STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	C 10/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 82801

(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 random observations and staff interview, the facility failed to ensure residents (#9, #13, #62, #82) were treated with dignity during the dining experience. In addition, a staff member failed to announce themselves before entering one resident's (#77) room, and another staff member changed his shirt in a public hallway. The findings were: 1. Observation on 10/10/06 from 8:35 AM until 8:45 AM showed licensed practical nurse (LPN) #92 was assisting resident #82 with dining. During the 10 minute observation the LPN stood to feed the resident. 2. Observation on 10/10/06 from 8:35 AM to 8:42 AM showed CNA #55 assisted resident #9 with dinning. The CNA stood while feeding the resident during the 8 minute observation. 3. Observation on 10/10/06 from 8:50 AM to 8:57 AM showed CNA #11 assisted resident #13 with dinning. The CNA stood while feeding the resident during the 7 minute observation. 4. Observation on 10/9/06 from 6:51 PM to 6:57 AM showed aide #73 assisted resident #62 with dinning. The aide stood while feeding the resident during the 6 minutes observation. In addition, during the observation the aide referred to the	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 conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG F241 – PLAN OF CORRECTION** This plan of correction is the facility's credible allegation of compliance. It is the policy and practice of this facility to promote care for residents in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1. Residents # 13, # 22, # 62 and # 82 & #77 have been interviewed regarding the unannounced entry. No negative effects noted from the alleged deficient practice. For residents # 82, # 9, # 13 and # 62 and all the C.N.A.'s have been sitting while assisting residents with meals. other Residents requiring assistance w/dining Resident # 62 has been interviewed regarding the alleged calling of clothing protectors a "bib" and expressed no negative effects from the alleged deficient practice. The employee who changed his clothing in the hallway area no longer works at the facility.	11/11/06

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

Donna Schultz NHA — 11-03-06

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.

Reviewed & accepted w/changes on 11/28/06 with DOC = 11/11/06

NOV 06 2006

Donna Schultz 11/28/06

Leslie Davis 11/28/06

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F 241	Continued From page 1 clothing protector the resident was wearing as a "bib" 5. Observation on 10/9/06 at 4:40 PM showed resident #77 was laying in bed and looking out the window. Registered nurse (RN) #22 then entered the resident's room without knocking or announcing herself. 6. On 10/10/06 at 8:10 AM, housekeeping employee #111 was observed to change his shirt in the hallway adjacent to the physical therapy room. He removed his shirt and donned a blue uniform shirt, being briefly exposed from the waist up during the process. He was visible from 30-35 feet away in the hallway. Interview with the housekeeping supervisor on 10/10/06 at 2:40 PM revealed employees were not expected to change clothes in the hallway. Interview with the DON on 10/12/06 at 9:25 AM confirmed an expectation that employees would not change clothes in a public area. Interview with the director of nursing on 10/12/06 at 1:45 PM confirmed it was her expectation that staff knock before entering a resident's room. She also stated staff should be seated to assist with dining unless otherwise indicated.	F 241	2. Staff will be inserviced by the SDC on the following issues: a. Appropriate location to change their clothing. b. Knocking on residents' doors and announcing yourself before entering the residents' rooms. c. The appropriate procedure for assisting residents at mealtime, sitting beside the resident. d. Appropriate term for clothing protectors. 3. Random daily reviews of the dining service will be designated by the Nursing Home Administrator to the IDT members utilizing the the Dining Service Observation Form to ensure that staff is sitting while assisting residents and utilizing proper terms for the clothing protectors. 4. Random weekly environmental rounds will be done by the DON/designee to ensure that staff are knocking and announcing self to the residents before entering the residents' rooms. 5. Random weekly environmental reviews will be done by the NHA/designee to ensure that there is no further incidence of staff changing their clothes in the hallway. 6. The random daily reviews of the dining service and the weekly	

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F 241	Continued From page 2 On 10/10/06 at 8:10 AM, housekeeping employee #111 was observed to change his shirt in the hallway adjacent to the physical therapy room. He removed his shirt and donned a blue uniform shirt, being briefly exposed from the waist up during the process. He was visible from 30-35 feet away in the hallway. Interview with the housekeeping supervisor on 10/10/06 at 2:40 PM revealed employees were not expected to change clothes in the hallway. Interview with the DON on 10/12/06 at 9:25 AM confirmed an expectation that employees would not change clothes in a public area.	F 241	review for staff on the following issues: a. Appropriate location for changing clothes, b. Knocking on residents' doors and announcing self, c. Appropriate term for clothing protectors will be reviewed by the QA/A Committee for recommendation and continued compliance.	
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 observation and staff interview, the facility failed to ensure a clean, comfortable interior. Two resident areas were used for storage. A ceiling vent in one area resident area was dirty. The findings were: Observation of the Medicare hall lounge on 10/11/06 at 3:30 PM revealed it had a TV set, a wall lined with books, and several lounge chairs. In addition, there was a mechanical sling lift, a sit-to-stand lift and a linen cart stored in the area. At 4:28 PM, resident #51 was wheeled into the	F 253	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 conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG F253 – PLAN OF CORRECTION** This plan of correction is the facility's credible allegation of compliance. It is the policy and practice of this facility to provide housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior. 1. The lounge on the Medicare Hall has been emptied of the linen cart and lift. Boxes have been removed from	11/11/06

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F 253	Continued From page 3 room and positioned to watch TV. Interview with the director of nursing (DON) on 10/12/06 at 7:44 AM revealed the facility was short of storage areas and the Medicare lounge was used. The DON then stated this area was used by residents and family members. Observation of the therapy hallway on 10/10/06 at 8:34 AM revealed the hallway contained filing cabinets, chairs, and folding table. A second observation on 10/12/06 9:30 AM through 1:30 PM revealed various boxes of medical supplies and equipment were stored in the hallway. Interview with the DON on 10/12/06 at 7:44 AM revealed the facility lacked storage areas and resident areas were sometimes used. Observation of the telephone room on 10/11/06 at 3:26 PM revealed a ceiling vent in the room was coated with a dust build-up. Observation during the survey revealed residents made private phone calls from the room.	F 253	the therapy hall. The fan in the ceiling vent in the telephone room has been cleaned. 2. Staff will be inserviced on the need to remove items sitting in the hall and to not park resident care equipment in lounges and living rooms. All ceiling fans will be inspected and cleaned if needed. 3. The facility does not have a loading dock. When deliveries are left in the hall by UPS or trucking companies, boxes and delivered goods will be removed to storerooms as quickly as possible. The clearance of hallways will be monitored daily by the maintenance staff. Housekeeping staff will continuously monitor the cleanliness of ceiling fans and report those needing cleaned to the maintenance department. 4. The Safety Committee will review the clearance of halls, lounges and living rooms, the timely removal of deliveries, and cleanliness of ceiling fans monthly for three months. The results of these reviews will be reported to the Quality Assurance Committee which will direct further action as needed.	

