POC accepted 5/15/14 Jeanne Cook, LPN/C

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

PRINTED: 04/08/2014
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
	535027	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set RA-Restorative Aide RN-Registered Nurse SDC-Staff Development Coordinator TCS food- food that requires time/temperature control for safety to limit pathogenic microorganism growth or toxin formation Less commonly used abbreviations will be annotated in each deficiency.	F 000	APR 18 2014 Wyoming Department of Health Healthcare Licensing and Statistics	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure residents who were determined unsafe for self-administration of medications did not have medications left unattended with the resident for 1 non-sample resident (#23) observed during medication pass. The findings were: Review of the current care plan for resident #23 revealed the following, "I cannot keep track of my medications and need the nurse to watch me	F 176	The facility will continue to ensure that residents who are determined unsafe for self-administration of medications will not give their own medications. 1) A new medication administration evaluation was completed for Resident #23 on 4/11/2014 which determined that resident remains unsafe for self-administration of medications in the dining room, and the resident's care plan remains accurate. 2) RN #1 was provided one-to-one education on 3/25/2014 regarding the correct process for determining each resident's safety for self-administration of medications.	5/10/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeanne Kaiser, NHA	Administrator	04/18/2014

RECEIVED
APR 18 2014
Wyoming Department of Health
Healthcare Licensing and Statistics

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.

POC accepted. Message left for Jeanne Kaiser, NHA on 5/15/14 @ 2:48pm. JC

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F 176	Continued From page 1 swallow them." Observation during morning medication pass on 3/25/14 at 8:06 AM showed RN #1 left medications in the main dining room on the table with the resident. At 8:36 AM during the observation the nurse left the dining room. At that time there were two additional residents at resident #23's table and additional residents present at other tables. There were only two staff members in the dining area at the opposite end of the dining room, and they had their backs turned to the resident. At 8:47 AM the nurse returned to the dining area and administered the medications to resident #23. Interview with RN #1 on 3/26/14 at 3:35 PM confirmed she made an error leaving the medications for the resident because the resident was not capable of self-administration of medications.	F 176	3) Each resident's assessment for safety in self-administration of medications will be reviewed to ensure it is consistent with the resident's care plan. 4) All licensed staff will be provided education by the Staff Development Coordinator/Registered Nurse (SDC/RN) regarding the correct process for determining residents' safety for self-administration of medications, and the importance of following the care plan. 5) All residents who have been evaluated as unsafe to self-administer medications will be monitored by nursing staff to ensure they do not have independent access to any medications. 6) Regular observations of medication passes will be conducted by the Director of Nursing (DON) to assure that residents' plan of care for safety of self-administration of medications is followed. 7) A Quality Improvement (QI) indicator will be developed to monitor all residents who are unsafe for self-administration of medications, and the results of this monitoring will be reported to the facility's Quality Improvement/Performance Improvement (QI/PI) Committee on a quarterly basis until resolved. 8) The Director of Nursing will monitor.	
F 248 SS=E	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 review of the activity calendar and resident and staff interview, the facility failed to offer adequate activities during the weekends. The facility census was 70. The findings were: Confidential interview on 3/25/14 at 2 PM with nine residents revealed the facility failed to provide adequate activities on weekends. Each resident confirmed the only activities provided on			

