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

06/01/2006
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
	535023	A. BUILDING _____ B. WING _____	05/17/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON COUNTY HEALTH SERVICES	1124 WASHINGTON BLVD NEWCASTLE, WY 82701

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS 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. 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	F 225	**F 225** **The facility will 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 by:** **1) All staff will observe residents and gather data regarding potential abuse of resident #33 and all other residents.** **2) Allegations will be reported to the Charge Nurse.** **3) Charge Nurse will report to the DON, Social Services, and Administrator all incidents of questionable origin.** CERTIFIED MAIL 7005 0390 0002 2279 3159	06/28/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: DON — (X6) DATE: 6/07/06

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.

Revised/approved w changes on pages 2, 4, 5, 9, 10, 13, 16, 20 & 25 per JoAnn Farnsworth, DON on 6/20/06 @ 11:36 am — Jerry Goodman

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F 225	Continued From page 1	F 225		

by:
Based on staff and family interviews, review of policies and procedures, medical record review, and review of a photograph, the facility was unable to provide evidence of a thorough investigation for one of one allegations of abuse. In addition, the facility failed to report the allegation to the State Survey Agency (SSA) and to law enforcement or the Department of Family Services (DFS) as required. The findings were:

Interview with family member of resident #33 on 5/15/06 at 3:33 PM revealed the resident developed a large bruise of questionable origin on the anterior right lower leg "several months ago." Pictures of the bruise were provided by the family, which verified an extremely large bruise on the right lower leg. Medical record review revealed a nurses' note dated 3/22/06 that documented a "34 cm bruise...on the right anterior lower right leg of the resident. The resident stated it happened when repo [repositioning] and up for AM." The note further documented the resident as saying, "I don't think they know how rough it feels."

Interview with the director of nursing (DON) on 5/17/06 at 3:15 PM revealed the incident was investigated, but the results of the investigation did not suggest abuse. Therefore, the incident was not considered abuse and was not reported to the SSA or to DFS or the police. The DON was unable to provide a copy of the investigation or the incident report.

Review of the facility's undated policies and procedures related to abuse, prevention of abuse and reporting of abuse showed final results of the (abuse) investigation "must be reported to the Administrator and must be submitted to the Department of Health, Office of Health Quality by

4) Administrator will report to Police Dept., Adult Protective Services, Wyoming Department of Health, and Wyoming Board of Nursing, within 24 hours.

5) Resident Abuse flow record will be used to document all allegations of abuse. and will be filed in the SSD office.

6) Final results of the investigation will be reported to the Administrator and the Department of Health Office of Quality and the Wyoming Board of Nursing within 5 working days.

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F 225	Continued From page 2 the Administrator or his designee within five (5) working days."	F 225		
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of policies and procedures, the facility failed to assure their policies and procedures appropriately addressed one of the seven necessary components of an abuse prevention program. The findings were: Review of the facility's 10/03 policy and procedure, "Abuse, Prevention of Abuse and Abuse Reporting," revealed reporting allegations of abuse to the state survey agency was not addressed. In addition, staff were instructed to report allegations of abuse to law enforcement agencies or the Department of Family Services (DFS) "as deemed appropriate." Interview with the social services director (SSD), the director of nursing, and the administrator on 5/17/06 at 8:30 AM verified the policy failed to address immediate notification of the state survey agency as required by regulation. All three stated they were unaware of the newest information from the Centers for Medicare and Medicaid Services which defined "immediately" as within 24 hours. In addition, the SSD confirmed she only notified the police or DFS "if indicated."	F 226	**F 226** **The facility will develop and implement written polices and procedures that prohibit mistreatments, neglect, and abuse of residents and misappropriation of resident property.** **1) Policies and Procedures will be updated to include changes in regulations.** **2) All staff will be in-serviced on new Policies and Procedures.**	06/28/06

