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	53A049	A. BUILDING _____ B. WING _____	01/25/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2009 LARAMIE STREET TORRINGTON, WY 82240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to ensure staff provided care and services for two (#48, #65) sample residents and one non sample (#3) resident in a manner that maintained their dignity. The census was 75. The findings were: 1. Observation on 1/24/06 at 8:25 AM revealed resident #68 was seated at the dining room table. Observation further revealed the resident vomited/coughed food particles and liquids onto his/her clothing. Observation revealed the resident was assisted from the dining room, down the hallway, and to his/her room. Observation revealed, as staff assisted the resident down the hallway, his/her sweat pants were wet and had food particles dropping off as s/he walked down the hallway. Observation revealed staff did not attempt to clean or cover the resident's clothing to maintain his/her dignity while s/he was assisted to his/her room. 2. Review of the 12/05 resident council minutes revealed resident #3 verbalized a concern regarding a hole in his/her night clothing. Interview with the resident on 1/24/06 at 11:15 AM confirmed the concern and stated it embarrassed him/her. Observation of the item of clothing on 1/25/06 at 12:10 PM revealed a small hole approximately one-half inch in diameter that	F 241	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. This will be done by the following: 1(A) All nursing staff will be in-serviced on proper feeding assistance now and on an annual basis to include repositioning of residents and appropriate staff positioning to assume while assisting residents. (B) Facility policy and procedure will be implemented to ensure that residents who become ill or vomit during meal service will be cleaned of food particles, covered with a clean gown (available at all times in the dining room) and escorted across the hall to the activity room bathroom. The Residents will be cleaned thoroughly and clean clothing provided before being assisted to his/her room. The remaining dining room staff will clean and remove any contaminated trays and residents. Housekeeping will be notified to clean furniture and floors. Affected residents will receive new food trays. (C) Resident #68 will be monitored by the nurse in charge at each meal for potential dignity risks. 2(A) The Social Services Coordinator (SSC) will attend monthly resident council meetings upon request. The SSC will identify and take action to coordinate with resident/family repair or replacement needs of resident's clothing within 10 working days. Resident #3 requested a new gown and did receive one per her preference. Staff will be in-serviced to identify worn/damaged resident clothing and report to the SSC for follow-up. (B) All staff will be in-serviced on proper feeding assistance on an annual basis to include repositioning of residents and appropriate staff positioning to assume while assisting residents. (C) Resident #48 is being repositioned during meals as needed and will be monitored by the nurse in	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: February 21, 2006

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HEALTH FACILITIES

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.

The POC was accepted on 3/1/06 at 1035 by Jordan Bowen, administrator and Karen Nemecek, RN Health Surveyor

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F 241	Continued From page 1 was taped. Interview with the social services coordinator at that time confirmed tape was used to repair the hole. 3. Observation of resident #48 on 1/23/06 at 5:50 PM revealed the resident was slumped down and leaning to the right in a wheeled reclining chair, with his/her right shoulder on the right arm of the chair, and his/her head lying on the shoulder. The observation revealed the resident required total assistance to eat. The following concerns were identified: a. Observation revealed that even though there were chairs available, certified nurse aide (CNA) #11 stood while she assisted the resident with his/her meal from 6:17 PM to 6:26 PM (nine minutes). b. In addition, observation revealed no staff attempted to reposition the resident or the resident's chair so the resident could make eye contact with the person assisting him/her. c. Interview with the resident care director on 1/25/06 at 11:20 AM revealed staff were expected to be seated when they assisted residents with dining.	F 241	charge at each meal. Bilateral positioning supports have been added to Resident #48's gerichair to help maintain a proper feeding position more comfortably. 3(A) A QM process will be implemented to randomly monitor dignity issues on a monthly basis. The Social Services Coordinator will perform this monitor and report data / actions to the PI Steering Committee Quarterly.	3/11/06
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure resident living areas and/or common areas were maintained. The finding	F 253	The facility will provide housekeeping and maintenance services necessary to maintain a sanitary orderly and comfortable interior. This will be accomplished by: 1(A) All identified exit doors and frames will be painted. This will include the 200, 201 and 400 exit doors (B) All identified wooden interior doors will be stained and repaired. This will include rooms 409, 410, 303, 311, 312, 201 and both laundry doors (C) The tile missing from floor across from laundry will be replaced.	

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F 253	Continued From page 2 were: During random observations of the facility from 1/23/06 at 2 PM through 1/25/06 at 4 PM, the following concerns were identified: 1. Concerns found in the 400 hall included: a. The exit door at the end of the 400 hall was scratched and missing paint. For example, one scratched area was 32 inches by 2 inches. Another scratched area was 18 inches in length. Other areas had scratches or missing paint that varied in size from one-half inch to one inch. b. Wooden doors to resident rooms #409 and #410 had scraped areas. c. Wooden doors to the utility areas had damaged exteriors the width of the doors. The exteriors were visible to residents in the hallways. 2. Concerns found in the 300 hall included: a. Wooden doors to resident rooms #303, #311, and #312 had damage to the stained finish on the doors. b. Wood utility doors had damage to stained wood grain, including the linen room door between the 200 and 300 hall. 3. Concerns found in the 200 hall included: a. The exit door at the end of the 200 hall was badly scratched and missing paint. One scratched area was 24 inches by 1 inch. Another scratched area measured 18 inches by 3/4 of an inch. b. The door and door frame to room 201 required restaining and/or painting. 4. Other areas of concern included: a. The interior of the front entry doors were scratched and missing paint. b. All metal door frames to the dining and	F 253	2(A) The Maintenance staff will implement environmental walk through assessments will be done in all areas to identify needed repairs on a regular basis. These inspections will be monitored by the Plant Operations Manager through monthly preventative maintenance procedures. Results will be reported quarterly to the PI Steering Committee.	3/11/06

