Reviewed & approved 10/27/06 after discussion w/ Kathy Potter DNHP & Connie Claus DON & elsewhere on page

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING 1,2,3,5,6,9 14,15,24. Linda Brown RN B. WING	09/27/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES	BOX 517 SUNDANCE, WY 82729

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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 staff interview, the facility failed to properly sanitize oxygen equipment for resident #22. The findings were: Observation on 9/25/06 at 12:17 PM revealed resident #22 was seated at a table in the dining room. The resident had previously removed his/her nasal cannula for oxygen and dropped it on the floor. Licensed practical nurse #6 picked the cannula up, but failed to sanitize it before replacing it on the resident's face. Interview with the director of nursing (DON) on 9/26/06 at 4 PM revealed the facility did not have a policy for sanitizing cannulas. However, the DON stated she expected staff to sanitize nasal cannulas if they had been on the floor before placing them on the resident.	F 253	F253-The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior, this will be evidenced by: A procedure has been developed to cleanse oxygen cannulas that have fallen on the floor. The nursing staff will be educated and ongoing monitoring by the charge nurse will occur to include resident #22. A quality assurance tool has been implemented for monthly monitoring for quarterly reporting to the QI committee. 10/31/06	10/31/06 10/26/06 per request of Connie Claus DON & Larry Potter, DNHP on 10/25/06 Linda Brown RN

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

Larry Potter — CEO — 10/18/06

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. DEC 19 2006

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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 medical record review and staff interviews, the facility failed to complete comprehensive assessments for 1 (#27) of 10 sample residents. The findings were:	F 272	F 272- The facility will conduct a comprehensive accurate, standardized reproducible assessment of each residents functional capacity, this will be evidenced by: Utilizing the RAI specified by the state a significant change ~~to~~ for fall, pain and behavior comprehensive assessment MDS has been completed on resident #27 with a sign by date of 10/16/2006. 10/16/06 Education of the Director of Nursing and MDS nurse that a significant change MDS is necessary for improvement as well as decline in 2 or more areas have occurred. A quality assurance assessment tool has been developed to monitor all residents for significant changes, results will be reported to the QA committee quarterly. 10/16/06 10/16/06 The DON and MDS Nurse and MDS committee performed an audit of other records and identified 2 residents that needed assessments which were completed. additions per request of Connie Clarke (SOM) on 10/27/06 LB Brown RN	

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F 272	Continued From page 2 According to the 7/2/06 significant change Minimum Data Set (MDS) assessment, resident #27 required comprehensive assessments for activities of daily living (ADLs), dehydration, pain, and falls. Review of the entire medical record revealed these assessments were lacking. During an interview on 9/27/06 at 10:25 AM, the assessment coordinator stated she "just missed" these assessments.	F 272		
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to complete a significant change Minimum Data Set (MDS) assessment for one (#27) of three sample residents who had experienced a significant	F 274	F 274 The facility will conduct a comprehensive accurate, standardized, reproducible assessment of each residents functional capacity, this will be evidenced by: Utilizing the RAI specified by the state a significant change comprehensive assessment MDS has been completed on resident #27 with a sign by date of 10/16/2006. 10/16/06 Education of the Director of Nursing and MDS nurse that a significant change MDS is necessary for improvement as well as decline in 2 or more areas have occurred. A quality assurance assessment tool has been developed to monitor all residents for significant change, results will be reported to the QA committee quarterly. 10/16/2006 10/16/06 The DON and MDS Nurse & MDS committee performed an audit of other records and identified 2 resident who's needed assessments which were completed per added request of DON on 10/27/06 LB Brown RN LB	

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F 274	Continued From page 3 change. The findings were: According to the 7/2/06 significant change MDS assessment, resident #27 required extensive staff assistance with transfers, ambulation in the room, eating, and toilet use. In addition, the resident was coded as not ambulating at all in the hallways. Observation on 9/25/06 at 12:25 PM showed the resident ate independently. Further observation that day showed the resident stood without assistance at 12:56 PM, ambulated with a front wheeled walker to the bathroom from the dining room, and used the toilet independently. Interview with the director of nursing (DON) on 9/26/06 at 9:35 AM revealed the resident had improved significantly since returning to the facility from the hospital several weeks ago. The DON confirmed a significant change assessment was not completed and stated she did not realize one was required for improvements, as well as declines, in two or more areas.	F 274		

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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 observation, medical record review, and staff interview, the facility failed to develop a comprehensive care plan for 1 (#23) of 10 sample residents. The findings were: Review of the 8/16/06 nursing notes for resident #23 revealed the physician visited to "look at resident's L [left] red eye. New orders." No further information was documented in the notes. Review of the 8/16/06 orders showed the physician ordered a culture of the left eye and Bacitracin ophthalmic ointment (an antibiotic for the eye) to be applied twice a day for a week. Review of the	F 279	F 279 The facility will use the results of the residents assessment to complete/develop, review and revise the residents comprehensive plan of care. This has been evidenced by a repeat culture of resident # 23 lt. eye on 9/27/2006. The care plan for resident # 23 has been updated to include contact precautions for MRSA. Aide assignment sheet and nursing report sheet has been updated to indicate MRSA for staff knowledge and a MRSA information sheet for charts has been developed to assist in tracking. 9/27/2006 The DON and MDS Coordinator & committee performed an audit of all care plans. A quality assurance tool has been developed to monitor all residents for accurate & updated care interventions. added per request of DOP on 10/2/06 JBrowning	9/27/06

