STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: DON- Director of Nursing CNA- Certified Nurse Aide RN- Registered Nurse LPN- Licensed Practical Nurse MDS- Minimum Data Set	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	**F225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS** **The facility will not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the Sate nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.** 1)The CNA abuse registry has been checked for CNA #5. 2) The payroll clerk or designee will be responsible to check the CNA abuse registry prior to hiring. 3)The Executive Director will re-educate the payroll clerk and designees about the importance of checking the CNA abuse registry prior to hiring CNAs. 4) A performance improvement monitoring tool will be used to audit personnel files of all CNAs to ensure that the CNA registry has been checked for all	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jonya — TITLE: Executive Director — (X6) DATE: 2-23-12

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y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 /s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

Refer to Page 2, 3, 4

3/6/12

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F 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of personnel files and staff interview, the facility failed to review the State CNA abuse registry for 1 of 2 CNAs (CNA #5) for prior findings of abuse or neglect before hiring. The findings were: Review of the personnel file for CNA #5 failed to show the State CNA abuse registry was checked for findings of abuse or neglect prior to hiring the CNA on 1/22/12. The business office manager confirmed in an interview on 2/1/12 at 4:01 PM she forgot to check the CNA abuse registry prior to hiring this CNA.	F 225	currently hired CNAs. Any personnel files without verification of checking CNA abuse registry will be completed immediately. A member of the performance improvement committee will double check each CNA personnel file to ensure that the abuse registry has been checked for any prospective hires in the future. 5) Results of the audits will be presented at the Performance Improvement meeting for at least the next three months or until substantial compliance has been met.	03/17/12
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE 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	F 274	**F274 COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE** **A facility will 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.** 1)Resident #79 no longer resides in the facility.	

This POC accepted between Tonya Mercer - Administrator and Tony Madden on 3/6/12 with a DOC of 3/17/12.

3/6/12

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F 274	Continued From page 2 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 medical record review and staff interview, the facility failed to complete a significant change MDS assessment for 1 of 1 sample resident (#79) who experienced a significant change in condition. The findings were: Review of the 11/2/11 admission MDS assessment revealed resident #79's weight was stable, and the resident had no pressure ulcers. However, a comparison to the subsequent quarterly MDS assessment dated 1/12/12 showed the resident experienced a significant weight loss and developed a stage II pressure ulcer. Although the resident had a decline in at least two areas, a significant change MDS assessment was not completed. During an interview on 2/1/12 at 1:50 PM, MDS coordinator #1 revealed she was new in the position. She stated at the time of the quarterly assessment, she was not aware that a change in two or more areas would trigger a significant change MDS assessment.	F 274	2) The MDS coordinator received extensive MDS training about how to complete the RAI process and now knows about significant change assessments. 3) Changes in condition are discussed every Monday-Friday at the daily "stand up" meeting. The MDS coordinator attends the meeting and makes note of all changes so the resident's condition can be tracked for purposes of a potential change in status assessment to be completed. 4) A performance improvement audit tool will be used to randomly audit residents with changes in condition to ensure that a change in status MDS is completed when criteria is met. The audit will be conducted by a member of the performance improvement committee. If there are problems or trends noted re-education and/or corrective action will occur. 5) Results of the audits will be presented at the Performance Improvement meeting for at least the next three months or until substantial compliance has been met.	03/17/12
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	**F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** **The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care.**	

3/16/12

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F 282	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide care in accordance with the written plan of care for 3 of 14 sample residents (#19, #59, #72). The findings were: 1. Review of the care plan for resident #72 revealed on 1/15/12 the care plan for falls was revised to include a low bed and a floor mat. Observation on 1/31/12 at 9:12 AM, 10:15 AM, and again at 2:25 PM revealed the resident was in bed. However, the bed was not in the lowest position, nor was there a mat on the floor. On 1/31/12 at 3:25 PM the surveyor took the RN unit manager into the resident's room. The resident was in bed. The RN confirmed a mat was not on the floor, and in fact was not anywhere in the room. The RN stated she was not sure where the mat was, but confirmed one should be in use. In addition, the RN used the bed control to lower the bed approximately 12 more inches. She stated the bed should be in the lowest position. 2. Observation on 2/1/12 at 3:40 PM revealed CNA #7 and RN #2 performed a two person transfer of resident #19 from the resident's bed into a geri chair. Review of the most recent quarterly MDS assessment dated 10/30/11 showed resident #19 was unstable during surface to surface transfers and only able to stabilize with assistance. Review of the care plan dated 1/16/12 revealed "full body lift for all transfers." In addition, review of the monthly physician order sheet revealed "mechanical lift for all transfers."	F 282	1)Resident # 72 no longer resides in the facility. 2) Random weekly audits will be completed to ensure that care plans are being followed as written. The random weekly audits will include residents #s 59 and 19. 3) Re-education of all nursing staff will be completed regarding following care plans for all residents. The education will be conducted by the SDC and Nurse Managers. 4) A performance improvement audit tool will be used to randomly audit content of the care plan compared to the actual care provided to the resident to ensure consistency. The audits will be conducted by members of the performance improvement committee. 5) Results of the audits will be presented at the Performance Improvement meeting for at least the next three months or until substantial compliance has been met.	03/17/12