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F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a comprehensive care plan for one (#114) of 23 sample residents with a culture-confirmed methicillin-resistant Staphylococcus aureus (MRSA) infection. The findings were: Review of the closed medical record for resident #114 revealed s/he was placed on contact isolation precautions on 7/22/06 following culture confirmation of infection with MRSA. The record failed to review a care plan for the resident indicating the specific needs, goals, and care	F 279	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 conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG F279 – PLAN OF CORRECTION** This plan of correction is the facility's credible allegation of compliance. It is the policy and practice of this facility to develop a comprehensive care plan for any resident with an infection. 1. Resident # 114 died on August 6, 2006. 2. A complete review of residents with infections will be done to ensure that they have a care plan addressing the specific problem. Action will be taken on identified issues. 3. Nursing staff will be educated by the DON/Designee on the care plan process to include goals and approaches when a resident is identified with an infection to include any residents identified to be on isolation. 4. Telephone orders will be reviewed in the AM meeting. The Infection Control Nurse/Designee will review the charts of residents that are identified with an infection to ensure	11/11/06

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F 279	Continued From page 5 approaches appropriate for his/her contact isolation. Interview with the infection control nurse (ICN) on 10/12/06 at 10:25 AM confirmed a care plan had not been developed for the resident reflecting contact precautions and isolation.	F 279	that the care plans established are specific to the infection or isolation ordered by the physician. 5. The results of the random care plan reviews to ensure that the infections are addressed on the care plans will be reviewed monthly by the QA/A Committee for recommendation and continued compliance. 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 conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.	
F 286 SS=D	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to maintain 15 months of assessments for four (#14, #51, #77, and #82) of 23 sample residents. The findings were: 1. Review of the medical record for resident #77 showed it contained a significant change resident assessment instrument (RAI) dated 7/19/06. Further review of assessments revealed the record lacked the previous RAI assessment. The review found a section "V" dated 9/6/05, but it failed to have the RAI which went with it. Interview with the health information manager on 10/12/06 at 9:34 AM revealed she was unable to find the missing full RAI and stated it was most likely purged form the record. 2. Review of the medical record for resident #14 revealed a face sheet (not dated) which showed the resident entered the facility on 8/18/06. Review of assessments for the resident revealed a section "V" dated 8/30/06, but the record lacked	F 286	**TAG F286 – PLAN OF CORRECTION** This plan of correction is the facility's credible allegation of compliance. It is the policy and practice of this facility to maintain all resident assessments completed within the previous 15 months in the active medical record. 1. For residents # 77, # 14, # 51 and # 82, missing Resident Assessment Instruments, Section V and Resident Assessment Protocols have been reprinted and put in the medical record. 2. Medical records will be reviewed to assure that 15 months of Resident Assessments are present. Any that are missing will be	11/11/06

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F 286		F 286	reprinted and put in the record. 3. When a resident is discharged to the hospital with return anticipated, the Health Information Manager will ensure that 15 months of assessments are available in the new chart. The Health Information Manager will purge charts according to schedule and will ensure that 15 months of assessments remain in the active record. The Resident Care Management Director will review (according to admit date) for placement of appropriate number of assessments (15 months) in charts for care plan work group. Filing staff will be inserviced to check for 15 months of assessments in the chart as new assessments are being filed. A check off list will be placed next to the filing basket and staff will check the name off the list as they file the assessment. 4. The Health Information Manager will audit the medical record according to the Quality Assurance audit schedule. 5. Medical Records audits will be reviewed by the Quality Assurance Committee quarterly.	

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F 286	Continued From page 6 the resident's admission RAI. Interview on 10/12/06 at 10 AM with the assessment coordinator revealed she was unable to find the original RAI. The coordinator provided the surveyor with a copy of the transmitted assessment. 3. Review of the 7/25/06 admission Minimum Data Set (MDS) assessment for resident #51, and the 9/6/06 annual MDS assessment for resident #82 showed both lacked section V and the resident assessment protocols (RAPs) for the triggered areas. Interview on 10/12/06 at 1:50 PM with the medical records supervisor revealed the original RAPs and section V for these assessments could not be located. At that time a copy was printed off the computer and provided.	F 286		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure one (#69) of 14 sample residents at risk for pressure sores, received care and services to reduce the	F 314	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 conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG F314 – PLAN OF CORRECTION** This plan of correction is the facility's credible allegation of compliance. It is the policy and practice of this facility to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable;	11/11/06

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F 314	Continued From page 7 risk of pressure sores. The findings were: Observation of resident #69 on 10/10/06 from 7:26 AM to 12:14 PM (four hours and 48 minutes) revealed the resident was up sitting in an upright geri-chair (a wheeled chair with the ability to recline). At 12:14 when the observation ended, the resident was in the dining area waiting for meal service. At 1:25 PM when the observation restarted, the resident was observed in his/her room in the upright geri-chair where the resident remained until 2:47 PM. At that time, CNA #20 assisted the resident to the bed using a sling mechanical lift, and changed the resident. The following concerns were noted related to care and services the resident required to prevent pressure sores: a. During the morning aforementioned observation, the resident was neither checked for incontinence nor did s/he have a position change while in the geri-chair. Interview with CNA #20 at 2:47 PM on 10/10/06 revealed when he received the resident report at 2 PM, he was not informed of the last time this resident was repositioned or checked for incontinence. The CNA then stated the resident could not be repositioned in the chair and needed to lie down prior to the evening meal. b. The observation at 2:47 PM on 10/10/06 revealed the resident smelled strongly of urine, and when changed, the disposable brief was saturated. The observation revealed multiple creases in the resident's skin over his/her hips. The lower buttocks and upper thighs were red and did not blanch when the CNA cleansed the area with wipes. c. Review of the resident's medical record revealed a care plan dated 11/30/06 which identified the resident at risk for pressure sores	F 314	and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This will be accomplished through the following interventions: 1. A total skin assessment was done on Resident # 69 on 10/12/06 to assure there is no skin breakdown. The skin was found to be clear and intact. 2. A complete review of all Residents charts will be completed utilizing the resident's Braden Scales to determine residents at high risk for skin breakdown. Appropriate action for prevention of skin breakdown will be implemented to include a repositioning program for residents. 3. Staff will be inserviced by the Restorative Manager on Repositioning Programs. Unit Coordinators, Team Leaders and Charge Nurses will be inserviced on procedure and importance of monitoring performance on Restorative Programs by C.N.A.s. C.N.A.s will be inserviced on proper charting on Restorative Documentation Sheets. Unit Coordinators, Team Leaders and Charge Nurses will monitor the repositioning programs weekly for the next 3 months.	