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F 248	Continued From page 2 weekends were a movie on Saturdays and church services on Sundays. The residents stated they mentioned this to activity staff "a while ago," but were uncertain as to when. Review of the March 2014 activity calendar showed a movie was offered each Saturday and church services were offered each Sunday. Further review revealed no additional activities were offered on the weekends. Interview with the activity director on 3/26/14 at 5:26 PM confirmed the facility failed to offer activities on the weekend beyond that listed on the activity calendar due to the lack of weekend activity staff.	F 248	The facility will continue to provide for an ongoing program of activities designed to meet the interests and physical, mental and psychosocial well-being of each resident. The activities schedule will be expanded to include additional activities on weekends. 1) The certified activities assistant's work hours will be adjusted to provide weekend activities on Saturdays. 2) An additional employee will work part time hours on the weekends to provide additional activities. 3) Residents will be queried at each bi-monthly Resident Council meeting regarding their satisfaction with the scheduling of activities, including weekends, and adjustments made in accordance with the residents' feedback. 4) A QI indicator will be developed from the residents' response to the activities program, and the results reported to the facility's QI/PI Committee on a quarterly basis. 5) The Administrator will monitor.	5/10/2014
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 by: Based on observation, medical record review, and staff interview, the facility failed to ensure care was provided in accordance with the written plans of care for 2 of 13 sample residents (#3, #65). The findings were: 1. Review of the current care plan showed resident #3 had a gel cushion in his/her wheelchair. However, periodic observations during the survey from 3/25/14 at 7:56 AM through 3/26/14 at 2 PM revealed the resident utilized a geri-chair (wheeled recliner). However, there was no gel cushion in the geri-chair. During an interview on 3/26/14 at 2:05 PM, CNA #1 and	F 282	The facility will continue to ensure that care is provided in accordance with the written plan of care for each resident.	5/10/2014

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F 282	Continued From page 3 CNA #2 stated the resident had a gel cushion in the geri-chair when the resident lived upstairs, but they had not seen it since the resident moved downstairs to the first floor East unit about a month ago. 2. Review of the 2/9/14 quarterly MDS assessment showed resident #65 had functional limitations and upper extremity impairment on one side. Review of the current care plan showed staff were to apply a hand roll to the resident's left hand daily and the RA was to provide passive range of motion to the left hand 2-3 times weekly. Review of the restorative care documentation showed the resident received this restorative care 6 times from 12/30/13 to 3/26/14 (almost 3 months). Periodic observations from 3/24/14 to 3/26/14 revealed staff did not provide restorative care for this resident. During an interview on 3/26/14 at 10:30 AM, RA #1 verified the accuracy of the documentation. The RA further stated range of motion and hand massages improved the resident's ability to move his/her fingers. The RA further stated the restorative staff were unable to provide the restorative care 2-3 times a week due to staffing schedule changes.	F 282	1) The Restorative Nurse/RN will interview resident # 3 to determine her choice regarding the use of a gel cushion or other device for comfort and pressure reduction. Whichever type of cushion the resident chooses will be provided and the care plan will be updated to reflect this information. If the resident chooses a type of cushion that may not provide adequate pressure reduction, appropriate patient education will be provided and documented in the resident's medical record. 2) The Restorative Nurse/RN will re-assess Resident #65 to determine the resident's tolerance and acceptance of passive range of motion. The resident's plan of care will be updated with the results of the assessment. 3) Whenever a resident changes unit location their care plan will be reviewed to ensure that all care needs will continue to be met on the new unit. 4) Staff education will be provided by the D.O.N. to ensure all staff is aware of the importance of following the plan of care, and to notify supervisory staff if a resident is not receiving services, including due to refusal of treatment, so that resident education can be provided and documented in the medical record.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			