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F 282	Continued From page 4 During an interview on 2/1/12 at 4:13 PM, RN #2 stated she did not check the care plan prior to the two person transfer of the resident into the geri chair. She stated she should have followed the care plan and used a mechanical lift. 3. Review of the most recent quarterly MDS assessment dated 1/19/12 showed resident #59 was unstable during surface to surface transfers and only able to stabilize with assistance. Review of the resident's most recent care plan dated 1/9/12 showed fall interventions that included a mat beside the bed on the floor. Observation on 2/1/12 at 10:48 AM revealed the resident was still in bed and there was no landing mat on the floor beside the bed. In addition, observation on 1/30/12 at 2:48 PM and on 1/31/12 at 9:13 AM revealed there was no landing mat available in the resident's room. Interview with CNA #6 on 2/1/12 at 11:48 AM revealed she was not aware the resident had a floor mat.	F 282		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 manufacturer's instructions and facility documentation, the facility	F 323	**F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/ DEVICES** **The facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.** 1)A side rail assessment was completed for resident #5 during the survey. This is a temporary measure until the interdisciplinary team decides what the safest interventions are to prevent falls for this resident. The plan of care for resident #17 was changed from transferring using	

4/16/12

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F 323	Continued From page 5 failed to ensure safety with transfers for 3 of 6 sample residents (#17, #78, #79) who utilized a sit-to-stand lift. In addition, the facility failed to implement interventions to prevent falls for 2 of 13 sample residents (#59, #72) who were at risk for falls. Furthermore, the facility failed to ensure the safety of side rails for 1 of 5 sample residents (#5) who utilized side rails. The findings were: Review of the medical record face sheet showed resident #5 was admitted on 11/25/11 and had diagnoses that included macular degeneration and left lower leg amputation. Review of the 2/16/11 falls care plan showed the resident was at risk for falls, and one of the approaches was for the staff to remind the resident not to ambulate or transfer without assistance. In addition, the 2/16/11 activities of daily living care plan showed the resident required extensive assistance with bed mobility, transfers, ambulation and wheelchair mobility. Observation of the resident on 1/30/12 at 5:15 PM showed s/he had a lower leg amputation on the left side, and did not wear any prosthetic device. Review of the 1/19/12, 7 PM nursing note showed the resident fell while "trying" to transfer from bed to his/her wheelchair and there were no injuries noted. Review of the post fall recommendations showed the resident would be evaluated by physical therapy, and the 1/30/12 entry on this recommendation sheet showed there had been no other falls and to continue the current interventions. The following concerns were identified related to safety for this resident: a. Observation on 1/31/12 at 8:05 AM showed the resident had self transferred out of bed, and was positioning him/herself in the wheelchair located next to his/her bed. The bed	F 323	a sit to stand lift to using a full body mechanical lift. 2) Resident #79 no longer resides in the facility. Resident #72 no longer resides in the facility. Random weekly audits will be conducted to ensure that the appropriate safety measures are being used for to prevent accidents and keep residents safe. The audits will include residents #s 5, 17, 78, and 59. 3) Re-education of the nursing staff will be conducted regarding how to properly use all mechanical lifts according to manufacturer's instructions and when to report that the appliance may no longer be appropriate for the resident (for instance when the resident is unable to hold on to the handlebars). The education will also include using the safety device list which is provided to all nurses and CNAs to ensure that they are following current interventions for providing safety to all residents. The education will be conducted by the SDC and the Restorative Nurse. 4) A performance improvement audit tool will be used to randomly audit residents' care weekly to ensure that all safety interventions are being used. If non-compliance is noted, immediate re-education and/or corrective action will occur. The audits will be conducted by members of the performance improvement committee. 5) Results of the audits will be presented at the Performance Improvement meeting	

