837	The facility will identify a qualified individual to be	09/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER: South Lincoln Nursing Center	STREET ADDRESS, CITY, STATE, ZIP CODE: 711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101		

(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
F0837 SS = F	Continued from page 14 CFR(s): 483.70(d)(1)-(3) §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. §483.70(d)(3) The governing body is responsible and accountable for the QAPI program, in accordance with §483.75(f). This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, review of the facility change in personnel form, and review of Wyoming's active nursing home administrator's licenses, the Governing Body failed to employ a qualified nursing home administrator. The census was 18. The findings were: 1. Review of the state survey agency "Healthcare Facility Change in Personnel/E-mail Address Form" showed the previous administrator was being changed to the Director of Quality and Compliance and a new administrator was named. The change was indicated as effective 6/16/25. 2. Review of the Wyoming State Board of Nursing Home Administrators "Active Roster" last updated on 7/14/25 showed the facility administrator did not hold an active license or an active provisional license. 3. Interview with the facility administrator on 7/7/25 at 3:52 PM revealed the administrator was the CEO of the facility and confirmed he did not hold an active nursing home administrator's license.	F0837	Continued from page 14 the nursing home administrator by or before September 9, 2025. If the qualified individual identified is an Administrator in Training (AIT) , the CEO of South Lincoln Hospital District will ensure that the qualified individual has been approved for a Nursing Home Administrator Provisional License by the Wyoming State Board of Nursing Home Administrators and will perform monthly audits related to this licensee to ensure they are meeting all requirements of the AIT Program.	
F0880 SS = E	Infection Prevention & Control	F0880	In regard to the facility failing to ensure proper infection control practices, all staff will be required	08/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Lincoln Nursing Center	**711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101**

(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
F0880 SS = E	Continued from page 15 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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	F0880	Continued from page 15 to view a video on proper perineal care and complete a short quiz on the information within the video. This will be completed by 08/15/2025. Related to the dining room services and cross contamination during feeding practices. Along with this, all staff will also be required to attend an in-service on proper feeding of residents and delivery of meal trays, which will have a quiz associated with this that all staff will be required to take, this will also be completed by 08/15/2025. The facility determined that any one of the resident's could be at risk at any time due to the facility staffs failure to be aware of the appropriate way to use gloves and hand hygiene. With this said, staff have been educated on the risks to infection that were witnessed while state surveyors were present at the facility. Starting the week of 08/18/2025-08/22/2025 the DON will randomly enter resident rooms as well as the dining room to complete audits at least weekly to ensure that staff are completing appropriate hand hygiene and making use of gloves appropriately. If the DON does find that a staff member is noncompliant with infection control processes staff will be educated immediately after what the DON witnesses on what was wrong and how to appropriately care for residents. This will be tracked through the Quality Assurance and Assessment (QAA) committee monthly to ensure compliance and sustainment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Lincoln Nursing Center	711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101

(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
F0880 SS = E	Continued from page 16 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 and procedure review, the facility failed to ensure proper infection control practices for 1 of 2 sample residents (#15) reviewed for urinary catheters or urinary tract infections and during 1 of 1 meal observation. The census was 18. The findings were: Regarding perineal care: 1. Observation on 7/9/25 at 11:09 AM showed CNA #3 and CNA #4 entered the room of resident #15 and provided perineal care to the resident. During the observation, CNA #4 assisted the resident to roll towards her. While wearing gloves, CNA #3 removed the resident's brief. At that time, the resident was to noted to have been incontinent of feces and urine and had open areas on his/her buttocks. CNA #3 performed perineal care to remove the urine and feces. Without removing the contaminated gloves, the CNA applied a barrier cream to the resident's buttocks and open areas, assisted the resident with positioning by touching the resident's side and arms, and adjusted the residents clothing and bed linens. 2. Interview with the infection preventionist on 7/10/25 at 9:06 AM revealed staff were expected to remove soiled gloves after providing perineal care,	F0880		

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Lincoln Nursing Center	711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101

(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
F0880 SS = E	Continued from page 17 before touching other surfaces, to prevent cross contamination. Regarding meal services: 1. Observation on 7/7/25 at 6:07 PM showed CNA #5 applied gloves and began preparing and serving resident meal trays. During the observation, the CNA touched the residents' arms, shoulders, wheelchair handles, and wheelchair wheels and then was observed touching the rims of resident drinking glasses. Observation on 7/7/25 at 6:14 PM showed the CNA touched the wheelchair arm rest and wheel of resident #5 then used a spoon to assist resident #18 to eat. Continued observation showed the CNA sat behind the assisted table, to assist resident #5, #16, and #18, by providing a bite to one resident and alternating to another using the same hand. Observation showed CNA #5 used her gloved hand to remove resident #16's bread, remove bacon from his/her sandwich, and return the bread to the sandwich. The CNA then placed a gloved hand on top of the sandwich, cut the sandwich, and handed a smaller portion to the resident to eat. No glove changes or hand hygiene were performed during the observation. 2. Interview with the infection preventionist on 7/10/25 at 9:06 AM revealed that the staff had been asked not to wear gloves during dining services. Further interview revealed staff were to use hand hygiene after touching objects and before touching meal trays and staff should never touch resident's food. The Infection preventionist revealed if there was a problem with the meal, it should be sent back to dietary to correct the issue. 3. Review of the policy titled "Hand Hygiene" provided by the facility on 7/10/25 showed "... Hand Hygiene... At all other times, staff will be expected to use alcohol-based hand sanitizer. This should be used when entering resident rooms, prior to providing care to a resident, before and after donning and doffing gloves, when leaving resident rooms, prior to handling food or trays, etc..."	F0880		