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

PRINTED: 03/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	03/07/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: RN - registered nurse LPN - licensed practical nurse DON - director of nursing MDS - Minimum Data Set CNA - certified nursing assistant RD - registered dietitian Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interview, the facility failed to post a notice of the availability of health survey results. The findings were: Periodic observation from 2/28/11 at 4:48 PM through 3/3/11 at 9:48 AM revealed a plastic bin attached to the wall near the entrance to the facility. Inside the bin was a notebook with the inscription "Please return to front lobby when	F 167	F167 RIGHT TO SURVEY RESULTS-READILY ACCESSIBLE The facility will make the results available for examination and will post in a place readily accessible to residents and must post a notice of their availability. 1) The survey binder will be labeled clearly on the front and side cover as "Survey Results". The receptacle where the binder is kept will also be clearly labeled as "Survey Results". 2) Staff, residents, and visitors will be informed about the location of the survey results on or before April 18, 2011. 3) The location and availability of survey results will be covered in General Orientation for staff and also at the monthly Resident Council meetings. 4) The Executive Director (ED) will conduct random audits of the survey binder to ensure that it is in place and clearly marked. A Performance Improvement Auditing Tool will be used to conduct audits. 5) The results of the audits will be presented at the monthly Performance Improvement Meeting. Any trends or problems will be identified and acted upon. This will occur for a period of at least three months and until substantial compliance is met.	4/18/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tonya [illegible] | TITLE: Executive Director | (X6) DATE: 3/28/11

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.

RECEIVED
Wyoming Dept of Health
MAR 31 2011

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: EDYB11 Facility ID: WY00[illegible] Office of Healthcare Licensing and Surveys If continuation sheet Page 1 of 18

This POC accepted on 4/12/11 @ 1557 c additional information via phone conversation c Tonya Murray, Adm, & Betty Nelson, RD, State Health Surveyor.

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F 167	Continued From page 1 finished." Neither the notebook cover, the wall behind the notebook, nor the bin holding the notebook identified the notebook as containing survey results. Interview with a receptionist on 3/3/11 at 8:15 AM confirmed the survey results were not identified as such. Confidential interview with six of ten residents on 3/1/11 at 2:30 PM revealed they were unaware of the existence of the previous year's survey results. They also stated they would be interested in reviewing them.	F 167		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on review of the Resident Council minutes and resident and staff interviews, the facility failed to resolve 1 of 1 council grievances pertaining to wandering residents. The findings were: A confidential interview with ten residents was conducted on 3/1/11 at 2:30 PM. During this interview, residents reported that at several recent council meetings they had requested wandering residents be prevented from entering their rooms. Concerns expressed about the behaviors displayed by the wandering residents included removal of personal items, rummaging through clothing drawers and closets, and leaving trash behind.	F 244	F244 LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility will listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. 1) Mesh barriers have been placed in doorways of residents who had concerns about wandering residents. 2) The question will be posed at each resident council meeting about wandering residents to determine if there are still concerns. 3) Any further concerns about wandering residents will be referred to the Social Services Director immediately. A mesh barrier will be placed on the door of the resident who is voicing concern. 4) Results of the question posed at the monthly Resident Council Meeting will be reported at the monthly Performance Improvement Meeting. Any trends or problems will be identified and acted upon. This reporting will occur for at least three months and until substantial compliance has been achieved.	4/18/11

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F 244	Continued From page 2 Review of the Resident Council meeting minutes for December 2010, January 2011 and February 2011 revealed the following: a. Resident Council meeting minutes from 12/14/10: Old Business - "a few residents complained about other residents wandering into their rooms." New Business - "some residents are still wandering in and out of other resident's rooms." b. Resident Council meeting minutes from 1/11/11: Old Business - "some residents are still wandering in and out of other resident's rooms." New Business - "some residents are still wandering in rooms at times." c. Resident Council meeting minutes from 2/8/11: Old Business - "some residents are still wandering in rooms at times." Interview with the recreation manager on 3/3/11 at 10:30 AM confirmed the resident council meeting minutes were correct. She verified the grievance related to wandering residents had not been resolved.	F 244		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop an individualized activity program for 1 of 14 sample residents (#71) that enhanced his/her life and	F 248	F248 ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT The facility will provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. 1) Resident #71 no longer resides in the facility. 2) The Recreation Director will conduct a ~~monthly audit of participation~~ facility audit of activity records to determine if a consistent level of activity participation is being achieved and determine if further intervention is required.	4/18/11