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F 323	Continued From page 6 had a half side rail attached in the upright position the resident had maneuvered around to get out of the bed. As the resident was getting seated, s/he was calling out for help. In less than a minute, CNA #2 came to the resident's assistance. b. Interview with CNA #2 on 1/31/12 at 8:07 AM revealed the resident gets him/herself up. The aide was uncertain if the half side rail was assessed to be safe for the resident. The aide stated they reminded the resident to use the call light instead of transferring without assistance. c. Review of the care plan failed to show the side rail was an intervention for mobility or for any other reason, and further medical record review failed to show any safety assessment for the use of the siderail. Interview with the DON on 2/1/12 at 9:49 AM verified the side rail was being used however, had not been considered for safety for this resident. RELATED TO TRANSFERS: 1. Review of facility documentation showed on 11/12/11, CNA #1 transferred resident #79 by herself using the mechanical sit-to-stand lift. The resident started to slide out of the sling, but the daughter (who was in the room) helped the CNA get the resident back into the sling. The CNA received a verbal warning for using the lift by herself, instead of with two staff. After the incident, there lacked evidence the facility re-educated the nursing staff, including CNA #1, on using the sit-to-stand lift. Refer to F498 regarding the facility's failure to ensure CNA #1 was competent to perform sit-to-stand lift transfers. 2. Observation on 1/31/12 at 8:55 AM and again	F 323	for at least the next three months or until substantial compliance has been met.	03/17/12

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F 323	Continued From page 7 at 11:30 AM revealed CNAs #1 and #4 transferred resident #78 using the sit-to-stand lift. During both transfers, the CNAs did not attach the waist strap to the resident. During an interview on 1/31/12 at 11:35 AM, CNA #1 stated they did not attach the waist strap because it didn't fit the resident because "[she/he] is too wide." During an interview on 2/1/12 at 2:30 PM, the rehabilitation services director stated staff were instructed to clip the waist strap of the sling when using the sit-to-stand lift. She further stated the waist strap of the sling did in fact fit the resident, because she used it herself that day with the resident. Review of the Sabina [sit-to-stand lift] instruction guide revealed "...Hook and tighten the belt around the chest." Further review of the Liko SupportVest [sling] instruction guide showed "...the waist belt on the Support Vest is intended to hold the vest in place around the user...Adjust the waist belt gently to the girth of the user's upper body and fasten the waist belt's plastic buckle." 3. Observation on 1/31/12 at 8:10 AM showed CNAs #2 and #3 used a sit-to-stand mechanical lift to transfer resident #17 from the bed to the wheelchair. After attaching the sling around the resident under the arms, the aides told the resident to hold on to the lift bar and used a hand over hand technique to have the resident hold onto the bar. As soon as the lift started to raise, one of the resident's hands came off, and then the other one came off before the resident was off the bed. The resident was not gripping the bar and during the transfer the resident hung by the sling under his/her arms. During the observation, the CNAs did not attempt to stop the transfer, ask the resident, or assist the resident to hang on. At	F 323		

2/16/12 JM

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F 323	Continued From page 8 that time, interview with CNAs #2 and #3 revealed the resident did not usually hang on while being transferred with the sit-to-stand lift. CNA #2 left the room, and when CNA #3 was asked what they were taught to do when a resident was unable to hang on to the lift bar, she stated they were told to "just do our best." She further revealed they followed the care plan and had never tried to use a different lift for this resident. Review of the Sabina [sit-to-stand lift] instruction guide revealed "The patient should hold on to the handlebar, and the lift can begin." Interview with the rehabilitation services director on 2/1/12 at 2:30 PM verified if a resident was unable to hold on to the lift bar, the sit-to-stand lift may not be appropriate for the resident and an evaluation should be done to determine the best method of transfer. She then stated she was not aware resident #17 was in need of an evaluation. RELATED TO FALL INTERVENTIONS: 1. Review of the 12/16/11 fall risk assessment revealed resident #72 was at risk for falls. According to nursing notes, the resident was found on the floor next to his/her bed on 1/12/12. Review of the care plan revealed on 1/15/12 the care plan for falls was revised to include a low bed and a floor mat. Observation on 1/31/12 at 9:12 AM, 10:15 AM, and again at 2:25 PM revealed the resident was in bed. However, the bed was not in the lowest position, nor was there a mat on the floor. On 1/31/12 at 3:25 PM the surveyor took the RN unit manager into the resident's room. The resident was in bed. The RN confirmed a mat was not on the floor, and in fact was not anywhere in the room. The RN stated she was not sure where the mat was, but	F 323		

