STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING _____ B. WING _____	03/22/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	4041 SOUTH POPLAR STREET CASPER, WY 82601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to ensure dependant residents dined in a dignified manner during two of three observations in the Unit II dining area. In addition, a dignified dining experience was lacking during one of two meals for resident #58. Furthermore, staff failed to treat residents #43 and 65 in a dignified manner. The findings were: 1. Observation during two of three meals in the day room on Unit II revealed the following concerns related to lack of dignified meal consumption; a. On 3/19/06 at 5:30 PM, certified nurse aides (CNA) #88 and #112 assisted seven residents with the evening meal. However, CNA #88 assisted one resident and sporadically encouraged another while CNA #112 went from resident to resident. Three residents required extensive to total assistance and two needed encouragement to eat. The CNA going from resident to resident would feed a resident for three or four minutes then go to the next resident and feed that person for three or four minutes and on around the table until arriving back at the first resident approximately 10 minutes later. Residents requiring feeding assistance were forced to wait for the CNA to return until they could receive more of their meal. b. On 7/20/06 at 7:30 AM, CNA #69 served	F 241	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. F241 The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This will be accomplished by: 1. • Resident's requiring total assist with feeding will receive meal in a timely manner with all direct nursing staff assisting as needed. • Resident #58 will receive diet texture as prescribed per physician order and served with proper feeding utensils per nursing staff. • Resident #65 will receive assistance with ADL's as resident requests by nursing staff and will be addressed in a dignified manner. • Resident #43 will receive assistance with ADL's, as resident situation requires by nursing staff. 2. • All residents will receive care in a manner that maintains or enhances their dignity and respect.	5/01/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alethia Shawver, Executive Director — TITLE — (X6) DATE: 4/14/06

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.

On 4/24/06 @ 1525 The POC was accepted as written by Alethia Shawver, Adm. and Karen Womack, RN, Health Surveyor.

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F 241	Continued From page 1 and assisted six residents; four residents required extensive to total assistance and two required encouragement. The CNA scooted a rolling stool around the table as she gave a few bites to one resident, then left to feed or encourage another. Again, approximately 10 minutes elapsed between each assisted feeding effort for individual residents. 2. Review of the 9/26/05 significant change Minimum Data Set (MDS) assessment showed resident #58 had a diagnosis of a stroke, and was totally dependant on staff for activities of daily living. Observation on 3/19/06 at 12:50 PM revealed CNA #13 fed resident #58 a pureed diet using a spoon. Observation on 3/21/06 at 5:45 PM revealed CNA #14 fed resident #58 a pureed meal. However instead of attempting to feed the resident using a spoon, the CNA added ice water to the pureed chicken, and assisted the resident to drink it as a liquid. When asked, the CNA said she added the ice water to cool the food, and it was too thin to use a spoon. 3. Observation on 3/21/06 at 5:08 PM revealed resident #65 was sitting on the seat of her walker near the Unit I nurses' station when the surveyor overheard her asking CNA #14 for assistance to the bathroom. CNA #14 told the resident she could go without assistance. The resident commented s/he was feeling dizzy and needed help. The aide responded "It's not my job." Interview with resident #65 on 3/21/06 at 5:15 PM revealed she was not happy with how this CNA responded to her. The resident further stated this CNA often calls her "mama", and she has told the CNA not to call her that.	F 241	3. • Nursing staff will be inserviced to the deficiency by the Director of Nursing. 4. • The Asst. Director of Nursing or designee will perform random audits weekly to monitor dignity with immediate inservicing to follow as needed for 12 weeks. • The Director of Nursing will report results of audits and corrective actions taken to QA team monthly for three months.	

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F 241	Continued From page 2 4. Observation on 3/21/06 at 4:12 PM revealed resident #43 was in the hallway outside of his/her room. The resident had dried food on the front of the shirt, and the lap portion of his/her pants was wet. Two CNAs walked past and there was no offer to clean or change the resident. Interview with the resident at this time confirmed s/he was cognitively impaired.	F 241	F253 It is the practice of the facility to provide housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior.	5/01/06
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on random observation and resident and staff interview, the facility failed to assure adequate housekeeping and sanitation measures regarding ceiling tile, air vents, light bulbs and covers. In addition, the facility failed to assure adequate sanitation measures regarding cleanliness of the floor and a soap dispenser in a bathing room. The findings were: 1. Observation with the facility maintenance director on 3/22/06 at 8:36 AM in room 228 revealed a fiber board ceiling panel, approximately two feet by four feet, drooped away from the ceiling support frame. The edge of the ceiling tile was directly over the head of resident bed "A". 2. Observation on 3/22/06 at 8:43 AM revealed two hard plastic ceiling light covers, approximately	F 253	1. • The ceiling tile in room #228 was replaced on 3/24/06 by the maintenance supervisor. • The light covers for medical records and the kitchen has been ordered and will be replaced by 4/30/06 by the maintenance supervisor. • The ceiling air vents in kitchen unit #1 & #2, HR office, and conference rooms were cleaned on or before 4/14/06 by housekeeping staff. • The light bulbs in the chandeliers were replaced on 3/30/06 by the maintenance staff. • The bathing area on SCU was thoroughly cleaned on 4/14/06 by the housekeeping staff. • The soap dispenser was removed from the wall in the SCU bathing area by the maintenance staff on 4/14/06. • The thermostat cover in the SCU bathing area was repaired on 3/24/06 by the maintenance staff. • The missing ceramic tile on the SCU shower floor will be replaced by the maintenance staff by 4/30/06.	