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F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain or enhance dining dignity for four residents (#2, #9, #11, #24) during one of three meal observations in the main dining room. The findings were: Observation of the evening meal on 5/15/06 at 5:37 PM showed certified nurse aide (CNA) #12 stood while assisting residents #2, #9, #11, #24 with eating. The CNA walked around the table, stopping to assist each resident with bites of food and drinks of beverages. At 5:41 PM the CNA pulled a chair over to the table; however, she continued to stand while assisting the residents until 5:45 PM (eight minutes later) when she moved the chair to the inside of the horseshoe-shaped table and sat down. Interview with the director of nursing on 5/17/06 at 2:37 PM confirmed she expected staff to sit down while assisting residents with dining.	F 241	**F241** **The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality by:** **1) Educating staff about appropriate dining protocol of sitting while assisting residents #2, #9, #11, and #24 and all other residents while eating.** **2) Random monitoring of mealtimes to assess whether feeding assistants are seated during meal assists.** by IDT **3) Report findings at monthly Quality Assurance meetings.**	06/28/06

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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, medical record review, and staff interview, the facility failed to assure personal hygiene was completed correctly during one of three observations of care for dependent residents. Perineal care (incontinence care) was performed incorrectly for resident #41. The findings were: According to the 2/1/06 significant change and 4/19/06 quarterly Minimum Data Set assessments, resident #41 was incontinent of urine, but not of bowel. However, on 5/15/06 at 4:10 PM an unidentified certified nurse aide stated the resident had diarrhea and was currently incontinent of bowel. Observation on 5/16/06 at 8:10 AM showed registered nurse (RN) #18 requested assistance from RN #51 to provide care for resident #41. The two RNs transferred the resident to the toilet as s/he was "too weak" to transfer with just one assistant. The resident was incontinent of bowel and bladder, and RN #18 provided perineal care while RN #51 assisted the resident to stand. RN #18 cleansed the resident's perineum after cleansing the anal area. The RN used a back and forth motion over the perineum with the same area of the wipe. RN #51 observed the procedure, but made no attempt to correct the technique used by RN #18. Review of the laboratory results showed the	F 312	**F312** 06/28/06 **The Facility will provide necessary services to maintain good nutrition, grooming and personal and oral hygiene to those residents unable to carry out ADLS independently. by:** **1. Educating internal staff and contracted staff about proper method of wiping from front to back.** for resident #4 and all other residents require perineal care. **2. An in-service will be presented on 6/15 to address perineal care.** **3. Random observation will be done and reported to Quality Assurance meetings.** by IDT	

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F 312	Continued From page 5 resident had seven urinary tract infections (UTIs) during the past year (4/19/05, 5/20/05, 8/1/05, 9/13/05, 10/22/05, 11/15/05, 12/31/05). In addition, the laboratory results also showed one episode of blood in the urine in 2005 (12/21/05) and two episodes in 2006 (1/4/06 and 2/13/06). Furthermore, the resident was treated with Pyridium (relieves pain, urgency or frequency, and burning) on 6/24/06 for a chronic UTI. According to the facility's undated policy and procedure entitled "Perineal Care" staff should "wash perineal area, wiping from front to back." Then they should cleanse the rectal area.	F 312		
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the environment was safe from electrical hazards. The findings were: 1. Observation on 5/15/06 at 4:48 PM and again on 5/17/06 at 1:30 PM revealed a live electric outlet on the wall in a small enclave next to the office of the director of nursing (DON) in the main hallway. The enclave contained a soda machine, a portable set of scales and a wall telephone. The outlet was approximately 5 feet from the floor. A water faucet was 6 inches directly above the outlet. The wall telephone was located horizontally within 3 feet from the faucet. Interview	F 323	**F323** **1. The electrical outlet was removed and the water faucet was capped to prevent accidental discharge.** **2. A new cover plate was installed on 5/15/06. Rooms will be inspected monthly to prevent reoccurrence. Housekeeping staff was briefed on this discrepancy and will report similar events as detected. This will allow for more timely repair.**	06/28/06