2/6/12

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F 323	Continued From page 9 confirmed one should be in use. In addition, the RN used the bed control to lower the bed approximately 12 more inches. She stated the bed should be in the lowest position. 2. Review of the quarterly MDS assessment dated 1/19/12 showed resident #59 was unstable during surface to surface transfers and only able to stabilize with assistance. Further review of the resident's record revealed a physician order dated 8/10/11 that showed "fall prevention mat at bedside." Review of the resident's most recent care plan dated 1/9/12 showed an intervention of placing a mat beside the bed on the floor. Although fall risk and interventions were established, observation on 1/30/12 at 2:48 PM and again on 1/31/12 at 9:13 AM revealed there was no landing pad available in the resident's room. On 2/1/12 at 10:48 AM, the resident was observed to be in bed, and there was no landing pad on the floor beside the bed. Interview with CNA #6 on 2/1/12 at 11:48 AM revealed she was unaware the resident had a floor mat.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	**F371 FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY** **The facility will** **1-procure food from sources approved or considered satisfactory by Federal, State or local authorities; and** **2- store, prepare, distribute and serve food under sanitary conditions** 1) CDM will re-educate all dietary staff including dishwashers on the regulation regarding hand hygiene. All staff will be able to demonstrate as well as verbalize appropriate hand hygiene during dishwashing. Audits will be conducted by	

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F 371	Continued From page 10 by: Based on observation, review of sanitizer logs, and staff interview, the facility failed to ensure hand hygiene was completed as needed during dish washing, and that sanitizer solution used for surfaces was at an effective concentration. In addition, the facility failed to ensure food equipment was cleaned to prevent build up and contamination. The findings were: 1. Observation in the kitchen during the evening food preparation on 1/31/12 from 4:15 PM to 5:15 PM showed two separate occasions at 4:45 PM and at 4:50 PM when cook #1 took dirty dishes into the "dirty" side of the dishroom, sprayed them off, and put them into the dish machine to be cleaned. Each of these times, without performing any hand hygiene, the cook walked to the "clean" side of the dishroom and proceeded to put away clean dishes. Interview with cook #1 on 1/31/12 at 4:50 PM revealed he did not perform handwashing because the water out of the sprayer was so hot. He then verified the education he had been provided was to wash hands between handling the dirty dishes and the clean dishes. According to Food Code 2009, U.S. Public Health Service, 2-301.14 When to Wash: "FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS..." 2. Observation in the kitchen of the evening food preparation on 1/31/12 from 4:15 PM to 5:15 PM showed a bucket containing 6 wiping cloths in a solution. The bucket was located near the food preparation table, and an interview with cook #1	F 371	CDM to ensure proper procedures are being followed. 2). CDM will educate dietary staff on the appropriate concentration, testing and recording the mixture of sanitation solution. CDM will conduct audits of the sanitation log book to ensure the solution contains the appropriate concentration upon mixing. 3). CDM has ensured that the stove was cleaned appropriately and the "burned on food" was removed from the range top, interior of both ovens and the oustside of each oven door. CDM will continue to audit how the stove is being cleaned and ensure it meets all federal requirements and specifications. The hood vent was cleaned and removable vents cleared of all dust and grease build up. The mixers were cleared of all dried food debris including underneath the mixing arms. The meat slicer was also cleaned and food debris was removed from the crevasses around the dial and blade sheild. Sheet pans, skillet and muffin tins that were corroded and had burned surfaces have been discarded and replaced. 4) A Performance Improvement Audit Tool will be used to conduct all audits. If there is a problem identified during audits immediate re-education and/or corrective action will take place. 5) The results of these audits will be presented at the monthly Performance Improvement meeting for a period of three months and until substantial	

3/16/12

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	535039	A. BUILDING _____ B. WING _____	C 02/01/2012