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F 253	Continued From page 3 two feet by four feet, were missing in the medical records room and in the kitchen. Interview at that time with the facility maintenance director revealed the two covers were on order. 3. Observation on 3/22/06 between 9:41 AM and 9:59 AM revealed the following rooms had dirty exhaust ceiling air vent covers: the two small kitchen units #1 and #2, the Human Resources director's office, and the conference room. Interview with the facility administrator and director of nursing on 3/22/06 at 11:33 AM confirmed the air vent in the conference room was dirty. 4. Observation on 3/22/06 at 9:34 AM revealed five of the seven chandeliers in the main dining room had burnt out light bulbs. A total of 12 light bulbs were burned out. The facility Food Service Supervisor confirmed the bulbs were burnt out and should be replaced. 5. Observation on 3/22/06 at 10:02 AM revealed several concerns in the Special Care Unit bathing room. The concerns were as follows: a. The floor in the part of the bathing room used for storage was encased with accumulated dirt and soap. b. Only the bottom half of a soap dispenser unit on the wall next to the bathing tub was attached to the wall. The partial dispenser was being used as a small shelf to hold a large bottle of lotion. In addition, the partial dispenser was coated with a thick, sticky, soapy residue. c. The wall thermostat unit was covered with a vented thick clear plastic covering; however, the unit was separated from the wall exposing the internal wiring and sensitive control electronics to	F 253	2. • A facility inspection was conducted by the maintenance supervisor and the housekeeping supervisor on 4/4/06 to identify any additional housekeeping or maintenance services that are needed to maintain a sanitary, orderly and comfortable interior. Any concerns that were identified will be corrected by 4/30/06 by the maintenance supervisor or designee. 3. • The maintenance supervisor and housekeeping supervisor will complete monthly rounds of the facility, which will include ceiling tile, air vents, light bulbs, and bathing areas to identify any maintenance or housekeeping concerns. The rounds and any identified concerns will be documented on an audit form. Corrective action will be taken for any identified concerns. 4. • The results of the monthly environmental rounds and corrective actions taken will be documented on audit forms and reviewed at the Quality Improvement / Environment of Care meeting by the maintenance supervisor.	

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F 253	Continued From page 4 the high humidity of the bathing room environment. d. Two 2 inch by 2 inch pieces of ceramic tile were missing from the shower floor directly next to the floor drain exposing rough concrete underneath the tile.	F 253		

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F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to complete comprehensive assessments in various areas for 4 (#4, #12, #54, #73) of 22 sample residents. The	F 272	F272 The facility will make a comprehensive assessment of resident needs, using the RAI specified by the State. This will be accomplished by: 1. • Resident #4 will have a comprehensive bowel and bladder assessment by the Restorative Nurse. The resident has been assessed for the proper use of anti-anxiety medication by IDT team. • Resident #12 will have a comprehensive cognitive, mood state and behavior assessment by the Social Services. • Resident #54 will have a comprehensive bowel and bladder assessment by the Restorative Nurse. • Resident # 73 will have a comprehensive cognitive, mood state and behavior assessment by the Social Services. 2. • An audit of triggered RAP's will be completed by Director of Nursing or designee to determine if a comprehensive assessment is present. A comprehensive assessment will be completed as needed by IDT members. 3. • The interdisciplinary care plan team will perform comprehensive assessments on all residents at least quarterly and prn using the RAI. • The interdisciplinary care plan team will be in-serviced to the deficiency by the Director of Nursing.	5/1/06

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F 272	Continued From page 6 findings were: 1. According to the 10/3/05 admission Minimum Data Set (MDS) assessment, resident #4 was totally incontinent of bowel and required further assessment in that area. However, review of the entire medical record revealed an assessment was lacking. In addition, review of the 2/10/06 quarterly MDS assessment showed the resident was on an antianxiety medication. According to the physician's 1/11/06 order, the resident was started on BuSpar (antianxiety medication) at 7.5 milligrams, and the dose was increased on 1/31/06. Review of the January, February, and March 2006 medication administration records confirmed the resident received the medication as ordered. Medical record review revealed a comprehensive assessment was lacking. Interview with the director of nursing on 3/21/06 at 10:40 AM confirmed the facility had not completed a comprehensive bowel assessment or an initial assessment for the use of psychotropic medications. 2. Review of the 1/31/06 significant change MDS assessment showed resident #12 triggered for comprehensive assessments of cognitive loss, mood state, and behavioral symptoms. The location of the assessments was listed as an undated RAP (Resident Assessment Protocol) summary. However, review of the RAP summary for that MDS revealed comprehensive assessments were lacking. Interview with the MDS coordinator on 3/22/06 at 10:43 AM confirmed the facility failed to comprehensively assess the resident in the aforementioned areas. 3. Review of Section V for the 3/9/06 significant	F 272	4. • The Director of Nursing or designee will perform random audits on five charts monthly to monitor comprehensive assessments with immediate inservicing to follow as needed for 6 months. • The Director of Nursing will report results of audits and corrective actions taken to QA team monthly for six months.	

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F 272	Continued From page 7 change MDS assessment for resident #54 revealed s/he required a comprehensive assessment for urinary incontinence. Further review of this section revealed the assessment information for this area was located in the 3/3/06 RAP summary. However, review of this RAP summary revealed there was not a comprehensive assessment completed for this area. Interview with the MDS coordinator on 3/22/06 at 10:45 AM confirmed a comprehensive assessment was not completed. 4. Review of Section V for the 11/22/05 significant change MDS assessment revealed resident #73 required comprehensive assessments for cognitive loss and mood. Further review of this section revealed the assessment information for these areas was located in the 11/9/05 RAP summary. However, review of this RAP summary revealed the assessments for these areas were incomplete. Interview with the MDS assessment coordinator on 3/22/06 at 10:45 AM confirmed comprehensive assessments were not completed.	F 272		
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312		

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F 312	Continued From page 8 Based on observation, family and staff interviews, medical record review, and review of policies and procedures, the facility failed to assure staff provided appropriate personal care for dependent residents. During seven observations of perineal (incontinence) care provided for incontinent residents, four (involving sample residents #4, #33, and #40 and non-sample resident #64) were completed incorrectly. The findings were: 1. Observation on 3/20/06 at 1:55 PM revealed resident #33 was incontinent of bowel and bladder. Certified nurse aide (CNA) # 155 provided perineal care for the resident. The CNA twice cleansed the resident's perineum by wiping from the rectal area over the urethra with wipes covered with feces. According to the facility's undated policy and procedure, "Personal Hygiene Care for the Female Resident," staff should "...wash urethral area first wiping downward from front to back." 2. On 3/19/06 at 4 PM observation showed resident #40 was incontinent of urine. CNA #88 cleansed the resident's buttocks but failed to cleanse the perineum and anterior groin which were also in contact with urine. During an interview on 3/21/06 at 9 PM, a family member stated staff frequently failed to provide perineal care to the resident after incontinent episodes. The family member also reported the resident had frequent urinary tract infections (UTIs). On 3/22/06 at 2:45 PM, the director of nursing (DON) verified the resident was currently on an antibiotic for a UTI. According to the facility's aforementioned policy and procedure, staff should cleanse the perineum, thighs, rectal area, and buttocks when providing perineal care.	F 312	F312 The facility will ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene. This will be accomplished by: 1. • Resident #33 will receive perineal care by nursing staff per facility protocol and Wyoming State Board of Nursing CNA certification guidelines. • Resident #40 will receive perineal care by nursing staff per facility protocol and Wyoming State Board of Nursing CNA certification guidelines. • Resident #64 will receive perineal care by nursing staff per facility protocol and Wyoming State Board of Nursing CNA certification guidelines. • Resident #4 will receive perineal care by nursing staff per facility protocol and Wyoming State Board of Nursing CNA certification guidelines. 2. • All residents that require perineal care will receive perineal care in a manner that promotes good hygiene. • The Asst. Director of Nursing or designee will perform perineal skill checks on CNA staff to ensure proper perineal care. Retraining will be provided as needed for any performance issues identified.	5/1/06