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F 248	Continued From page 3 provided meaningful, life-affirming experiences. The findings were: Observation on 3/2/11 showed resident #71 was sleeping at 3:10 PM. At 4:30 PM that day the resident remained in bed with his/her eyes shut. Except for meals, the resident stayed in bed, apparently sleeping, when observed at various times earlier in the survey. Review of the medical record revealed the resident showed a steady decline in the number of activities s/he had participated in since September 2010. According to the 6/28/10 admission activity assessment, the resident had been interested in animals/pets, with cats being described as very important. The assessment also showed the resident found bingo, cards, current events, dominoes/games, educational programs, walking, and visits from family or friends to be "somewhat important" and of current interest at the time of the assessment. Review of the individual participation records from September 2010 through February 2011 showed no evidence the resident was ever offered animal/pet visits or that cats were involved in the resident's life in any way. After September 2010, there was no evidence the resident was offered or participated in current events, dominoes, or educational programs; there was no evidence the resident attended, or was invited to attend, bingo and card games after October 2010. By January 2011 the resident was primary activities were noted as "walking" and "social visits." Interview with the activity director on 3/2/11 at 4:30 PM revealed "walking" as documented in the participation record was actually propelling his/her wheelchair to and from meals, and "social visits" were very brief visits to ask each resident how s/he was doing. Even though the resident initially did well in smaller groups, the activity director	F 248	3) The recreation staff will be educated about the importance of proper documentation regarding participation to reflect activities offered, attended, or refused. Recreation staff will also be educated about care plan content for activities. The Recreation Director will conduct the education on or before April 18, 2011. The Rec Director will conduct random monthly audits. DW 4) A Performance Improvement Monitoring Tool will be used to record audits. If problems are identified during audits, immediate re-education or corrective action will take place. 5) The results of the audits will be presented at the monthly Performance Improvement Meeting for a period of at least three months and until substantial compliance is achieved. Any problems or trends will be identified and acted upon.	

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F 248	Continued From page 4 stated the resident's involvement in activities declined after some of the residents were rude. However, activities with other group members were not arranged. The activity director stated the resident was not receiving one-to-one visits from activity staff as she "didn't think [the resident] would accept" them, but she reported they had not been attempted. Finally, the director confirmed the resident spent most of his/her time sleeping; she reported that if the resident got to his/her room, s/he would not leave.	F 248		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review,	F 280	F280 RIGHT TO PARTICIPATE PLANNING CARE – REVISE CARE PLAN A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment. 1) Care plans for residents #33, #9, #44, #55, and # 88 have been revised to reflect the actual care being provided to the residents. 2) Care plan for resident #4 has been changed to include a measurable goal for the activity problem. 3) A complete audit of all care plans will be conducted on or before April 18, 2011 to	4/18/11