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F 323	Continued From page 6 with the facility maintenance manager on 5/17/06 at 1:30 PM confirmed the water faucet was operational. Interview with the DON on 5/17/06 at 2:16 PM revealed residents used the phone daily, usually after dinner. 2. Observation on 5/15/06 at 4:13 PM and on 5/17/06 at 2:00 PM revealed a partially missing electric outlet cover plate on the wall in resident room #5. The outlet was approximately 6 inches from the floor. Closer observation revealed the metal electric box was visible behind the damaged cover plate. Interview with the facility maintenance manager on 5/17/06 at 2 PM confirmed the cover plate should be replaced.	F 323		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations, review of a temperature log, and staff interview, the facility failed to ensure one of four refrigerators was maintained at an appropriate temperature. The findings were: Observation on 5/15/06 at 3:15 PM revealed the temperature of the cafeteria refrigerator in the main dining room was 50 degrees Farenheit (F). The refrigerator contained resident foods including yogurt, mighty shakes, and	F 371	**F371** **The facility will store, prepare, distribute and serve food under sanitary conditions.** **1. Refrigerator temperatures will be recorded and ~~reported~~ by dietary staff twice daily.** **2. Temperatures greater than 40 degrees will be reported to FSS and maintenance immediately.** **3. FFS will report to Quality Assurance meeting monthly.**	06/28/06

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F 371	Continued From page 7 approximately 10 gallons of milk. When asked on 5/15/06 at 3:20 PM, the dietary manager took a temperature reading of a one quarter full gallon of milk from this refrigerator. The result was 47.8 degrees F. Interview with the dietary manager at this time revealed the door didn't always get shut tightly. Observation on 5/16/06 at 8:46 AM and again at 9:50 AM revealed the temperature of the refrigerator remained higher than 41 degrees F respectively (42.3 degrees F and 47.9 degrees F). Review of the temperature log posted on the door of the refrigerator for the month of May 2006 revealed temperatures were to be recorded twice daily (in the AM and PM). On 5/4/06 the temperature was 43 degrees in the AM, and the PM temperature was blank. On 5/5/06 the AM temperature was 48 degrees F and the PM temperature was 41 degrees F. On 5/1, 5/2, 5/3, 5/6, 5/8, 5/10, 5/14, and 5/15 of 2006 the PM temperatures were blank. On 5/13/06 there was no temperature recorded for either AM or PM. On 5/17 the AM temperature was 42 degrees F. Interview with the dietary manager on 5/17/06 at 11 AM confirmed the temperature of the refrigerator should be maintained at 41 degrees or below. She stated the temperatures should be recorded on the log twice daily. The dietary manager further stated she had not been notified on the days when temperatures were too high. According to Food Code 2005, U.S. Public Health Service, 3-501.16: Potentially Hazardous Food (Time/Temperature Control for Safety Food), Hot and Cold Holding. Potentially hazardous food (time/temperature control for safety food) shall be maintained: (2) At a temperature specified in the following: (a) 5o [degrees] C (41oF) or less;	F 371		

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F 428 SS=D	483.60(c)(1) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to assure drug regimen reviews were completed for one (#26) of 13 sample residents. The findings were: According to the 8/9/05 admission Minimum Data Set assessment, resident #26 was admitted with diagnoses including depression, coronary artery disease, hypothyroidism, high blood pressure, arthritis, chronic pain, sick sinus syndrome, diabetes, diabetic neuropathy, strokes, emphysema, chronic renal failure, congestive heart failure, esophageal varices, and leg weakness from childhood polio. Review of the May 2006 medication administration record showed the resident routinely received 25 medications. However, review of the entire medical record showed the last drug regimen review completed by the pharmacist was dated December 2005. Interview with the director of nursing (DON) on 6/17/06 at 7:20 AM confirmed drug regimen reviews for 2006 were not in the medical record. The DON stated she checked with the pharmacist, and he did not know what happened. During an interview on 6/17/06 at 7:50 AM, the pharmacist verified he was unable to locate any drug regimen reviews for 2006.	F 428	**F428** **Currently MDS Coordinator reviews DURs as part of her CQI/Performance Improvement. The Pharmacy department will review this documentation so as to stay compliant.** The Pharmacy department will bring resident #26 DUR up to date.	06/28/06

