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Healthcare Licensing and Surveys

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. BUILDING _____ B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER	777 AVENUE H POWELL, WY 82435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: DON- Director of Nursing IP- Infection Preventionist MAR- Medication Administration Record MDS- Minimum Data Set PRN- As Needed RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	F 253 The facility shall provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This will be accomplished by, A. The visible dark cracks in the floor on the West Unit will be repaired. A. The wallpaper in the hallway near room #302 will be repaired. A. The wallpaper tears in the television room across from the North Nursing Station will be repaired. A. The Baseboards by the floor near the North Nursing Station has been replaced. A. The wallpaper tears in room #110 will be repaired. A. The flooring in the bathroom of room #110 will be repaired A. The flooring in the bathroom of room #114 will be repaired. A. The wallpaper tears in room #303 will be repaired. B. All residents have the potential to be affected by the failure to ensure that housekeeping and maintenance services are provided to maintain sanitary, orderly, and comfortable interior.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES 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 provide adequate maintenance to ensure 3 resident rooms (#110, #114, #303), 2 of 5 hallways, and 2 of 3 television rooms (South Nursing Station, West Nursing Station) were in good repair. The findings were: During a tour of the facility on 2/27/13 from 8:35 AM through 9:10 AM the following issues were identified that had the potential to affect the facility's ability to clean the resident environment: 1. In the secure unit (West Nursing Station) television room, 4 separate visible dark cracks were observed in the floor that affected a total of	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nicole Osteymiller — TITLE: Administrator — (X6) DATE: 4/2/2013

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.

4-3-13 This plan of correction was accepted as written. Nicole Osteymiller, Adm. was notified at 10:10 AM. RaeAnne White

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F 253	Continued From page 1 35 tiles.(12 inch by 12 inch). In the secure unit circular hallway across from room #215, 2 separate dark cracks were observed in the floor that affected a total of 13 tiles (12 inch by 12 inch). 2. During an observation near the North Nursing Station, in the hallway across from room #302, a tear was identified in the wall 1 foot from the floor and 2 inches across. In the television room across from the North Nursing Station, an observation showed small tears in the back wall 3 feet above the floor that measured 93 inches across. 3. During an observation by the North Nursing Station before the start of the 400 hallway, 2 walls each had a missing baseboard by the floor. One measured 29 inches across, and the other measured 80 inches across. 4. During an observation in room #110 (near the South Nursing Station) by bed A, a 2 inch tear was noted in the wall. On the wall behind a recliner by the bed, the observation showed a 20 inch by 16 inch area of multiple tears on the wall. Observation in the adjoining bathroom revealed a 24 inch by 24 inch brown-stained area on the floor in front of the toilet. To the left of the stained area, there were various blackened scrape lines 34 inches by 14 inches across. During an observation in room #114 (near the South Nursing Station), 4 visibly brown-stained 12 inch by 12 inch tiles were noted in the resident's bathroom in front of the toilet. During an observation in room #303 (near the North Nursing Station) by bed B, a 6 inch by 1 inch tear on the wall at 5 feet in height was noted.	F 253	F 253 Cont. C. Education will be provided to Nursing, Maintenance, and Housekeeping staff regarding the importance of maintaining the resident's environment including reporting cracks in flooring and tears in the wallpaper. Ongoing maintenance will be performed to ensure a sanitary, orderly and comfortable environment. The Maintenance Director or designee will conduct weekly rounds throughout the Care Center to observe for areas in need of repair D. The Maintenance Director will aggregate monthly data and report the results to the Administrator and Care Center Medical Director monthly and to the Quality Council Quarterly. The Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date F 309 The facility will ensure that pain relief interventions are monitored for effectiveness. This will be accomplished by, A. All nursing staff will be instructed to assess and document the effectiveness of pain medication following administration to resident #7 within 2 hours of medication administration.	4/12/2013