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F 312	Continued From page 9 3. Observation on 3/20/06 at 8:33 AM showed CNA #110 provided perineal care to resident #64 who was incontinent of bowel and bladder. The CNA twice cleansed the resident using back and forth strokes from the rectum to the urethra. Review of the facility's aforementioned policy and procedure related to perineal care showed staff should "proceed from the least contaminated area to the most contaminated area" and should "wash...from front to back." In addition, a required element for passing the nurse aide "Written (or oral) Examination and Skills Evaluation" is "Washes entire perineal area...while using a clean area of the washcloth...for each stroke." 4. On 3/20/06 at 11:35 AM resident # 4 used the bedpan and was assisted to roll to the left by CNA #166. The CNA cleansed the resident's right buttock but did not complete perineal care. The CNA then changed the resident's brief and cleansed the resident's left inner thigh. The CNA stated the resident "dribbles some" [urine] with the bedpan. However, the CNA never cleansed the resident's perineal area. According to the facility's policy and procedure for perineal care, staff should "Separate labia and wash urethral area first.." and then "Continue to wash the perineum..." 5. Interview with the director of nursing on 3/21/06 at 5:04 PM revealed her expectation was that staff perform perineal care "per protocol."	F 312	3. Nursing staff will be in-serviced to the deficiency by the Director of Nursing. 4. • The Asst. Director of Nursing or designee will perform ten random perineal skill checks monthly to monitor perineal care with immediate inservicing to follow as needed for six months. • The Director of Nursing will report results of random audits and corrective actions taken to QA team monthly for six months.	

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F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the physical environment in one of three units remained free of accident hazards. The findings were: 1. Observation in the Special Care Unit (SCU) dining room on 03/19/06 at 5:32 PM revealed the facility used metal warming plates and plastic insulated plate holders to keep resident food warm during delivery to the unit. During the process of serving resident food, CNAs #36 and #152 used plastic menu cards to lift resident plates from the plate warmers. The staff then handled residents' food plates with hand towels, folded in quarters to provide a thick insulating surface. Interview with these two CNAs at the same date and time revealed the plates were too hot to lift and carry with bare hands, hence the use of a plastic card and hand towels to minimize the risk of burns for the serving staff. The surveyor briefly touched one of the plates and found it to be uncomfortably hot to the touch. Further interview with CNA #36 indicated plates from the kitchen were "too hot to touch for the last several days", clarified as "the last 3 or 4 times I worked in the SCU." CNA #36 carried a hot plate with hand towels, placed it in front of resident #104, and offered these instructions, "Don't touch your plate, it's too hot." The CNA then left and the resident received no further assisting in eating. Review of the most	F 323	F323 The facility strives to ensure that the resident environment is as free of accident hazards as is possible. 1. • The Dietary Manager on 4/14/06 adjusted the temperature on the plate warming system to a level, which allows for warm plates. 2. • The dietary manager or designee will check the temperature of plates that were warmed by the plate warming system that go to other areas of the facility, in addition to SCU, to see if they are too hot. If additional concerns are noted corrective action will be taken. 3. • Dietary staff will be inserviced by the Dietary Manager on proper settings for the plate warming system and appropriate temperature of plates that were warmed. 4. • The Dietary Manager or designee will conduct random weekly audits of plate temperatures for the next four weeks and monthly thereafter. If plates are found to be too hot to touch corrective action will be taken. • The audit findings and actions taken will documented and reviewed at the Quality Assurance Meeting monthly for the next three months by the Dietary Manager.	5/01/06

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F 323	Continued From page 11 recent Minimum Data Set assessment for the resident, dated 03/12/06, revealed poor cognitive and decision making skills and difficulty understanding others. The documentation also indicated the resident experienced confusion, periods of altered awareness, and short-term memory problems. The record established the resident was not a good candidate for oral instruction to avoid a potential burn hazard. 2. Interview with the dietary manager and the registered dietician on 03/20/06 at 3:40 PM verified the kitchen staff was using the plate warming system. These staff denied knowing unit personnel used hot pads (hand towels) to handle plates or that plates were potentially hot enough to constitute a burn hazard to residents. 3. Interview with licensed practical nurse #89 on 03/20/06 at 4:40 PM further confirmed plates received in the SCU were "...too hot to touch without towels..." and that this condition was apparent over the past several days. 4. Observation on 03/20/06 at 5:25 PM in the SCU dining room revealed CNA #152 placed two hand towels on the counter adjacent to the serving area prior to the arrival of the food cart from the kitchen. The CNA was not aware the evening meal consisted of sandwiches and salad (cold plates).	F 323		

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	535049	A. BUILDING _____ B. WING _____	03/22/2006

