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

PRINTED: 02/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A002	A. BUILDING _____ B. WING _____	01/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIE HOLT CARE CENTER	407 W LOTT BUFFALO, WY 82834

(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: CNA Certified Nurse Aide DON Director of Nursing MAR Medication Administration Record MDS Minimum Data Set RN Registered Nurse Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 226 SS=E	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	F 226	The facility will ensure that all CNAs have the required nurse aide registry checks. This will be accomplished by: A)The DON has reviewed the CNA registry database for CNAs #1 and #2. They are now listed on the registry with no abuse findings. B)The DON will ensure the CNA registry database is reviewed prior to hiring CNAs. C)The DON will maintain a log of potential new CNAs, dates the CNA registry is checked, a registry print out verifying no abusive findings, and date of hire for each CNA to ensure the appropriate checks are completed. D)A performance improvement tool will be implemented by the DON to ensure proper nurse aide registry checks are maintained. This monitor will be completed monthly and reported quarterly at the PI Committee meeting. Appropriate follow-up actions will be initiated by the PI Committee as necessary.	3/5/12

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

Administrator 2/13/12

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.

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F 225	Continued From page 1 investigation is in progress. 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 staff interview and review of personnel files and policies and procedures, the facility failed to ensure 2 of 3 CNAs (#1, #2) whose records were reviewed had the required nurse aide registry checks. The findings were: The personnel records for 5 employees hired within the last 120 days were reviewed on 1/19/12 at 3:25 PM. Of 3 CNA records reviewed, 2 (CNA #1 and #2) failed to show evidence the state nurse aide registry was checked to determine if the CNAs were listed on the registry and/or had substantial findings of abuse, neglect or misappropriation of resident property. Review of the facility's policy for pre-hire screening of CNAs showed the policy required review of the CNA registry prior to hiring. The DON confirmed in interview on 1/19/12 at 4:01 PM she had not reviewed the CNA registry database before hiring CNAs #1 and #2.	F 225		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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F 279	Continued From page 2 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 medical record review and staff interview, the facility failed to develop an individualized care plan for 2 of 10 sample residents (#20, #37). The findings were: 1. Review of the medical record showed resident #20 had a diagnosis of constipation. The 6/2/11 significant change MDS assessment also indicated the resident had constipation. Review of physician orders showed the resident received Senokot-S (stool softener/laxative) 2 tablets three times per day. A physician's progress note dated 7/19/11 revealed the resident was constipated despite receiving six doses of Senokot-S. The physician documented the resident required a	F 279	The facility will ensure that individual care plans are developed for each resident. This will be accomplished by: A)The Nurse Team Leader for resident #20 will revise the care plan to include the problem of constipation. The Nurse Team Leader for resident #37 will revise the care plan to include planned weight loss. B)All residents with the DX of constipation or the goal of planned weight loss could potentially be affected. The Nurse Team Leaders will review each resident's care plan at the time of his/her quarterly care conference and make revisions as appropriate to reflect each resident's individual needs. C)The IDT (Interdisciplinary Team) will discuss and review care plan details quarterly to ensure accuracy and determine if individual needs have been addressed, especially involving constipation and planned weight loss. D)A performance improvement tool will be implemented to ensure care plans are individualized in accordance with each resident's assessed needs. This monitor will be completed monthly and reported quarterly to the PI Committee. The DRC (Director of Resident Care) will be responsible for compliance.	3/5/12