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F 253	Continued From page 3 activity rooms had scratches and missing paint. c. The door to the laundry clean and soiled linen areas had a strip of varnish missing. In addition, a triangular piece of tile flooring was missing near the door to the boiler room. These areas were visible to residents who used the public restroom area. Interview and observation with the maintenance technician on 1/25/06 at 8:36 AM revealed the facility had been unable to do the routine maintenance due to the unavailability of staff.	F 253		
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications;	F 272	The facility will conduct initial and periodic comprehensive, accurate and standardized reproducible assessments of each resident's functional capacity. 1(A) The facility's current policy will be revised to include the completion of a bladder and bowel assessment to be completed on each resident upon admission and quarterly with each MDS. (B) Bladder and bowel assessments will be completed on Residents #52 and #57. 2(A) Fall Occurrence Reports are completed on each resident for every fall. These reports will be followed up with a comprehensive assessment of the reason for the resident's fall. The contributing factors will be considered. If warranted, preventative measures will be placed to aid in the prevention of future falls. (B) Fall assessments will be completed on Residents #52 and #65. 3(A) A QM process will be implemented to monitor comprehensive assessments of resident needs. The Patient Care Director will monitor this process monthly and report quarterly to the PI Steering Committee	3-11-06

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F 272	Continued From page 4 Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff completed comprehensive assessments for three (#52, #57, #65) of thirteen sample residents. The findings were: 1. Review of the 4/28/05 significant change Minimum Data Set (MDS) assessment, and the 7/28/05 and 10/27/05 quarterly MDS assessments for resident #52 revealed s/he was incontinent of bowel all or almost all of the time. Review of the entire medical record revealed there was no bowel assessment completed. Interview with the resident care director on 1/25/06 at 4:35 PM confirmed there was no bowel assessment for this resident. In addition, review of the interdisciplinary progress notes revealed the resident was found on the floor on 8/15/05. Review of the entire medical record revealed there was no assessment of the reason for the resident's fall. Review of the occurrence report dated 8/15/05 revealed no comprehensive assessment of the reason for the fall or contributing factors was completed. Interview with the resident care director on 1/25/06 at 4:15 PM confirmed there was no evidence a comprehensive assessment of the cause or contributing factors for the fall was completed.	F 272		

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F 272	Continued From page 5 2. Review of the 8/30/05 and 12/20/05 interdisciplinary progress notes for resident #65 revealed s/he had falls on those dates. Review of the entire medical record revealed there was no assessment of the cause or contributing factors for the fall. Review of the occurrence reports dated 8/30/05 and 12/20/05 revealed there was no comprehensive assessment of the cause or contributing factors for the falls. Interview with the resident care director on 1/25/06 at 4:15 PM confirmed there was no evidence a comprehensive assessment of the cause or contributing factors for the falls was completed. 3. Observation on 1/24/06 at 8:50 AM showed resident #57 was incontinent of bowel and bladder. Review of the 11/17/05 significant change MDS assessment revealed the resident triggered for comprehensive assessments in those areas. Review of the assessment information listed in Section V of that MDS revealed a comprehensive assessment of the resident's urinary status was not completed. In addition, the facility did not perform a bowel assessment. During an interview on 1/24/06 at 11:50 AM, the restorative nurse confirmed the bladder assessment was not comprehensive and verified the lack of a bowel assessment for this resident.	F 272		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		

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F 281	Continued From page 6 Based on observation, staff interview, medical record review, and review of policies and procedures, the facility failed to assure staff maintained professional standards of practice related to medication administration for 2 of 13 sample residents (#52, #58). In addition, the medication cart was left unlocked on three separate occasions. The findings were: 1. Review of the medical record showed a physician's order dated 10/4/05 for a weekly protime (laboratory test determining clotting time of blood) for resident #58. Further review showed nursing documentation dated 11/30/05, which indicated a physician was notified the test was not done. Review of the lab results confirmed the protimes were not completed. Interview with the chief nursing officer (CNO) on 1/24/06 at 5:05 PM revealed the ordering physician was a surgeon who was not privileged to practice at the facility. Therefore, nursing should have contacted the primary care physician (PCP) to confirm the order. However, review of the record with, and interview of, the resident care director on 1/25/06 at 12:15 PM confirmed there was no evidence the PCP was notified of the desired test until 11/30/06. According to the sixth edition of Clinical Nursing Skills Basic to Advanced Skills, by Smith, Duell, and Martin, if an order is "questionable for any reason, the physician must be notified for clarification." 2. Review of the January 2006 medication administration record (MAR) for resident #52 revealed s/he had an order for "safgel, selesite, intrasite apply to affected area (buttock and periarea) lightly coat apply prn at least tid (three times per day)." Further review of the MAR revealed this treatment was only provided once	F 281	The facility will provide or arrange for services of professional standards of quality. 1(A) All licensed nursing staff will review the facility policy of "Safe Medication Practices". (B) All medication carts will be locked when out of visual contact of the administering nurse. (C) All orders received from non-privileged physicians will be confirmed by the resident's primary care physician upon receipt. Nursing staff will follow up with the PCP within 24 hours if no confirmation has been received. A new policy will be implemented on this professional standard and nursing staff will be educated. (D) Resident #58 was not prescribed Coumadin at the time of the protime order and a physician order by the PCP has been obtained stating "no protime needed". 2(A) All licensed nursing staff will be educated on the expectation that all wound treatments orders must be approved and ordered by the resident's PCP. (B) Resident #52's wound treatment order was changed by clarification of the resident's PCP. 3(A) QM process will be implemented to monitor professional standards. The Patient Care Director will monitor this process monthly and report quarterly to the PI Steering Committee.	3/11/06

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F 281	Continued From page 7 daily at bedtime instead of the prescribed "at least" three times per day. Interview with licensed practical nurse #34 on 1/25/06 at 12:45 PM revealed she was unsure why the medicated treatment was not provided as ordered. 3. Observation on 1/23/06 at 4:02 PM revealed a medication cart was left unlocked for three minutes. The licensed practical nurse (LPN), employee #31, was out of visual contact with the cart for that time period and a visitor passed within reach of the cart. Observations on 1/24/06 at 7:18 AM and 7:25 AM also revealed registered nurse (RN) #45 left the cart unlocked while she was out of visual contact with it. At 7:18 AM the RN was in a resident's room for one minute while the cart remained in the hallway. At 7:25 AM the cart was outside the dining room where five residents and several staff members had access to it. According to the facility's 10/05 policy and procedure, "Safe Medication Practices," medications "will be stored securely to prevent access or tampering by patients, visitors, and unauthorized staff." Review of Mosby's 3rd edition of Nursing Interventions & Clinical Skills, 2004, by Elkin, Perry, and Potter confirmed "medication carts must be kept locked when unattended."	F 281		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282		