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F 431 SS=E	483.60(d) LABELING OF DRUGS AND BIOLOGICALS Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This REQUIREMENT is not met as evidenced by: Based on random observation, staff interview, and review of policies and procedures, the facility failed to assure medications were labeled and stored in one of one medication carts according to accepted professional principles. Multiple expired medications were available for resident use, a facility applied label for non-sample resident #13 covered the expiration date of the medication, and nursing staff transferred the contents of one container to another. In addition, an expired medication was available in the storage cabinet. The findings were: On 5/17/06 at 1:50 PM, the surveyor reviewed the medications on the medication cart and in the storage cabinets with the director of nursing (DON). The following concerns were identified: a. Observation of the medication cart revealed multiple expired medications including: - Two bottles of Flunisolide nasal spray, expired 4/05 - Three bottles of AKWA tears, expired 5/05 - One bottle of Artificial tears, expired 1/05 - One bottle of Artificial tears, expired 7/06 - Two bottles of AKWA tears, expired 2/06 - One bottle of Fluorometholone	F 431	**F431** **Starting in June/2006 the Pharmacy Department created a monthly medication room inspection. This inspection will cover out dated medications, and inappropriately labeled or store medications. Inappropriate resident purchased medications will be removed. Pharmacy department will no longer deliver bulk medications (Lactulose). From here on the Pharmacy will inspect the status of the bulk medications and fill the dispensing container as needed. Additionally the labeling will be inspected monthly.**	06/28/06

Identify and discard

will be corrected.

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F 431	Continued From page 10	F 431		

Ophthalmic suspension 0.1%, expired 4/06
- One Advair Diskus (inhaled medication) with the expiration date worn off.

b. Observation of the storage cabinet revealed one bottle of S.T. 37 solution for oral pain, expired 4/05.

c. Review of medication labels failed to show an expiration date on an Advair Diskus for resident #13. At 2 PM on the same day, the DON stated the expiration date was actually on the Advair Diskus, but was covered by the label applied by the pharmacist. At 4:55 PM on 5/17/06, the DON stated all facility labels should include the expiration date.

d. Observation showed a large pump bottle of Lactulose stored on top of the medication cart. The label lacked an expiration date. However, at 1:55 PM on 5/17/06 the pharmacist stated the medication was not outdated because the nursing staff filled the container with Lactulose from a new bottle which he sent up. The pharmacist reached up and obtained the new, correctly labeled bottle from a shelf above the cart. The DON stated she was unaware the nursing staff were pouring Lactulose from one container to another.

e. During an interview on 5/17/06 at 4:55 PM, the DON confirmed all the medications were available for resident use. The DON stated it was her expectation that expired medications not be administered to residents. She further stated the pharmacist was responsible for checking for expired medications.

According to the facility's undated policy and procedure, "Labeling of Medications," the purpose of this procedure "is to insure that all medications maintained in the facility are properly labeled...labels must include: The expiration

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F 431	Continued From page 11 date." In addition, according to that policy and procedure, "Any drug label that is soiled, incomplete, illegible, worn, or makeshift must be returned and replaced by the issuing pharmacy...Only the issuing pharmacy may place a drug label on a medication container...Contents of one container may not be transferred to another container." Furthermore, the nursing staff could not have removed the label and found the expiration date on the Advair Diskus (in c. above) because (per the facility's aforementioned policy), "Only a physician or pharmacist may change a medication label." Review of a policy and procedure entitled "Pharmacy Policies," revised 3/5/98 revealed "Discontinued, outdated drugs,... are returned to Pharmacy for proper disposition."	F 431		
F 441 SS=E	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, staff interview, review of policies and procedures, and review of professional standards of practice, the facility	F 441	**F441** **The Facility will 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, and corrective actions related to infections by.** **1) The infection control Practitioner will conduct an annual in-service to all staff on Policy and Procedures to include:**	06/28/06

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F 441	Continued From page 12 failed to comply with infection control policies related to isolation of ill residents and reporting requirements for one of one gastrointestinal (GI) outbreaks. The findings were: Interview with the director of nursing (DON) on 05/15/06 at 1:55 PM revealed the facility was in the midst of an outbreak of gastrointestinal (GI) illness. The following information was provided by the DON: a. A total of 15 residents had diarrhea, or diarrhea accompanied by nausea and vomiting, within the past 72 hours. An additional 7 employees were reported to have been sick with the same symptomatic presentation. A presumed index case was traced to 05/11/06. b. Residents with GI symptoms were not mandatorily restricted in their movements about the facility and were free to eat in a group dinning room if they chose to do so. The deciding factor in whether a resident ate in group settings or in his/her room was the resident's choice. c. Residents with GI symptoms were not prohibited from attending and participating in group activities. Each resident had the choice to attend, or not, depending upon how s/he felt. d. Staff calling in sick were instructed to remain home until they felt better. The DON stated staff members were returning to work "...once they felt better." The DON further stated she was ill over the weekend (5/13/05 and 5/14/06) with symptoms of the GI outbreak, but returned to work that morning. e. An unknown number of employees complained of a recent bout with "stomach flu" (reporting symptoms consistent with GI illness) on their "off weekend", that is, days other than those scheduled for work.	F 441	**A) Report all Group A diseases within 24 hours of diagnosis.** to the WYO DOH. LJ **B) Report all Group B diseases within 7 days of diagnosis.** to the WYO DOH. **C) Restrict residents with symptoms of illness to rooms according to the Wyoming Department of Health guidelines.** **D) Staff who are ill will report illness to the Infection Control Practitioner who will instruct them on appropriate time frame to remain off of work, dependent upon signs and symptoms and the Department of Health guidelines.**	