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F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide adequate supervision to prevent accidents for 2 (#58, #12) of 19 sample residents. The findings were: 1. According to the 1/31/06 significant change Minimum Data Set (MDS) assessment, resident #12 had chewing and swallowing problems and moderately impaired cognition (required cues and supervision). Evaluation by the speech language pathologist (SLP) on 9/26/05 determined the resident required nectar thick liquids. Review of the 2/3/06 care plan showed staff were to "hand the cup" of nectar thick liquids to the resident and s/he "can drink from it." On 3/21/06 at 4:40 PM observation showed the resident was yelling while seated in the hallway by the nurses' station on Unit II. The SLP walked up, stopped, and handed the resident a glass of regular water. The resident took a drink, and the SLP walked away. The resident resumed yelling, but did take another drink before spilling the remaining water. The resident continued yelling that s/he had spilled the glass of water and asking someone to clean it up. The two licensed nurses at the nurses' station ignored the resident and continued with their paper work and medications, and the certified nurse aides (CNAs) were not in the vicinity. Interview with the SLP on 3/21/06 at 6:17 PM	F 324	F324 The facility will ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This will be accomplished by: 1. • Resident # 12 will receive hydration fluids as prescribed per physician order and will receive assist and supervision while consuming fluids as required for safety per nursing staff. • Resident #58 will receive diet texture as prescribed per physician order and will receive assist and supervision while consuming meals as required for safety per nursing staff. 2. • All residents will receive adequate supervision and assistance devices as required to promote safety. 3. • Nursing staff will be in-serviced to the deficiency by Director of Nursing and Speech Therapist. 4. • The Asst. Director of Nursing or designee will perform a random audit of assistance and supervision of oral intake weekly for six months with immediate inservicing to follow as needed for six months.	5/1/06

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F 324	Continued From page 13 confirmed she gave the resident regular water instead of thickened water. During the interview, the SLP stated she could give the resident regular water instead of thickened water when the resident was supervised and not yelling. However, no one was supervising the resident while s/he continued to yell and drink the water. 2. Review of the 9/26/05 significant change MDS assessment showed resident #58 had a diagnosis of a stroke and was totally dependant on staff for activities of daily living. Review of the resident's diet order dated 1/20/05 revealed s/he was to have a pureed regular diet with nectar thick liquids. The following concerns were noted with the assistance provided to resident #58 during the 3/21/06 evening meal: a. Observation at 5:45 PM revealed CNA #14 added ice water to a cup of pureed chicken and fed it to resident #58 as a liquid. b. The CNA then poured approximately two ounces of ice water into a cup containing approximately two ounces of Boost (a nutritional supplement drink) swirled it around in the cup and fed it to the resident. c. Interview with the CNA on 3/21/06 at approximately 5:50 PM revealed she added the ice water to cool the pureed chicken. The CNA further stated the resident was a "choking hazard" and required nectar thick liquids. When asked how she knew what the correct consistency was, the CNA pointed out a cup of thickened water on the tray, and indicated it should be as thick as that water. d. Observation showed the remaining chicken the CNA was feeding the resident, was much thinner than the thickened water. The chicken was more of a broth like consistency. When	F 324	• The Director of Nursing will report results of audits and corrective actions taken to QA team monthly for six months.	

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F 324	Continued From page 14	F 324		

asked about this, the CNA responded, "It's okay".

e. During this observation and interview, another CNA was seated at the table assisting another resident; the second CNA made no attempt to correct CNA #14.

f. RN #145 was seated at the nurse's station across from the dining room. During the interview with CNA #14, the RN came into the dining room and helped re-position resident #58. However, she failed to correct the CNA about the consistency of the liquids being fed to the resident.

Interview with the SLP on 3/22/06 at 7:55 AM confirmed the resident was to be given nectar thick liquids. When asked, she agreed that undiluted Boost is considered to be nectar thick. She further stated it would not be her expectation for water to be added to the pureed food to cool it down, but rather an ice cube. Medical record review showed a physician response dated 10/18/05 denying a request for a swallowing evaluation. The physician order said, "Do not change from nectar-thick liquids[.] No known dysphasia dx [diagnosis]- [the resident has] no teeth [and] limited chewing/swallowing coordination[.] Tolerating nectar-thick."

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F 328 SS=E	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of policies and procedures, the facility failed to assure 6 (#4, #24, #33, #38, #40, #61) of 13 sample residents received oxygen as ordered. In addition, the oxygen flow rate for resident #40 was set by a certified nurse aide (CNA), but the flow rate was not posted. The findings were: Observation from 3/19/06 through 3/22/06 revealed the following concerns with oxygen administration: a. Resident #4 was sleeping on 3/19/06 at 3:15 PM with the oxygen set at 2.5 liters per minute (LPM) as posted on the concentrator. On 3/20/06 at 11:35 AM, the oxygen concentrator was set at 2.5 LPM as posted. On 3/22/06 at 9:23 AM the posted liter flow had been changed to 2 LPM, but the concentrator was still set at 2.5 LPM. According to the 3/1/06 recapitulation (Recap) of orders, the resident's oxygen was ordered at 2 LPM; there was no order for oxygen saturation levels or titration of the amount of liter	F 328	F328 The facility will ensure that residents receive proper treatment and care for the following special services: Respiratory care. This will be accomplished by: 1. • Residents #4, #33, #38, #61, #24 and #40 will receive oxygen at liter flow as prescribed per physician order. Physician order for oxygen, oxygen saturation levels and titration per facility protocol will be written as needed by RN/LPN nursing staff. Resident concentrator and portable oxygen will be posted with oxygen liter flow per RN/LPN nursing staff. 2. • All residents will receive oxygen therapy per prescribed physician orders with oxygen saturation levels and titration orders in place. All residents receiving oxygen therapy concentrator and portable oxygen will be posted with liter flow by licensed nurse. 3. • Nursing staff will be in-serviced to the deficiency by Director of Nursing. 4. • The Asst. Director of Nursing or designee will perform random concentrator and portable oxygen checks twice weekly for 3 months to monitor this process with immediate inservicing to follow as needed.	5/1/06