JB

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F 279	Continued From page 5 culture results showed the resident had an infection of the eye which was identified as methicillin resistant staphylococcus aureus (MRSA). Observation of the resident on 9/26/06 at 10:30 AM showed the resident's left eye remained red. However, review of the care plan showed it lacked interventions to prevent spreading the infection to the resident's right eye or to other residents and staff. According to recommendations from the Centers for Disease Control (CDC), contact isolation should be initiated for MRSA infections. During a conference on 9/27/06 at 7:25 PM, the administrator stated he visited the resident and touched the resident's hands daily. The administrator further stated he was unaware the resident had MRSA or that contact isolation was required.	F 279		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure staff maintained professional standards of practice related to preparation of injectable medications for one (#23) of one sample residents. The findings were: Observation on 9/25/06 showed licensed practical nurse (LPN) #6 prepared and then administered Lantus and Humalog insulins for resident #23 at 12:17 PM. When preparing the insulins, the LPN had her fingers on the plunger of both syringes	F 281	F 281 Services provided or arranged by the facility must meet professional standards of quality this will be evidenced by education and random monitoring of all nursing staff by the DON to utilize sterile technique when preparing injections for all residents. Nurse #6 was in serviced on proper injection preparation and technique for resident #23. A quality indicator tool has been developed to monitor the nurses on sterile technique for injections and will be reported quarterly to QA committee. 10/31/2006	10/31/06 10/26/06 chgd per request of Connie Clouse & Kathy Potter WHP on 10/25/06 Linda Beaver RN

RB

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F 281	Continued From page 6 when she drew up and injected air into the vials of insulin. This practice contaminated the sterile syringe so that the insulins withdrawn from the vials back into the syringes became contaminated. Furthermore, the LPN was unable to remove the air bubbles in the syringes, so she re-injected the insulins back into the vials, thus contaminating both vials. Finally, the LPN withdrew the insulins into the syringes and administered them both subcutaneously into the resident. Interview with the director of nursing (DON) on 9/26/06 at 4 PM revealed she expected syringes to be handled "aseptically." The DON defined "aseptically" as maintaining sterility of each syringe. Review of the 3rd edition of "Nursing Interventions & Clinical Skills," by Elkin, Perry, and Potter, showed one should avoid touching the plunger of a syringe and tap the side of a syringe to remove air bubbles.	F 281		
F 312 SS=D	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: Based on observation, staff interview, and review of policies and procedures, the facility failed to assure staff provided appropriate perineal care for two (#15, #21) of three residents who were dependent on staff for assistance. The findings were:	F 312	F 312 A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene this will be evidenced by: Appropriate perineal care will be performed on all incontinent residents including residents #15 and # 21 according to facility guidelines, policies and procedures for male/female perineal care. All CNA's are being in serviced on facility policies and procedures for appropriate male/female perineal care. A quality indicator tool will be developed for quarterly reporting to the QA committee. 10/19/2006	10/19/06

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F 312	Continued From page 7 Interview with the director of nursing (DON) on 9/26/06 at 4 PM revealed her expectation was that staff provide perineal care by using a clean area of the wipe for each stroke, or disposing of the wipe if it was "bad" and using a clean one. The DON also stated her expectations had been discussed with the staff numerous times. The following concerns were identified: a. Observation on 9/25/06 at 11:45 AM showed certified nurse aides (CNAs) #4 and #9 assisted resident #15 to the bathroom. The resident was incontinent of bowel and bladder, and CNA #4 provided perineal care. While cleansing the resident, the CNA wiped back and forth several times with the same area of the wipe. Review of the facility's policy and procedure, "Female Perineal Care on Toilet," last reviewed 2/24/04, showed staff should use "gentle front to back strokes." However, using a clean area of the wipe or cloth for each stroke was not specifically addressed. b. Observation on 9/25/06 at 12 PM showed resident #21 was incontinent of bowel. CNA #4 cleansed the resident's anal area by wiping back and forth several times with the same area of the wipe. Review of the facility's policy and procedure entitled "Male Perineal Care," last reviewed 2/04, revealed using a clean area of the wipe for each stroke and cleansing front to back was not addressed by the policy. Review of the November 2001 "Nurse Aide Written (or Oral) Examination and Skills Evaluation Candidate Handbook" documented that candidates failed the test if critical steps were not performed. One of the critical steps for perineal care included, "Washes entire perineal area...moving from front to back, while using a	F 312		

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F 312	Continued From page 8 clean area of the washcloth or clean washcloth for each stroke."	F 312	F 329 Each residents drug regime must be free from unnecessary drugs this will be evidenced by all unnecessary drugs being discontinued in a timely manner including resident #3. Resident #3's physician was contacted and Namenda was discontinued on 9/28/2006. The Physicians will be instructed at the October 20, 2006 medical staff meeting that they are to review all monthly orders for unnecessary medications as well as at the residents 60 day visits. A statement will be added to the bottom of the monthly physician orders that states "I have reviewed the above medications and the above medications are appropriate for the resident's current diagnosis." 10/20/2006 Random audits will be completed by DON with results to be reported to the QA committee on a quarterly basis. added per request of DON on 10/27/06 L Brown RN	10/20/06 10/26/06
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure resident drug regimens were free of unnecessary drugs for one (#3) of ten sampled residents. The findings were: Review of the 8/31/06 monthly recapitulation of the physician's order revealed resident #3 was prescribed Namenda 5mg by mouth, twice a day. Further review revealed the resident was first prescribed Namaenda on 7/28/06. Review of the current September Medication Administration Record (MAR) revealed the resident was continuing to receive the prescribed medication for the current month (from 9/1/06 to the current survey date of 9/27/06). According to the 2006 Mosby's Nursing Drug Reference, page 1622, Namenda is prescribed "for moderate to severe dementia of the Alzheimer's type." Medical	F 329		