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f. At the time of the interview, the facility had not contacted the local public health office, the Wyoming Department of Health, Epidemiology Section, or the State Survey Agency.

Interview with the facility infection control practitioner (ICP) on 05/16/06 at 2:15 PM revealed the nursing home collected infection control data and consolidated that data into a monthly summery report for the facility ICP. The facility ICP further stated she was only notified of the ongoing GI outbreak in the nursing home "...within the past 30 minutes", being unaware of the outbreak until that time. During the course of the interview, the hospital ICP confirmed the required public health and state officials had not been contacted regarding the GI outbreak.

Review of infection control records on 05/16/06 at 4:15 PM, updated to reflect current conditions in the nursing home, revealed the total number of residents reported with GI illness was 24; nine new cases were reported on 05/15/06 after the initial tour of the facility.

Review of facility-wide infection control policies and procedures revealed policies relevant to GI illness and disease outbreaks. The facility's policies included the following:

a. A copy of Wyoming Department of Health Reportable Diseases and Conditions, dated 05/24/01, was posted and referenced in the facility infection control policies. This document cited the requirement to notify the Epidemiology Section, Wyoming Department of Health, of selected reportable conditions, to include "Diarrheal Disease Clusters and Outbreaks." The document further provided a telephone number and stated a requirement for "Immediate notification...to coordinate epidemiology and lab response."

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F 441	Continued From page 14 b. Facility policy entitled, "Isolation Precautions", dated 11/96, revision 11/99, directed facility personnel to use universal precautions and initiate contact isolation for several infectious disease conditions, to include "Enteric infections with a low infectious dose or prolonged environmental survival", with special emphasis placed on those individuals exhibiting incontinence. c. Facility policy entitled, "Employee Infection Report", dated 08/97, revised 03/06/98, stated that "...employee illness due to infections will be reported to the infection control officer." The policy further directed facility employees to complete a form labeled "Employee Infection Report" for submission to the infection control officer. Among the indications for submitting an employee infection report was "...gastro-intestinal infection." The Wyoming Department of Health, Epidemiology Section, in "Guidelines for the Control of a Suspected or Confirmed Outbreak of Viral Gastroenteritis in a Nursing Home", specifically recommends employees refrain from returning to work after being symptomatic with gastrointestinal symptoms (such as diarrhea and vomiting) for a period of 72 hours after the cessation of symptoms. The state guidelines are based on standards published in "Recommendations and Reports" by the CDC, "Norwalk-Like Viruses; Public Health Consequences and Outbreak Management", June 2001. Observations and interviews revealing a facility practice of allowing staff to return to work immediately after the cessation of symptoms were inconsistent with the recommended standards of practice.	F 441		

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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, resident and staff interviews, review of policies and procedures, and review of professional standards of practice, the facility failed to enforce isolation procedures for 2 of 24 (#26, #41) potentially contagious residents to contain an outbreak of gastrointestinal (GI) illness. The findings were. Review of the facility-wide infection control policies and procedures revealed the facility had adopted the standard of practice of the WDH, Epidemiology section and addressed GI illness in a policy entitled, "Isolation Precautions", dated 11/98, revised 11/99. This policy directed facility personnel to use universal precautions and initiate contact isolation for several infectious disease conditions, to include "Enteric infections with a low infectious dose or prolonged environmental survival", with special emphasis placed on those individuals exhibiting incontinence. Interview with the facility infection control practitioner (ICP) on 05/16/06 at 2:15 PM confirmed the referenced policy was current. Based on interview with the DON on 05/15/06 at 1:55 PM, this policy was not followed. The DON reported 24 residents were ill with GI symptoms from May 11, 2006 through May 16, 2006. The DON further stated residents were not limited in their movement about the nursing home, nor	F 442	**F442** **Facility will prevent the spread of infection:** **1) Restrict symptomatic residents to their rooms according to the Wyoming Department of Health's guideline.** Residents will be identified and reported as per F441,	06/28/06

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were symptomatic residents restricted in their ability to participate in group or individual activities. Residents remained free to eat in a group setting if they chose to do so.