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F 280	Continued From page 5 staff interview, and review of infection control logs, the facility failed to ensure care plans for 5 of 17 sample residents (#9, #33, #44, #55, #88) were revised to reflect each resident's current status and care. In addition, individualized, measurable goals were not developed for resident #4. The findings were: 1. According to the 2/16/11 care plan, resident #33 was to receive a mechanical soft diet and "Prostat" three times daily, eat in the assisted dining room, have a thin gel cushion in the wheelchair, and was on an unspecified toileting program. Observation throughout the survey showed the resident received a regular diet and ate independently in the main dining room or in his/her room. The resident did not have a thin gel cushion in the wheelchair, but had a Roho cushion, instead. It was observed that the resident routinely informed staff of the need to use the toilet. Review of physician's orders showed the resident was not receiving "Prostat." Interview with the DON on 3/7/11 at 10:55 AM confirmed the care plan not been revised to reflect the care presently being provided to the resident. 2. Review of the care plan for resident #9, last revised on 2/23/11, showed s/he was to receive a mechanical soft diet and "Prostat" three times daily. The care plan also showed the resident was to be toileted upon arising, before and after meals, at bedtime, and as needed. Although the resident did receive an antipsychotic medication, the time lines indicating how often to monitor the resident's behavior, review the medication, and for social service to evaluate the resident were not designated. Review of the physician's orders showed the resident did not receive "Prostat" and	F 280	ensure that the care plans match the care being provided. 4) Unit Managers and Director of Nursing (DON) will use a Performance Improvement Auditing Tool to randomly audit care plans weekly, including care plans for residents #4, #33, #9, #44, #55, and #88 to ensure that care plans are up to date with revisions added or resolved. If problems are identified during audits, immediate re-education and/or corrective action will take place. measurable goals 4/12 DV 5) The Director of Nursing will educate all licensed nurses and department leaders responsible for writing care plans about how to correctly write care plans including goals that are measurable. The education will also include how to revise care plans. The education will be conducted on or before April 18, 2011. 6) The results of audits will be presented at the monthly Performance Improvement Meeting for a period of at least three months and until substantial compliance is achieved. Any problems or trends will be identified and acted upon.	

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F 280	Continued From page 6 that s/he was on a regular diet. Interview with CNAs #2 and #3 on 3/1/11 at 2:10 PM revealed the resident was on a check and change program and was not toileted. Interview with the DON at 10:55 AM on 3/7/11 confirmed the care plan had not been revised to reflect the resident's current status. 3. According to the care plan for resident #44, dated 2/16/11, metolazone had been discontinued. The care plan also instructed staff to apply compression wraps to the resident's lower extremities. Review of the physician's orders showed metolazone was actually restarted on 2/25/11. Observation on 2/28/11 at 4:45 PM and on 3/1/11 at 9:50 AM showed the resident's legs were elevated on pillows on top of the raised recliner foot rest. During neither observation was the resident wearing compression wraps. On 3/7/11 at 10:55 AM, the DON confirmed the care plan had not been updated to reflect the resident's current care. 4. Review of the care plans for residents #55 and #88 on 3/2/11 failed to show whether either resident was placed on isolation precautions following culture reports of pathogenic organisms. Refer to F 441 for detailed information. 5. Review of the 1/19/11 care plan showed resident #4 was to have one-to-one visits three times per week for sensory stimulating activities and hygiene. However, the care plan failed to identify an individualized, measurable goal for the activity plan. Interview with the activity director on 3/2/11 at 4:52 PM confirmed the specified goal, "will accept 1:1's 3x per week by next review," did not match the response they wanted to elicit from the resident.	F 280		

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F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of educational information, the facility failed to ensure staff conformed to professional standards of practice related to assessments, documentation, and medication administration. Medical record review showed 6 of 10 sample residents (#9, #33, #44, #84, #91), whose nutritional status required a comprehensive assessment, were not assessed by the RD. Documentation was incomplete for 1 of 6 sample residents (#44) reviewed for pain. Physician's orders were not followed during medication administration for 1 of 1 sample residents (#83) observed with an inhaled medication. The findings were: 1. Review of the individual annual MDS assessments for residents #9, #33, #44, #84, and #91 showed each resident required a comprehensive nutrition assessment. Review of the information identified as each resident's assessment showed each was completed by the certified dietary manager (CDM) instead of the RD. The RD stated in interview on 3/1/11 at 9:10 AM she tried to get her assessments completed after the dietary manager collected nutritional data, but did not always do so in a timely manner. The RD acknowledged if resident records lacked her comments, she had not reviewed and annotated the charting. Interview with the DON on 3/7/11 at 10:55 AM confirmed the CDM had	F 281	F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility will meet professional standards of quality. 1) The Registered Dietician (RD) will complete dietary assessments for residents, # 9, #33, #44, #84, and #91 & all other residents requiring that assessment. 2) The DON will conduct random weekly audits to ensure the documentation and effectiveness of PRN medications is completed on back of medication administration record (MAR) or pain flow sheet. The audits will include resident #44. 3) The DON will conduct random weekly audits of residents who receive inhaler treatments to ensure that nurses are administering per physician orders. The audits will include resident # 4. 4) The registered dietician will audit all resident charts to ensure that there is a current dietary assessment completed by the R.D. 5) The Certified Dietary Manager (CDM) will use a Performance Improvement Auditing Tool to conduct random weekly audits to ensure that residents have a current dietary assessment completed by the R.D. If problems are noted during the audit, immediate re-education and/or corrective action will take place. 6) The DON or designee will use a Performance Improvement Auditing Tool to conduct random weekly audits of MAR and/or pain flow sheets to ensure proper documentation of PRN medications. The DON or designee will also conduct random weekly audits of residents receiving inhaler treatments. If problems are noted during audit, immediate re-education and/or corrective action will take place.	4/18/11