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F 329	Continued From page 9 record review revealed the resident was never diagnosed with dementia. In fact, review of the medical record revealed a 9/12/06 progress note written by the resident's primary care provider stated "The diagnosis of dementia is not valid in this patient - in my opinion." Additionally, a 9/14/06 mental health center progress note stated "There are no behaviors consistent with dementia in this patient." Observation on 9/26/06 at 9:48 AM revealed the resident had normal cognitive function. Interview with the director of nursing (DON) on 9/27/06 at 2:48 PM revealed the order prescribing Namenda was a "mistake" and "should have been caught."	F 329		
F 364 SS=E	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, medical record review, and food temperatures and taste, the facility failed to provide 4 (#11, #13, #21, #23) of 10 sample residents with palatable meals. The findings were: 1. Observation on 9/25/06 showed an unidentified staff member served a meal to resident #11 at 5:18 PM. The resident was sleeping, but the employee set the plate down and left without awakening the resident. At 5:34 PM the resident	F 364	F 364 Each resident will receive and the facility will provide food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature this will be evidenced by: Staff will serve all independent residents their food first, dependent residents will then be served to include residents #11, #13, #21, #23 one staff person will start assisting the dependent residents while the remainder will assist with serving. Resident #23's food will remain in the steam table and served last. When all trays are passed all available staff is to assist with resident feeding. There will not be any employee lunch breaks taken during resident meal times to assure meals are served from the steam table immediately and residents are fed promptly. A quality indicator tool will be developed for quarterly reporting to the QA committee. 10/16/2006	10/16/06

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F 364	Continued From page 10 was awakened for medications by licensed practical nurse #6, but was not assisted or encouraged to eat. The resident received no assistance with the meal until 5:37 PM. However, the meal was not reheated after sitting at room temperature for 19 minutes. 2. Review of the 8/29/06 quarterly Minimum Data Set (MDS) assessment showed resident #21 required total staff assistance with meals. Review of the 9/6/06 care plan showed staff were to encourage the resident and assist as s/he would allow. Observation on 9/25/06 at 12:17 PM revealed the resident was seated at the dining room table with a meal of regular consistency. The resident received no assistance or encouragement to eat until 12:37 PM when CNA #5 sat down and gave the resident a drink. Then she left, and the resident received no further assistance until 12:41 PM when CNA #5 returned. However, the CNA did not warm the resident's food, which sat at room temperature for 24 minutes before being consumed. Observation on 9/25/06 showed staff served the evening meal to the resident at 5:27 PM. The meal included soup (in a cup) and a muffin. The resident drank some of the soup independently but was unable to remove the paper baking cup from the muffin, so the resident picked some pieces out of the middle. Then the resident tried to eat it with the paper cup still attached. No staff assistance or encouragement was provided until 5:47 PM. No attempt was made to determine whether or not the meal needed to be re-warmed. The resident was still being fed the meal, which was never reheated, when observations ceased at 6:10 PM, 43 minutes after it was originally served.	F 364		

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F 364	Continued From page 11 3. According to the 9/8/06 MDS assessment, resident #23 was totally dependent on staff for eating. Review of the current care plan revealed "Fed by staff but will hold glass needs cuing to drink." Observation on 9/25/06 at 12:17 PM showed staff served the resident a pureed meal, which was covered with plastic wrap. The resident received no assistance until 12:37 PM when CNA #5 removed the plastic wrap. Then the CNA left without offering the resident any food and did not return until 12:41 PM. The CNA made no effort to determine whether or not the meal required reheating prior to feeding the resident. Observation on 9/25/06 showed staff served the evening meal to the resident at 5:25 PM. The meal was again wrapped in plastic when placed in front of the resident. No assistance was provided until 5:48 PM, 23 minutes after it was served. Again, the CNA did not attempt to determine whether or not the food required reheating prior to feeding the resident. The CNA was still feeding the resident when the observation ceased at 6:10 PM. 4. Confidential interview with fourteen residents on 9/26/06 at 11:00 AM revealed facility food is "frequently cold because it takes a long time for the food to be served up and passed from the food cart to the resident's trays." 5. During an interview on 9/27/06 at 9:30, resident #3 stated the food "could be better." The resident stated the waffle s/he had for breakfast yesterday was "thoroughly burned" on one side. The resident further stated the food was sometimes cold.	F 364	F365 5. The Dietary staff will prepare and hold high quality foods at the appropriate temperature. The Dietary staff will be inserviced on the appropriate food holding temperatures and food quality standards. Random test trays will be conducted by the Dietary Manager (DM) and Registered Dietician (RD), and the RD will report on this with a quality indicator.	

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F 364	Continued From page 12 6. The surveyors requested and received a test tray after the last resident was served on 9/26/06 at 5:25 PM. Testing the temperature and taste of the meal at that time revealed the following: a. The ground meat was 80 degrees Fahrenheit (F.) and tasted cold. b. The french fries were 110 degrees F. and tasted lukewarm. c. The broccoli was 150 degrees F. and was hot. d. The meatloaf sandwich was 100 degrees F. and was palatable. Retesting the temperatures at 5:40 PM (15 minutes later) revealed the following temperatures: a.The ground meat remained at 80 degrees. b.The french fries were 90 degrees. c. The broccoli was 100 degrees. d. The sandwich was 86 degrees F.	F 364	F364 6. The Dietary staff will prepare and hold foods at the appropriate temperatures to maintain high quality food and acceptance by those served. The Dietary staff will be inserviced on the appropriate food holding temperatures. The Dietary staff will record the food temperatures when the food is placed on the steam table and also at the end of the meal service to assure acceptable temperatures were maintained during the meal service. Lower than desired temperatures will be reported to the Dietary Manager (DM). The temperature logs will be randomly monitored by both the Registered Dietician and the DM, with the DM formally reporting on this as a quality indicator.	
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 staff interview and observation, the facility failed to provide sanitary conditions in the facility refrigerator for all residents who eat food prepared in the kitchen by the facility. The findings were:	F 371		