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F 328	Continued From page 16 flow per percentage of saturation level. b. On 3/19/06 at 3 PM and 3/30/06 at 11:20 AM, resident #33 received oxygen at 2 LPM; the rate posted on the concentrator was 1 LPM. Interview with CNA #37 on 3/20/06 during the 11:20 observation verified the liter flow did not agree with the amount posted. On 3/22/06 at 9:18 AM, the posted liter flow rate had been changed to 2 LPM, but the oxygen concentrator was set at 1 LPM. According to the March 2006 Recap of orders, the resident was to receive oxygen at 2 LPM with saturation levels per protocol. c. On 3/21/06 at 4:18 PM, the flow rate of oxygen was set at slightly above 1.5 LPM for resident #38; the posted flow rate on the concentrator was 2 LPM. On 3/22/06 at 9:18 AM the posted rate had been changed to 1 LPM, but the rate was set between 1.5 and 2 LPM. The resident's March 2006 orders were for oxygen at 1 LPM with saturation levels per protocol and as needed. d. Observation on 3/21/06 at 4:35 PM revealed resident #61 used a portable oxygen tank, and had an oxygen concentrator in his/her room. The portable unit did not have the flow rate posted on it; however, the concentrator had a posted flow rate of 2 liters per minute. Review of the medical record revealed there was no evidence of a current order for oxygen for this resident. Interview with the director of nursing (DON) on 3/22/06 at 9:40 AM confirmed the was no order for oxygen. e. On 3/22/06 at 9:20, the flow rate of oxygen was set between 1.5 and 2 LPM for resident #24; the posted rate was 2 LPM. Review of the March 2006 orders revealed the resident was to received oxygen at 2 LPM with saturation levels per protocol.	F 328	• The Director of Nursing will report to QA team monthly for three months.	

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/S LIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4/24/06 KS

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F 328	Continued From page 17 f. On 3/19/06 at 4 PM observation showed resident #40 had oxygen at 2 LPM per concentrator. CNAs #88 and #150 assisted the resident from the recliner to a wheelchair, transferred the oxygen to a portable tank, and CNA #88 set the flow rate to 1.5 LPM. The flow rate was not posted on the portable tank, but was posted at 2 LPM on the concentrator. CNA #150 confirmed the flow rate was not posted on the portable tank, and she confirmed the flow rate did not agree with the rate as posted on the concentrator. On 3/22/06 at 9:16 AM the posted rate was "titrate to 92% + [plus]," but the oxygen was turned off. According to the March 2006 Recap of orders, oxygen was to be titrated to saturation levels of 90% or greater. According to the 6/31/01 letter from the Wyoming State Board of Nursing, the task of turning on and adjusting oxygen liter flow may be done by the CNA "if the liter flow is clearly marked..." Review of the facility's undated policy and procedure, "Oxygen Delivery Policy," revealed it did not address oxygen saturation levels. Interview with the DON on 3/22/06 at 10:06 AM revealed the facility did not have a policy and procedure for oxygen administration. However, the DON stated CNAs could only set the liter flow rate at the amount posted on the concentrator and tank. The DON also stated the posted liter flow rate should agree with the physician's order.	F 328		

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F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interviews, the facility failed to maintain a medication error rate below five percent (%). Observation revealed 5 non-significant medication errors out of 49 opportunities for error which resulted in an error rate of 10.2 %. The findings were: 1. Observation on 3/19/06 at 4:30 PM showed registered nurse (RN) #70 prepared and administered medications to resident #19. However, the RN stated she did not administer Ultram as the resident was "out of it." Review of the March 2006 medication administration record (MAR) confirmed Ultram was scheduled at 4 PM. Reconciliation of the medication pass with the physician's orders showed Ultram was ordered four times a day. Interview with the RN on 3/19/06 at 5:35 PM revealed she checked the emergency storage area and did not find any Ultram. 2. Observation on 3/20/06 at 7:55 AM showed RN #120 administered medications including Vitamin C 500 milligrams (mg) and Dapsone to resident #20. Reconciliation of the medication pass with physician's orders dated 3/1/06 revealed the resident should have received Vitamin C 250 mg "if on Dapsone." Interview with the director of nursing on 3/21/06 at 5 PM verified the medication error.	F 332	F332 The facility will ensure that it is free of medication error rates of 5% or greater. This will be accomplished by: 1. • Resident #19 will receive Ultram as prescribed per physician order per RN/LPN nursing staff. • Resident #20 will receive Vitamin C 250mg as prescribed per physician order per RN/LPN nursing staff. • Resident #75 has been discharged to home. 2. • All residents will receive medications as prescribed per physician orders. • The ADON or designee will complete a medication pass competency check on licensed nurses by 5/01/06. Retraining will be provided as needed for any performance issues identified. 3. • RN/LPN nursing staff will be in-serviced to the deficiency and procedure for medication administration by the Director of Nursing. 4. • The ADON or designee will perform monthly random medication pass audits for six months. Immediate inservicing will follow as needed.	5/1/06

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F 332	Continued From page 19 3. Observation on 3/20/06 at 8:08 AM showed RN #22 administered Coreg 12.5 mg, to resident #75. Reconciliation of the medication pass with the 3/1/06 recapitulation (Recap) of orders revealed the current order was for Coreg 25 mg. In addition, those orders included Glucosamine Sulfate 500 mg twice daily and Calcium Carbonate with Vitamin D 500/200 mg twice daily. However, neither the Glucosamine nor the Calcium Carbonate were administered, and review of the MAR showed they were discontinued on 2/22/06. Interview with the medical director on 3/22/06 at 11:10 AM confirmed the 3/1/06 Recap contained the physician's current orders.	F 332	• The Director of Nursing will report results of audits and corrective actions taken to QA team monthly for three months.	

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F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to 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. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) 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 observation, resident, family, and staff interviews, and review of the daily and monthly nursing schedules, the facility failed to assure staff were available to provide care and services for residents in a timely manner. The census at the time of the survey was 109. The findings were: 1. Observation during two of three meals in the day room on Unit II revealed the following concerns: a. On 3/19/06 at 5:30 PM, certified nurse	F 353	F353 The facility respectfully disagrees with F353. The facility asserts that it provides sufficient staffing to provide nursing and related services to all residents in accordance with resident care plans on a 24-hour basis. The direct observations cited in the Statement of Deficiencies were isolated incidents and staffing levels were adequate on the days of the survey. The facility requests Informal Dispute Resolution and asks that this alleged deficiency be removed. The facility will have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual care plans. 1. • Resident's requiring total assist with feeding will receive meal in a timely manner with all nursing staff assisting as needed. • Resident #68 will be assisted to lie down per his request in a timely manner by nursing staff. 2. • The Director of Nursing will coordinate a review by the IDT of dining room assignments for residents and staff assignments at meal times and changes will be made as needed to best meet the needs of the residents by 4/21/06.	5/01/06