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F 279	Continued From page 3 suppository and digital disimpaction, and ordered a trial of Mag Citrate. However, review of the current care plan (undated) showed constipation was not addressed. On 1/19/12 at 2:30 PM the MDS coordinator stated constipation was not addressed on the care plan, but should have been. 2. Review of the 6/27/11 significant change MDS assessment revealed resident #37 was on a planned weight loss program. Review of nutritional assessments showed the resident weighed 337 pounds on 2/8/11 and 223 pounds on 1/2/12, a loss of 114 pounds. However, review of the current care plan (undated) revealed the goal for nutrition was to maintain the current weight within 5 or less pounds. The care plan was not individualized to reflect the planned weight loss program for the resident. During an interview on 1/19/12 at 2:30 PM, the MDS coordinator confirmed the care plan did not reflect the planned weight loss for the resident, but should have.	F 279		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS 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, staff interview, and medical record review, the facility failed to ensure staff complied with professional standards of practice for documenting and administering medications for 1 of 10 sample residents (#20) and two non-sample residents (#5, #6). The	F 281	The facility will ensure that services provided or arranged by the facility meet professional standards of quality. This will be accomplished by: A)Residents #20, #5, and #6 will be given their medications as ordered. Nursing staff will document that medications are given at the time of administration. B)All residents receive medications and could potentially be affected. The DON, DRC (Director of Resident Care), and pharmacy personnel will randomly observe medication nurses during the medication pass to ensure documentation takes place at the time of administration. At least 6 observations will be made per month.	

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F 281	Continued From page 4 findings were: Reference: Elkin, Perry, and Potter in "Nursing Interventions and Clinical Skills" Fourth Edition, 2009; 371, "Record the administration of each medication on the MAR as soon as you give it. Never document that you have given a medication until you have actually given it." In an interview on 1/17/12 at 5 PM, RN #2 stated his usual practice for administering the supper time medications began at approximately 3 PM when he pre-poured all of the medications, initialed the MARS, wrote the resident's name on the medication cups, and placed the medication cups of pre-poured medication in the drawers of the medication cart. Observation on 1/17/12 from 5 PM to 6:15 PM revealed the RN administered the pre-poured medications to the residents. In an interview on 1/17/12 at 6:15 PM the RN stated the medication pass was completed and all of the medications had been administered as scheduled. Review of the documentation in the MARS also showed the medications had been administered. However, observation of the drawers in the medication cart revealed the following cups of pre-poured medications had not been administered: liquid Risperdal for resident #20, crushed Senakot for resident #5, and Xanax and liquid Risperdal for resident #6. Interview with the RN at that time confirmed the four medications had been omitted during the medication pass. Reconciliation of the pass with the physician's orders showed the omitted medications should have been administered. During an interview on 1/19/12 at 5:15 PM the RN stated he should have followed the facility policy regarding documenting medications on the MAR	F 281	C)The DON will provide education to all nursing staff on professional standards relating to medication administration documentation. D)A performance improvement tool will be implemented by the DON to ensure professional standards of ~~quality~~ as relating to medication administration documentation. This monitor will be completed monthly and reported quarterly to the PI Committee. practice DS	3/5/12

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F 281	Continued From page 5 at the time of administration instead of before.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 medical record review, the facility failed to ensure staff provided appropriate incontinence care for dependent residents. This failure affected 1 of 4 residents (#10) observed for incontinence care. The findings were: Review of the 10/13/11 quarterly MDS assessment and care plan for resident #10 revealed s/he required extensive assistance with all activities of daily living. Review of the care plan showed staff were directed to use a peri wash solution to cleanse the resident after each episode of fecal incontinence. Review of the medical record showed s/he received antibiotic therapy for recurrent urinary tract infections in September, October and December 2011. Review of the 9/28/11 urine culture results showed Enterococcus faecalis, and the urine culture results dated 10/27/11 showed Escherichia Coli. On 1/17/12 at 6:50 PM CNA #3 was observed while providing urinary and fecal incontinence care for the resident. During the observation, the resident was positioned on his/her back in bed, and the CNA cleansed the	F 312	The facility will ensure that a resident who is unable to carry out activities of daily living receives appropriate incontinence care. This will be accomplished by: A)It is not possible to observe cares on resident #10, as this resident passed away on 2/6/12. B)All residents who are incontinent of bowel or bladder could be affected. The Infection Control Nurse or her designee will observe incontinence cares, and if improper infection control technique is identified, immediate in-servicing and corrective action will be taken with the aide. At least 6 random observations will be made per month. Results will be reported to the Infection Control Nurse. C)All nursing and CNA staff will be required to view a 10 minute video demonstrating appropriate incontinence care. All nursing and CNA staff will be required to demonstrate appropriate bowel incontinence care on a mannequin to the Infection Control Nurse or her designee. D)A performance improvement tool will be developed to ensure appropriate incontinence care. This monitor will be completed monthly and reported quarterly to the PI Committee. The Infection Control Nurse will be responsible for compliance.	3/5/12