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F 371	Continued From page 11 on 1/31/12 at 4:25 PM revealed it was a sanitizer solution used to clean the counter surfaces and equipment. He stated the chemical was a quaternary ammonia, and was not sure when it was last tested for chemical concentration. Review of the product label for the "Oasis 146 multi- quat" sanitizer showed a concentration of 200- 400 parts per million (ppm) was needed to sanitize surfaces. At 4:25 PM the certified dietary manager (CDM) tested the solution and the test strip showed it was at a concentration of 0 to 150 ppm. The CDM knew the concentration needed to be greater and said it should have been tested when mixed and recorded in the log book. Review of the log book showed the page for recording the chemical concentration of the bucket during January 2012 was blank. According to Food Code 2009, U.S. Public Health Service, 3-304.14: "(B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114;" According to Food Code 2009, U.S. Public Health Service, 4-501.114: "(C) A quaternary ammonium compound solution shall: ...(2) Have a concentration as specified under § 7-204.11 and as indicated by the manufacturer's use directions included in the labeling..." 3. Interview with the CDM on 2/1/12 at 9:59 AM verified there was a cleaning schedule for items in the kitchen; however, better cleaning was needed. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other	F 371	compliance is achieved. Any trends or problems will be acted upon.	03/17/12

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F 371	Continued From page 12 debris." During the tour of the facility kitchen on 1/30/12 at 3:36 PM and again on 1/31/12 at 4:15 PM showed the following food equipment not in use that was in need of cleaning: a. The stove unit that consisted of the range top and two ovens. The range top and interior of both ovens had areas of black burned on food. On the outside of each oven door near the floor, there was dripping brownish grease. b. The hood vent system located above the stove unit had grease and dust build up visible in the removable vents, and there were grease trails that streamed down the hood surface. c. One large and one small stand mixer both located on a preparation table were noted to have dried splatters of food on the underside of the mixing arms. d. The meat slicer located on a preparation table had dried food debris in the crevasses around the dial and dried food splatters on the blade shield. e. Observation of cooking equipment showed a storage rack containing 8 full size sheet pans and 4 half size sheet pans that were corroded with thick black burned on grease/food around the outside edges and blackened cooking surfaces. Interview with cook #1 on 1/31/12 at 4:21 PM revealed the equipment was "Very old and can't really be cleaned any more." In addition, there was one skillet, and 8 muffin tins that were also corroded in an uncleanable condition.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441	**F441 INFECTION CONTROL, PREVENT SPREAD, LINENS** **The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.** 1)Random weekly audits of glucometer cleaning will take place and will include residents #s 40, 43, 48, 57, 76, and 82.	

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F 441	Continued From page 13 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy and procedure review, and review of professionally accepted standards, the facility failed to disinfect	F 441	Resident # 46 no longer resides in the facility. 2) The SDC conducted re-education with all nurses working during the week of the survey. The education specified the glucometer cleaning policy and which sani-wipe was appropriate to use and why. 3) Re-education will be conducted with all nursing staff again regarding the glucometer cleaning policy. The education will be conducted by the SDC and/or the Nurse Managers. 4) A performance improvement audit tool will be used to conduct random weekly audits of glucometer cleaning. If non-compliance is noted, immediate re-education and/or corrective action will occur. Audits will be conducted by members of the performance improvement committee. 5) Results of the audits will be presented at the Performance Improvement meeting for at least the next three months or until substantial compliance has been met.	03/17/12

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F 441	Continued From page 14 resident care equipment during two random observations which affected 7 non-sample residents (#40, #43, #46, #48, #57, #76, #82). The findings were: According to the facility policy titled, "Cleaning and Disinfection of the Glucometer," revised 2010, supplies used to clean the glucometer included, "Super Sani-cloth or Sani-Cloth Plus wipe or equivalent product that kills hepatitis B and blood-borne pathogens." The procedure included, "Use a sani wipe to completely clean the surface of the glucometer-pay attention to any blood or debris on the glucometer. Allow the glucometer to dry after observing the "wet" time of the wipe." The following concerns were noted: 1. During an observation on 1/31/12 at 4 PM, LPN #1 performed glucose monitoring on four non-sample residents (#46, #48, #76, #82), with a single Optimum E2 glucometer. The LPN used the glucometer in each room, and cleansed the glucometer with a Sani-Hands ALC wipe after each test. According to the Sani-Hands ALC package, the wipe contained alcohol as the active ingredient, an ineffective disinfecting agent against bloodborne viral pathogens.	F 441		
	2. During an observation on 1/31/12 at 4:15 PM, LPN #2 performed glucose monitoring on three non-sample residents (#40, #43, #57), with a single Optimum E2 glucometer. The LPN used the glucometer in each room, and instead of using an effective disinfecting wipe, she cleansed the glucometer with a Sani-Hands ALC wipe after each test. 3. Review of the Sani-Hands ALC packaging			