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F 314	Continued From page 8 and instructed the staff to reposition the resident every one hour per shift while up in the chair and every two hours in bed. A restorative service delivery record showed the resident required repositioning every two hours and instructed staff to "chart if refused." No refusals were documented. A second restorative service delivery record instructed staff to check the resident every two hours for incontinence. Review of the resident's most recent Minimum Data Set (MDS) assessment, a quarterly assessment dated 8/31/06, it documented the resident as assessed as totally dependent for bed mobility, needing extensive assistance for transfer, and totally incontinent of urine and bowel. Review of the resident assessment protocol review report dated 3/21/06 stated "At risk for skin breakdown r/t [related to] incontinence and decreased mobility....Restorative repositioning program per care plan...." d. Interview with the director of nursing on 10/12/06 at 7:44 AM revealed she expected the resident to be checked for incontinence every two hours and changed and repositioned every two hours.	F 314	4. SDC/Designee will inservice nursing staff on repositioning and checking residents for incontinent episodes in a timely manner according to each resident's specific plan of care. SDC/Designee will inservice nursing staff on the policy and procedure SSP1401.00 Skin Care. 5. The list of residents that need to be laid down after meals or repositioned will be reviewed and updated monthly by the Restorative Manager. Turning/ Repositioning Schedules will be individualized and placed on the Restorative Daily Documentation Sheets. 6. Unit Managers/Designee will do random daily reviews to ensure that residents that require repositioning are turned in a timely manner. 7. Restorative Documentation Sheets will be reviewed monthly by the Unit Coordinators for proper charting and documentation of programs. 8. C.N.A.'s will be inserviced by the DON/Designee on proper use of C.N.A. Assignment Sheets and timely communication of information to the relieving shift. 9. Results of weekly reviews for ensuring that residents are toileted in a timely manner will be reviewed by the Quality Assurance Committee for recommendation and continued compliance.	

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F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure incontinence care for one (#69) of 12 sample residents who required incontinence care. The findings were: Observation of resident #69 on 10/10/06 from 7:26 AM to 12:14 PM (four hours and 48 minutes) revealed the resident was up in an upright geri-chair (a wheeled chair with the ability to recline). At 12:14 PM when the observation ended, the resident was in the dining area waiting for meal service. At 1:25 PM when the observation restarted, the resident was observed in his/her room in the upright geri-chair. At 2:47 PM, CNA #20 assisted the resident to the bed and changed the resident. The following concerns were noted related to incontinence care and services the resident received: a. During the morning aforementioned observation, the resident was neither checked nor changed for for incontinence. Interview with CNA #20 at 2:47 PM on 10/10/06 revealed when he received the resident report at 2 PM, he was not	F 315	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 conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG F315 – PLAN OF CORRECTION** This plan of correction is the facility's credible allegation of compliance. It is the policy and practice of this facility to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and restore as much normal bladder function as possible. This will be accomplished by the following interventions: 1. A total skin assessment was done on Resident # 69 on 10/12/06 to assure there is no skin breakdown. 2. A complete review of charts will be completed to ensure that residents have a toileting plan and that it coordinates with a Restorative Program. Action will be taken on identified issues.	11/11/06

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F 315	Continued From page 10 informed when the resident was last check or changed for incontinence. b. The observation at 2:47 PM on 10/10/06 revealed the resident smelled strongly of urine, and when changed, the disposable brief was saturated. The observation revealed multiple creases in the resident's skin over his/her hips. The lower buttocks and upper thighs were red and did not blanch when the CNA cleansed the area with wipes. c. Review of the resident's medical record revealed a care plan dated 11/30/06 that showed the resident required a check and change program every two hours and used pads and briefs. A restorative service delivery record instructed staff to check the resident every two hours for incontinence. Review of the resident's most recent Minimum Data Set (MDS) assessment, a quarterly assessment dated 8/31/06, documented the resident was assessed as totally dependent for bed mobility, needing extensive assistance for transfer, and totally incontinent of urine and bowel. Review of the resident assessment protocol review report dated 3/21/06 showed the resident was incontinent of bladder and required a restorative check and change program. d. Interview with the director of nursing on 10/12/06 at 7:44 AM revealed she expected the resident to be checked for incontinence every two hours and changed if incontinent.	F 315	3. Nursing staff will be inserviced by Restorative Manager/Designee on repositioning and checking residents for incontinent episodes in a timely manner according to each resident's specific plan of care. 4. Unit Managers/Designee will perform random daily observations and documented reviews of the residents to ensure that residents are toileted in a timely manner. 5. A list of residents that require toileting will be placed in the TAR's (Treatment Administration Record) and the RFPR (Resident Functional Performance Record). The Restorative Manager will update the lists with changes. 6. Restorative Documentation Sheets will be reviewed monthly by the Unit Coordinators for proper charting and documentation of programs. 7. Results of the weekly reviews for ensuring that residents are toileted in a timely manner will be reviewed by the QA/A Committee for recommendation and continued compliance.	

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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, staff interview, and review of an instruction guide, the facility failed to ensure two (#27, #82) of four sample residents who required a mechanical standing lift for transfer, were capable of transferring in the lift safely. The findings were: 1. Review of the 7/17/06 Quarterly Minimum Data Set (MDS) assessment for resident #27 showed s/he was totally dependant on staff for activities of daily living (ADLs). Review of the 5/9/06 resident care plan for transfers showed a Viking (sling type) mechanical lift was to be used to transfer the resident to and from chair, bed and toilet. Observations on 10/10/06 at 7 AM, and on 10/11/06 at 2:50 PM showed the resident was transferred from a wheelchair into bed using a Sabina II (a sit to stand mechanical lift). During these observations it was noted the resident was not able to hold onto the bars or participate in the process. In addition, a vest that wrapped around the torso under the arms was used rather than a sling. Review of the 7/26/06 resident transfer evaluation showed the resident scored a "26" which correlated to a category 4 on this form. The form showed category 4 was where the "Caregiver performs 100% of the task" and the equipment to be used was listed as a "total body/sling lift". Review of the instruction guide for the Sabina II revealed "Sabina is intended for patients who are able to actively participate in the	F 324	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 conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG F324 – PLAN OF CORRECTION** This plan of correction is the facility's credible allegation of compliance. The Facility will ensure that each resident receives adequate supervision and assistive devices to prevent accidents. 1. For residents # 27 and # 82, the Transfer Evaluation and care plan were reviewed for accuracy. Nursing assistants have been instructed in the use of the correct lift for these residents. 2. A complete review of all resident Transfer Evaluations will be reviewed for correspondence to the care plan. The evaluations will also be reviewed to ensure that they are accurate to meet the residents' specific needs for transfer. Action will be taken on identified issues. 3. Random weekly reviews will be done by the Charge Nurse/Designee to ensure that the appropriate lift for each specific resident is being utilized by the C.N.A.	11/11/06