Observation confirmed the following residents who exhibited signs and symptoms of the GI illness ate in group settings:

a. On 5/15/06 at 3:20 PM resident #26 stated s/he had had nausea, vomiting, and diarrhea "since yesterday or the day before." However, the resident was eat in the dining room on 5/15/06 at 5:40 PM. On 5/16/06 at 10:15 AM the resident stated s/he was not feeling well. The resident further stated s/he felt good after eating last night, then became nauseated again.

b. On 5/15/06 at 4:10 PM interview with an unidentified certified nurse aide revealed resident #41 had diarrhea. However, the resident was in the dining room that evening at 5:55 PM. The resident complained of being "sick" and said the staff were aware his/her stomach hurt.

The standard of practice for healthcare facilities, as stated by the Wyoming Department of Health, Epidemiology Section, requires facilities to "...isolate ill residents from others by confining them to their rooms (until 3 days after their last symptoms). Group ill people together if possible. Discontinue activities where ill and well residents would be together. Group activities should be kept to a minimum or postponed until the outbreak is over." Interview with a state epidemiologist, Wyoming Department of Health, on 05/22/06 at 9:35 AM indicated acute gastroenteritis in long-term care facilities is often attributed to a viral pathogen (Noroviruses). S/he further stated the basis for isolation is the "...highly contagious nature of the viral pathogen"

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F 442	Continued From page 17 and reiterated the need for stringent adherence to isolation and containment to prevent the spread of infection.	F 442		
F 443 SS=E	483.65(b)(2) PREVENTING SPREAD OF INFECTION The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of policies and procedures, and review of professional standards of practice, the facility failed to monitor potentially infectious employees in a manner intended to prevent the spread of gastrointestinal (GI) illness. The findings were: 1. Interview with, the director of nursing (DON) on 05/15/06 at 1:55 PM revealed the facility had 7 staff members with GI illness during the period of May 11, 2006 through May 15, 2006. The DON stated she was ill over the weekend (5/13/05 and 5/14/06) with symptoms of the GI outbreak, but returned to work that morning. The DON further stated other employees were sick on their "off time" (time other than a period of scheduled duty). According to the DON, the 7 ill staff included 2 nurses and 5 certified nursing aides (CNAs), all of whom were involved in direct care activities. The DON stated staff were not permitted to work while sick, but returned when "...they felt better."	F 443	**F443** **The Facility will 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 by:** **1) Staff who are ill will report illness to the Infection Control Practitioner who will instruct them on appropriate time frame to remain off of work, dependent on signs and symptoms and the Wyoming Department of Health guideline.**	06/28/06

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2. Interview with the infection control practitioner (ICP) in the nursing home on 05/17/06 at 2:55 PM confirmed the prevalence of staff reported as ill, who returned to work once symptoms subsided. Potentially infectious staff members, not otherwise scheduled for duty, were detected only through anecdotal evidence as the facility lacked a method to accurately identify and monitor employees experiencing GI illness if the timing of the illness did not require missing a scheduled work shift. There was no documentation available during the survey to accurately determine the total number of direct care staff or other employees that experienced GI illness during the outbreak period.

3. Interview with the facility laundry supervisor on 05/16/06 at 1:50 PM revealed one laundry employee left work with GI-related symptoms on 05/16/06. Interview with the dietary manager on 5/17/06 at 11 AM revealed a cook and a dietary aide left work on 5/14/06 because they were ill (symptoms not reported). Interview with the nursing home ICP on 05/17/06 at 3:50 PM revealed information on sick ancillary staff, such as laundry and dietary personnel, was not reported on the infection control monthly report. Interview with the facility ICP on 05/17/06 at 1:25 PM revealed an unawareness of the number or types of ancillary staff reporting sick with GI infections. The facility ICP was unable to produce evidence ill staff members had completed an "Employee Infection Report" as required in facility infection control policies.