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F 371	Continued From page 13 1.Observation on 9/25/06 at 9:18 AM and on 9/27/06 at 4:48 PM revealed the two metal fan coverings on the condenser unit in the kitchen refrigerator were coated in dust and grime. Directly beneath the condenser uncovered food items, including fresh fruit and vegetables, were stored. Interview with the dietary manager on 9/27/06 at 4:49 PM confirmed the grates were dirty. She stated that "she didn't know if the kitchen or housekeeping staff was responsible for cleaning them." 2. Observation on 9/25/06 at 9:19 AM and on 9/27/06 at 4:38 PM revealed a 10 pound package of hamburger in a metal tray sitting on the bottom shelf in the refrigerator. The package was sitting in a large pool of red liquid. The hamburger was not frozen. Interview with the dietary manager on 9/27/06 at 4:49 PM confirmed the meat had been transferred from the freezer sometime over the previous weekend and placed in the refrigerator to thaw. However, she did not know how long the meat had been thawed. 3. On 9/26/06 at 5:17 PM, observation showed dietary aide #2 dropped a loaf of bread enclosed in a plastic sack onto the floor. The aide picked up the sack while wearing the same gloves she wore when serving the previous meals. Without removing the contaminated gloves, the aide prepared and served 10 additional meals; she handled the plates and serving utensils and folded a piece of bread over to make half a hamburger sandwich for resident #25. According to the facility's policy and procedure entitled "Handwashing," last reviewed 2/04, "Handwashing to control infection will be completed ...before handling food or food trays..."	F 371	F371 1. The facility will assure that sanitary conditions are maintained in the facility refrigerator for all residents who eat food prepared in the kitchen by the facility. The metal fan coverings have been cleaned and will remain clean. The Dietary Manager (DM) will complete a monthly work order to the maintenance department to remove and clean the fan covers. The DM and Registered Dietician will randomly inspect the fan coverings to assure their cleanliness with a work order completed sooner as needed. 2. The facility will assure that sanitary conditions are maintained in the facility refrigerator for all residents who eat food prepared in the kitchen by the facility. Meat will be maintained in a sanitary environment. The Dietary staff will be inserviced on appropriate storage practices. Meat will be pulled according to a formal posted "meat pull list" that correlates to the menu cycle. The daily cooks will be responsible for the maintenance of these products, placing them on clean trays as appropriate. This will be randomly monitored for compliance by the Dietary Manager and Registered Dietician, with immediate actions taken as needed. 3. The facility will assure sanitary conditions are maintained while handling food, including proper hand washing and glove techniques. The Dietary staff will be inserviced on proper hand washing, including the proper use of gloves and the associated policy along with random inspections by the Dietary Manager and Registered Dietician. These processes will be monitored & results reported to QA on a quarterly basis.	

added per request of Linda Sepeda dietary manager on 10/27/06 @ 10 AM Linda Brown RN

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F 386 SS=D	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, a physician failed to adequately review the needs of a patient, before signing an incorrect physician order sheet for one (#3) of three residents for which mental health consults were requested. The findings were: Review of the physician's order sheet for resident #3 for September 2006 revealed the resident's primary care physician signed and dated the order sheet on 8/31/06. Included on the list of medications the resident was to receive was Namenda 5mg PO BID. According to the 2006 Mosby's Nursing Drug Reference, page 1622, Namenda is prescribed "for moderate to severe dementia of the Alzheimer's type." Review of the September 2006 Medication Administration Record (MAR), revealed resident #3 had received Namenda from the beginning of the month (9/1/06) to the current survey date of 9/27/06. Additional medical record review revealed the resident was first prescribed	F 386	F 386 Physicians must review the residents total program of care at least monthly, this will be evidenced by: No unnecessary medications being ordered on each resident. The attending physician for resident #3 and the Namenda was discontinued on 9/28/2006. The Physicians will be instructed at the October 20, 2006 medical staff meeting that they are to review all monthly orders for unnecessary medications as well as at the 60 day visits. A statement will be added to the bottom of the monthly physician orders that states "I have reviewed the above medications and the above medications are appropriate for the residents current diagnosis." 10/20/2006 Random audits will be conducted by the DON with results to be reported to the QA committee on a quarterly bases added per request of DON on 10/27/06 L Braun RN	10/20/06

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F 386	Continued From page 15 Namenda by a psychiatrist on 7/28/06. However, the prescription was based upon the psychiatrist's examination of and the diagnosis of dementia in another resident. Further medical record review revealed resident #3 was never diagnosed with dementia. In fact, review of the medical record revealed a 9/12/06 progress note written by the resident's primary care provider stated, "The diagnosis of dementia is not valid in this patient - in my opinion." Additionally, a 9/14/06 mental health center progress note stated, "There are no behaviors consistent with dementia in this patient." Interview with the director of nursing (DON) on 9/27/06 at 2:48 PM revealed the "order prescribing Namenda for resident #3 was a mistake and "should have been caught."	F 386	F 441 Infection Control-The allegation of compliance was faxed to the Wyoming Department of Health on 10/12/2006. CCMSD has established new infection control policies and procedures, monitors and tracking devices have been developed and implemented, surveillance data is now being collected and analyzed and is part of the QI/QA process. Based on the resurvey of 10/17/2006 we have been placed back into compliance. Infection Control is now an integral part of every departments QI/QA for the facility and our Medical Director will monitor for compliance as an active member of the QI/QA committee with reports going monthly to the Medical staff for review and discussion.	10/12/06
F 441 SS=L	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, and staff	F 441		

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F 441	Continued From page 16 interview, the facility failed to establish, implement, monitor, and maintain an infection control program based on current standards of practice. The facility failed to provide care and treatment consistent with current infection control polices and standards of practice for 3 of 3 residents (#23, #30, #34) with culture-confirmed methicillin-resistant Staphylococcus aureus (MRSA). The facility failed to consistently follow infection control protocols established for monitoring and tracking an infection for 1 of 7 residents (#35) who experienced an upper respiratory infection. The facility also failed to follow its protocol for tuberculosis testing and monitoring for 4 of 5 new employees (#15, #18, #20, and #11). Observed practices related to medication administration, hand hygiene, potential for cross contamination, and respiratory care revealed the staff did not follow standards to minimize the risk for spread of infection. These findings resulted in an immediate jeopardy situation. The findings were: 1. Review of the medical record for resident #23 revealed the resident was diagnosed with culture-confirmed methicillin-resistant Staphylococcus aureus (MRSA) on 8/18/06, isolated from an infection of the left eye. The infection was designated "nosocomial" by the facility infection control nurse (ICN). Review of the facility ' s policy for isolation revealed that contact isolation was to be used for residents known to be infected or colonized with "...multidrug-resistant bacteria..." and, in a handwritten note, "MRSA" was specified as a condition requiring contact precautions. Contact precautions listed in the policy included measures intended to prevent transmission through direct contact or indirect	F 441		