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F 324	Continued From page 12 standing exercise." Interview with the director of nurses on 10/12/06 at 10:38 AM confirmed the resident should be transferred according to the transfer evaluation. She further confirmed the 7/26/06 evaluation was the most current. 2. Review of the 9/6/06 annual Minimum Data Set (MDS) assessment for resident #82 showed s/he was totally dependant on staff for ADLs. Review of the 9/13/06 resident care plan showed a mechanical lift was to be used for transfers. However, the type of lift was not specified. Review of the 6/22/06 resident transfer evaluation showed the resident scored a "22" which correlated to a category 4 on this form. The form showed category 4 was where the "Caregiver performs 100% of the task" and the equipment to be used was listed as a "total body/sling lift". Review of the instruction guide for the Sabina II revealed "Sabina is intended for patients who are able to actively participate in the standing exercise". Further review showed if an appropriate sling is applied this lift can be used for passive lifting from a sitting position. However, this is "intended as an occasional solution". Observation on 10/11/06 at 4:33 PM revealed certified nurse aides (CNAs) #36 and #37 assisted the resident using a Sabrina lift (a sit to stand mechanical lift). During the observation the aides used a vest rather than a sling, it wrapped around the torso of the resident under the arms. The vest had straps attached that were then hooked onto the lift. The resident was unable to participate, and his/her right hand was between the strap and vest during the transfer. Interview with the director of nurses on 10/12/06 at 10:38 AM confirmed the resident should be transferred according to the transfer evaluation. She further	F 324	4. The Staff Development Coordinator will provide an inservice to Charge Nurses and C.N.A.'s on the need for accurate transfer assessment and adherence to the care plan for resident safety and accident prevention. 5. The Nursing Unit Managers will review monthly a random sample of residents requiring lift transfers by review of the Transfer Assessment, care plan and direct observation of staff practice. 6. The Unit Coordinator/Designee will do random weekly reviews of the RFPR to ensure that the lifts utilized are appropriate for the residents designated care needs, and to ensure that documentation is accurate. 7. Results of the random weekly reviews to ensure that lifts are utilized according to the residents care needs will be reviewed by the QA/A Committee monthly for three months and assessed for recommendation and continued compliance.	

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F 324	Continued From page 13 confirmed the 6/22/06 evaluation was the most current.	F 324		
F 371 SS=F	483.35(i)(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: Based on observations, staff interview, and review of facility policy and procedure, the facility failed to ensure dietary staff used acceptable handwashing procedures. In addition, one refrigerator contained resident food items that were not dated or labeled. The findings were: a. Observation on 10/10/06 at 10:20 AM showed cook #1 was wearing disposable gloves while preparing sandwiches. While making the sandwiches she was called away to complete another task. Then without taking off her gloves, cook #1 performed various tasks which included opening 3 separate reach in refrigerator doors, and walking into the dirty dish room. Without removing the soiled gloves, cook #1 then went back to making and handling the sandwiches. Review of the 4/2005 facility policy and procedure titled "Food Handling Practices" showed "...change gloves before and after non-food contact..." b. Observation on 10/10/06 at 7:50 AM showed	F 371	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 conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG F371 – PLAN OF CORRECTION** This plan of correction is the facility's credible allegation of compliance. It is the policy and practice of this facility to store, prepare, distribute, and serve food under sanitary conditions. 1. The Dietary manager held an inservice with dietary staff on 10/11/06 to address proper food handling practices. The Director of Nursing discarded food items not labeled in Medicare Hall refrigerator on 10/12/06. Hand sanitizer was removed from the dish room on 10/30/06. 2. The Dietary Manager will observe food handling practices daily for the next 30 days and routinely thereafter to ensure proper food handling techniques during food preparation and meal service. Deviations from the standard will be immediately corrected. Dietary	11/11/06

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F 371	Continued From page 14 dietary aide #1 served resident meals from a steam table in the secure unit dining room. She did not wear disposable glover rather utilized tongs and utensils to handle the food. The dietary aide then left the room, and was gone for approximately 2 minutes. When she returned to the steam table, she continued to serve resident meals without washing or sanitizing her hands. c. Observation on 10/10/06 at 10:05 AM showed dietary aide #2 wiped down a soiled dish cart, without washing her hands, she used a hand sanitizer solution that was in a dispenser attached to the wall near the dish machine. She then proceeded to handle clean dishes. According to Food Code 2005, U.S. Public Health Service 2-301.16: "(A) A hand antiseptic used as a topical application, a hand antiseptic solution used as a hand dip, or a hand antiseptic soap shall: (1) Comply with one of the following ...(3) Be applied only to hands that are cleaned as specified under 2-301.12." d. Observation of the Medicare hall refrigerator on 10/12/06 at 8:33 AM revealed it held resident nourishments. The observation also revealed a sandwich wrapped in paper without a label, resident name, or date. Three disposable containers were stored in the refrigerator that were not labeled or dated. Interview with the director of nursing on 10/12/06 at 9 AM revealed the refrigerator stored resident food. She then stated the containers could not be identified and were discarded. According to Food Code 2005, U.S. Public Health Service 3-501.17: "Date Marking. ...Refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD... prepared and held in a FOOD ESTABLISHMENT for more	F 371	Manager will observe activities in the dish room daily for the next 30 days and routinely thereafter to ensure appropriate hand washing in the dish room. Dietary Manager will include refrigerators at nursing stations in weekly sanitation check-list, undated or unlabeled food will be discarded. 3. The Registered Dietitian and Dietary Manager will hold routine inservices with dietary staff to address any issues identified in observation of staff and to further review food handling practices and handwashing. An inservice with staff will be held to address proper labeling, dating and storing of food containers. 4. The Dietary Manager will report findings related to food handling practices and refrigerator sanitation to the Quality Assurance Committee monthly. The Quality Assurance Committee will direct further corrective action as needed.	

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F 371	Continued From page 15 than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded..." Interview with the dietary manager, the assistant dietary manager and the dietitian on 10/10/06 at 5:15 PM confirmed the dietary staff should be washing hands between tasks, and before meal service. According to Food Code 2005, U.S. Public Health Service, 2-301.14: "Food employees shall clean their hands and exposed portions of their arms...(G) When switching between working with raw food and working with ready-to-eat food; (H) Before donning gloves for working with food; and (I) After engaging in other activities that contaminate the hands."	F 371		
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policies and procedures, staff interview, and review of	F 441	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 conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG F441 – PLAN OF CORRECTION** This plan of correction is the facility's credible allegation of compliance. It is the policy and practice of this facility to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and	11/11/06