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F 253	Continued From page 2 5. During an interview with maintenance staff #1 on 2/28/13 at 10 AM, he acknowledged the issues identified by the surveyors on tour had the potential to affect facility cleanliness. He stated an outside contractor was working to remodel resident rooms. However, he further stated the facility had no specific plan or timeline to address these issues.	F 253	F 309 Cont. A. All nursing staff will be instructed to assess and document the effectiveness of pain medication following administration to resident #10 within 2 hours of medication administration B. All residents have the potential to be affected by failure to assess and document the effectiveness of pain medication following administration. C. All nursing staff will be educated to assess and document the effectiveness of pain medication following administration. Staff will also be educated on the use of a new reassessment tool that will be implemented for assessing and documentation of effectiveness after pain medication administration. The Nursing Director will conduct random monthly audits to ensure nursing staff assesses, reassesses, and documents pain medications appropriately. D. The Nursing Directors will aggregate the random monthly audit and report results to the Administrator and Care Center Medical Director monthly and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 by: Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure pain relief interventions were monitored for effectiveness for 2 of 12 sample residents identified as experiencing pain (#7, #10). The findings were: 1. Review of the medical record for resident #7 showed diagnoses including colon resection with colostomy, cancer, peripheral vascular disease, and arthritis. Review of the 2/7/13 admission MDS assessment showed the resident received PRN pain medications. Review of the 2/1/13 physician orders showed the resident had orders for hydrocodone/APAP 5/325, 1-2 pills by mouth	F 309	Completion Date	4/13/2013

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F 309	Continued From page 3 every 4 hours as needed for pain. Review of the February 2013 MAR and progress notes, showed the resident received pain medications on 2/2/13, 2/4/13, 2/5/13, 2/6/13, 2/8/13, 2/9/13, 2/10/13, 2/11/13, 2/12/13, 2/13/13, 2/14/13, 2/20/13, 2/23/13, and 2/24/13; however, there was no documentation of the effectiveness of the pain medication following administration. 2. Review of the medical record for resident #10 showed diagnoses including cerebral vascular accident, arthritis, peripheral neuropathy, gastroesophageal reflux disease, and atonic bladder. Review of the 12/25/12 quarterly MDS assessment showed the resident received PRN, and scheduled pain medications. Review of the 2/1/13 physician orders showed the resident was ordered oxycodone IR Tab 10-30 mg by mouth every 4 hours as needed for pain. Review of the February 2013 MAR and progress notes, showed the resident received pain medications on 2/1/13, 2/2/13, 2/3/13, 2/4/13, 2/5/13, 2/6/13, 2/7/13, 2/8/13, 2/9/13, 2/10/13, 2/11/13, 2/12/13, 2/13/13, 2/14/13, 2/15/13, 2/16/13, 2/17/13, 2/18/13, 2/19/13, 2/20/13, 2/21/13, 2/23/13, 2/24/13, 2/25/13, 2/26/13 and 2/27/13, during this time the resident received 75 doses of oxycodone IR. However, the facility failed to document the effectiveness of the pain medication for 25 doses (33.33%). During an Interview with DON #1 on 2/27/13 at 1:05 PM, she stated the facility expectation was for all PRN medications to be documented in the nursing notes after administration to document effectiveness of the medication. Review of the Pain Assessment and Management	F 309	F 441 1a. A. All Nursing, Housekeeping, and Maintenance staff will be instructed that the West Unit should not be used as a pass- through to get to the other units of the Care Center. Signs will be placed on the exterior of both West doors indicating that the West unit should not be used as a pass- through. Staff entering the Unit will be instructed to wash hands before entering and prior to leaving any isolated areas at all times and during any outbreaks. B. All residents have the potential to be affected by staff using the West Unit as a pass-through and the failure to wash hands before entering and prior to leaving any isolated areas containing an outbreak. C. Education will be provided to all Nursing, Housekeeping and Maintenance staff regarding the need to avoid using West as a pass-through and to perform appropriate hand hygiene before entering and prior to leaving any isolated areas containing an outbreak. The Nursing Director or designee will conduct random audits to ensure staff is not using West as a pass-through and that proper hand hygiene is being performed before entering and prior to leaving	