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F 312	Continued From page 6 resident's perineal area by placing the disposable wipes between the resident's thighs and wiping from posterior to anterior areas. Further observation showed the CNA did not use the peri wash solution. Interview and continued observation with the CNA at that time revealed she had almost completed the task before she realized she was not providing the appropriate care. In an interview on 1/19/12 at 2:55 PM, RN #1 stated the peri wash solution thoroughly cleanses the skin without harsh rubbing, therefore, it was important for staff to use it as directed by the care plan.	F 312		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to maintain a medication error rate under five percent (%). Five errors occurred out of 50 opportunities for error, resulting in an error rate of 10%. Residents effected by these errors were sample resident #20 and non-sample residents #1, #5 and #6. The findings were: 1. According to the facility policies and procedures entitled, "Opus Medication Administration", effective 7-3-03, staff should "... chart all mediations at the time of administration." In an interview on 1/17/12 at 5 PM, RN #2 stated	F 332	The facility will ensure that it is free of medication error rates of five percent or greater. This will be accomplished by: A)Residents #20, #5, and #6 will be given their medication as ordered. Resident #1 will be given his/her medication within the ordered time frame. B)All residents receive medication and could potentially be affected. The DON, DRC (Director of Resident Care), and pharmacy personnel will randomly observe medication nurses during the medication pass to ensure medications are given as ordered, including at the appropriate time in relation to meals. At least 6 observations will be made per month. C)The DON will provide education to all nursing staff on medication administration, especially as it pertains to medication omission errors, timeliness in relationship to meals (a.c.), and medication error rates. D)A performance improvement tool will be implemented by the DON to ensure medication error rates do not exceed five percent. This monitor will be completed monthly and reported quarterly to the PI Committee.	3/5/12

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F 332	Continued From page 7 his usual practice for administering the supper time medications began at approximately 3 PM when he pre-poured all of the medications, initialed the MARS, wrote the resident's name on the medication cups, and placed the medication cups of pre-poured medication in the drawers of the medication cart. Observation on 1/17/12 from 5 PM to 6:15 PM revealed the RN administered the pre-poured medications to the residents. In an interview on 1/17/12 at 6:15 PM the RN stated the medication pass was completed and all of the medications had been administered as scheduled. Review of the documentation in the MARS also showed the medications had been administered. However, observation of the drawers in the medication cart revealed the following cups of pre-poured medications had not been administered; liquid Risperdal for resident #20, crushed Senakot for resident #5, and Xanax and liquid Risperdal for resident #6. Interview with the RN at that time confirmed the four medications had been omitted during the medication pass. Reconciliation of the pass with the physician's orders showed the omitted medications should have been administered. During an interview on 1/19/12 at 5:15 PM the RN stated he did not follow the facility policy regarding documenting medications on the MAR at the time of administration instead of before. Four errors of omission occurred with this pass. 2. Observation on 1/18/12 at 10:20 AM revealed RN #3 administered Prilosec ten milligrams (medication used for treatment of symptoms associated with gastroesophageal reflux disease) to resident #1 after breakfast. According to Turkoski, Lance, and Tomsik, "2010 Drug Information Handbook for Nursing, Eleventh	F 332		