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F 441	Continued From page 16 professional standards of practice, the facility failed sustain an effective infection control program based on consensus standards and guidelines. The facility failed to apply appropriate criteria for terminating precautions for one (#115) of two closed sample residents with culture-confirmed methicillin-resistant Staphylococcus aureus (MRSA) consistent with recommended standards of practices. Further, the facility failed to consistently monitor staff adherence to infection control principles and an ensure an effective mechanisms was implemented to monitor employees with potentially infectious or communicable diseases. Resident census at the time of survey was 112. The findings were: 1. Review of the closed medical record for resident #115 revealed s/he was admitted to the facility on 7/2/06 from a healthcare facility in Pennsylvania. The resident was diagnosed with three culture-confirmed multi-drug resistant organisms (MDROs) in the two-week period prior to his/her transfer. MRSA was reported on 6/28/06 from a sputum specimen, vancomycin-resistant enterococci (VRE) was reported on 6/15/06 from a stool specimen, and Eschericia coli was reported on 6/14/06 isolated from a urine specimen and confirmed to produce extended-spectrum beta lactamase (ESBL). Detailed review of the resident's medical record reveled the following concerns: a. The facility could not provide documentation to show the resident was culture-negative for MRSA or VRE prior to transfer or following admission on 7/2/06. Interview with the DON on 10/11/06 at 3:25 PM revealed she was aware the resident was culture-positive for MRSA and VRE. The	F 441	transmission of disease and infection. 1. Resident # 115 was discharged. 2. Residents' charts will be reviewed for MRSA/VRE and to ensure that there has been a culture to identify if it was negative or colonized. Action will be taken on identified Issues. 3. The NHA/DON will educate the physicians and nursing staff on the CDC recommendations to ensure that residents who have positive cultures for MRSA/VRE are on full isolation precautions until the cultures come back negative as follows: a. MRSA – 2 negative cultures b. VRE – 3 negative cultures 4. The Medical Director will assist the Infection Control Nurse in developing an employee based health program to review staff that call in sick. Reported symptoms of illness will be logged to ensure that the employee is asymptomatic before returning to work. 5. The DON/Designee will review the daily staff call-ins. If necessary, a follow up call with the staff member will be made to identify symptoms and ensure that these are tracked and trended. 6. The Infection Control Nurse/Designee will educate staff on hand-washing according to the infection control guidelines. Random daily observation and documentation of proper hand-washing will be done.	

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F 441	Continued From page 17 DON requested the discharging healthcare facility send culture results confirming the resident was negative for the MDROs, but no culture-negative laboratory reports were received for either the MRSA or VRE infections. b. The resident was placed on isolation with contact precautions on 7/2/06 upon admission to the facility; these cautionary measures were discontinued by physician order on 7/19/06. The resident's medical record failed to document multiple culture-negative results for MRSA or VRE as evidence to terminate contact precautions. One culture was reported as negative for MRSA in the resident's sputum and another culture was reported negative for VRE in a stool specimen. c. The Association for Professionals in Infection Control and Epidemiology (APIC) recommend residents diagnosed culture positive for MRSA or VRE be confirmed negative by reculture at the site of infection before precautions are terminated. The APIC Text of Infection Control & Epidemiology, 2nd edition, January 2006, indicates precautions should be continued until the patient "...completes antimicrobial therapy and until surveillance cultures are obtained at least 48 hours apart and are culture-negative from the original site of infection. The patient should have completed antibiotic therapy for at least 72 hours before cultures are obtained." The APIC recommendations for contact precautions instituted for VRE are to "...discontinue after the resident completes antimicrobial therapy and has three negative cultures at least 1 week apart from the original culture-positive site...". d. Interview with the Chief, Emerging Diseases/Health Statistics Section, Wyoming Department of Health, on 10/12/06 at 2:40 PM	F 441	7. Results of random daily reviews of hand-washing will be reviewed by QA/A Committee monthly for three months for recommendation and continued compliance.	

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F 441	Continued From page 18 confirmed the Wyoming Department of Health endorsed the recommendations of the Hospital Infection Control Practices Advisory Committee (HICPAC) that individuals be considered free of MRSA after two cultures of the infected body site are negative. Similarly, the Wyoming Department of Health supports the HICPAC recommendations that VRE precautions be continued until three culture-negative results are obtained, at one week intervals, from the original site of infection. APIC and HICPAC guidelines are recognized current consensus standards for MRSA and VRE infection in the long-term care setting. e. Interview with the infection control nurse (ICN) on 10/10/06 at 3:40 PM revealed she was not aware of the APIC or HICPAC recommendations for multiple reculture prior to termination precautions for MDROs. Review of a facility policy summarizing procedures for residents with MRSA and VRE, IC 0701.00 A2, release date April 2005, revealed the practice of removing a resident from MRSA precautions when "...a negative culture from any previously infected/colonized site and a negative culture from the nares is probably a reasonable guideline." With regard to VRE, the summary referred to "...negative cultures from any previously infected/colonized site, and negative stool cultures on three consecutive occasions obtained at greater than one-week intervals." However, these policies were not consistent with the APIC or HICPAC standards of practice for infection control in long-term care facilities or the recommendations of the Wyoming Department of Health. f. Joint interview with the DON and facility administrator on 10/12/06 at 10:25 AM revealed the facility was not aware the resident was also culture-positive for ESBL E. coli. According to the	F 441		

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F 441	Continued From page 19 APIC Text, the precautions for ESBL organisms are the same as those prescribed for MRSA or VRE. 2. Interview with the ICN on 10/10/06 at 2:45 PM revealed the facility did not routinely report to the ICN those employees that called in sick or went home because they were too sick to work. According to the ICN, employees are required to notify their supervisors when they are sick and cannot make a scheduled work shift, but this information is primarily used for scheduling purposes. The ICN stated she did not consistently receive information about employees with potentially transmissible infections or diseases and, therefore, did not monitor return-to-work status or make specific recommendations to limit contact with residents. 3. Interview with the ICN on 10/11/06 at 2:40 PM revealed she did not systematically monitor employee adherence to infection control principles or practices. The ICN stated she conducted "...spot checks...", but had not implemented a regular and recurring program to evaluate staff compliance or the effectiveness of hand hygiene training. The ICN stated she last conducted a spot check of hand hygiene in April 2006, but was unable to document the outcome of her evaluation. Joint interview with the DON and facility administrator on 10/12/06 at 10:05 AM revealed other individuals conducted periodic monitoring of infection control practices and, according to the administrator, this information was not necessarily always known to the ICN. Documents provided by the facility administrator showed "...infection control practices (such as handwashing and isolation procedures)..." was	F 441		

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(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 441	Continued From page 20 recorded for 3 months in 2006; April, May, and August. These documents failed to: identify monitoring criteria indicate if the reviews focused on hand hygiene or isolation link lack of compliance with interventions document the effectiveness of any interventions A hand written annotation related to hand hygiene monitoring for April 2006 stated "Staff washed hands when entering DR [dining room] - but not after going from one resident to another with feeding". A review of statistics complied by the Epidemiology Section, Wyoming Department of Health, revealed the facility experienced a gastrointestinal outbreak in April 2006 causes diarrheal illness in 62 residents and at least 10 staff. The outbreak was confirmed by laboratory analysis to involve norovirus.	F 441		
F 442 SS=E	483.65(b)(1) PREVENTING SPREAD OF INFECTION When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policies and procedures, staff interview, and review of professional standards of practice, the facility failed to apply current infection control recommendations for terminating precautions for one of two closed sample residents infected with multi-drug resistant organisms. The findings	F 442	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 conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG F442 – PLAN OF CORRECTION** This plan of correction is the facility's credible allegation of compliance. It is the policy and practice of this facility that when the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility will isolate the resident.	11/11/06