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F 281	Continued From page 8 completed the assessments. According to the 2008 Standards of Practice for Registered Dietitians in Nutrition Care, published by the American Dietetic Association, Standard 1: Nutrition Assessment, The registered dietitian (RD) uses accurate and relevant data and information to identify nutrition-related problems. Rationale: Nutrition Assessment is the first of four steps of the Nutrition Care Process. Nutrition Assessment is a systematic process of obtaining, verifying, and interpreting data in order to make decisions about the nature and cause of nutrition-related problems. It is initiated by referral and/or screening of individuals ...for nutrition risk factors. ..It provides the foundation for Nutrition Diagnosis, the second step of the Nutrition Care Process. Further, the 2008 Standards of Practice specifically state: "The RD does not delegate the nutrition care process, but may assign certain tasks for the purpose of providing the RD with needed information (e.g., screens, gathering of data and other information) or communicating with and educating patients." 2. According to the care plan, staff were to document the effectiveness of pain medications received by resident #44. Review of the medication administration record (MAR) for February 2011 showed the resident received "prn" (as needed) doses of Percocet on February 5, 6, 8, 9, 15, 17, 22, 26, and 28 for additional control of pain. Further review of the record showed the only documentation was completed on 2/5/11. On 3/2/11 at 11 AM the DON reviewed the MAR and pain flow record and confirmed the required information had not been entered. She stated an inservice was conducted for licensed nursing staff related to documentation of "prn" medications in February 2011. Review of the	F 281	7) The ED will educate the RD regarding timeliness of assessments and policies and procedures about completing assessments. The DON will educate licensed nurses about how to properly document PRN medications on the MAR or pain flow sheet and how to correctly administer inhalers per physician orders. The education will take place on or before April 18, 2011. 8) The results of these audits will be presented at the monthly Performance Improvement Meeting for a period of at least three months and/or until substantial compliance is achieved. Any problems or trends will be identified and acted upon.	

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F 281	Continued From page 9 educational information verified staff were to complete the back of the MAR or enter the information on the pain flow sheet. According to Elkin, Perry, and Potter in "Nursing Interventions & Clinical Skills," 4th Edition, 2007, documentation is one of the "6 Rights" of medication administration and should include "...response to the medication." 3. Observation on 2/28/11 showed LPN #4 administered Symbicort at 5:25 PM for resident #83. The inhaled medication was followed by a sip of water as the resident swallowed his/her oral medications. According to the MAR, staff were to have the resident rinse his/her mouth after inhaling the medication. At 5:28 PM the LPN stated the resident swallowed water in place of rinsing when in the dining room. Reconciliation of the medication showed the physician's orders were for the resident to rinse out his/her mouth after use of the inhaler. On 3/1/11 at 6 PM the DON stated that swallowing water with medications was not the same as swishing water around and thoroughly rinsing the mouth. According to the Wyoming State Board of Nursing Rules and Regulations Chapter 3 Standard of Nursing Practice... nurses are to carry out orders from physicians.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312	F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1) The DON or designee will conduct random weekly observations of residents receiving perineal care. The observations will include residents #65 and #44.	4/18/11