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F 332	Continued From page 8 Edition", this medication is most effective if administered before breakfast. Interview with the RN at that time revealed she was completing the medication pass another nurse had started earlier that day. Reconciliation of the pass with the physician's orders showed the Prilosec was to be administered before breakfast. One timing error occurred with this pass.	F 332		
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 by: Based on observation and staff interview, the facility failed to prevent 2 of 2 resident food preparation areas from exposure to possible contamination. The findings were: Observations on 01/17/12 at 2:48 PM, on 01/18/12 at 9 AM and on 01/19/12 at 3:30 PM revealed the following concerns: 1. There was an accumulation of dirt and dust noted in the following locations: a. On the hinges of the walk-in freezer; b. On the wall mounted thermometer next to the freezer; c. On two wall mounted escutcheons directly	F 371	It is the policy of this facility to procure, store, prepare, and serve food in a sanitary manner. A)The dietary staff has cleaned both identified food preparation areas to assure non food contact surfaces are kept free of an accumulation of dust, dirt, food residue and other debris. B)The Certified Dietary Manager (CDM) will conduct random observation of the sanitary environment in the food service areas. Monitoring will also be recorded twice daily by the cook in charge to assure non food contact surfaces are kept free of an accumulation of dust, dirt, food residue and other debris. The CDM will randomly monitor the cleanliness of the kitchen including: the walk-in freezer hinges, the wall mounted thermometer, both wall mounted escutcheons over the garbage disposal sink, the protective grid of a portable fan on the ice machine, the radio, the wheels of the moveable convection oven and on the hinges of the food shelf on the food serving cart. This will all remain clean and dust free, as well as the protective milk crate over a drain pipe, the edge of the spice counter and the drawer below the tea dispenser.	

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F 371	Continued From page 9 over the garbage disposal sink; d. On the protective grid of a portable fan sitting on the ice machine; e. On a radio sitting on a shelf next to the fan; f. On the wheels of a moveable convection oven; and g. On the hinges of the food shelf on the food serving cart. 2. There was an accumulation of dried food particles on an up-side-down two square foot milk crate sitting on the floor partially under a food preparation cupboard. The crate was on the floor protecting a water drain pipe. In addition, next to the crate was a four inch gap between the baseboard and the wall where additional food particles had accumulated. 3. Multiple pieces (approximately eight) of Scotch tape were noted still attached to the edge of a spice counter where diet requisition forms were attached. 4. There was an accumulation of dried food particles and dried tea stains in the fourth drawer directly below a tea dispenser in the staff kitchen. 5. Interview with the dietary manager on 1/19/12 at 2:48 PM confirmed the above observations. She stated the cleaning schedule would be revised to include periodic deep cleaning. According to the 2009 Food Code, U.S. Public Health Service, 4-601.11, Equipment, Nonfood-Contact Surfaces, (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other	F 371	This tea dispenser is located in the AHCC staff kitchen (pantry). The drawers in the area will be cleaned as drips occur and with a bleach solution on a monthly schedule by noc shift CNAs. This will be recorded on a cleaning schedule. The Supervising Noc Nurse will be responsible for randomly checking the area and monitoring compliance. The CDM submitted a work order which was completed by the maintenance department to attach the baseboard to the wall to eliminate the noted gap after it was cleaned. C)To maintain the currently compliant operation under the direction of the CDM with input from the Registered Dietitian (RD), all dietary staff will receive in-service training regarding state and federal requirements for the storage, preparing, distribution, and serving of food under sanitary conditions by 2/20/12. This will also include the review of the updated cleaning logs to assure compliance in the areas identified as stated above. The CDM will also review with the dietary staff the revised periodic deep cleaning schedule list to further assure compliance. The DON will review the cleaning chart for the pantry drawers with the AHCC noc shift staff. D)The CDM will enforce and monitor weekly the proper compliance through the Food Borne Illness Prevention-Daily Checklist which includes the documentation of proper cleaning and sanitizing of the food serving areas, and the revised periodic deep cleaning schedule. These results will be reported to the PI Committee on a quarterly basis.	3/5/12

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AMIE HOLT CARE CENTER	497 W LOTT BUFFALO, WY 82834

(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 371	Continued From page 10 debris.	F 371	The facility will establish and maintain an Infection Control Program designed to provide a safe,	
F 441 S9=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 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.	F 441	sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. This will be accomplished by: A)1)Resident #37's Flagyl was added to the antibiotic monitoring log. 2)All non-nursing personnel will be in-serviced on correct infection prevention practices. This will include the beautician, as well as housekeeping, laundry, maintenance, dietary, and activities staff. 3)Nursing staff will disinfect the glucometer for the disposable wipes manufacturer's recommended timeframe when using for residents #28, #37, #23, and #33. 4)It is not possible to observe cares on resident #10, as this resident has passed away. B)1)A Surveillance record of all infections in the facility is monitored monthly for antibiotic therapy, including resident's clinical response to antibiotic therapy and conclusion of treatment or need for further evaluation. 2)All residents who have contact with non-nursing personnel may be affected by poor infection control practices. A surveillance monitoring program will be developed and implemented. ICN (Infection Control Nurse) or her designee will conduct random surveillance monthly on non-nursing personnel. If infection control practices are not in compliance, immediate in-servicing and corrective action will be taken. At least 5 random observations will be made per month. 3)All residents who require blood sugar testing could be affected. The ICN or her designee will observe glucometer sanitization, and if inadequate disinfectant contact is identified, immediate in-servicing and corrective action will be taken. At least 6 random observations will be made per month.	