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F 309	Continued From page 4 policy, dated April 2011, showed the resident should be reassessed following every pain intervention and the assessment documented in the medical record.	F 309	F 441 Cont. isolated areas during containment. D. The Nursing Directors will aggregate the random monthly audit and report results to the Administrator and Care Center Medical Director monthly and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	1b. A. All Nursing and Housekeeping staff was required to read and sign guidelines that were implemented on 2/27/2013 provided by the Wyoming Department of Health for control of suspected outbreak of Acute Viral Gastroenteritis. Facility policy regarding infection prevention surveillance and reporting will be reviewed at the Infection Prevention Committee meeting on 3/25/13. Language will be developed to include in the policy to identify the procedure when an outbreak has been identified. B. All residents have the potential to be affected by the failure to ensure staff is aware of an outbreak and the appropriate precautions to prevent the spread of infection.	

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F 441	Continued From page 5 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 policies, procedures, and product label information, the facility failed to implement infection prevention processes to safeguard the health of residents and staff. Deficiencies were evident in the lack of timely and reliable surveillance activities during an outbreak of acute gastroenteritis (AGE), lack of appropriate precautions to prevent the spread of infections among residents and staff, failure to practice acceptable hand hygiene in 1 of 2 wound care observations and 2 of 2 meal observations, and failure to monitor the expiration of hand hygiene products on 1 of 4 units and 2 of 3 housekeeping carts. The findings were; 1. Interview with RN #2 while touring the facility on 2/25/13 at 2:30 PM revealed residents in the secure unit were currently experiencing an outbreak of AGE; the onset was stated to be 2/21/13 and 6 of 16 (37%) residents in the secure unit reported nausea, vomiting, and/or diarrhea. The RN further stated the secure unit was "isolated" from the remainder of the facility and symptomatic residents were not cohorted or otherwise restricted from moving throughout the secure unit. Subsequent observations and interviews revealed the following concerns: a. Between 2/25/13 and 2/27/13, staff were randomly observed to use the main hallway in the	F 441	F 441 Cont. C. All staff will be educated regarding the procedure to follow when an outbreak has been identified including the appropriate prevention measures to prevent the spread of infection. The Infection Prevention Nurse or designee will perform random monthly audits to ensure the appropriate procedure is followed in the case of an outbreak. D. The Infection Prevention Nurse Directors will aggregate the random monthly audit and report results to the Administrator and Care Center Medical Director monthly and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. **1c.** A. All contract staff will be educated when they pick up their contractor name badge that the West Unit should not be used as a pass-through to get to the other units of the Care Center. Signs will be placed on the exterior of both West doors indicating that the West unit should not be used as a pass-through. Contractors entering the Unit will be instructed to wash hands before entering and prior to leaving any isolated areas containing an outbreak.	

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F 441	Continued From page 6 secure unit as a shortcut to pass between two other units (200 hallway and 400 hallway). Further, housekeepers and their carts moved from the secure unit, to include the rooms of symptomatic residents, to other areas in the long-term care facility as well as a collocated acute care facility. Staff using the secure unit as a pass-through shortcut on 2/25/13 through 2/27/13 were not observed to perform hand washing before entering the unit nor when leaving the "isolated" area containing the AGE outbreak. b. Interview with housekeeper #3 in the secure unit on 2/27/13 at 10:40 AM revealed he was unaware there was an ongoing outbreak of diarrheal illness until informed by facility staff that same morning. He further acknowledged he had not been instructed to use any special precautions or environmental cleaning protocols appropriate for a potential viral gastroenteritis. The housekeeping staff working in the secure unit were not observed to perform hand washing when entering or leaving the area, nor was housekeeper #3 wearing gloves when observed on multiple occasions on 2/25/13 and 2/26/13. c. On 2/26/13 at 9:35 AM, 10:05 AM, and 1:50 PM, an outside painting contractor was observed passing through the secure unit to access the 400 hallway. He was further observed on 2/26/13 at 10:15 AM to enter several resident rooms on the secure unit, two of which belonged to symptomatic residents. He stated at the 10:15 AM observation that he was evaluating rooms he was contracted to paint the following week. The contractor was not observed to wash his hands before entering the secure unit, nor when he left the area. d. Observations on 2/25/13 (evening meal) and 2/26/13 (noontime meal) revealed direct care	F 441	F 441 Cont. B. All residents have the potential to be affected by contractors using the West Unit as a pass-through and the failure to wash hands before entering and prior to leaving any isolated areas containing an outbreak. C. Education will be provided to all contractors and the need to avoid using West as a pass-through and to perform appropriate hand hygiene before entering and prior to leaving any isolated areas containing an outbreak. The Nursing Director or designee will conduct random audits to ensure staff is not using West as a pass-through and that proper hand hygiene is being performed before entering and prior to leaving isolated areas during containment. D. The Nursing Directors will aggregate the random monthly audit and report results to the Administrator and Care Center Medical Director monthly and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. **1d** A. All nursing staff will be instructed to perform hand washing using soap and water prior to handling resident food. The staff will also be	