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F 353	Continued From page 21 aides (CNA) #88 and #112 assisted seven residents with the evening meal. However, CNA #88 assisted one resident and sporadically encouraged another while CNA #112 went from resident to resident; three residents required extensive to total assistance and two needed encouragement to eat. The CNA would go to the next resident and feed that person for three or four minutes until arriving back at the first resident approximately 10 minutes later. Residents requiring feeding assistance were forced to wait for the CNA to return until they could receive more of their meal. b. On 3/20/06 at 7:30 AM, CNA #69 served and assisted six residents; four residents required extensive to total assistance and two required encouragement. The CNA scooted a rolling stool around the table as she gave a few bites to one resident, then left to feed or encourage another. Again, approximately 10 minutes elapsed between each assisted feeding effort for individual residents. 2. Observation on 3/22/06 at 9:56 AM showed resident #68 sitting in his/her wheel chair across from the Unit I nurses' station. The resident called the surveyor over and said s/he wanted to lie down. The surveyor told RN #145 the resident would like to lie down, and the RN responded she would tell a CNA as soon as one passed by. Observation at 10:56 AM (one hour later) revealed resident #68 was still sitting across from the Unit I nurses' station asleep in his/her wheelchair. Interview with RN #145 at this time revealed she had not yet seen a CNA to tell. 3. Interview with residents revealed the following concerns:	F 353	• The Director of Nursing will review utilization and assignment of nursing staff and resident needs by 4/21/06. 3. • All direct care nursing staff, (nurses and CNA's) will be assigned to assist with resident dining in dayrooms, main dining rooms or room trays beginning 4/21/06. • Licensed nurses will be inserviced on supervisory responsibilities for resident care by the Director of Nursing. • Nursing staff will be inserviced on responsibilities and assistance during meals, call bell response, response to resident needs by the Director of Nursing. • The Director of Nursing or designee will review staffing roster daily to assess staffing levels beginning on 4/14/06. • The Administrator will continue to schedule a Manager on Duty and a Nursing Manager each weekend that will assist in addressing any staffing issues. 4. • The Asst. Director of Nursing or designee will perform random audits of meal service, including timeliness and appropriate levels of assistance two times weekly for three months. Corrective actions will be taken as needed for any identified concerns. • The Asst. Director of Nursing or designee will perform random audits of call bell response time two times weekly for three months. Corrective action will be taken as needed for any identified concerns.	

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F 353	Continued From page 22 a. Interview with resident #76 on 3/22/06 at 8:45 AM revealed staff were slow to respond to call lights or other requests for assistance. The resident stated the lack of timely response was more common on weekends and nights as compared to weekday periods. b. During a confidential interview on 3/21/06 at 3:30 PM, three residents stated call lights could "take a while" to be answered. c. Interview with resident #65 on 3/20/06 at 1:10 PM revealed more staff was needed. The resident stated "[staff] do the best they can, it takes a long time sometimes to get things." 4. Interviews with family members revealed the following; a. On 3/21/06 at 3 PM, family member #1 stated s/he recently saw a resident on the floor but was unable to find any staff to assist. The family member further stated his/her loved one was frequently not toileted or provided incontinence care. b. On 3/19/06 at 1:01 PM, family member #2 stated the facility needed more staff as his/her loved one had to wait up an hour to go to the bathroom, and "That's much too long." The family member also stated as many as five lights could be on at once for an hour. When asked if the lights could be different ones, c. On 3/20/06 at 3:20 PM, family member #4 reported finding his/her loved one wet with particles of medication on the gown. The family member stated s/he was told by a licensed nurse, after a 20 minute wait for the light to be answered, that all the staff were busy in the dining rooms, and they did not take time to clean his/her loved one after the feeding tube separated while administering medications d. On 3/21/06 at 9 PM, family member #5	F 353	• The Asst. Director of Nursing or designee will perform random audits of direct resident care including grooming, oral care, toileting, perineal care and assisting to bed in a timely manner two times weekly for three months. Corrective action will be taken for any identified concerns. • The Director of Nursing will report results of audits and corrective actions taken to QA team monthly for three months.	

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F 353	Continued From page 23	F 353		

stated his/her loved one's face was frequently not washed nor the teeth brushed. In addition, the family member stated perineal care was not always completed and the resident's clothing not changed if it was wet. Furthermore, no one came to check on the resident for an hour and a half (per his/her observation), and CNAs and licensed staff have told him/her the facility is frequently short staffed.

5. Interviews with staff revealed the following:

a. On 3/22/06 at 7:30 AM licensed nurses #4 and #61 stated the facility was always short staffed on weekends due to numerous staff calling off. They stated staffing levels were supposed to be the same as on the weekends and defined that as five CNAs on days, four CNAs on evenings, and three on nights for Unit II. When asked what was not done, they stated perineal care and oral care were skipped, baths were missed, and staff were always so rushed no one had time to talk with the residents. Licensed nurse #4 stated they were always busy with paperwork and medications and asked, "Who's caring for the residents? We're not!"

b. Interview with CNA #88 on 3/19/06 at 5:50 PM revealed there were usually two CNAs assisting residents with the evening meal on Unit II. The CNA further stated they could use more staff during dining and needed more than four on the shift.

c. Interview with CNA #69 on 3/20/06 at 7:45 AM revealed there were supposed to be three CNAs assisting with dining in Unit II instead of just one. The CNA stated the others were too busy to assist yet.

6. Review of the daily roster and staffing schedule for March 2006 revealed Unit II was short of the

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F 363	Continued From page 24 defined CNA staffing level on the following dates and shifts: a. Evenings (2 PM to 10 PM) - 3/1/06 , 3/3/06, 3/12/06, and 3/17/06 b. Nights (10 PM to 6 PM) - 3/10/06, 3/11/06	F 363		
F 371 SS=F	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Observation on 3/22/06 at 9:48 AM revealed a frozen pot pie in the freezer of the Unit #1 kitchen. The door of the refrigerator/ freezer instructed staff that only resident foods were to be place in the unit. The pot pie was labeled " Kara " . Registered nurse #93 confirmed the pot pie belonged to a staff CNA and immediately throw the pot pie in the garbage can. Observation on 3/22/06 at 9:53 AM revealed several meal entrées in the refrigerator of the Unit #2 kitchen. RN #45 confirmed the food belonged to staff and stated they need to be in the " staff refrigerator down the hall " . The door of the refrigerator/ freezer also stated only resident foods were to be place in the unit. Based on observation and staff interview, the facility failed on two of four days of the survey to assure food was stored in a manner that preserved the sanitary condition of resident food. The findings were:	F 371	F371 It is the practice of the facility to store, prepare, distribute and serve food under sanitary conditions. 1. • Dietary staff on 3/23/06 cleaned the condenser unit and the ceiling around the fan in the walk in refrigerator. • Nursing staff on 4/14/06 cleaned the refrigerators on SCU, Unit 1 and Unit 2. Any staff food items were removed. 2. • All refrigerators that are used for storage of food will be inspected to ensure that they are clean and contain no employee food items and that all food is properly stored. The Dietary Manager will check the kitchen storage and the Asst. Director of Nursing will check the refrigerators on the nursing units. Any identified concerns will be corrected.	5/1/06