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AMIE HOLT CARE CENTER	407 W LOTT BUFFALO, WY 82834

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F 441	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of medical records and surveillance activities, the facility failed to actively track antibiotic usage for 1 of 4 sample residents (#37) currently receiving an antibiotic. The infection control program further failed to monitor non-direct care staff for compliance with infection prevention practices. In addition, facility staff failed to properly sanitize glucometers for 4 of 4 observations and failed to properly perform perineal care during 1 of 4 observations. The findings were: 1. Infection surveillance activities were reviewed with the infection control nurse and the DON on 1/19/12 at 11:15 AM. Surveillance records showed 4 sample residents were currently being monitored for antibiotic therapy. However, resident #37 was not listed on either the December 2011 or January 2012 surveillance logs; the resident was receiving topical applications of a metronidazole (Flagyl) gel on alternate days to wounds on his/her legs. Review of physician orders for resident #37 showed an order dated 1/10/12 which included applying Flagyl gel to the wounds on the resident's thighs every other day. Observation on 1/19/12 at 9:45 AM of wound care revealed the wound care nurse applied topical Flagyl to the wounds of both inner thighs. During the observation, the wound care nurse stated she had been using Flagyl on the wounds for about four months.	F 441	4)All residents who are incontinent of bowel or bladder could be affected. The ICN or her designee will observe incontinence care, and if improper infection control technique is identified immediate in-servicing and corrective action will be taken with the aide. At least 6 random observations will be made per month. Results will be reported to the IC N. C)1)Infection control surveillance logs are compiled monthly and reported to the infection control physician and Infection Control Committee. This log will include all residents currently on antibiotic therapy within the month. 2)All non-nursing staff will be required to watch an infection control practices video. 3)The policy for care and cleaning of the glucometer will be updated to reflect the necessary disinfectant contact time. The DON will review this policy with all nursing staff and CNA IIs, with emphasis on the cleaning requirements. 4)All nursing and CNA staff will be required to view a 10 minute video demonstrating appropriate peri-care. All nursing and CNA staff will be required to demonstrate appropriate bowel incontinence care on a mannequin to the ICN or her designee. D)1)Infection control performance improvement is monitored monthly and reported quarterly to the PI Committee. The ICN is responsible for compliance. 2)A surveillance monitor tool will be developed to ensure proper infection control practices by non-nursing personnel in the AHCC. Surveillance will be completed monthly and reported quarterly to the PI Committee. The ICN is responsible for compliance.	

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F 441	Continued From page 12 The infection control nurse stated in interview on 1/19/12 at 11:35 AM she had not included resident #35's topical metronidazole on the surveillance logsheets; she noted the resident was also receiving an oral antibiotic that was listed on the surveillance log, but acknowledge the topical was not currently tracked. 2. Interview with the infection control nurse and DON on 1/19/12 at 11:50 AM revealed the facility had an active monitoring program to evaluate nursing staff compliance with infection control practices, in particular hand hygiene. Continued interview determined these same monitoring steps did not extend to non-nursing staff working in the facility. The infection control nurse stated at this time that housekeeping and laundry services were shared with the co-located acute care hospital. She further stated housekeeping and laundry supervisors observed work practices for their employees. However, there was no documentation to show active monitoring was conducted nor was it apparent that support supervisors included the long-term care facility when observing their employees. The infection control nurse acknowledged she was not aware if long-term care was specifically monitored for housekeeping and laundry practices. Review of monthly infection control meeting minutes on 1/19/12 at 2:10 PM revealed data summaries of monitoring activities for nursing tasks such as resident contact, hand hygiene, and provision of cares. These documents failed to show evidence that non-nursing staff and	F 441	3)A performance improvement tool will be developed to ensure appropriate glucometer sanitation. This monitor will be completed monthly and reported quarterly to the PI committee. The ICN will be responsible for compliance. 4)A performance improvement tool will be developed to ensure appropriate incontinence care. This monitor will be completed monthly and reported quarterly to the PI Committee. The ICN will be responsible for compliance. 3/5/12	