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F 442	Continued From page 21 were: Review of the medical record for resident #115 revealed s/he was admitted to the facility on 7/2/06 with laboratory reports of culture-confirmed multi-drug resistant organisms, Methicillin-resistant Staphylococcus aureus (MRSA) and vancomycin-resistant enterococci (VRE), in his/her medical records. The laboratory findings were dated 6/28/06 (MRSA) and 6/15/06 (VRE). The resident was admitted by transfer from another healthcare facility. Interview with the infection control nurse (ICN) on 10/12/06 at 9:48 AM revealed the facility was aware of the MRSA and VRE reports and implemented contact precautions when the resident was admitted on 7/2/06; the cautionary measures were terminated on 7/19/06 by physician order. Review of the resident's medical record revealed a single negative culture result from a sputum specimen (previously MRSA positive) and from a stool specimen (previously VRE positive) were reported by the laboratory prior to terminating precautions for the resident. Interview with the DON on 10/12/06 at 10:10 AM confirmed a single reculture was performed for each of the drug-resistant bacteria. She further confirmed the facility had not received any additional information from the discharging facility regarding negative culture results. The Association for Professionals in Infection Control and Epidemiology (APIC) recommend residents diagnosed culture positive for MRSA or VRE be confirmed negative by reculture at the site of infection before precautions are terminated. The APIC Text of Infection Control & Epidemiology, 2nd edition, January 2006,	F 442	1. Resident # 115 was discharged. 2. Residents' charts will be reviewed for MRSA/VRE to ensure that there has been a culture to identify if it was negative or colonized. Action will be taken on identified issues. 3. NHA/DON will educate physicians and nursing staff on the CDC recommendations to ensure that residents that have positive cultures for MRSA/VRE are on full isolation precautions until the culture comes negative as follows: a. MRSA – 2 negative cultures b. VRE – 3 negative cultures 4. The Infection Control Nurse/Designee will review labs and telephone orders in the AM meeting for existing residents and new admissions for recurrence of MRSA/VRE. Residents will be placed on the appropriate specific isolation. The care plan will be updated to reflect the specific resident needs. Cultures will be done according to the CDC recommendations and the resident will remain on isolation until cultures are negative as follows: a. MRSA – 2 negative cultures b. VRE – 3 negative cultures 5. The review of telephone orders and labs ensure that for residents with MRSA/VRE the necessary precautions are done will be reviewed by the QA/A Committee for recommendation and continued compliance.	

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F 442	Continued From page 22 indicates precautions should be continued until the patient "...completes antimicrobial therapy and until surveillance cultures are obtained at least 48 hours apart and are culture-negative from the original site of infection. The patient should have completed antibiotic therapy for at least 72 hours before cultures are obtained." The APIC recommendations for contact precautions instituted for VRE are to "...discontinue after the resident completes antimicrobial therapy and has three negative cultures at least 1 week apart from the original culture-positive site...". Interview with the Chief, Emerging Diseases/Health Statistics Section, Wyoming Department of Health, on 10/12/06 at 2:40 PM confirmed the Wyoming Department of Health endorsed the recommendations of the Hospital Infection Control Practices Advisory Committee (HICPAC) that individuals be considered free of MRSA after two cultures of the infected body site are negative. Similarly, the Wyoming Department of Health supports the HICPAC recommendations that VRE precautions be continued until three culture-negative results are obtained, at one week intervals, from the original site of infection. APIC and HICPAC guidelines are recognized current consensus standards for MRSA and VRE infection in the long-term care setting. Interview with the ICN on 10/10/06 at 3:40 PM revealed she was not aware of the APIC or HICPAC recommendations for multiple reculture prior to termination precautions for MDROs. The current facility policy, IC 0701.00 A2, release date April 2005, stated a resident could be removed from MRSA precautions when "...a negative culture from any previously infected/colonized site	F 442		

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F 442	Continued From page 23 and a negative culture from the nares is probably a reasonable guideline." With regard to VRE, the summary referred to "...negative cultures from any previously infected/colonized site, and negative stool cultures on three consecutive occasions obtained at greater than one-week intervals." The practice of terminating precautions for multi-drug resistant organisms (MDROs) with only a single culture-negative result is not consistent with the APIC or HICPAC standards for MDRO control in long-term care facilities or the recommendations of the Wyoming Department of Health.	F 442		
F 443 SS=F	483.65(b)(2) PREVENTING SPREAD OF INFECTION The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. This REQUIREMENT is not met as evidenced by: Based on review of policies and procedures, employee health records, and staff interview, the facility failed to monitor employees with potentially infectious or communicable illness in a manner that minimized the potential transmission of infections to residents. The facility failed to monitor employee illness and two of five new employees failed to have tuberculin testing prior to resident contact as required by Wyoming rules and regulations. The resident census at the time of survey was 112. The findings were:	F 443	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 conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG F443 – PLAN OF CORRECTION** This plan of correction is the facility's credible allegation of compliance. For monitoring of employee health see F 441. For Tuberculin testing see F000.	11/11/06

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F 443	Continued From page 24 1. Interview with the infection control nurse (ICN) on 10/11/06 at 1:30 PM revealed the infection control program lack a mechanism to identify employees that reported sick or were sent home when they were too sick to work. According to the ICN, employees were expected to notify their supervisor if they could not make a scheduled work shift, but this information was not systematically reviewed to ensure employees did not inadvertently expose residents to infections or potentially communicable diseases. The ICN stated she did not routinely receive information about employees with potentially transmissible infections or diseases and, therefore, could not monitor return-to-work status or make specific recommendations for employees to limit contact with residents as specified in facility policies and procedures. The ICN further stated she suspected a certified nursing assistant (CNA) may have been the sentinel case of a norovirus-associated gastrointestinal outbreak in the facility in September 2006. 2. The State of Wyoming Rules and Regulations for Program Administration of Nursing Care Facilities, Section 5(b)(iv)(A), instructs facilities that "Tuberculin [TB] testing shall be accomplished for each employee upon employment and before resident contact begins and annually thereafter." Review of two employee files revealed neither had TB testing prior to resident contact. The following concerns were found: a. The file for employee #80 showed he was hired on 9/12/06. Interview with the staff development coordinator (SDC) on 10/12/06 at 10:45 AM revealed this employee started working in the facility the day he was hired. However,	F 443		

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F 443	Continued From page 25 review of the immunization surveillance record showed the TB test was read on 9/17/06, five days after the employee had resident contact. b. Review of the health file for employee #81 showed a hire date of 6/23/06 for a food service position. Interview with the SDC on 10/12/06 at 10:45 AM revealed this employee started working in the kitchen the day she was hired. However, review of the immunization surveillance record showed the TB test was read on 6/25/06, two days after contact with food and residents.	F 443		
F 444 SS=F	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 and staff interview, the facility failed to ensure staff and a personal care assistant followed appropriate hand hygiene practices while assisting residents to eat during two of three meals observed during survey. The findings were: 1. Observations during two of three meals revealed the following concerns with regard to hand hygiene: a. On 10/10/06 CNA #55 was observed assisting residents during the morning meal from 8:35 AM to 8:57 AM (22 minutes). At no time during the observation did the CNA clean her hands by	F 444	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 conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG F444 – PLAN OF CORRECTION** This plan of correction is the facility's credible allegation of compliance. It is the policy and practice of this facility that staff wash their hands after each direct resident contact. 1. Staff, including private duty aides and nursing assistant students will receive inservice on the need to wash their hands after touching potentially hazardous surfaces and before assisting residents with dining. 2. Hand sanitizer dispensers are available in all dining rooms.	11/11/06