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F 441	Continued From page 15 showed the product contained alcohol 65.9% as the active ingredient. According to the Centers for Disease Control website, accessed on 7/8/11, "70% ethanol solutions are not effective against bloodborne viral pathogens." 4. During an interview with the DON on 2/1/12 at 11 AM, she confirmed that it was unacceptable to use alcohol based wipes to clean glucometers. During an interview on 2/1/12 at 3 PM, the infection control nurse stated nursing staff had been educated to use the Sani-Cloth wipes (ammonia based) to sanitize the glucometers.	F 441		
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of facility documentation, nursing rules and regulations, and review of employee education files, the facility failed to ensure 1 of 4 CNAs (CNA #1) who were observed providing mechanical lift transfers was competent in that skill. In addition, the facility failed to verify competency skills for 1 of 1 nurse aide (#1) who was working with residents, and not yet certified. The findings were: 1. Review of facility documentation showed on 11/12/11, CNA #1 transferred resident #79 by	F 498	**F498 NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS** **The facility will ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.** 1)The facility will continue to conduct annual competencies, but also ensure that all CNAs demonstrate competencies at least once during a twelve month period. The facility will also ensure that each new temporary NA or CNA will demonstrate basic competencies prior to providing resident care. The competencies will include how to properly use a mechanical lift to transfer residents. 2) The Executive Director or designee will audit all personnel files of current CNAs and temporary NAs to ensure that competencies have been completed. 3) Education will be provided to the SDC and Nurse Managers regarding completion of competencies annually and	

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F 498	Continued From page 16 herself using the mechanical sit-to-stand lift. The resident started to slide out of the sling, but the daughter (who was in the room) helped the CNA get the resident back into the sling. The CNA received a verbal warning for using the lift by herself, instead of with two staff. The following concerns were identified: a. After the incident, there lacked evidence the facility re-educated the CNA or ensured her competency with the sit-to-stand lift. Review of the education files for the CNA revealed she had a competency done 9/11/10, which included mechanical lifts. However, there lacked an annual competency for this CNA. During an interview on 2/1/12 at 5:10 PM, the DON stated the CNA did not have an annual competency because she was on leave during the time the competencies were done. b. Observation on 1/31/12 at 8:55 AM and again at 11:30 AM revealed this same CNA used the sit-to-stand lift with CNA #4 to transfer resident #78. During both transfers, the CNAs did not attach the waist strap to the resident. During an interview on 1/31/12 at 11:35 AM, the CNA (#1) stated they did not attach the waist strap because it didn't fit the resident because "[she/he] is too wide." During an interview on 2/1/12 at 2:30 PM, the rehabilitation services director stated staff were instructed to clip the waist strap of the sling when using the sit-to-stand lift. She further stated the waist strap of the sling did in fact fit the resident, because she used it herself that day with the resident. Review of the Sabina [sit-to-stand lift] instruction guide revealed "...Hook and tighten the belt around the chest." Further review of the Liko SupportVest [sling] instruction guide showed "...the waist belt on the Support Vest is intended to hold the vest in place	F 498	at time of hire prior to providing resident care. 4) Random audits will be completed at least quarterly following the complete audit to ensure compliance with competencies. Audits will be conducted by members of the performance improvement committee. 5) Results of the audits will be presented at the Performance Improvement meeting for at least the next three months or until substantial compliance has been met.	03/17/12

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F 498	Continued From page 17 around the user...Adjust the waist belt gently to the girth of the user's upper body and fasten the waist belt's plastic buckle." 2. Interview with the DON on 2/1/12 at 5:05 PM revealed nurse aide (NA) #1 had worked in various positions over the years in the facility and on 12/12/11 she completed the course to become a nurse aide. The NA was working in the facility as a nurse aide while waiting to take the certification exam. The DON verified the facility had not completed a competency skills check related to the duties or assignments the NA participated in while working in the facility. According to the Wyoming State Board of Nursing rules and regulations for licensure requirements, Chapter 2 Section 9: "...(H) A graduate nursing assistant/nurse aide holding a graduate Nursing Assistant temporary permit shall be held to the established Standards of Nursing Assistant/Nurse Aide Practice. Any hiring facility shall be responsible for verifying individual competency as it relates to individual staff assignments."	F 498		