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AMIR HOLT CARE CENTER	497 W LOTT BUFFALO, WY 82834

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F 441	Continued From page 13 related tasks in the long-term care facility were monitored for compliance with infection prevention practices. 3. On 1/17/12 from 5:15 PM to 5:34 PM, RN #1 was observed using the same glucometer for glucose testing for four residents and cleaned the glucometer with Sani-Cloth disposable wipes after each use. Continuous observation revealed the RN cleaned the glucometer for thirty-five seconds after testing resident #28, for twenty-one seconds after testing resident #37, for ninety-three seconds after testing resident #23 and for forty-five seconds after testing resident #3. Interview with the RN on 1/17/12 at 6:35 PM revealed she was not aware of the manufacturer's requirements for cleaning and disinfecting the glucometer after each resident use. According to the manufacturer's instructions the Sani-Cloth disposable wipes must remain visibly wet for a full three minutes for disinfecting treated surfaces. 4. Review of the medical record for resident #10 showed s/he received antibiotic therapy for recurrent urinary tract infections in September, October and December 2011. Review of the 9/28/11 urine culture results showed Enterococcus faecalis, and the urine culture results dated 10/27/11 showed Escherichia Coli. On 1/17/12 at 6:50 PM CNA #3 was observed while providing urinary and fecal incontinence care for the resident. During the observation, the resident was positioned on his/her back in bed and the CNA cleansed the resident's perineal area by placing the disposable wipes between the resident's thighs and wiping from posterior to anterior areas. According to the care plan, staff	F 441		

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F 441	Continued From page 14 were directed to use a peri wash solution for cleansing the resident after each episode of fecal incontinence. Further observation showed the CNA did not use the peri wash solution. Interview and continued observation with the CNA at that time revealed she had almost completed the task before she realized she was not providing the appropriate care. In an interview on 1/19/12 at 2:66 PM, RN #1 stated the peri wash solution thoroughly cleanses the skin without harsh rubbing, therefore, it was important for staff to use it as directed by the care plan.	F 441		
F 498 SS=E	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24	F 498	The facility will ensure that all CNAs have the required nurse aide registry checks. This will be accomplished by: A)The DON has reviewed the CNA registry database for CNAs #1 and #2. They are now listed on the registry with no abuse findings. B)The DON will ensure the CNA registry database is reviewed prior to hiring CNAs. C)The DON will maintain a log of potential new CNAs, dates the CNA registry is checked, a registry print out verifying no abusive findings, and date of hire for each CNA to ensure the appropriate checks are completed. D)A performance improvement tool will be implemented by the DON to ensure proper nurse aide registry checks are maintained. This monitor will be completed monthly and reported quarterly at the PI Committee meeting. Appropriate follow-up actions will be initiated by the PI Committee as necessary. 3/5/12	

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F 496	Continued From page 15 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of personnel files and policies and procedures, the facility failed to ensure 2 of 3 CNAs (#1, #2) whose records were reviewed had the required nurse aide registry checks. The findings were: The personnel records for 5 employees hired within the last 120 days were reviewed on 1/19/12 at 3:25 PM. Of 3 CNA records reviewed, 2 (CNA #1 and #2) failed to show evidence the state nurse aide registry was checked to determine if the CNAs were listed on the registry and/or had substantial findings of abuse, neglect or misappropriation of resident property. Review of the facility's policy for pre-hire screening of CNAs showed the policy required review of the CNA registry prior to hiring. The DON confirmed in interview on 1/19/12 at 4:01 PM she had not reviewed the CNA registry database before hiring CNAs #1 and #2.	F 496		