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contact with environmental surfaces. The following concerns were noted with regard to infection control:

a. This resident's medical record failed to reveal a care plan for isolation or contact precautions consistent with facility policies. Further, review of the infection control surveillance records for August 2006 failed to show whether or not the resident was placed in an appropriate level of isolation or if standard precautions were in place.

b. Review of the resident's medical records revealed no evidence that the resident ' s left eye was ever recultured to show the MRSA infection was effectively treated. Interview with the laboratory manager on 9/27/06 at 2:10 PM verified the laboratory had not received any eye cultures for this resident since the initial report issued 8/18/06. Interview with the DON on 9/27/3:30 PM confirmed that a reculture of the initial infection site was not done. Interview with the ICN on 9/27/06 at 11:55 AM revealed she was unaware of APIC and CDC recommendations that MRSA infections be confirmed "culture negative" to verify efficacy of treatment.

c.Observations during the 3 days of survey revealed this resident was present in group settings and ate in the facility dining room without limitations or precautions related to drug-resistant organisms. Interview with the DON on 9/27/06 at 3:35 PM confirmed the resident was allowed a similar level of movement around the facility and social interaction while being treated for the MRSA infection. During a conference on 9/27/06 at 7:25 PM, the administrator stated he visited with the resident daily and often touched the resident's hand. The administrator stated he was unaware the resident had MRSA or that contact

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F 441	Continued From page 18 isolation was required. 2. Review of infection control surveillance data sheets for May 2006 revealed resident #30 was diagnosed with culture-confirmed MRSA isolated from a urine specimen submitted to the laboratory on 5/8/06. The following concerns were noted related to the facility ' s infection control program and this resident's infection. a. Review of the resident's medical record failed to reveal a care plan or nursing notes citing isolation and contact precautions consistent with facility policies. b. The medical record further lacked evidence of reculture after antibiotic therapy to confirm effective treatment of the drug-resistant organism. Interview with the ICN on 9/27/06 at 1:15 PM confirmed the lack of documentation to show culture-negative results after treating for MRSA. 3. Review of infection control surveillance data sheets for March 2006 revealed resident #34 was noted by the ICN to be colonized with MRSA. Interview with the ICN on 9/27/06 at 11:45 AM confirmed the resident was colonized with MRSA. When asked, the ICN agreed knowledge of MRSA colonization would be important to staff although it was not clear how the information would be communicated to appropriate care providers in the facility. The following concerns were noted related to this issue and the facility's infection control program: a. Interview with LPN#11 on 9/26/06 at 6:55 PM revealed she was unaware of the resident's MRSA colonization status. b.Interview on 9/27/06 at 9:35 AM with the laundry supervisor who was responsible for	F 441		

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cleaning and disinfected soiled resident clothing revealed she was unaware of the colonization of the resident or the significance of knowing that information. Interview at 10:05 AM with the housekeeper (#20) who was responsible for cleaning the resident's room, confirmed she was also unaware of MRSA colonization of the resident or the significance of that information in the healthcare setting.

c. Facility policies revealed contact precautions would be used for residents colonized with MRSA. Notes appended to the facility contact precaution policy, entitled "Precaution and Isolation Policies" stated "...following resident use, proper cleansing of the community areas will be performed (table, chair, etc.)." The policy addendum failed to specific the cleaning and disinfecting methods to be used, the frequency of cleaning, mechanisms to educate visitors or volunteers, or how the cleaning process would be monitored to ensure effective disinfection of common use areas.

d.The APIC Text of Infection Control and Epidemiology, 2nd ed., January 2006, Chapter 53, Long-Term Care, recommends MRSA colonized residents be placed in private rooms, if possible, or grouped in a cohort of residents with similar colonization or roommates with a low risk of developing MRSA infection. In addition, precautions are recommended " ...until the resident completes antimicrobial therapy and until surveillance cultures are obtained at least 48 hours apart and are culture-negative from the nares and original site of infection. The resident should have completed antibiotic therapy for at least 72 hours before cultures are obtained.

e. Interview with the Chief of Emerging Diseases/Health Statistics Section, Wyoming

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F 441	Continued From page 20 Department of Health, on 9/28/06 at 1240 PM revealed the Wyoming Department of Health recommendations that a resident may be considered free of MRSA after two cultures of the colonized or infected body site is negative. If the first or second of these cultures remains positive for MRSA, cultures should continue to be taken one week apart until two consecutive negative cultures have been documented. 4. The health file for LPN #11 revealed she had previously tested positive for TB by a purified protein derivative (PPD) skin test at another healthcare facility. This employee had been working in the facility since 8/16/06 (39 days at the time of the survey) and had not yet been confirmed negative for TB by the facility and did not have a certificate from a physician to indicate she was noninfectious. The infection control nurse (ICN) stated in interview on 9/07/06 at 12:10 PM that she was aware that the LPN was previously positive by PPD skin test, but was not sure if further screening had been accomplished to ensure the LPN was negative for TB. 5. Review of personnel files, and interview with the human resources director on 9/27/06 at 11:15 AM, revealed the following staff members were allowed to have resident contact prior to the receipt of TB test results: a. Licensed practical nurses (LPN) #15 started working in the facility, which included direct resident contact, for 5 days prior to a confirmed negative TB test. b. CNA #18 worked three days in the facility, to include performing tasks requiring resident contact, without receiving a TB test. c. Housekeeping employee #20 worked in the	F 441		