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F 371	Continued From page 25 1. Observation with the DM on 3/20/06 at 3:35 PM revealed the fans of the condenser unit and the ceiling around the fans in the walk-in refrigerator had an accumulation of dust and debris. At this time there were two trays containing approximately 50 glasses of juice without any covering sitting on a cart inside the door of the walk-in refrigerator. Interview with the dietary manager at this time confirmed the dust build-up needed to be cleaned and the juices should be covered. According to the Food Code 2005, U.S. Public Health Service, Food and Drug Administration, 3-307.11: Miscellaneous Sources of Contamination, " FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301-3-306. " 2. Observation on 03/19/06 at 12:05 PM revealed several items of unlabeled, undated, and partially-consumed food in the facility's walk-in refrigerator which was commingled with resident food. Interview with the cook, employee #52, identified these items as employee food. Multiple observations on 02/19/06 confirmed the food remained in the cold storage area. Interview with the dietary manager (DM) on 03/19/06 at 4:35 PM confirmed the food belonged to kitchen staff. Observation on 3/22/06 at 9:48 AM revealed a frozen pot pie in the freezer of the Unit 1 kitchen. The pot pie was labeled with a name which registered nurse (RN) #93 identified as a certified nurse aide (CNA). A sign on the door of the refrigerator/ freezer instructed staff that only resident foods were to be place in the unit. Observation on 3/22/06 at 9:53 AM revealed	F 371	3. • The refrigerators on the nursing units and in the kitchen will be checked daily for cleanliness and food storage. Any employee food will be removed and any spills will be cleaned up promptly. • The refrigerators on the nursing units and the kitchen will be placed on the weekly cleaning schedules. • Nursing staff and dietary staff will be inserviced on cleanliness of refrigerators and proper storage by the Dietary Manager and the Director of Nursing. 4. • The Dietary Manager or designee will complete random audits of refrigerators in the kitchen and on the nursing units weekly. • The Dietary Manager will review results of the audits and corrective actions taken at the Quality Assurance meeting monthly for the next three months.	

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F 371	Continued From page 26 several meal entrées in the refrigerator of the Unit 2 kitchen. RN #45 confirmed the food belonged to staff and stated the food needed to be in the "staff refrigerator down the hall.." Again, a sign on the door of the refrigerator/ freezer instructed staff that only resident foods were to be place in the unit. Interview with the DM and registered dietician (RD) on 03/20/06 at 3:30 PM revealed an awareness of staff food commingled with resident food as observed on 03/19/06. The DM stated the policy of the facility was that staff food was not to be commingled with resident food; a staff refrigerator was provided specifically for that purpose. 3. Observation on 03/19/06 at 3:30 PM revealed the inside of refrigerators located on Units I and II and the Special Care Unit (SCU) were soiled with spilled liquid and other food debris. These same refrigerators were used to store resident food (sandwiches, health shakes, milk, supplements in cans and cartons). There was no visible evidence to show the refrigerators were monitored to confirm storage temperatures sufficient to preserve the quality and wholesomeness of resident food. Repeated observations on 03/19/06 through the morning of 03/21/06 confirmed the refrigerators remained dirty, In addition, the facility was unable to produce evidence that the refrigerators on Unit 2 and the SCU were monitored for storage temperatures. On 3/19/06 at 4:35 PM, the DM stated the dietary staff was not responsible for cleaning unit refrigerators or monitoring storage conditions outside the kitchen. Interview with the assistant director of nursing (ADON) on 03/21/06 at 11:20 AM revealed a policy assigning the nursing	F 371		

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F 371	Continued From page 27 department with the responsibility for cleaning unit refrigerators and monitoring storage temperatures. The ADON stated the specific responsibility was delegated to the "...night CNAs..." to accomplish these tasks.	F 371		
F 426 SS=D	483.60(a) PHARMACY SERVICES - PROCEDURES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and medical record review, the facility failed to assure medications were available for administration for one (19) of nine non-sample residents. The findings were: 1. Observation on 3/19/06 at 4:30 PM showed registered nurse (RN) #70 prepared and administered medications to resident #19. However, the RN stated she did not administer Ultram as the resident was "out of it." The RN further stated she did not "know why the pharmacy did this." Review of the 3/1/06 physician's orders showed Ultram was ordered four times a day, and according to the March 2006 medication administration record, was scheduled at 4 PM. Interview with the RN on 3/19/06 at 5:35 PM revealed she had checked the emergency storage area and did not find any	F 426	F426 The facility will provide pharmaceutical services (including a procedure that ensures the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet each residents needs. This will be accomplished by: 1. • Resident #19 will receive Ultram as prescribed per physician order per RN/LPN nursing staff. 2. • All residents will receive medications per prescribed physician order. 3. • RN/LPN nursing staff will be in-serviced on procedure for obtaining medications from pharmacy when medication not available by the Director of Nursing. 4. • RN Night House Supervisor or designee will perform random audit of medication availability weekly for three months. Corrective action will be taken for any identified concerns.	5/1/06