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WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 10 by: Based on observation and staff interview, the facility failed to ensure staff provided appropriate perineal (incontinence) care for 2 of 5 incontinent residents (#44, #65) who were observed during the provision of perineal care. The findings were: 1. Observation on 3/1/11 showed resident #65 rang for assistance at 7:20 AM, and the light was answered by occupational therapist #5. When the resident stated s/he had been incontinent of urine and needed a dry disposable brief, the therapist replied that she would change the brief. Using a back and forth motion, the therapist cleansed the anterior lower groin and rectal area, but failed to cleanse the genitalia, the entire perineal area, or the buttocks prior to applying a clean brief. 2. Observation at 9:50 AM on 3/1/11 showed resident #44 was incontinent of urine. During the provision of perineal care, CNA #2 used a back and forth motion with the same area of the wipe to cleanse the perineal area four times. The CNA discarded that wipe and obtained a clean one. She then used the same section of the new wipe to cleanse the perineal area three times, again using a back and forth motion. 3. On 3/7/11 at 2:28 PM the DON stated that perineal care for both men and women should be done from front to back and from clean to dirty. Back and forth motions should not occur, and each stroke of the wipe should be made with a clean, unused section. The DON verified that the techniques described in the above instances were incorrect.	F 312	2) The DON will conduct re-education for nursing staff and therapists regarding how to perform proper perineal care. The education will occur on or before April 18, 2011. 3) The DON or designee will use a Performance Improvement Audit Tool to conduct observations of perineal care. If any problems occur during observation immediate re-education and/or corrective action will take place. 4) The results of these audits will be presented at the monthly Performance Improvement Meeting for a period of three months and until substantial compliance is achieved.	
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	F371 FOOD PROCURE, STORE/PREPARE/SERVE -SANITARY	4/18/11

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✓ bc 4/12/11	535039	A. BUILDING _____ B. WING _____	03/07/2011

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F 371	Continued From page 11 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the 2009 Food Safety Code, the facility failed to assure liquid nutritional supplements were labeled with the date they were thawed in 2 of 3 refrigerators. In addition, the facility failed to prevent resident food from exposure to possible contamination. The findings were: 1. Periodic observation in the main facility kitchen from 2/28/11 at 4:11 PM through 3/3/11 at 9:48 AM revealed a half full, 75-count box of individual, 4 ounce containers of thawed nutritional supplements. In addition, observation on 3/1/11 at 1 PM revealed four unlabelled, thawed containers of supplement in the resident refrigerator behind the Saddle Ridge nurses' station. The instructions printed on the cartons revealed the product was to be used within 14 days of thawing. However, no date was written on either the box or on the individual cartons. During an interview on 3/3/11 at 10:45 AM, the dietary supervisor confirmed the supplements in the main kitchen refrigerator and unit refrigerator lacked thaw dates. The dietary supervisor stated staff were supposed to place a date on both the box and on each individual carton when moved from the freezer into the main	F 371	The facility will 1) procure food from sources approved or considered satisfactory by Federal, State or local authorities; and 2) store, prepare, distribute and serve food under sanitary conditions. 1) The CDM has ensured that all liquid nutritional supplements are labeled with the date they were removed from the freezer for thawing. All refrigerators have been checked to ensure that all food is free of mold. The ceiling air vent has been cleaned. All clean food preparation equipment has been checked for cleanliness. Kitchen staff has been informed that eating in food preparation areas is prohibited. 2) The CDM or designee will conduct random weekly audits to ensure that all liquid food supplements are properly labeled when removed from the freezer; checks of all refrigerators to ensure that all food is free of mold; checks of all food preparation equipment to ensure cleanliness; check to ensure that vent over food preparation area is clean; observation of dietary staff to ensure that there is no eating in food preparation areas. 3) A Performance Improvement Audit Tool will be used to conduct all audits. If there is a problem identified during audits immediate re-education and/or corrective action will take place.	