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F 441	Continued From page 7 staff involved with food preparation, serving, and eating assistance in the secure unit failed to wash their hands with soap and water prior to handling resident food. Residents known to have experienced nausea, vomiting, and/or diarrhea within the previous 5 days were among those individuals assisted by staff. e. During the 2/25/13 and 2/26/13 meal observations, none of the 16 residents in the secure unit were offered or assisted to wash their hands prior to eating. DON #1 stated in interview on 2/26/13 at 3:40 PM the facility had previously implemented a hand hygiene program for residents prior to meals, but acknowledged the practice was not presently in use. 2. Infection surveillance activities were reviewed with the IP on 2/27/13 beginning at 10:05 AM; these records revealed the program was principally based on passive data collection and failed to generate timely information on infections or antibiotic treatment. The lack of timely data collection contributed to the following concerns: a. Review of employee illness surveillance data on 2/27/13 and again on 2/28/13 revealed the facility had inconsistent and unreliable processes for identifying staff reporting with symptoms of AGE during the present outbreak. On 2/27/13 the IP reported to the survey team that 4 staff were sick with nausea, vomiting, and/or diarrhea, the last of which was noted on 2/10/13. Data reported by DON #1 to a State Epidemiologist the same day indicated 3 staff reported symptoms of AGE between 2/10/13 and 2/25/13. However, when "Sick Call Forms" provided by DON #1 on 2/28/13 were reviewed by state surveyors, the review revealed that 7 staff members had called in sick with symptoms	F 441	F441 Cont. instructed to offer and assist the residents to perform hand hygiene prior to eating. B. All residents have the potential to be affected by the staff's failure to wash their hands prior to handling food and offer the residents assistance prior to mealtimes. C. The Nursing staff will be educated to perform hand hygiene using soap and water prior to handling food and to offer and assist the residents to perform hand hygiene prior to mealtimes. The Nursing Director will conduct random audits to ensure the staff performs hand hygiene using soap and water prior to handling resident food and offers and assists the residents to perform hand hygiene prior to mealtimes. D. The Nursing Directors will aggregate the random monthly audit and report results to the Administrator and Care Center Medical Director monthly and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Ie A. All nursing staff will be instructed to perform hand washing using soap and water prior to handling resident food. The staff will also be	