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F 282	Continued From page 8 by: Based on observation, medical record review, and staff interview, the facility failed to ensure staff followed the care plan for 1 (#52) of 13 sample residents. The findings were: Observation of resident #52 on 1/23/06 at 3:30 PM revealed his/her left hand was contracted. Review of the 4/28/05 significant change and the 7/28/05 and 10/27/05 quarterly Minimum Data Set (MDS) assessments revealed s/he had partial loss of the left arm and hand. Review of the 1/12/05, 4/12/05, 7/25/05, and 10/25/05 restorative nursing assessments revealed the resident was on the "level one" restorative program. Review of the restorative care plan dated 10/27/05 revealed the resident required passive range of motion (PROM) to the upper and lower extremities during dressing and undressing with five repetitions each time. Review of restorative records revealed there was no evidence the resident received the PROM as recommended. Interview with the resident care director on 1/25/06 at 5:15 PM confirmed there was no evidence the PROM was provided for the resident.	F 282	The facility will provide or arrange for services by qualified persons in accordance with each resident's written plan of care. 1(A) All certified nursing assistants will be in-serviced on Restorative Care Practice and Procedure and the documentation of the Restorative Care they provide in accordance with the resident's care plan. (B) Resident #52 will be provided with PROM per her care plan with documentation reflecting such. 2(A) Restorative Care staff will monitor RC care plan compliance on randomly selected residents monthly. The data/actions will be reported quarterly to PI Steering by the Life Enrichment coordinator. Non-compliance will be corrected immediately.	3/11/06
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309	The facility will provide for each resident the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessments and plan of care. 1(A) All nursing staff will be in-serviced on proper feeding assistant techniques now and on an annual basis to include repositioning of residents and proper staff positioning to assume	

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F 309	Continued From page 9 by: Based on observation, medical record review, and staff interview, the facility failed to ensure proper positioning for one (#48) of one sample resident who was dependent on staff for positioning. The findings were: Observation of resident #48 on 1/23/06 at 5:50 PM revealed the resident was slumped down and leaning to the right in a wheeled reclining chair. The resident's right shoulder was on the right arm of the chair, and his/her head was lying on his/her shoulder. Observation revealed the resident required total assistance with eating. Observation revealed a certified nurse aide (CNA) was seated to the resident's right and was assisting the resident with eating. At 6:17 PM, a second CNA, assumed the feeding task and stood on the resident's left side while she assisted the resident. Neither CNA attempted to reposition the resident. The observation continued until 6:26 PM (36 minutes). A second observation of the resident on 1/24/06 at 7:38 AM revealed the resident was capable of sitting in an upright fashion during the breakfast meal. A third observation of the resident on 1/24/06 at 5:49 PM revealed the resident was leaning to the right at the beginning of the meal. Continued observation at 5:54 PM revealed the resident had slumped further to the right with his/her head on the arm of the chair. The following concerns were identified related to the resident's positioning: a. Review of the 10/19/05 Minimum Data Set (MDS) significant change assessment revealed the resident required partial physical assistance for balance while in a seated position. Review of the care plan (start date of 10/21/05) revealed staff were instructed to maintain good body alignment for the resident and to reposition the	F 309	while assisting residents. (B) Resident #48 is being repositioned as needed during meals. She has bilateral positioning supports added to her gerichair to maintain a proper feeding positioning more comfortably. The nurse in charge will monitor for appropriate positioning of Resident #48 and all others. 2 (A) A QM process will be implemented to monitor proper positioning based on resident needs. The Patient Care Director will monitor this process monthly and report quarterly to the PI Steering Committee.	3/11/06

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F 309	Continued From page 10 resident as needed to prevent injury to the resident's neck. b. Interview with the restorative CNA on 1/25/06 at 10:45 AM revealed the best method for maintaining good body alignment for this resident was repositioning as needed by staff. The restorative CNA also stated the resident should be fed in the upright position. Interview with the resident care director on 1/25/06 at 11:20 AM revealed she expected staff to assist the resident with eating with the resident in an upright position.	F 309		
F 312 SS=E	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, staff interview, and policy and procedure review, the facility failed to ensure five (#39, #46, #65, #68, #70) of 11 sample and two (#33, #53) non-sample residents who were dependent for care, received assistance in the areas of personal hygiene and/or nutrition and dining. The findings were: 1. Review of the 9/21/05 significant change Minimum Data Set (MDS) assessment revealed resident #46 was frequently incontinent of bladder and required extensive assistance with toileting. Review of the 9/20/05 Resident Assessment Protocol (RAP) summary documented the	F 312	The facility will ensure that 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. 1(A) All nursing staff will receive in-servicing on proper pericare now and annually. (B) Caregivers of Resident #46 and Resident #53 will be assessed and instructed individually on proper pericare. The charge nurse will monitor and provide education pertaining to proper pericare when caring for these residents and all others. 2(A) All staff will be in-serviced on proper feeding assistance now and on an annual basis to include proper cueing and encouragement. (B)Resident #39 will be cued and encouraged to eat at all meals. (C) Dining room changes have been implemented to better meet the needs of residents requiring assistance. (D) Resident #70 is receiving consistent cueing to stay awake during meals and DR changes have been made to take advantage of her brief awake periods. (E) Resident #33 is receiving cueing to eat and encouragement for greater intake. (F) Resident #68 will be assessed individually for assistance in providing appropriate bite sizes and	

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F 312	Continued From page 11 resident used incontinence briefs at all times and required "good pericare [perineal care] at least every shift and after each incontinence episode." Observation on 1/23/06 at 3:48 PM revealed the resident's disposable brief was saturated with urine. Continued observation revealed certified nurse aide (CNA) #15 cleansed the resident's buttocks and the back of his/her upper thighs but did not cleanse the front perineal area which also had contact with the urine soaked brief. Interview with CNA #15 at that time revealed the front perineal area was not cleansed because she was unable to reach through the resident's legs to cleanse the area. Interview with the resident care director on 1/25/06 at 11:20 AM revealed the director's expectation was that during perineal care, staff should cleanse all skin areas that have come in contact with urine. 2. On 1/23/06 at 4:05 PM observation showed licensed practical nurse (LPN) #31 provided perineal care for non-sample resident #53 who was incontinent. The LPN cleansed the resident's buttocks, then cleansed the perineal area using a back and forth motion with the same portion of the wipe. The LPN discarded that wipe and repeated the cleansing process using a back and forth motion with the same portion of the second wipe. According to the facility's policy and procedure, "Perineal Care," from the 2002 Springhouse Corporation, cleanse "from the front to the back of the perineum" using a "clean section...for each stroke..." This prevents "intestinal organisms from contaminating the urethra..." 3. Observation of resident #39 on 1/23/06 at 5:56 PM revealed the resident was confused, and unable to identify his/her seat in the dining area.	F 312	completion of swallowing of food between bites, giving fluids as needed to aid in the ease of swallowing. (G) Resident #39, #70, #33 and #68 will be monitored by the nurse in charge at all meals to ensure appropriate assistance is provided. 3(A) QM process will be implemented to monitor resident needs of activities of daily living. The Patient Care Director will monitor this process monthly and report quarterly to the PI Steering Committee	3/11/06