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F 441	Continued From page 21 facility and had contact with residents for 2 days prior to being confirmed negative for TB. 6. The facility's infection control policy manual contained a two-page addendum entitled, "Pneumonia Protocol." The document was noted to be unsigned and undated. The ICN stated in interview on 9/27/06 at 12:05 PM, the document had been written by the infection control physician (ICMD) for use in the facility. Resident #35 was listed by the ICN as having pneumonia in February 2005 and "...URI (upper respiratory infection)..." in April 2006. In neither case was the pneumonia protocol used to intake surveillance data or track the course of infection. 7. The following concerns related to staff practices and hand hygiene were noted: a. On 9/25/06 at 12:05 PM CNA #4 provided personal care for resident #21, cleansing the anal area after a period of bowel incontinence. While still wearing the gloves used when cleaning feces from the resident, the CNA was observed to handle a water container and straw to assist the resident with a drink. After removing the gloves, and without any hand washing, the CNA handled a sling, lift, wheelchair, and the resident's clothing. b. On 9/26/06 at 5:17 PM, observation showed dietary aide #2 dropped a loaf of bread enclosed in a plastic bag onto the floor. The aide picked up the sack while wearing disposable gloves, thus contaminating the gloves. Without removing the gloves, the aide continued to prepare and serve resident meals. The facility policy entitled, "Handwashing," reviewed 2/18/05, state "...handwashing to control infection will be completed...after contact with each resident...	F 441		

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F 441	Continued From page 22 before handling food or food trays... (and) ...after contact with contaminated objects..." 8. Observation on 9/25/06 at 12:17 PM showed LPN #6 prepared and then administered injectable medications to resident #23. When preparing the injectable products, LPN #6 placed her fingers on the plunger of two separate syringes when drawing up and then injected air into two glass medication vials. The procedure contaminated the sterile syringe and, by reinjecting medicine back into the vials, contaminated the contents of the vial. The LPN administered both doses subcutaneously to the resident. Interview with the director of nursing (DON) on 9/26/06 at 4 PM revealed she expected syringes to be handled aseptically, defined by the DON as maintaining sterility of each syringe and medicine vial. 9. Facility staff failed to provide appropriate perineal (incontinence) care for two (#15, #21) of three residents who were dependent on staff for assistance. Review of the November 2001 Nurse Aide Written (or Oral) Examination and Skills Evaluation Candidate Handbook showed candidates failed the test if critical element steps were not performed. One of the critical element steps for perineal care included, "Washes entire perineal area...moving from front to back, while using a clean area of the washcloth or clean washcloth for each stroke. "The following infection control concerns were identified: a. Observation on 9/25/06 at 11:45 AM showed certified nurse aides (CNAs) #4 and #9 assisted resident #15 to the bathroom. The resident had been incontinent of bowel and bladder, and CNA #4 provided perineal care.	F 441		

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F 441	Continued From page 23 While cleansing the resident, the CNA wiped back and forth several times with the same area of the wipe. Review of the facility's policy and procedure, "Female Perineal Care on Toilet," last reviewed 2/24/04, showed staff should use "gentle front to back strokes." However, using a clean area of the wipe or cloth for each stroke was not specifically addressed. b. Observation on 9/25/06 at 12 PM showed resident #21 had been incontinent of bowel. CNA #4 cleansed the resident's anal area by wiping back and forth several times with the same area of the wipe. Review of the facility's policy and procedure entitled "Male Perineal Care," last reviewed 2/04, revealed using a clean area of the wipe for each stroke and cleansing from front to back was not addressed. 10. Observation on 9/25/06 at 12:17 PM revealed resident #22 was seated at a table in the dining room. The resident had apparently removed his/her nasal cannula and dropped it on the floor. Licensed practical nurse (LPN) #6 picked up the cannula, but failed to sanitize it before replacing it on the resident's face. Interview with the DON on 9/26/06 at 4 PM revealed the facility did not have a policy for sanitizing cannulas. However, the DON stated staff should sanitize a nasal cannula before putting it back on a resident if this item of equipment came in contact with the floor. 11. A hand-written note on the precautions policy made reference to cohorting (grouping) residents with similar infectious agents for meals; the practice of cohorting during meals or group activities was not observed during survey for the MRSA colonized resident #34 or either of the other two residents (#23, #30) previously found	F 441		

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F 441	Continued From page 24 culture-positive for MRSA. 12. Interview with the infection control nurse (ICN) on 9/27/06 at 9:30 AM revealed she was hired for the infection control position in October 2005. She stated she had no formal training or education in the epidemiology of infectious diseases, infection control processes, or infection control issues specifically relevant to long-term care facilities. She stated that she had a background in acute care nursing with "...very little experience in infection control..." The ICN further noted she had received no additional training in infection control principles or practices since she started her current position; she did not have a reference text or other reference publications outlining infection control procedures for the long-term care environment, current recommendations for diagnosis and treatment of infections, or recognized standards and guidelines for infectious or communicable diseases. She stated a general awareness of surveillance techniques and data collection, but lacked specific guidance for conducting surveillance and was unsure as to the extent and detail of information needed in the infection control program. The ICN prepared monthly summaries of surveillance data, reporting number and types of infections by general diagnosis. The infection control logbook failed to include evidence of seasonal prevalence data, analysis of infection or culture isolate trends, stratification of infections to identify potential risk factors, policies or procedures for cohorting similar infections, review of culture and sensitivity data to evaluate the appropriateness of antimicrobial therapy, infection rates, or any reporting system beyond the monthly summary. When specifically asked about the role of the	F 441		