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F 314	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to ensure interventions were consistently implemented to prevent pressure ulcers from developing for 1 of 7 sample residents (#3) identified at risk for pressure ulcers. The findings were: Review of the 1/14/14 annual MDS assessment revealed resident #3 did not have pressure ulcers, but was at risk for the development of pressure ulcers. The care area assessment (CAA) for pressure ulcers dated 1/14/14 showed the resident was at risk for pressure ulcers, and a gel cushion was used in the wheelchair. A 12/27/13 skin risk assessment revealed the resident was at moderate risk for pressure ulcers due to very limited mobility and very limited sensory perception. Review of the current care plan showed the resident had a gel cushion in the wheelchair. The following concerns were identified: a. Review of nursing notes showed on 3/15/14 a reddened area to the left inner buttock was observed on the resident. Observation on 3/26/14 at 3:20 PM confirmed the resident had a reddened area on his/her buttocks. b. Observations on 3/25/14 from 7:56 AM until 5:20 PM revealed there was no cushion in the geri-chair when the resident was seated in it. Observation on 3/26/14 at 2 PM revealed two pieces of egg crate foam were in the geri-chair. During an interview on 3/26/14 at 2:05 PM, CNA #1 and CNA #2 stated the resident had a gel cushion in the geri-chair when the resident was	F 282	5) Each resident's care plan will be reviewed on at least a quarterly basis and revised with any change in the resident's needs or significant change in condition to assure there is a comprehensive plan of care that meets the resident's needs. 6) A QI/PI indicator will be developed to monitor that care plans are reflective of the care and services being provided to the resident. A representative sampling of the care plans will be reviewed on a monthly basis, and the results of the monitoring will be reported to the facility's QI/PI Committee. 7) The D.O.N. will monitor. The facility will continue to ensure that interventions are implemented to prevent pressure ulcers from developing. 1) The Restorative Nurse/RN will interview resident # 3 to determine her choice regarding the use of a gel cushion or other device for comfort and pressure reduction. Whichever type of cushion the resident chooses will be provided and the care plan will be updated to reflect this information. If the resident chooses a type of cushion that may not provide adequate pressure reduction, appropriate patient education will be provided and documented in the resident's medical record.	5/10/2014
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F 314	Continued From page 5 upstairs, but they had not seen it since the resident moved downstairs to the first floor East unit about a month ago. c. During an interview on 3/27/14 at 8:15 AM the DON stated the gel cushion should have stayed in the geri-chair when the resident moved downstairs. At 9:50 AM the DON came back to the surveyor and stated she was told by staff that the resident had refused the gel cushion, and preferred the egg crate in the geri-chair. However, review of the medical record showed no documentation the resident had ever refused the gel cushion. On 3/27/14 at 10:30 AM the resident was interviewed. The resident stated s/he had not refused a gel cushion. When asked if s/he preferred the gel cushion or the egg crate foam, the resident said "gel."	F 314	2) Whenever a resident changes unit location their care plan will be reviewed to ensure that all care needs will continue to be met on the new unit. 3) The skin risk assessments will be reviewed for all residents who are at moderate risk or higher for pressure ulcers. The resident will then be observed to ensure that adequate pressure reduction devices are provided and consistently in use. The residents' care plans will be updated to reflect pressure relieving devices that are being used, and any refusals of treatment will be documented in the medical record. 4) Staff education will be provided by the SDC/RN regarding the importance of pressure relieving devices to prevent the development of pressure ulcers. 5) A QI/PI indicator will be developed from the review of the skin risk assessments for all residents who are at moderate or higher risk for pressure ulcers, and the results reported to the facility's QI/PI Committee on a quarterly basis. 6) The D.O.N. will monitor.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN 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 consistently provide range of motion and hand massage therapy for 1 of 3 sample residents (#65) with range of motion limitations. The finding were:	F 318	The facility will continue to ensure that residents with a limited range of motion receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	5/10/2014

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F 318	Continued From page 6 Review of the 2/9/14 quarterly MDS assessment showed resident #65 had functional limitations and upper extremity impairment on one side. Review of the current care plan showed staff were to apply a hand roll to the resident's left hand daily and the RA was to provide passive range of motion to the left hand 2-3 times weekly. Review of the restorative care documentation showed the resident received this restorative care 6 times from 12/30/13 to 3/26/14 (almost 3 months). Periodic observations from 3/24/14 to 3/26/14 revealed staff did not provide restorative care for this resident. During an interview on 3/26/14 at 10:30 AM, RA #1 verified the accuracy of the documentation and stated range of motion and hand massages improved the resident's ability to move his/her fingers. The RA further stated the restorative staff were unable to provide the restorative care 2-3 times a week due to staffing schedule changes.	F 318	1) The Restorative Nurse/RN will re-assess Resident #65 to determine the resident's tolerance and acceptance of passive range of motion. The resident's plan of care will be updated with the results of the assessment and services provided in the accordance with the care plan. 2) All patients with orders for range of motion treatment will be assessed by the Restorative Nurse/RN to determine the appropriateness and efficacy of the treatment. Based on the assessment, the appropriate frequency of services will be provided and documented in the residents' medical record and on the residents' care plan. 3) Staff education will be provided by the SDC/RN to ensure all staff is aware of the importance of providing range of motion, and to notify supervisory staff if a resident is not receiving services, including due to refusal of treatment, so that resident education can be provided and documented in the medical record. 4) A weekly review of the provision of range of motion will be conducted by the Restorative Nurse/RN, and the information will be developed into a QI/PI indicator and reported to the QI/PI Committee on a quarterly basis. 5) The D.O.N. will monitor.	
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a	F 368	The facility will continue to ensure that snacks are offered to all residents at bedtime on a daily basis, and that the snacks will be documented as given or refused per the resident's preference.	5/10/2014