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F 312	Continued From page 12 Staff showed the resident where his/her seat was and served the resident the evening meal. Although the resident did take bites of the meal, at 6:05 PM (nine minutes later) the resident stood, and asked staff what room was his/hers. Staff did not cue or encourage the resident to eat more or offer an alternative. The resident left the dining room. A second observation on 1/24/06 at 7:59 AM revealed the resident entered the dining room and again required direction to his/her seat. At 8:01 AM the resident was served breakfast. Observation from 8:07 to 8:22 AM revealed a staff member cued and encouraged the resident to eat and s/he did. Observation revealed the resident left the dining room at 8:22 AM but returned at 8:41 AM and, with encouragement, ate more breakfast. Review of the resident's care plan (start date of 9/14/05) revealed the resident required supervision for eating and had a goal to consume 75% of his/her meal, 75% of the time. The plan instructed staff to encourage intake due to the resident's confused periods. 4. Review of the 9/1/05 significant change MDS assessment revealed resident #70 had severe cognitive impairment, rarely understood what was said to him/her, and required limited assistance with eating, defined as "resident highly involved; received physical help in guided maneuvering..." during the last 7 days over all shifts. On the 12/1/05 quarterly MDS assessment, the facility documented the resident "sometimes understands (responds adequately to simple, direct communication)" and required supervision (oversight, encouragement or cueing) with eating. According to the 12/1/05 care plan, the resident required assistance from staff with meals. The following concerns regarding staff assistance	F 312		

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F 312	Continued From page 13	F 312		

during the evening meals were identified:

a. Observation on 1/23/06 showed staff brought the resident into the dining room at 5:30 PM. Observation revealed the resident fell asleep shortly after s/he was seated at the table. At 5:48 PM staff woke the resident, served the meal, and left. By 6:03 PM, the resident was again sleeping and continued to sleep until 6:14 PM. Observation revealed staff provided no assistance for 26 minutes (from 5:48 PM to 6:14 PM) after the meal was served. At 6:16 PM the resident ate the potatoes after being cued by staff. At 6:18 PM the resident was looking around but not eating. Staff did not cue the resident until 6: 21 PM; the resident did take a bite, tried to drink pureed plums, then slept. At 6:23 PM staff woke and cued the resident to take a bite. At 6:27 PM the resident was eating independently.

b. Observation on 1/24/06 at 5:30 PM showed the resident was sleeping at the dining room table. At 5:46 PM licensed practical nurse (LPN) #35 woke the resident, served his/her meal, and left; the resident responded when awakened but kept his/her eyes shut. At 5:50 PM LPN #31 unwrapped the silverware and gave it to the resident. The LPN encouraged the resident to eat, then left. The resident did not open his/her eyes or attempt to eat, but sank lower in the wheelchair. At 5:53 PM a CNA woke the resident, cut up the sandwich, and gave the resident a bite of fruit after the resident refused the sandwich. The CNA worked to wake the resident for two minutes and got him/her to start eating independently. However, the CNA left and the resident went back to sleep. The resident slept until 6:07 PM when a CNA tried to awaken the resident, but sat back down after the resident mumbled a response. Staff shook the resident's shoulder for 5 to 17 seconds at 6:08 PM, 6:13

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F 312	Continued From page 14 PM, 6:24 PM, 6:27 PM; 6:30 PM, 6:31 PM, and 6:34 PM, but left each time after the resident mumbled something. After 5:53 PM the resident never opened his/her eyes or raised his/her head and staff did not attempt to wake the resident for the remainder of the meal. 5. Review of the 10/12/05 significant change MDS assessment for resident #33 showed s/he was independent in eating and only required set up help. However, review of the 11/11/05 care plan showed s/he required set up help and cueing for meals, and at times required assistance. Further review revealed staff were to "encourage" the resident to try foods offered. The following concerns were identified: a. Observation on 1/23/06 revealed the resident was served his/her meal at 5:57 PM, but did not eat anything until 6:13 PM when s/he took a few bites of the plums and the sherbet. The resident did not eat any of the Salisbury steak, hominy, or potatoes. The observation ended at 6:28 PM and during the 31 minute observation there was no cueing or encouragement from the staff. Review of the meal intake record showed the resident ate 15% of this meal. b. Observation of the evening meal on 1/24/06 revealed the resident received his/her meal at 5:55 PM. Observation from 5:55 PM until 6:48 PM (53 minutes) revealed the resident ate approximately one half of the sandwich, and all of the ice cream (approximately 2 ounces). Observation during this time revealed staff did not provide any cueing or encouragement for the resident. Review of the meal intake record showed the resident ate 35% of this meal. 6. Interview with the resident care director on 1/25/06 at 11:20 AM revealed sometimes there	F 312		

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F 312	Continued From page 15 were not enough qualified staff in the dining area, particularly during the evening meal, to cue and assist residents with their meals. 7. According to the facility's 8/04 policy and procedure, "Meal Service," nursing personnel "will assist in the prompt feeding of residents requiring any level of assistance." 8. Observation in the dining room on 1/24/06 at 8:25 AM revealed CNA #5 assisted resident #68 with breakfast. The CNA fed the resident three large tablespoons of cereal in a period of approximately 90 seconds. After the third spoonful of cereal, the resident vomited a large quantity of undigested food onto himself/herself and onto the dining table. S/he repeatedly coughed and sneezed to clear his/her mouth and nose of emesis. An overheard interview from CNA #5 revealed "...I guess I fed him [her] too much too fast." Review of the current care plan dated 9/30/05 revealed the following caution, "Be aware that he [she] is using Exelon and Wellbutrin...Welbutrin can also cause taste changes, dry mouth, and stomatitis." Review of the 2005 edition of the PDR (Physician's Desk Reference) Nurse's Drug handbook revealed Wellbutrin is known to cause dysphagia (difficulty in swallowing). 9. Review of the 9/29/05 and 12/29/05 significant change MDS assessments for resident #65 revealed s/he required extensive assistance of one staff member with eating. Observation of the breakfast meal at 8 AM on 1/24/05 revealed CNA #5 was assisting the resident and also resident #68 who was seated beside him/her. Observation at 8:25 AM revealed resident #68 became ill and at 8:35 AM, CNA #5 assisted him/her out of the	F 312		