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F 441	Continued From page 25 infection control physician (ICMD) in the infection control program, the ICN stated that the ICMD" comes over occasionally, but is usually busy." The ICN stated she was mentored in her infection control tasks by the DON and "...calling lots of other people..." In joint interview on 9/27/06 at 1:25 PM, both the DON and ICN confirmed a need to "...go back to school..." and receive training in infection control principles and practices. 13. The ICMD stated during an interview on 9/27/06 at 1:40 PM that she was involved in the infection control program "peripherally" citing conflicts with time and workload. The ICMD added that she had come up with ideas, but was not actively involved in collecting or analyzing data. She further noted the medical staff communicated most issues, to include infections and follow-ups "by word of mouth."The ICMD stated there was no formal plan for follow-up of residents with infections, and stated the ICN's monthly report of infections in the facility and occasional discussions during medical staff meetings were the facility's only post-surveillance actions. 14. The director of nursing (DON) stated in interview on 9/26/06 at 10:15 AM the long-term care facility maintained a copy of infection control policies and procedures at the nurses' station. Review of the infection control policies and procedures provided by the DON revealed the policies were incomplete, not uniformly based on current recommendations, and failed to address several critical areas of a comprehensive infection control program. These policies and procedures were the only written guidance	F 441		

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F 441	Continued From page 26 available to the staff and were noted by the DON to constitute the current infection control program. Review of the policies, procedures, and practices revealed the following concerns: a. The facility lacked a policy or protocol to identify residents at increased risk for infectious or communicable diseases potentially associated with underlying conditions or treatments, such as chronic obstructive pulmonary disease (COPD), diabetes mellitus, indwelling catheters, respiratory care, or the potential for suppressed immune responsiveness associated with cancer treatments. The facility had one or more residents in each of these high risk categories. Interview with the infection control nurse (ICN) confirmed during interview on 9/27/06 at 9:55 AM the lack of a systematic method for identifying residents at increased risk for infections or communicable diseases. The Association for Professionals in Infection Control and Epidemiology (APIC), a recognized authority in infection control practices and standards, emphasizes the importance of identifying factors unique to the long-term care facility and the facility population that predisposes residents to infection and disease. This information is found in the APIC Text for Infection Control and Epidemiology, Chapter 53, Long-Term Care, published January 2006. Similar recommendations are endorsed by the Centers for Disease Control and Prevention (CDC). b. The facility policy entitled, "Infection Control Reporting for the Long-Term Care Facility," dated 11/9/06, contained a flowchart showing information flow and interactions between the ICN, the infection control physician (ICMD), and the Infection Control Committee. The policy indicated close communication was required between the ICN, ICMD, and DON.	F 441		

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F 441	Continued From page 27 Interview with the ICN on 9/27/06 at 9:30 AM revealed the information flow as depicted in the policy was not consistent, monthly meetings with the ICMD as noted in the policy had not occurred in "...several months...", and policies and procedures sent to the ICMD for review and comment had not been returned "...for over six months..." There was no documentation of quarterly infection control meetings or evidence of interdepartmental communication of infection disease concerns as required by facility policy. c. A policy entitled, "Infection Control Worksheet," dated 9/13/06, was designated as a surveillance data collection tool for the infection control surveillance officer to be used in the "Nursing Home" and was required to be initiated with "any Patient/Resident presenting with signs & symptoms of infection or anytime a culture of any kind is collected." A detailed review of surveillance data collected from January through April 2006 failed to show the required form had been used to track any of the 20 infections recorded in the long-term care facility during the time period investigated. Of the 20 surveillance intake forms reviewed, 18 were either incomplete, lacked substantive follow-up, or contained information inconsistent with other sources. d. There was a lack of policies, procedures, or guidelines for conducting a surveillance of infections among residents, no references or criterion-based definitions of infection, health care acquired infections, or surveillance techniques. Further, issues relevant to surveillance of infections in the long-term care setting were absent from the facility's policies (i.e., chronic infections, diseases, or conditions; concomitant infections; immune function in geriatric residents; indwelling catheters, altered or impaired	F 441		

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F 441	Continued From page 28 cognition). e. The long-term care unit was located within a critical assess hospital, sharing the same building, physicians, and ancillary services. Residents were observed during survey to walk through the corridors of the acute care portion of the building and 2 swing-bed patients were observed to eat in the resident dining room all three days of survey. The DON and ICN confirmed in a joint interview on 9/27/06 residents commingled with patients in common areas throughout the facility and, further, the facility did not have in place a mechanism to ensure the dissemination of infection control information between the acute and long-term care units.	F 441	F 442 When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility will isolate the resident. This is evidenced by: Isolation policies have been updated to include standard precautions, contact precautions and MRSA guidelines for long term care. Residents #34 & #30 have been placed on contact precautions, the staff has been educated and all appropriate report sheets have been marked to notify that residents #34 & 30 are MRSA positive. Both care plans have been updated to include contact precautions. All facility wide staff has been updated on infection control including employees #40 & #20. Infection control will add a QI indicator to assure all residents with MRSA are placed on contact precautions. 10/18/2006	10/18/06
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, and staff interview, the facility failed to implement isolation and precautions for 2 of 2 residents (#23, #30) infected with multi-drug resistant bacteria as stated in facility policy. Further, the facility failed to educate staff regarding precautions for 1 of 1 (# 34) resident colonized with methicillin-resistant Staphylococcus aureus (MRSA). The findings were:	F 442		

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F 442	Continued From page 29 1. Review of the medical record for resident #23 revealed an isolate from an infection in his/her left eye was culture-confirmed MRSA on 8/18/06. Thoroughly review of the resident's record failed to reveal a care plan outlining isolation or contact precautions consistent with facility policies. Further, review of the infection control surveillance records for August 2006 failed to document whether the resident was placed in an appropriate level of isolation or if standard precautions were in place. Interview with the infection control nurse (ICN) on 9/27/06 at 11:55 AM confirmed the resident was not placed in isolation or subjected to contact precautions while infected with MRSA. Observation over three days of survey revealed resident #23 was present in group settings and ate 3 of 3 meals in the facility dining room without limitations or precautions related to drug-resistant organisms. Interview with the director of nursing (DON) on 9/27/06 at 3:35 PM confirmed resident #23 was permitted a comparable degree of freedom to move about common areas of the facility and engage in social settings while being treated for MRSA. During a conference on 9/27/06 at 7:25 PM, the administrator stated he visited with the resident daily and often touched the resident's hand. The administrator stated he was unaware the resident had MRSA or that contact isolation was required by facility policy. 2. Review of infection control surveillance log sheets for May 2006 revealed resident #30 was diagnosed with culture-confirmed MRSA isolated from a urine specimen submitted to the laboratory on 5/8/06. Review of the resident's medical record failed to reveal a care plan or nursing	F 442		