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F 371	Continued From page 12 kitchen refrigerator. 2. Periodic observation from 2/28/11 at 4:11 PM through 3/3/11 at 9:48 AM revealed the following concerns: a. A box in the walk in refrigerator contained 3 cantaloupe. Each melon was noted to have some degree of mold on it. b. The ceiling air vent in the kitchen was coated in dust and lint. The vent was directly over the food preparation table. During an interview on 3/3/11 at 9:48 AM the facility's dietary supervisor confirmed she was aware that dirt and mold represented a possible source of food contamination during food storage and preparation. According to Food Code 2009, U.S. Public Health Service, 3-306.11 Food Storage. (A) food shall be protected from contamination by storing the food: (2) Where it is not exposed to splash, dust, or other contamination. 3. Observation on 2/28/11 at 4:11 PM revealed a small amount of dried food stuck to "clean" food preparation equipment, including a rolling pin, a ladle and a frying pan. Interview with the dietary supervisor at the time of the observation revealed staff should check to see if the utensils were completely clean prior to putting them away. According to Food Code 2009, U.S. Public Health Service, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. 4. Observation on 3/1/11 at 3:48 PM revealed a	F 371	4) The CDM will conduct re-education with dietary staff regarding labeling liquid food supplements when removed from freezer, checking for mold on food and removing it from the food supply, checking all food preparation equipment for cleanliness, and the policy of no eating in a food preparation area. 5) The results of these audits will be presented at the monthly Performance Improvement Meeting for a period of three months and until substantial compliance is achieved. Any problems or trends will be acted upon.	

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F 371	Continued From page 13 dietary aide standing over the food preparation table eating a slice of pie. On the food preparation table were many (approximately 20) individual serving plates containing of slices of pie. Interview with the dietary supervisor at 4 PM revealed staff should not be eating in the kitchen when preparing resident meals. According to Food Code 2009, U.S. Public Health Service Hygiene Practices 2-401.11 Eating, Drinking, or Using Tobacco. (A)...an employee shall eat, drink... only in designated areas where the contamination of exposed food; clean equipment, utensils...or other items needing protection can not result.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission 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.	F 441	F441 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1) The facility will establish an accurate, data driven infection surveillance program. The surveillance log will indicate if there are any epidemiologically significant pathogens. The log will also show outcomes and resolution to infections. Culture sensitivity results will be reviewed to ensure that proper antibiotic treatment is ordered. Aseptic technique will be used for all wound care. 2) The Staff Development Coordinator (SDC) will audit all charts weekly to ensure that all infections are recorded on the infection log for that month. Unit Managers will audit all culture sensitivity results to ensure proper	4/18/11

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F 441	Continued From page 14 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of infection control logs and medical records, the facility failed to maintain an effective infection control program. The cumulative effects of this failure were evident in 3 critical areas: a. The facility failed to maintain an accurate, data-driven infection surveillance program. The lack of accurate and timely surveillance resulted in the facility's failure to recognize infections attributed to multidrug-resistant microorganisms (MDROs) for 2 of 17 sample residents (#55, #88). b. The facility failed to review antibiotic sensitivity results for 1 of 14 (#9) sample residents; this failure resulted in inappropriate antibiotic therapy. c. Facility staff failed to use aseptic technique during 1 of 3 wound care observations (#33). The findings were: A. Regarding infection surveillance:	F 441	antibiotic treatment is ordered. The DON or designee will randomly audit care plans to ensure that isolation precautions have been added to care plans when appropriate. Random weekly observations of nurses performing wound care will be conducted by the SDC or designee to ensure that aseptic technique is used. The audits will include resident # 33. 3) A Performance Improvement Audit Tool will be used to conduct the audits. If problems are identified during the audits immediate re-education and/or corrective action will take place. 4) The DON will conduct education regarding infection control surveillance, monitoring culture sensitivity results to ensure proper antibiotic treatment, updating care plans to include isolation precautions when appropriate, and using aseptic techniques when performing wound care. The re-education will occur on or before April 18, 2011. 5) The results of these audits will be presented at the monthly Performance Improvement Meeting for a period of three months and until substantial compliance is achieved. Any problems or trends will be acted upon.	