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F 312	Continued From page 16 dining room. Observation revealed resident #65 was left unattended for approximately 5 minutes. At 8:40 AM a second CNA wheeled the resident back to his/her room without first asking or establishing whether or not the resident was finished with his/her meal.	F 312		
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide restorative services to prevent decline in functioning for 1 (#52) of 13 sample residents. The findings were: Observation of resident #52 on 1/23/06 at 3:05 PM revealed his/her left hand was contracted. Review of the 4/28/05 significant change and the 7/28/05 and 10/27/05 quarterly Minimum Data Set (MDS) assessments revealed s/he had partial loss of the left arm and hand. Review of the 1/12/05, 4/12/05, 7/25/05, and 10/25/05 restorative nursing assessments revealed the resident was on the level one resorative program. Review of the restorative care plan dated 10/27/05 revealed the resident required passive range of motion (PROM) to the upper and lower	F 318	The facility will ensure that a resident receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. 1(A) All certified nursing assistants will be in-serviced on appropriate range of motion services. (B) Resident #52 is receiving daily PROM to the upper and lower extremities as per plan of care. (C) Resident #52 will be reassessed and care plan changes made if appropriate on range of motion needs. 2(A) QM process will be implemented to monitor comprehensive assessments of resident needs. The Patient Care Director will monitor this process monthly and report quarterly to the PI Steering Committee 3/11/06	

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F 318	Continued From page 17 extremities during dressing and undressing with five repetitions each time. The following concerns were identified: a. Review of the 1/18/06 14-2200 (2 PM to 10 PM) nurses notes revealed "Lt hand is contracted and has an odor..." b. Review of restorative records revealed there was no evidence the resident received the PROM as directed c. Interview with the director of nursing on 1/25/06 at 5:15 PM confirmed there was no evidence the PROM was provided for the resident.	F 318		
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, staff interview, and review of policies and procedures, the facility failed to assure possible accident hazards were prevented. One of three medication carts was left unlocked on three separate occasions. The findings were: Observation on 1/23/06 at 4:02 PM revealed a medication cart on the 400 hall was left unlocked for three minutes. The licensed practical nurse (LPN), employee #31, was out of visual contact with the cart for that time period and a visitor passed within reach of the cart. Observations on 1/24/06 at 7:18 AM and 7:25 AM also revealed the registered nurse (RN) on the 400 hall,	F 323	The facility will ensure that the resident's environment remains as free of accident hazards as possible. 1(A) All licensed nursing staff will review the facility policy of "Safe Medication Practices." (B) All medication carts will be locked when out of visual contact of the administering nurse. (C) Monitoring by supervisory staff using PI requirements will ensure compliance. 2(A) QM process will be implemented to monitor Safe Medication Practices. The Patient Care Director will monitor this process monthly and report quarterly to the PI Steering Committee	3/11/06

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F 323	Continued From page 18 employee #45, left the cart unlocked while she was out of visual contact with it. At 7:18 AM the RN was in a resident's room for one minute while the cart remained in the hallway. At 7:25 AM the cart was outside the dining room where five residents and several staff members had access to it. The cart contained oral, topical, ophthalmic (eye), and injectable medications. On 1/24/06 at 5:20 PM, the chief nursing officer and resident care director confirmed the medication cart should be locked when unattended. According to the facility's 10/05 policy and procedure, "Safe Medication Practices," medications "will be stored securely to prevent access or tampering by patients, visitors, and unauthorized staff." Review of Mosby's 3 rd edition of Nursing Interventions & Clinical Skills, 2004, by Elkin, Perry, and Potter confirmed "medication carts must be kept locked when unattended."	F 323		
F 367 SS=E	483.35(e) THERAPEUTIC DIETS Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, review of the menu, and staff interview, the facility failed to provide the physician ordered calorie controlled diabetic diets for 9 (#7, #13, #29, #43, #53, #58, #59, #69, #74) of 16 diabetic residents for one day's menu. The findings were: Review of the 1/24/06 menu showed 1200, 1500 and 1800 calorie diabetic diets were listed.	F 367	The facility will ensure Therapeutic diets will be followed as prescribed by the attending physician. 1(A) The registered dietitian will correct the 1200 and 1500 calorie diabetic diet to reflect the calorie range given for each diet order. (B) An in-service will be provided to the dietary staff to address the differences in all therapeutic diets to address portion sizes to ensure therapeutic diets are being followed correctly. (C) Resident #13, #59, #69, #58, #53, #74, #7, #29 and #43 diabetic diets have been corrected. 2(A) Periodic random checks will be done by the dietitians and dietary manager to monitor serving sizes on therapeutic diets provided. Findings will be addressed by the dietitian or dietary manager and reported to the PI committee quarterly. 3-11-06	

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F 367	Continued From page 19 However, the items and amounts to be served for each calorie specific diet was the same. The following concerns were identified: a. Review of physicians' orders revealed a diet order for a 1200 calorie diabetic diet for resident #13, a 1500 calorie diabetic diet for resident #59, a 1200 calorie diabetic diet for resident #69, and an 1800 calorie diabetic diet for resident #43. However, observation of the 1/24/06 lunch meal service at 11:48 AM revealed all four residents were served the same items and amounts of food (equivalent to 1800 calories). b. In addition, review of the physicians' orders for all residents on a diabetic diet revealed orders for a 1500 calorie diet for resident #58, a 1600 calorie diet for resident #53, a 1200 calorie diet for resident #74, a 1400 calorie diet for resident #7, and a 1200-1300 calorie diet for resident #29. Interview on 1/25/06 at 9 AM with the registered dietitian confirmed this day's menu was the same for all diabetic diets. She further confirmed this menu provided 1800 calories to all residents with a diabetic diet order, and it was an error on the menu that should be corrected. Additionally, she confirmed that all diet orders were current and correct.	F 367		
F 371 SS=F	483.35(h)(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 observation and staff interview, the facility failed to follow acceptable hand washing	F 371	The facility will ensure that food is stored, prepared, distributed and served under sanitary conditions. 1(A) Proper hand washing procedures were in serviced at the January 26, 2006 Dietary Staff Meeting. (B) The Dietary Manager will monitor all dietary staff for appropriate hand washing practices. If inadequate hand washing is observed immediate coaching will be done. (D) Hand washing signs will be posted at each hand washing sink. (E)All Dietary Staff will be	