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F 426	Continued From page 28 Ultram for the resident. Interview with the consultant pharmacist on 3/20/06 at 10:30 AM revealed routine medications were supplied on a monthly cycle, but they had to be reordered by nursing. The pharmacist stated they did keep an emergency box with some stock medications, but they also had a pharmacist on call 24 hours a day, seven days a week, and special deliveries could be made when necessary. Interview with the director of nursing on 3/20/06 at 10:55 AM confirmed the medication was not reordered until the morning of 3/20/06.	F 426	• The Director of Nursing will report results of audits and corrective actions taken to QA team monthly for three months.	
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy and procedure, the facility failed to ensure proper handwashing procedures were followed during one random observation. The findings were: Observation on 3/21/06 at 5:45 PM revealed CNA #14 was eating a sandwich with her left hand while she used her right hand to feed resident #58. After finishing one half of her sandwich, and without washing or sanitizing her hands, the CNA used both of her hands to handle the resident's food. In addition, during this observation the CNA	F 444	F444 The facility will require staff to wash their hands after each direct resident contact for which handwashing is indicated by professional practice. This will be accomplished by: 1. • Resident #58 will be assisted with feeding after nursing staff member has cleansed hands with anti-microbial agent. 2. • All staff will cleanse hands when appropriate before resident contact. 3. • The Asst. Director of Nursing or designee will perform handwashing skill checks on all CNA staff for proper handwashing to ensure infection control guidelines are maintained. Retraining will be provided as needed for any performance issues identified.	5/1/06

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F 444	Continued From page 29 coughed into her left hand and without washing or sanitizing her hands continued to feed the resident. Interview with the administrator on 3/22/06 at 9:50 AM confirmed that it was not her expectation for staff to eat while feeding residents. She further stated there have been special occasions where she would give prior approval for staff to eat with the residents; however, this was not one of them. Interview with the director of nursing on 3/22/06 at 3 PM confirmed it was her expectation that staff would wash their hands after eating or coughing. Review of the facility policy and procedure titled "Hand Hygiene" last reviewed 5/21/04 showed, "when hands are visibly dirty or contaminated...wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water."	F 444	• Nursing staff will be in-serviced to deficiency. 4. • The Asst. Director of Nursing or designee will perform ten random handwashing skill checks monthly for three months to monitor handwashing with immediate inservicing to follow as needed. • The Director of Nursing will report results of audits and corrective actions taken to QA team monthly for three months.	
F 465 SS=D	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe environment for staff. The findings were: Observation on 03/19/06 at 12:35 PM revealed the ice machine drain pipe in the kitchen discharged water onto the floor. The residual water pooled in a high traffic area frequented by	F 465	F465 It is the practice of the facility to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. 1. • The maintenance supervisor has ordered parts to repair the leak under the ice machine. The repair work to repair the leak will be completed when parts arrive by 4/30/06. • The floors in the walk in refrigerator and freezer were cleaned on 3/23/06 by the dietary staff.	5/01/06

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F 465	Continued From page 30 staff. Observation on 3/22/06 at 10:18 AM revealed the drain pipe still discharged water directly onto the kitchen floor rather than into the floor drain located beneath it. Interview with the facility administrator on 3/22/06 at 11:33 AM confirmed the facility was aware of the above. Observation on 3/22/06 at 10:18 AM showed part of the floor in the walk in refrigerator in the kitchen was covered with dirt. Interview with the dietary manager (DM) on 3/20/06 at 4 PM confirmed the walk-in refrigerator and freezer floors both had a build-up of dirt, food particles, and paper under the shelves. The DM stated they were scheduled to be swept and mopped weekly. In addition, there was a puddle of liquid in the corner by the door of the walk-in refrigerator that the DM reported was from a draining problem with the condenser. Review of the February and March 2006 cleaning schedules showed the walk-in refrigerator floor was cleaned one time on 3/4/06. There was no evidence the walk-in freezer floor was cleaned in February or March. Interview with the dietary manager on 3/20/06 at 4 PM confirmed the walk-in refrigerator and freezer floors both had a build-up of dirt, food particles, and paper under the shelves, and they were scheduled to be swept and mopped once a week. In addition, there was a puddle of liquid in the corner by the door of the walk-in refrigerator that she reported was from a draining problem with the condenser. Review of the February and March 2006 cleaning schedules showed the walk-in refrigerator floor was last cleaned on 3/4/06, and there was no evidence the walk-in	F 465	2. • The Maintenance Supervisor and the Dietary Manager will conduct a kitchen inspection by 4/30/06 to identify any additional environmental concerns in the kitchen. Any concerns identified will be corrected by 4/30/06 by the Maintenance Supervisor or Dietary Manager. 3. • The dietary staff will be inserviced by the Dietary Manager on cleaning schedules. 4. • The Dietary Manager or designee will complete weekly kitchen sanitation reviews, which will include the floors in the walk in refrigerator and freezer and under equipment. • The rounds and any identified concerns will be documented on an audit form. Corrective action will be taken for any identified concerns. • The results of the kitchen sanitation reviews and corrective actions taken will be reviewed at the Quality Assurance meeting monthly for three months by the Dietary Manager.	

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F 465	Continued From page 31 freezer floor was cleaned in February or March.	F 465		
F 467 SS=E	483.70(h)(2) OTHER ENVIRONMENTAL CONDITIONS - VENTILATION The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and staff and family interview, the facility failed to provide proper ventilation in several locations throughout the facility. The findings were: During interviews on 3/21/06 at 1:45 PM and 9 PM, family members of resident # 44 and #40, respectively, stated the bathrooms of their loved ones stank.Observation on 3/22/06 from 8:38 to 9:08 AM revealed ventilation fans in several rooms throughout the facility were not working. Bathrooms affected included those in rooms 228, 103, 220 and 219. In addition, the ventilation fan in the dry storage room in the kitchen was not working. Interview with the facility maintenance manager on 3/22/06 at 10:30 confirmed the fans were not working..	F 467	F467 It is the practice of the facility to have adequate outside ventilation by means of windows, or mechanical ventilation or a combination of the two. This will be accomplished by: 1. ◦ Bathrooms in rooms 228, 103, 220 and 219 were deep cleaned on or before 4/15/06 by the housekeeping staff. • The ventilation fans in bathrooms of rooms 228, 103, 220 and 219 and the dry storage room in the kitchen were repaired by the Maintenance Supervisor on 3/28/06. 2. • The maintenance supervisor inspected all exhaust fans in the facility on 3/23/06 for proper functioning. Any additional non working ventilation fans were repaired. 3. • The maintenance supervisor will inspect ventilation fans monthly to ensure they are in proper working order. The rounds and any identified concerns will be documented on an audit form. Corrective action will be taken for any identified concerns.	5/01/06

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