4. The Wyoming Department of Health, Epidemiology Section, in "Guidelines for the

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F 443	Continued From page 19 Control of a Suspected or Confirmed Outbreak of Viral Gastroenteritis in a Nursing Home" specifically recommends employees refrain from returning to work after being symptomatic with gastrointestinal symptoms (such as diarrhea and vomiting) for a period of 72 hours after the cessation of symptoms. The state guidelines are based on standards published as "Recommendations and Reports" by the Centers for Disease Control "Norwalk-Like Viruses; Public Health Consequences and Outbreak Management," June 2001. Observations and interviews revealing a facility practice of allowing staff to return to work immediately after the cessation of symptoms were inconsistent with the recommended standards of practice. In addition, the facility lacked a method to identify and track all symptomatic employees.	F 443		
F 444 S8=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on random observation, review of policies and procedures, and review of professional standards of practice, the facility failed to monitor hand hygiene among staff to prevent the potential transmission of gastrointestinal (GI) illness among residents in the facility. The findings were:	F 444	**F444** **The Facility will require staff to wash their hands after each direct resident contact for which hand washing is indicated by ~~accepted~~:** **1) Instruction to CNA #11 and all staff on hand washing protocols.** **2) Random monitoring of staff hygiene and report to monthly Quality Assurance Committee.**	06/28/06

by JDT

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F 444	Continued From page 20 1. Observation on 05/17/06 at 7:15 AM revealed certified nurse aide (CNA) #11 handled toast for resident #19 in the special care unit (SCU) dining room. The resident had eaten part of the toast. Resident #19 was reported ill with diarrhea on 05/15/06. Without washing his/her hands, CNA #11 proceeded to peel a banana for resident #17, handling both the peel and the banana. This same CNA removed the garment protector from resident #17, as it was soiled from wiping the resident's face and mouth. Resident #17 was reported to exhibit GI illness on 05/15/06. CNA #11 continued to feed other residents in the SCU without any observed hand hygiene. Over a 12 minute observation period from the initial contact with resident #19, CNA #11 made contact with 4 other residents' food, plates, utensils, and condiments. The Wyoming Department of Health, Epidemiology Section, in "Guidelines for the Control of a Suspected or Confirmed Outbreak of Viral Gastroenteritis in a Nursing Home," specifically identified the potential for healthcare providers to aid in transmitting infection between residents. These guidelines further detail recommendations for healthcare providers to exercise stringent hand hygiene practices when caring for or assisting ill residents. Interview with a staff epidemiologist from the Wyoming Department of Health on 05/22/06 at 10:20 AM confirmed the necessity for aggressive hand hygiene practices, particularly in the midst of a GI outbreak. 2. Observation on 5/16/06 at 9:47 AM showed CNA #45 provided perineal care for resident #41. At 9:53 AM the CNA turned on the water faucet, washed her hands, obtained paper towels and	F 444		

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F 444	Continued From page 21 turned off the water faucet, then dried her hands on the same towels. According to the facility's undated policy and procedure entitled "Handwashing," staff should "dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel."	F 444		
F 445 SS=E	483.65(c) INFECTION CONTROL - 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, and review of standards of practice, the facility failed to store soiled linens in a manner that minimized the spread of infection. The findings were: Observation on 05/17/06 at 9:20 AM revealed the facility kept soiled linens in a room adjoining the nursing home, connected through a glass door to the main hallway in the vicinity of room 35. In addition to facility linens and resident clothing, the room served as the collection point for personal clothing for residents whose families did their laundry. The linen storage room was not insulated, lacked forced air ventilation, and did not have an exhaust fan. The room had a corrugated metal roof and the interior temperature was noticeably warmer than the adjacent hallway. The combination of elevated room temperature and the lack of an exhaust fan facilitated the movement of air from the soiled linen room into the nursing home when the	F 445	**F445** **All openings in this room have been sealed.** **A letter will be submitted requesting this citation be waived pending the renovation of the Manor. This renovation project will begin on or about the 19th of June. As part of this project the existing soiled linen room will be replaced by new construction with a room specifically designed for soiled linens.**	06/28/06