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F 371	Continued From page 20 procedures, and failed to ensure cooking and serving equipment was maintained in good condition. The census was 75. The findings were: 1. Observation in the production kitchen on 1/24/06 at 10:30 AM revealed a dietary assistant preparing to cut apple pies. After putting on an apron, he went into the dry storage area and took a tray of cooked pies from a rack, he returned to a preparation area, and without washing his hands, he cut the pie and placed the pieces onto plates. He again went into the dry storage area and returned with a can of sliced apples and, without washing his hands, he portioned out the apples into bowls. Next, he took these servings of pie and apples to a reach-in cooler, returned to the preparation area, and placed the remaining sliced apples into a storage container. the dietary assistance then took the storage container into the walk-in refrigerator, and without washing his hands, assistant returned to the preparation area and continued to cut up another ready-to-eat apple pie. 2. Observation in the serving kitchen on 1/24/06 at 11:45 AM revealed cook #1 lifted the corner of the garbage can lid to discard a used paper towel. Continued observation revealed, without washing his hands, the cook opened a drawer, took out a scoop, and placed it into food on the steam table. 3. Interview on 1/24/06 at 8:55 AM with the dietary manager and the registered dietitian (RD) confirmed there was not a dietary policy and procedure to address hand washing. Additionally they both agreed that the cook should have washed his hands after handling the garbage can lid.	F 371	required to attend a ServSafe Food Safety class or comparable competency will be obtained. (F) The Dietary Manager will replace garbage receptacles that are more user friendly and prevent inappropriate handling. (G) Although there is not a specific policy for hand washing in the Dietary Policy Manual, the Infection Control Manual does include a hand washing policy which does adequately address this issue. Staff will be re-educated on this policy. 2(A) Dietary Manager will conduct a monthly observation of kitchen equipment and supplies to ensure safe and sanitary conditions of such. (B) Equipment that is cracked, pitted, stained, or otherwise deemed in poor condition will be replaced. Equipment including the identified trays, pitchers, measuring cups and knives that are in poor condition will be replaced. 3(A) A QM process will be implemented to monitor kitchen sanitation. The Dietitian will monitor this process monthly and the results will be reported quarterly to the PI Steering Committee. 3-11-06	

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F 371	Continued From page 21 According to Food Code 2005, U.S. Public Health Service, 2-301.14: Food employees shall clean their hands and exposed portions of their arms...immediately before engaging in food preparation...(I)After engaging in other activities that contaminate the hands. 4. Observation in the production kitchen on 1/24/06 from 10:10 AM to 11:10 AM revealed 84 tan/brownish plastic trays and 36 green trays (used in a food transport unit) that were cracked, scraped and stained. The trays also had broken and chipped edges and corners. Observation revealed these trays were used daily. Additionally, in the preparation area, there were two knifes with a yellowish brown build-up in the grooves of the handles. 5. Observation in the serving kitchen on 1/24/06 from 11:15 AM to 11:58 AM revealed a gray plastic bin with clean drinking glasses inside. As cook #2 took glasses out to fill them, it was noted the sides and bottom of the inside of the bin were stained with a yellowish brown color. In addition, there were four plastic beverage pitchers on a shelf with a substantial number of stains and scratches on the interiors. Two plastic 8 cup measures were also noted to have many small cracks and fissures on the interior surfaces. 6. Interview and additional observation on 1/25/06 at at 9 AM with the dietary manager and the RD confirmed the aforementioned equipment was in poor condition and needed to be replaced. According to Food Code 2005, U.S. Public Health Service, 4-202.11: (A) Multiuse food-contact surfaces shall be...(2) free of breaks, open seams, cracks, chips, inclusions, pits, and similar	F 371		

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F 371	Continued From page 22 imperfections...	F 371		
F 432 SS=E	483.60(e) STORAGE OF DRUGS AND BIOLOGICALS In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to ensure oral narcotic medications for all shifts, which were contained in individual cassettes, were kept under two separate locks at all times. This involved three of three medication carts when the carts were out of the locked medication rooms. The findings were: On 1/25/06 observation of the 400 hall medication cart at 10:37 AM, the 300 hall medication cart at 10:47 AM, and the 200 hall medication cart at 10:55 AM showed oral narcotic medications for all three shifts were kept in individual cassettes in	F 432	The facility will provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse. 1(A) All medication carts will be upgraded with separately locked and permanently affixed locking drawers for the exclusive storage of controlled drugs. (B) All nursing staff will be in-serviced on the use of the double locking system. 2(A) A QM process will be implemented to monitor safe storage of controlled drugs. The Patient Care Director will monitor this process monthly and report quarterly to the PI Steering Committee 3-11-06	

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F 432	Continued From page 23 the medication cart drawers along with non-narcotic medications. These narcotics included Vicodin, Hydrocodone, Phenobarbital, Lorazepam, MS Contin, Percocet, Ambien, Halcion, Darvocet, Endocet, Tylenol with Codeine, and Clorazepate. Although observation showed a separate locked compartment was available on each cart, on 1/25/06 at 10:37 AM licensed practical nurse (LPN) #34 stated, and observation of each cart at the aforementioned times confirmed, that only the topical, sublingual, and injectable narcotics were kept there. At 10:45 AM on 1/25/06, the resident care director stated narcotics should be kept under two locks. However, she also stated she was unaware they were under only one lock when the medication cart was unattended and not in the locked medication room. According to the facility's policy and procedure, "Control of Scheduled Medications," revised February 2005, scheduled medications will be secured "in the double-lock system at all times unless a dose is being prepared or a count is in progress."	F 432		
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.	F 441	F-441 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. The facility will establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.	