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F 368	Continued From page 7 nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on review of resident snack distribution documentation, and resident and staff interview, the facility failed to offer each resident a bedtime snack. The facility census was 70. The findings were: Confidential interview on 3/25/14 at 2 PM with nine residents revealed the facility failed to offer each resident a bedtime snack. Each resident confirmed they could ask for a snack and would receive one, but were not asked by staff if they desired a snack. During an interview on 3/26/14 at 4:20 PM, CNA #1 stated staff were supposed to offer snacks to residents, and then document the results. She stated staff were to circle "A" for accept, "R" for refuse, or "O" for other (resident sleeping or out of the facility). However, review of the "East Snacks" book for the time period 3/11/14 through 3/25/14 showed no documentation related to bedtime (HS) snacks for any resident. Review of the 2nd floor snack logbook on 3/26/14 at 5:10 PM showed that 9 days during the period of 3/11/14 through 3/25/14 failed to include documentation that HS snacks were offered to residents. CNA #3 stated in interview on 3/26/14 at 5:20 PM, residents were offered snacks, but acknowledged the lack of documentation to substantiate the practice. The CNA further stated evenings were busy and charting (HS snacks) did not routinely get done.	F 368	1) All staff were reminded via memo by the D.O.N. on 3/31/2014 regarding the importance of ensuring that residents are offered a bedtime snack. 2) Nursing staff will be educated by the Director of Nursing regarding the requirement to provide and document bedtime snacks on a daily basis. 3) The Director of Nursing will review the documentation of snacks on a weekly basis to ensure that bedtime snacks are being offered to residents and documented. 4) A QI/PI indicator will be developed to monitor the provision of bedtime snacks and the results will be reported to the facility's QI/PI Committee on a quarterly basis. 5) The Director of Nursing will monitor.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	The facility will continue to ensure that food is stored, prepared, and distributed under sanitary conditions.	4/29/2014

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F 371	Continued From page 8 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, review of posted instructions, staff interview, and review of logs, the facility failed to ensure the cooling process for cooked roasts (TCS food) was followed during a random observation in the main kitchen. The findings were: Observation during the initial tour of the kitchen on 3/24/14 from 4:57 PM until 5:15 PM revealed a pork roast, cut into smaller pieces, in a pan in the walk-in refrigerator. The food service manager took the temperature of the roast, which was 88 degrees Fahrenheit (F). The executive chef stated the roast started cooling about "30 minutes ago." Review of a posted sign on the refrigerator door showed the following instructions: "Cooked food MUST be cooled from 135 degrees to 70 degrees within 2 hours. And then, From 70 degrees to 41 degrees within an additional 4 hours." During an observation on 3/25/14 at 11 AM, the "cooling log" was reviewed, which was posted on the refrigerator. It indicated the following: 1) Roast turkey, 165 degrees on 3/24/14 at 4:30 PM; 85 degrees at 6:30 PM; and 60 degrees at 8 PM. 2) Roast pork, 180 degrees	F 371	1) The cooling log form was revised on 3/26/2014 to more accurately document the cooling temperature of cooked food, and was immediately put into use. 2) A policy and procedure for cooling of foods was written and approved on 4/15/2014. 3) Nutrition Services staff will be provided inservice education on 4/29/2014 by the Nutrition Services Director regarding the policy and procedure for proper cooling of foods and completion of the cooling log. 4) Cooling logs will be regularly reviewed on a daily basis by the Executive Chef and/or Nutrition Services Director to ensure cooked food is being properly cooled. 5) The information from the cooling logs will be developed into a QI/PI indicator and reported to the facility's QI/PI Committee on a quarterly basis. 6) The Director of Nutrition Services will monitor.	