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F 441	Continued From page 8 consistent of nausea, vomiting, and/or diarrhea between 2/20/13 and 2/25/13. b. Review of the medical record for resident #1 showed the resident was started on an antibiotic, ciprofloxacin, on 11/30/12 pending the results of a urine culture and sensitivity submitted the same day. Laboratory results dated 12/1/12 reported Escherichia coli was isolated from the resident's urine specimen and the isolate was resistant to ciprofloxacin. The resident continued to received ciprofloxacin until 12/4/12 when antibiotic therapy was changed to an effective antimicrobial agent. There was no documentation in the record to explain the 3 day delay in assessing the sensitivity report and changing antibiotics. c. The IP and DON #1 acknowledged in interview on 2/27/13 at 10:45 AM that current surveillance techniques were based on data summaries that were one or more weeks in retrospect. The IP further stated she collected culture reports and antimicrobial data on a monthly basis to summarize and report to the facility QAPI program. On 2/28/13 at 11:10 AM, DON #1 acknowledged in interview that data regarding sick staff was not actively reported to the IP and, further, information on employee illnesses could lapse a week or more in time before being reported to the IP. 3. Observation on 2/27/13 at 10:40 AM showed RN#1 completed wound care to 3 separate sites for resident #7. The RN failed to wash her hands prior to starting the procedure. The RN performed wound care and dressing changes to the left great toe, midline abdominal incision, and coccyx areas. The RN changed gloves as she completed each of the three sites, but did not wash her	F 441	F 441 Cont. instructed to offer and assist the residents to perform hand hygiene prior to eating. B. All residents have the potential to be affected by the staff's failure to wash their hands prior to handling food and offer the residents assistance prior to mealtimes. C. The Nursing staff will be educated to perform hand hygiene using soap and water prior to handling food and to offer and assist the residents to perform hand hygiene prior to mealtimes. The Nursing Director will conduct random audits to ensure the staff performs hand hygiene using soap and water prior to handling resident food and offers and assists the residents to perform hand hygiene prior to mealtimes. D. The Nursing Directors will aggregate the random monthly audit and report results to the Administrator and Care Center Medical Director monthly and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. **2a** A. The Infection Prevention Nurse is attending Care Center rounds Monday through Friday to obtain real-time data regarding infections, antibiotic use, and illness of staff and residents.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 9 hands prior to donning new gloves. Furthermore, the RN failed to wash her hands at the completion of the wound care prior to leaving the resident room. Interview on 2/27/13 at 2:30 PM with RN #1 revealed she was aware of the facility policy to wash hands between glove changes, but she was "working with the same resident and did not consider her hands contaminated." Review of the hand hygiene policy, dated November 2010 showed staff members' hands were required to be washed between glove changes as well as "...before and after touching dressings of wounds." 4. Observation while on tour of the facility on 2/25/13 between 3:30 PM and 4:30 PM revealed 2 of 3 housekeeping carts had containers of alcohol-based hand rub (ABHR) labeled with an expiration date of November 2011. During an interview with the IP on 2/26/13 at 9:45 AM she was informed of the expired product by the survey team. However, periodic observations on 2/26/13 and 2/27/13 revealed the expired ABHR containers remained available for use on housekeeping carts. Observation on 2/25/13 at 4:45 PM revealed 2 dispensers of ABHR, located at the nurses' station adjacent to the main entrance, lacked expiration dates for the product. Periodic observations on 2/26/13, 2/27/13, and 2/28/13 revealed the containers to be full in the morning and the contents diminished with use during the day. Interview with unit clerk #1 on 2/27/13 at 8:20 AM	F 441	F441 Cont. B. All staff and residents have the potential to be affected by failure to obtain real-time data regarding infections, antibiotic use, and illness of staff and residents. C. The Infection Prevention Nursing will attend Care Center rounds daily and document data on infections, antibiotic use, and illness of both staff and residents. She will develop a reporting tool in order to input this data for tracking and trending. The Infection Prevention Nurse will conduct random monthly audits to ensure real-time data is being tracked Monday through Friday. D. The Infection Prevention Nurse Directors will aggregate the random monthly audit and report results to the Administrator and Care Center Medical Director monthly and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. **2b** A. The Nursing staff will be instructed that the results for sensitivity reports should be phoned to the physician upon receipt and to document the notification and any orders as a result. B. All residents have the potential to be affected by the failure to assess and document reasons for delays in	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. BUILDING _____ B. WING _____	02/28/2013