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F 441	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of policies and procedures, and review of a report prepared by The Wyoming Department of Health, Epidemiology Section, the facility failed to monitor compliance with infection control measures intended to prevent the transmission of potentially infectious agents in the facility. The census was 75. The findings were: 1. Interview with the facility infection control practitioner on 1/25/06 at 10 AM revealed there was not an active program to monitor staff compliance with infection control policies and procedures. Specifically, she stated hand hygiene was not monitored among staff to ensure compliance with established procedures. 2. Observation in the dining room on 1/24/06 at 8:25 AM revealed resident #68 repeatedly regurgitated food on himself/herself, on the dining table, on the plates and utensils of the other residents seated at the table, and in the general area surrounding his/her table. Observation revealed certified nurse aide (CNA) #5 attempted to contain the emesis in the resident's clothing protector but the resident vomited again and additional towels were needed to clean the resident's face. At 8:28 AM observation revealed CNA #5 left the table to find additional towels and napkins and, during her absence, the resident repeatedly coughed and sneezed to clear his/her mouth and nose. Observation revealed these actions projected food and spittle onto the table, onto a container holding condiments, and onto adjacent residents' plates, glasses, and utensils. At 8:35 AM the resident was assisted from the table and taken to his/her room by CNA #5, which	F 441	1(A) A Facility policy and procedure will be implemented to address proper infection control procedures in the event of inadvertent contamination from body fluids in the dining room. (B) Applicable staff will be educated on this new policy. (C) Resident #68 will be monitored by the charge nurse for choking/regurgitation episodes and removed from the dining room if possible to prevent contamination. Staff will be educated on the need to feed this resident slowly and with small bites to assist him with swallowing difficulties. 2 (A) The facility will comply with guidelines of governing agencies pertaining to control of infectious disease by following policies. (B) The "Resident Activity Restrictions for Infection Prevention" policy in place will be amended to clarify using guidelines provided by governing agencies. (C) The department supervisor will monitor staff in their area(s) utilizing appropriate precautions as put forth in the guidelines. (D) In-servicing will be performed by the Infection Control Coordinator, department supervisors and other individuals as deemed appropriate. Participants will be documented. 3(A) A performance improvement hand hygiene program will be implemented by the Infection Control Coordinator. 4(A) A QM process will be implemented to monitor control of infections. The Infection Control Coordinator will monitor this process monthly and report quarterly to the PI Steering Committee 3-11-06	

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F 441	Continued From page 25 left the table unattended. During this time one of the two residents seated at the soiled table continued to eat food contaminated by the emesis and spittle. The other resident was unable to eat without assistance but was left at the table. Observation revealed CNA #5 returned to the table at 8:40 AM. At this time, the CNA pushed the soiled chair under the table but did not clean it. During the entire observation from 8:25 AM through 8:40 AM, observation revealed no staff member cleaned the emesis from adjacent residents, nor was the resident at the table prevented from eating or drinking food stuffs in the area that were contaminated. Interview with the infection control practitioner on 1/25/06 at 10 AM confirmed the plates, glasses, utensils, table, chair and surrounding area should have been cleaned immediately. 3. Interview with the infection control practitioner on 1/25/06 at 10 AM revealed there had been a recent outbreak of gastroenteritis in the facility with both residents and staff being ill. Review of the facility report entitled, "Gastroenteritis in a Long Term Care Facility (LTCF) in Goshen County, Wyoming, 2005" prepared by the Wyoming Department of Health, Epidemiology Section, revealed that during the recent outbreak, symptomatic infection was reported in 41 of 75 residents (54.7%) and in 10 of 50 staff (20%) during the interval from 11/20/05 to 12/12/05. The following concerns were identified: a. Interview with the infection control practitioner on 1/25/06 at 10 AM revealed she believed the gastroenteritis was probably caused by a viral pathogen (Noroviruses). She further stated the infected person was likely contagious for up to 72 hours after symptoms ended. However, she stated staff were allowed to return	F 441		

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F 441	Continued From page 26 to work following the cessation of symptoms (reported to be diarrhea, nausea, vomiting); the prompt return was attributed to "...short staffing at the time." All 10 of the infected staff were involved in direct resident care. b. Interview with the Chief; Emerging Diseases/Health Statistics Section, Wyoming Department of Health on 1/30/06 at 9:35 AM, indicated the acute gastroenteritis was likely caused by a viral pathogen (Noroviruses). He further stated the standard recommendation for staff returning to work after symptomatic viral gastroenteritis was to remain out of work for a period of 3 days after diarrhea and vomiting have subsided. The basis for the recommended practice was the high likelihood of individuals to continue to shed infectious viral agents (remain contagious) for 48 to 72 hours after symptoms have ended. The same recommendation was provided to the facility in the form of a specific document, "Guidelines for the Control of a Suspected or Confirmed outbreak of Viral Gastroenteritis in a Nursing Home" prepared by the Wyoming Department of health. 4. On 1/23/06 at 3 PM observation of CNA #10 revealed she assisted resident #65 to the toilet. Further observation revealed she did not wash her hands prior to assisting the resident nor did she wear gloves. Interview with the CNA at the time of the observation confirmed she should have washed her hands and worn gloves. Review of the facility's policy and procedure on hand hygiene, undated, revealed "Hands must be washed or sanitized before and after contact with any patient or items in the patient environment." In addition, interview with the infection control coordinator on 1/25/06 at 11:15 AM confirmed staff should wash their hands before and after	F 441		

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F 441	Continued From page 27 resident or patient contact. 5. Observation on 1/24/06 at 10:55 AM showed licensed practical nurse (LPN) #46 washed her hands, obtained paper towels, turned off the faucet, then dried her hands on the same paper towels. According to the facility's undated policy and procedure titled "Hand Hygiene," hands should be first dried with a disposable towel, then "use towel to turn off the faucet."	F 441		
F 444 SS=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 observation, staff interview, and review of facility policies and procedures, the facility failed to ensure staff followed handwashing protocols during two random observations. The findings were: 1. On 1/23/06 at 3 PM observation of certified nurse aide (CNA) #10 revealed she assisted resident #65 to the toilet. Further observation revealed she did not wash her hands prior to assisting the resident, nor did she wear gloves. Interview with the CNA at the time of the observation confirmed she should have washed her hands and worn gloves. Review of the facility's policy and procedure on hand hygiene, undated, revealed "Hands must be washed or	F 444	F-444 The facility will ensure that staff prevent the spread of infection by utilizing accepted professional practices of hand washing. This will be done by: 1(A) A performance improvement hand hygiene program will be implemented by the Infection Control Coordinator. This program will include random monitoring of staff technique on washing, use of hand sanitizers, and the collection of hand cultures. (B) Staff will be educated on proper hand washing techniques by the Infection Control Coordinator and supervisory staff within each department. (C) The department supervisor will monitor staff in their area(s) utilizing appropriate precautions as put forth in the guidelines. (D) In-servicing will be performed by the Infection Control Coordinator, department supervisors and other individuals as deemed appropriate. Participants will be documented. 2(A) A QM process will be implemented to monitor hand hygiene practices. The Infection Control Coordinator will monitor this process monthly and report quarterly to the PI Steering Committee 3-1-06	