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F 444	Continued From page 26 washing or using hand sanitizing gel. The CNA was observed to touch her hair twice, cover her mouth to yawn once, rub or scratch her face 4 times, rub her mouth/lips with the back of her right hand once, repositioned a wheelchair (touching the left arm and right wheel), touch resident's clothing, and touch the stool she was sitting on while repositioning herself. During this same time, CNA #55 assisted resident #9 to eat, touched the resident's spoon, cup, and a drinking straw. The CNA alternated assisting residents #44 and #16 at an adjacent table. The CNA patted resident #44 on the right hand, held his/her glass and straw while offering a drink, and handed toast to resident #16. b. On 10/10/06, from 8:50 AM to 8:59 AM (9 minutes), Nurse Aide (NA) #6 was observed assisting resident #25 with his/her morning meal. At no time during the observation did the CNA clean her hands by washing or using hand sanitizing gel. During the observation period, the staff member was seen to touch her hair 3 times, rub her mouth/lips with the back of her left hand, and place her right hand on the wheel of a resident's wheelchair. During the observation, Aide #6 handled the spoon, fork, and glass of resident #25 while assisting the resident to eat. At 8:59 AM, the employee left the dining room and walked across the hall to the food serving window. While walking, the employee placed her left hand into the back of her pants and appeared to be scratching herself. Then without washing or sanitizing her hands, the aide returned to the table with a small glass of milk and, using both hands, unwrapped a drinking straw, placed the straw into the glass of milk, and assisted resident #25 to drink. c. On 10/10/06, from 8:14 AM to 8:30 AM (26	F 444	Hand-washing sinks are available adjacent to dining rooms. 3. Dining Maitre'd's, Charge Nurses, Dietary Manager, Dietitian and Unit Managers will receive inservice on how and when to observe direct care staff during the dining experience and make immediate corrections in staff performance. 4. Direct observation of direct care during training sessions will be done at every dining session for the next month by the parties noted in # 3. Any deviation from the standard will be immediately corrected. Monthly observations will be made using the Dining Room Observation Tool. 5. The Quality Assurance Committee will review the Dining Room Observation Tool monthly and direct additional inservice as needed.	

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F 444	Continued From page 27 minutes), a personal care assistant assisted resident #54 with the morning meal. At no time during the observation was the care assistant observed to clean her hands by washing or using hand sanitizing gel. During the observation, the care assistant was seen to touch her hair repeatedly, scratch or rub her face, neck, and right arm, cover her mouth while clearing her throat, cover her mouth with the back of her hand when coughing, and touch the arm and wheel of a resident's wheelchair. At the same time, the care assistant touched the spoon, bowl, napkin, clothing protector, food, and glass of resident #54. In addition, the care assistant touched the napkin and utensils of another resident. At 8:26, the care assistant left the table and returned from the food serving area with a donut wrapped in a napkin. The care assistant unwrapped the donut, handed it to resident #54, then licked the fingers of her right hand. Without washing or sanitizing her hands, she then handled the resident's spoon and napkin with her right hand and transferred the spoon to the resident's hand. d. On 10/10/06 at 8:28 AM, CNA student #83 was observed to scratch his face with his left hand and rub his eyes with the same hand. He walked into the Ritz dining room, retrieved two drinking glasses by placing his fingers into the glasses as he picked them up. He placed the glasses on a serving tray, opened a milk container, poured milk into the glasses, and served the milk to residents #108 and #40. The student did not wash his hands or use a hand sanitizing agent during the observation. e. On 10/10/06 at 6:12 PM Aide #73 was observed to scratch his head and cover a cough with his right hand. The aide did not wash or sanitize his hands before serving three food trays	F 444		

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F 444	Continued From page 28 to residents in the East Dining Room. 2. Interview with the infection control nurse (ICN) on 10/11/06 at 2:45 PM revealed an expectation that staff wash their hands or use hand sanitizer prior to assisting residents to eat and after touching potentially contaminated surfaces. An additional interview with the DON on 10/12/06 at 9:50 AM confirmed an expectation of proper hand hygiene when assisting residents to eat. The DON added the facility did not have a handwashing policy or procedure other than for the direct care setting or for dietary staff.	F 444	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 conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.	
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the licensed staff performed tasks for which they were qualified and that were within their scope of practice. One random observation of non-sample resident #19 revealed his/her oxygen adjusted by certified nurse aide (CNA) staff. The findings were: Observation of resident #19 on 10/10/06 at 7 AM revealed CNA #8 assisted the resident with	F 492	**TAG F492 – PLAN OF CORRECTION** This plan of correction is the facility's credible allegation of compliance. It is the policy and practice of this facility to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. 1. Resident # 19 was placed on the correct flow rate with no negative effects from the alleged deficient practice. 2. Licensed Nurses and C.N.A.s will be inserviced on Wyoming Board of Nursing Regulations that a C.N.A. may be delegated the task of	11/11/06

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F 492	Continued From page 29 his/her oxygen tubing and then adjusted the flow rate from "0" to "2 and 1/2" liters per minute. There was no posting as to the liter flow prescribed for the resident on the tubing or the tank. Interview at that time with the CNA revealed she asked the nurse each morning if the residents had any changes. Review of October 2006 recapitulation orders for the resident revealed the oxygen flow rate was 2 liters. Review of the October 2006 medication administration record (MAR) revealed the flow rate as 2 liters. According to the May 2001 decision by the Wyoming Board of Nursing (BON), a CNA may be delegated the task of adjusting the oxygen liter flow if the liter flow is clearly marked by the nurse on the concentrator and/or oxygen tank. Interview with the director of nursing (DON) on 10/11/06 at 10:33 AM revealed she was unaware CNA staff could not adjust the oxygen flow rate without a posted rate, or of the Wyoming BON decision. The DON stated if the physician orders and the MAR stated the rate should be 2 liters, then it should be set at 2 liters.	F 492	setting the oxygen flow if it is clearly marked by the nurse on the concentrator and/or oxygen tank. 3. All residents with orders for oxygen will have the liter flow clearly marked on oxygen concentrators and/or oxygen tanks. All new orders for oxygen will be checked and have labels placed on O2 concentrators and/or tanks by the Unit Coordinator and/or Team Leader. 4. Random weekly reviews will be performed by supervisory staff to ensure oxygen concentrators and/or tanks are clearly marked with oxygen liter flow. 5. Results of random weekly reviews to ensure that oxygen protocol is being followed accordingly will be reviewed by the QA/A Committee for recommendation and continued compliance. Reviews will be monthly for three months and then re-evaluated.	
F 505 SS=D	483.75(j)(2)(ii) LABORATORY SERVICES The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to promptly notify a physician of laboratory results for one (#13) of two sample residents with eye infections. The findings were:	F 505	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 conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG F505 – PLAN OF CORRECTION** This plan of correction is the facility's	11/11/06