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F 445	Continued From page 22 intervening door was opened. In addition, the room had openings to the outside through a missing plywood panel and unsealed areas under the eaves. There were no screens across the openings in the walls or adjacent to the roof to prevent the entry of flies or other pests. Interview with the laundry supervisor on 05/17/06 at 3:45 PM in the soiled linen storage room revealed the room was often "...very warm and smelly..." in the summer months. The laundry supervisor also stated bats had been seen in the soiled linen room. She further stated there had been a "...large increase in soiled linens over the past week" and indicated a particular increase in linens and clothing that smelled of fecal contamination. The 2003 "Guidelines for Environmental Infection Control in Health-Care Facilities" published by the Centers for Disease Control constitute the standard of professional practice for infection control strategies in the healthcare setting. These guidelines recommend soiled linens be stored in a well-ventilated area, preferably with relative negative air pressure to prevent the movement of air from soiled and potentially contaminated linens into resident areas.	F 445		
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 staff interview, staff	F 454	**F454 (Physical Environment)** **a) Wiring to the heater was repaired and conduit was secured to the wall.** **b) This item was corrected immediately and staff has been briefed on the importance of keeping**	06/28/06

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F 454	Continued From page 23 failed to ensure the facility was maintained in a safe manner. The findings were: Interview with the maintenance director on 5/17/06 at 2:48 PM confirmed the following situations were safety hazards: a. Observation on 5/17/06 at 2:00 PM revealed a dirty laundry storage shed attached to the main building. Inside the shed was an overhead heater used in the winter. The heater was hard wired into the facility's main electrical circuit. The wires exiting the heater were exposed and not installed in accordance with NFPA 70 Section 430-131. b. Observation on 5/17/06 at 2:18 PM revealed a chair placed in front of a portable fire extinguisher in the hallway outside of resident room #42. When the chair was moved, a sign was visible posted to the fire extinguisher; it instructed staff, "Do not place items in front of extinguisher." Portable fire extinguishers in all health care occupancies must be in accordance with 9.7.4.1 NFPA 10; 18.3.5.6; 19.3.5.6. c. Observation on 5/17/06 at 2:22 PM revealed a storage room opposite the old oxygen storage room in the main hallway. The amount of stored material in the room was substantial and constituted a hazard storage area. The door into the room did not have a self closure device. Life safety code requires doors to hazard areas be self-closing in accordance with 7.2.1.8. In addition, materials were stored within 18 inches of the ceiling mounted sprinkler system (Violation of Life Safety Code NFPA 25 Section 2-2.1.1).	F 454	**fire extinguisher access clear of obstructions.** **c) Materials stored in this room were removed. Staff has been briefed on this Life Safety Code requirements concerning this storage room.**	

DEPARTMENT OF HEALTH AND HU[illegible]N SERVICES
CENTERS FOR MEDICARE & MEDIC[illegible]D SERVICES

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
	535023	A. BUILDING _____ B. WING _____	05/17/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON COUNTY HEALTH SERVICES	1124 WASHINGTON BLVD NEWCASTLE, WY 82701

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F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of Wyoming state rules and regulations, the facility failed to report in a timely manner one of one outbreaks of infectious disease as identified by Wyoming Statute section 35-4-107. The findings were: Interview with the facility DON on 05/16/06 at 1:45 PM confirmed 24 residents and 7 staff had gastrointestinal (GI) illness from May 11, 2006 through May 15, 2006. Interview with the facility infection control practitioner (ICP) on 05/16/06 at 2:15 PM confirmed the outbreak and revealed required state agencies had not been notified prior to 05/16/06. Wyoming Department of Health Rules and Regulations for Program Administration of Nursing Care Facilities specifies diseases/conditions will be reported to the Wyoming Department of Health, Epidemiology Unit, as per Wyoming Statute section 35-4-107. In failing to report the disease outbreak in a timely manner, the facility did not comply with applicable State law and regulations.	F 492	**F 492** **The Facility must operate and provide services in compliance with applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This Facility will provide compliance by:** **1. The charge Nurse will notify the Infection Control Practitioner of any outbreaks of infectious diagnosis.** **2. The Infection control Practitioner will report to the Wyoming Department of Health.** 3. Notification & reporting will be in a timely manner	06/28/06