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F 444	Continued From page 28 sanitized before and after contact with any patient or items in the patient environment." In addition, interview with the infection control coordinator on 1/25/06 at 10 AM confirmed staff should wash their hands before and after resident or patient contact. 2. Observation on 1/24/06 at 10:55 AM showed licensed practical nurse (LPN) #46 washed her hands, obtained paper towels, turned off the faucet, then dried her hands on the same paper towels. According to the facility's undated policy and procedure titled "Hand Hygiene," hands should be first dried with a disposable towel, then "use towel to turn off the faucet."	F 444		
F 465 SS=F	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the beauty shop sink, various areas of the production kitchen, and the floor in two resident rooms were maintained in a safe, functional, sanitary and comfortable manner. The findings were: 1. Observation of the sink in the beauty shop on 1/24/06 at 9:30 AM revealed the spray hose was extended and lying in the sink. Further inspection revealed there was no back flow prevention device on the hose or under the sink on the water	F 465	F 465 -- The facility will ensure a safe, functional, sanitary, and comfortable environment. This will be done by: 1(A) A back flow prevention device will be placed on the hose or under the sink. To prevent this deficiency in the future the staff will be informed of the importance of such devices. 2 (A) The power cable will be properly covered. Also, the area noted in the kitchen will be painted and tiled appropriately. (B) The missing tiles will be replaced in the kitchen. (C) The sink will be repaired and the surrounding wall painted. (D) The sink located next to the steam table will be cleaned and replaced if necessary. The staff will clean this sink more often to avoid the build up of hard water deposits in the future. (E) Dietary	

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F 465	Continued From page 29 intake valves to prevent contaminated water from entering the potable water system. Interview with the maintenance technician on 1/25/06 at 8:36 AM verified the beauty shop sink did not have a back flow prevention device. 2. On 1/24/06, the following concerns were noted in the production kitchen and dish room. a. Observation at 10:10 AM revealed the wall under the garbage disposal sink was damaged. The wall contained a metal plate with a power cable which connected to the garbage disposal unit. On the wall below this plate was an approximately 6-inch piece of dry wall or paint that was coming away from the wall. Additionally, tiles were missing at the base of the wall for an approximate two to three foot section. b. Observation at 10:10 AM revealed the wall next to the walk in freezer door was missing two tiles on the baseboard section of the wall. In addition, two tiles at the corner of this wall were missing. c. Observation at 10:20 AM revealed a hand washing sink in the dishroom area that was breaking away from the wall. There were cracks and chipped paint where the sink was connected to the wall. In addition, the wall on the right side of the sink was damaged. d. Observation at 10:15 AM revealed a sink located next to a steam table and across from the oven range unit was corroded with a green and white accumulation of hard water deposits. The deposits were on both the hot and cold water handles, as well as on the faucet. 3. Interview and additional observation with the dietary manager and registered dietitian on 1/25/06 at 9 AM of the aforementioned areas confirmed they should be repaired, and the hard	F 465	Manager and Maintenance Manager will conduct now and annual inspection of the condition of walls, floors, and major equipment. (F) Maintenance will be notified by Dietary Manager immediately with a work order if any deficiencies are found throughout the year. 3(A) Lifted tile seams in room #'s 413 and 211 will be repaired or placed. The flooring will be monitored by the Plan Operations Department on a regular basis for further areas that need repair or replacement. 4(A) The environment will be monitored by the Plant Operations Department on a monthly basis and reported to the PI Steering Committee by the Plant Operations Manager quarterly to prevent this deficiency in the future.	3-11-06

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F 465	Continued From page 30 water deposits should be cleaned. 4. General observations of the facility were done on 1/24/06 at 9:04 AM. The observations revealed seven lifted tile seams in room 413 and two lifted tile seams in room 211. The areas were of rough texture and raised approximately 1/4 inch. Interview with the maintenance technician on 1/25/06 at 8:36 AM revealed the facility has had problems with the tiles lifting.	F 465		
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 medical record review, the facility failed to ensure licensed staff performed tasks for which they were qualified and which were within their scope of practice. The findings were: Review of the January 2006 medication administration record (MAR) for resident #52 revealed s/he had an order for "safgel, selesite, intrasite apply to affected area (buttock and periarea) lightly coat apply prn at least tid". Further review of the MAR revealed this treatment was only provided once daily at bedtime instead of the prescribed three times per day. Interview with the resident care director on 1/25/06 at 2 PM	F 492	F 492--The facility will operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. 1(A) All licensed nursing staff will be in-serviced on the expectation that all wound treatments must be approved and ordered by the resident's PCP. (B) A new policy will be implemented on professional standards of practice/scope of practice. Appropriate staff will be educated on this policy. (C) Resident #52's wound treatment has been reassessed and an order clarification for proper treatment has been noted by the PCP. 2(A) A QM process will be implemented to monitor professional standards/scope of practice. The Patient Care Director will monitor this process monthly and report quarterly to the PI Steering Committee.	3-11-06

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F 492	Continued From page 31 revealed the original physician's order was for cavilon every seventy-two hours at bedtime. She stated nursing changed the physician's order to safgel, selesite, and intrasite. She further stated when it was written the intent was for the medications to be applied as needed, but was misinterpreted by the nurse who wrote the order for as needed at least three times daily. The resident care director confirmed the physician was not contacted in regard to the change in orders. Review of the Wyoming State Board of Nursing Nursing Practice Act, July 2005 Administrative Rules and Regulations, November 2003 revealed nurses must function under the direction of a physician.	F 492		