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F 505	Continued From page 30 Review of the medical records for resident #13 revealed an entry on the interdisciplinary progress notes, dated 9/12/06 at 2:35 PM, indicating the resident's left eye was red and matted. A request to culture the resident's eye was faxed to his/her attending physician; an order to proceed with culture was noted on 9/13/06 at 11:35 AM. A laboratory reported dated 9/16/06 at 7:20 AM indicated the resident's left eye was infected with Staphylococcus aureus. Nursing notes in the resident's medical records indicated the laboratory report was received, noted, and filed on 9/16/06 at 10:25 AM. Nursing notes entered on 9/18/06 (two days later) at 1458 (2:58 PM) revealed the attending physician ordered antibiotic therapy and an ophthalmic ointment to be applied to the resident's eye. Nursing notes entered on 9/18/06 at 9:15 PM revealed the resident was begun on an oral antibiotic on at 6 PM and the ophthalmic ointment was received. The resident's medical record did not show if the facility attempted to notify the physician of the positive culture results or provide an explanation for the delay in initiating antibiotic treatment. Interview with registered nurse (RN) #93 on 10/11/06 at 2:10 PM revealed the laboratory typically faxes reports of positive cultures to both the facility and the requesting physician. She added the facility calls the physician if there has not been an order for treatment "...usually after about 24 hours...". The RN did not know why there was a lapse of over 48 hours between the resident's positive culture report and the initiation of antibiotic therapy, but added "...it was probably a weekend...". Telephone interview with the laboratory manager on 10/11/06 at 2:23 PM	F 505	credible allegation of compliance. It is the policy and practice of this facility that the facility must promptly notify the physician of the findings. The facility will ensure that the attending physician will be notified promptly of all abnormal laboratory findings. This will be accomplished by the following interventions: 1. Resident # 13 received antibiotic therapy for his eye infection from 9/18/06 until 9/25/06. He was assessed on 9/25/06 and IDT Notes at that time indicated improvement. The infection is now cleared. 2. The Inservice Educator will provide education to the nursing staff on notification to physicians of abnormal labs and the necessity of prompt treatment of infection. 3. A complete review of lab results will be completed to ensure that lab follow-up and notification of the physician has been completed. Action will be taken on identified issues. 4. Physicians will be notified by Unit Manager/Designee on receipt of abnormal labs for further instruction. The Medical Director will be notified if a physician does not respond within 24 hours. 5. Unit Coordinators and Nurse Team Leaders will review monthly lab results obtained and subsequent Physician notification. Deviations	

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F 505	Continued From page 31 confirmed the resident's laboratory report was faxed to both the facility and the requesting physician on 9/16/06 at 7:20 AM. Interview with the infection control nurse (ICN) on 10/11/06 at 9:50 AM revealed the facility did not have a policy for notifying physicians of positive culture results, but added her expectation that physician would be contacted to minimize a delay in treatment. Joint interview with the DON and facility administrator on 10/12/06 at 10:20 AM confirmed the two day delay form the positive culture report to the initiation of antibiotic therapy.	F 505	from the standard will prompt inservice with the nurse receiving the lab results. 6. Telephone orders and lab results will be reviewed by the IDT/Designee in the AM meeting to ensure that items have been followed up in a timely manner. 7. Results of monthly reviews to follow up on timely notification of the physicians on abnormal labs will be reviewed by the QA/A Committee for recommendation and compliance. Reviews will be monthly for three months and then re-evaluated.	
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure physician progress notes were included in the record for three (#51, #71, #108) of 20 sample residents. In addition, bathing documentation was lacking for one (#98) of 20 sample residents. The findings	F 514	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 conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG F514 – PLAN OF CORRECTION** This plan of correction is the facility's credible allegation of compliance. It is the policy and practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized. 1. For residents # 51, #71 and # 108,	11/11/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	C 10/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 32 were: 1. Review of the medical record face sheet showed resident #51 was admitted to the facility on 7/17/06. Additional review of the medical record revealed the area of the chart labeled physician progress notes was empty. Interview with the medical records supervisor on 10/12/06 at 10:15 AM confirmed the resident had visits with a primary care physician on 7/20/06, and 9/14/06, and consultant physician visits on 7/24/06 and 8/10/06. She further confirmed the progress notes from these visits were not in the medical record. 2. Review of the medical record face sheet showed resident #71 was admitted to the facility on 5/8/06. Additional review of the medical record revealed the area of the chart labeled physician progress notes was empty. Interview with the medical records supervisor on 10/12/06 at 10:15 AM confirmed the resident had visits with a primary care physician on 6/16/06, 7/20/06, and in August (exact date unknown). However, the progress notes had not yet been sent over from the physician's office to be included in the medical record. 3. Medical record review for resident #108 revealed a face sheet (not dated) which showed the resident was admitted on 7/18/06. Review of physician progress notes revealed no notes in the record. Yet, review of nursing notes showed the physician visited on 8/15/06 and 9/11/06. Interview with the health information manager on 10/12/06 at 11:02 AM revealed she thought all progress notes were in the resident record at one time and did not know why they were missing.	F 514	the Physicians Progress Notes were located and placed on the residents' records prior to the end of the survey. 2. A complete review of charts will be performed to determine missing Physician's Office Notes. These notes will be obtained and placed in the charts. 3. The Health Information Manager will review monthly to ensure that the Physicians Progress Note or consultation is received and filed in the chart in a timely manner. Staff will be inserviced on utilizing the 24 Hour Report to record all physician's visits. These reports, along with the van book, will be utilized by the Health Information Manager or her designee to request any missing notes. The Health Information Manager will review the van book weekly to ensure that notes from all appointments have been received and filed in the chart. 4. Unit Coordinators and Team Leaders will monitor the Resident Functional Performance Records twice monthly for three months to ensure that ADL documentation s complete. Results of reviews and observations will be reported to the Quality Assurance Committee for review and analysis. Further inservice will be directed as needed.	

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F 514	Continued From page 33 4. Medical record review for resident #98 revealed bathing documentation showed the resident received one bath during September 2006 on 9/6/06 and no baths for the month of October 2006, from the first through the twelfth. Interview with the resident and resident's family member on 10/12/06 at 11:19 AM revealed the resident did receive more that one bath during September and received a bath on 10/11/06. Interview with the director of nursing on 10/12/06 at 10:59 AM revealed no other documentation of bathing was available.	F 514	5. The Health Information Manager will audit the medical record per the Quality Assurance audit schedule. Missing information will be obtained. 6. The Quality Assurance Committee Committee will review Medical Records audits monthly for three Months and re-evaluate.	