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F 441	Continued From page 10 revealed housekeeping staff refilled the ABHR containers without regard to lot numbers or expiration date of the product. Interview with housekeeper #1 on 2/27/13 at 8:30 AM confirmed that the ABHR containers were refilled as needed with "GoGo" (brand name). Housekeeper #1 stated, "The corner of the "GoGo" bags were cut and the contents then squeezed into the ABHR containers." Observation of the "GoGo" bags showed an expiration date, but that information was not added to the final container label. Four of 7 ABHR pump dispensers were either outdated (label: November 2011) or lacked expiration dates on the label. During an interview on 2/26/13 at 10:10 AM the IP stated, "My expectation is that housekeeping maintains viable ABHR (in-dated) for staff, residents and visitors." On 2/28/13 at 8:20 AM during an observation of the housekeeping cart in the North long hall, housekeeper #2 stated "That hand sanitizer is out dated, I heard the other housekeepers talking about it."	F 441	F441 Cont. obtaining the sensitivity reports and changing antibiotics. C. The Nursing staff will be educated that the results for sensitivity reports should be phoned to the physician upon receipt and to document the notification and any orders as a result. The Nursing Director will conduct random audits to ensure the sensitivity reports are being assessed and documented to ensure there is no delay. D. The Nursing Directors will aggregate the random monthly audit and report results to the Administrator and Care Center Medical Director monthly and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of	F 520	2c A. The Infection Prevention Nurse and DON #1 will be instructed to ensure that surveillance data summaries are completed Monday through Friday in order to obtain information regarding trending or potential outbreaks. B. All residents and staff have the potential to be affected by the lack of timely and reliable surveillance activities during outbreaks. C. The Infection Prevention Nurse and DON #1 attend Care Center rounds	

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F 520	Continued From page 11 action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of the CMS-2567 (Centers for Medicare and Medicaid Statement of Deficiencies), and review of facility quality improvement (QI) documents, the facility failed to ensure the QI program was effective in resolving identified concerns. The findings were: During an interview with the administrator and QI manager on 2/28/13 at 10:30 AM, the QI manager revealed data was collected and analyzed concerning infection control. However, review of the CMS-2567 for last year's survey, dated 2/16/12 revealed that F441 (infection control citation) was written for deficiencies discovered on survey. The issues on the 2012 survey that pertained to a lack of handwashing were again identified as an area of non-compliance during the current survey conducted on 2/25/13 through 2/28/13. Further, the current survey identified additional infection control issues of non-compliance. That facility failure contributed to a lack of effective infection prevention processes to safeguard the health of	F 520	F441 Cont. Monday through Friday to ensure the surveillance data is obtained and input into a reporting tool in order to track and trend illness, antibiotic use, and infections. The Infection prevention Nurse will conduct quality audits to ensure the surveillance data summaries are completed Monday through Friday. D. The Infection Prevention Nurse Directors will aggregate the random monthly audit and report results to the Administrator and Care Center Medical Director monthly and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. 3. A. RN #1 will be instructed on proper hand hygiene according to facility policy when completing a procedure or dressing change. B. All residents have the potential to be affected by the lack of proper hand hygiene prior to procedures or dressing changes. C. RN # 1 will be educated regarding facility policy and proper hand washing techniques prior to any procedures or dressing changes. The Nursing Director or designee will perform random monthly audits to ensure to observe for proper hand washing techniques.	

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F 520	Continued From page 12 residents and staff.	F 520	F 441 Cont. D. The Nursing Directors will aggregate the random monthly audit and report results to the Administrator and Care Center Medical Director monthly and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. **4.** A. All Nursing staff and Housekeeping staff will be instructed that all alcohol based hand rub should have a visible expiration date and should be replaced with a new bottle if expired. All expired alcohol based hand rub has been removed from all areas of the Care Center. B. All residents have the potential to be affected by the failure to ensure the alcohol based hand rub has not expired. C. Education will be provided to all Nursing and Housekeeping staff that all alcohol based hand rub should have visible expiration dates and should be replaced with new bottles if expired. The Housekeeping Director or designee will conduct random monthly audits to ensure all alcohol based hand rubs have a visible expiration date and not expired.	

F441 Cont.

A. The Housekeeping Director will aggregate the random monthly audit and report results to the Administrator and Care Center Medical Director monthly and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.

Completion Date 4/12/2013

F520
The facility shall maintain a quality committee that is effective in identifying and resolving problems within the facility. This will be accomplished by,

A. The Care Center Administrator will ensure that aggregate data is gathered and benchmarked to assure quality and performance improvement in the area of hand washing and infection prevention
B. All residents have the potential to be affected by the lack of a quality program designed to assure quality and performance improvement.

C. Quality improvement projects will be developed for all survey deficiencies.

D. The Care Center Administrator will develop a quality indicator for all deficiencies related to the survey and submit benchmarked data along with information indicating revisions to processes if indicated to the Care Center Medical Director monthly and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.

E. Completion Date 4/12/2013