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F 442	Continued From page 30 notes documenting isolation and contact precautions consistent with facility policies. The ICN stated in interview on 9/27/06 at 12:05 she was not sure if isolation and contact precautions were used while the resident was infected with MRSA. The DON stated in interview on 9/27/06 at 3:45 PM absence of documentation of isolation and contact precautions was "...a pretty good indicator it didn't happen." 3. Review of infection control surveillance log sheets for March 2006 revealed resident #34 was noted as colonized with MRSA. Interview with the ICN on 9/27/06 at 11:45 AM confirmed the resident was colonized with MRSA. When asked, the ICN stated knowledge of MRSA colonization would be important to staff, although it was not clear how the information would be communicated to appropriate care providers in the facility. Interview with LPN#11 on 9/26/06 at 6:35 PM revealed an unawareness of the resident's MRSA colonization history. Similar interviews on 9/27/06 with ancillary service providers, laundry staff #40 (9:35 AM) responsible for cleaning and disinfected soiled resident clothing, and housekeeping staff #20 (10:05 AM) responsible for cleaning resident #34 room revealed these staff were unaware of MRSA colonization and did not fully understand the significance of multi-drug resistant bacterial colonization. Facility policies for contact precautions stated contact precautions would be used for residents colonized with MRSA. Notes appended to the facility contact precaution policy stated "...following resident use, proper cleansing of the community areas will be performed (table, chair, etc.)."	F 442		

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F 442	Continued From page 31 4. Facility policies for isolation (dated 4/6/04) and precautions (dated 4/7/04) as posted and available to facility staff stated contact isolation will be used for residents know to be infected or colonized with "...multidrug-resistant bacteria..." and, in a written margin note, specifically noted MRSA as a condition requiring contact precautions. Contact precautions listed in the policy included measures to prevent transmission through direct contact or indirect contact with environmental surfaces.	F 442	F 444 The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practices. This will be evidenced by: The facilities hand hygiene policy has been updated and staff educated on proper procedure. All nursing staff has been issued individual hand sanitizer and has constant access to more as needed, as well as wall dispensers throughout the facility. Before and after meal care for residents has been implemented to assist in the decrease spread of infection. A hand hygiene surveillance tool has been developed and implemented for monitoring proper hand hygiene. A quality indicator has been developed and results will be compiled monthly for review by staff and infection control committee and will be reported to the QA committee quarterly. 10/18/2006	
F 444 SS=E	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 policy review, the facility failed to ensure staff followed appropriate hand hygiene practices for 1 of 2 residents following personal care. Further, the facility failed to ensure staff used appropriate hand hygiene practices during 2 of 2 meals observed during survey. The findings were: 1. Observation on 9/25/06 at 12:05 PM showed CNA #4 provided personal care for resident #21, cleansing the anal area following bowel incontinence. While still wearing the gloves used when cleaning feces from the resident, CNA #21 was observed to handle a water container, the	F 444		10/18/06

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F 444	Continued From page 32 container lid, and a straw when assisting the resident with a drink. After removing her gloves, CNA #21 handled a sling, lift, wheelchair, and the resident's clothing without washing her hands. 2. On 9/26/06 at 5:17 PM, observation showed dietary aide #2 dropped a loaf of bread enclosed in a plastic bag onto the floor. The aide picked up the sack while wearing the same gloves she wore when serving the previous meals. Without removing the contaminated gloves, the aide prepared and served additional meals. The facility policy entitled, "Handwashing," reviewed 2/18/05, stated "...handwashing to control infection will be completed...after contact with each resident... before handling food or food trays... (and) ...after contact with contaminated objects..." 3. Observation on 9/25/06 at 12:36 PM revealed swing bed patient #36 was seated next to resident #11 at the lunch table. Resident #11 alternated between sleep and a minimal awareness of his/her surroundings. Patient #36 was observed to repeatedly wiped his nose and mouth with his left hand and removed viscous mucus from his nose. The patient frequently patted resident #11 with his left hand and held the resident's right hand on several occasions. At 12:41 PM, CNA #44 seated herself adjacent to resident #11 and held his right hand. The CNA then handled the resident's spoon and assisted him/her to eat soup with the spoon. At 12:57 PM, the CNA positioned the spoon in the resident's hand and cued him/her to eat 3 more spoonfuls of soup. CNA #44 was not observed to wash her hands during the 14 minute observation.	F 444		

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F 454 SS=E	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the facility was maintained in a safe manner. One sink was not equipped with a back flow device. One door was impeded by a rock. The findings were: 1.Observation on 9/25/06 at 9:22 AM and on 9/27/06 at 3:30 PM revealed the sink in the beauty shop did not have a back flow water valve. Interview with the director of maintenance on 9/27/06 at 3:48 PM revealed he was unaware the sink did not have a back flow valve and stated would put one on "as soon as possible." 2.Observation during the evening meal on 9/26/06 from 5 PM to 5:48 PM revealed one of the double doors leading from the dining room to the outside of the building was held open with a large rock. Both doors had self closure devices. Interview with the facility administrator on 9/27/06 at 5:48 PM revealed the doors should not have been propped open. He also stated it was his expectation that staff would understand the temperature in the nursing home was "for the benefit of the residents, not for the staff."	F 454	F454 1) The facility will have sink in beauty shop compliant with back flow water valve by 10/31/06. 2) The facility will meet compliance of self closure doors not being blocked from closing immediately. Staff will be inserviced on this. Maintenance staff will monitor by daily inspections and walk throughs. Results of inspections will be reported to the QA committee on a quarterly basis added per request of 1300 on 10/27/06 LBrown RN 10/26/06 chgd per request of Kathy Pettit MHA on 10/25/06 Linda Brown RN	10/31/06

LB