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F 441	Continued From page 15 1. Review of infection control surveillance activities on 3/2/11 and 3/3/11 showed the program failed to collect data for the months of January through September 2010. Further, data collected for November 2010 through January 2011 failed to show the outcome or resolution for 4 of 37 resident infections listed on the surveillance logs. 2. The surveillance data collected for November 2010 showed resident #55 had an eye infection; a swab of the eye was culture-confirmed for methicillin-resistant Staphylococcus aureus (MRSA). The surveillance log recorded "Staph. Aur. (Staphylococcus aureus), but failed to document the isolate as MRSA, an epidemiologically significant pathogen. The November 2010 surveillance logsheet also failed to included resident #88 after his/her urine culture was reported by the laboratory to contain vancomycin-resistant Enterococcus (VRE), another significant pathogen. 3. Review of the care plans for residents #55 and #88 on 3/2/11 failed to show either resident was placed on precautions following the isolation of MRSA and VRE, respectively. 4. RN #1 stated in interview on 3/2/11 at 4:35 PM that the infection surveillance program was inactive for most of 2010 following several personnel turnovers. She further stated the program was reinitiated in December 2010, with data for October and November collected retrospectively from resident medical records. The RN stated she was not aware the November 2010 surveillance logsheet failed to include significant findings for residents #55 or #88, who were culture confirmed with MRSA and VRE,	F 441		

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WESTVIEW HEALTH CARE CENTER	1090 WEST LOUCKS STREET SHERIDAN, WY 82801

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F 441	Continued From page 16 respectively. The RN verified the care plans for these two residents were not updated to show the facility followed contact precautions per the policy for residents with MRSA and VRE infections. B. Regarding antibiotic usage: Review of resident #9's medical records on 3/2/11 at 1:50 PM showed a laboratory report dated 1/28/11 documented the resident's urine specimen was culture-positive for Escherichia coli, a bacteria associated with urinary tract infection. The laboratory report further demonstrated the bacterial isolate was resistant to several antibiotics, among them ciprofloxacin (Cipro). A hand written note on the bottom of the laboratory report indicated the resident was currently receiving Cipro. A second note, "on Bactrim [trimethoprim/sulfamethoxazole]" was also found written on the laboratory report. According to the laboratory report, the E. coli isolate was sensitive to trimethoprim/sulfamethoxazole. Review of the resident's medication administration record (MAR) on 3/2/11 at 3:10 PM revealed Cipro was ordered and given to the resident beginning 1/27/11; the antibiotic was administered twice a day for 7 days. There was no evidence in the resident's record to show Bactrim was ever ordered or administered to the resident. RN #1 reviewed the resident's laboratory report on 3/2/11 at 9:30 AM and confirmed the results showed the isolate was resistant to Cipro. The RN added she did not know what the note "on Bactrim" meant; she stated her assumption that someone might have noticed the sensitivity report, but failed to follow-through with a corrective action. The RN acknowledged the lack	F 441		

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F 441	Continued From page 17 of evidence to show the resident's physician was notified or reviewed the laboratory information or that the resident was ever on Bactrim. C. Regarding wound care: On 3/1/11 RN #1 was observed as she changed the dressing for resident #33. After completing care, the RN pulled scissors from her pocket and used them to cut the dressing to the correct size. After applying the dressing, the RN returned the scissors to her pocket. The RN failed to clean the scissors either before or after using them on the dressing. According to Smith, Duell, and Martin in "Clinical Nursing Skills Basic to Advanced Skills," 7th Edition, 2008; 880: "Maintaining asepsis during dressing changes assists in preventing wound infections." In Elkin, Perry, and Potter. "Nursing Interventions & Clinical Skills" 4th Edition, 2007; 62: asepsis is defined as "...clean technique...includes procedures used to reduce the number of and prevent the spread of microorganisms."	F 441	-	