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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 371	Continued From page 9 on 3/24/14 at 4:30 PM; 90 degrees at 6:30 PM; and 60 degrees at 8 PM. The following concerns were identified: a. Facility staff did not indicate at what time the roasts reached 135 degrees F (to start the two hour timeframe to reach 70 degrees F). According to the facility log, the temperatures of the roast were both above 70 degrees F at two hours, but the starting temperatures were above 135 degrees F. b. Facility staff did not document any temperatures after 8 PM. The last recorded temperature at 8 PM was 60 degrees F for both roasts which was above the final required cooling temperature of 41 degrees F. Due to lack of documentation, it was unable to be determined when the roasts would have reached the final cooling temperature of 41 degrees F. c. During an interview on 3/26/14 at 10:55 AM, the food service manager and dietitian #1 both agreed that the proper cooling procedure could not be verified based on the documentation on the cooling log. According to the Food Code 2013, U.S. Public Health Service, 3-501.14, "Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled; (1) Within 2 hours from 57 degrees C (135 degrees F) to 21 degrees C (70 degrees F); and (2) Within a total of 6 hours from 57 degrees C (135 degrees F) to 5 degrees C (41 degrees F) or less."			
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	F 441	The facility will continue to 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.	5/10/2014

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	03/27/2014

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WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

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F 441	Continued From page 10 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to effectively disinfect the glucometer during	F 441	1) One to one education was provided to RN #2 on 3/27/2014 regarding the proper procedure for disinfecting the glucometer. 2) The Glucose Monitoring skills checklist was revised on 4/10/2014 to reflect the disinfection time of three (3) minutes in accordance with the properties of the new Sani-cloth product that is currently in use in the facility. 3) All nursing staff who conduct glucometer testing have been assigned a mandatory education module regarding the use and disinfection of the glucometer between residents. 4) Nursing staff utilization of glucometers will be observed by the D.O.N. to assure proper technique for infection control practices. 5) The D.O.N. will develop a QI/PI indicator regarding glucometer disinfection and report the findings to the facility's QI/PI Committee on a quarterly basis. 6) One to one education was provided to dietary staff #1 on 3/26/2014 regarding handwashing protocols. 7) All dietary staff will be educated regarding proper handwashing protocols at a staff meeting scheduled for 4/29/2014. 8) The Director of Nutrition Services will observe staff handwashing, and develop a QI/PI indicator from the observations, which will be reported to the facility's QI/PI Committee on a quarterly basis.	

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F 441	Continued From page 11 observations of blood glucose testing done for 3 of 3 residents (#9, #35, #73) observed receiving this test. The facility also failed to ensure staff complied with recognized standards of hand hygiene during 1 of 2 mealtime observations. The findings were: 1. On 3/26/14 from 11:45 AM to 11:56 AM, RN #2 was observed performing fingerstick blood glucose testing for residents. During the observation, the RN cleaned the glucometer with a Sani-cloth for ten seconds after using it for resident #9 and before using it for resident #35. Continued observation revealed the RN then used a Sani-cloth to clean the glucometer for fifteen seconds after using it for resident #35 and before using it for resident #73. An interview with RN #2 on 3/26/14 at 2:08 PM revealed she was not aware of the required Sani-cloth contact time for effectively disinfecting the glucometer. Review of the facility's Glucose Monitoring System and interview on 3/26/14 at 4:50 PM with the SDC revealed the procedure for disinfecting the glucometer between residents required the following steps: "Using two Sani-cloths thoroughly wet/wrap surfaces of the glucometer for five minutes, then allow to air dry." 2. Observation during the noontime meal on 3/26/14 at 12:15 PM showed a member of the dietary staff (#1) used a dishtowel to wipe up a spill on the floor of the main dining area. At that time she was not wearing gloves and failed to wash her hands. Immediately afterward, the dietary staff (#1) went to two resident dining tables and placed her unwashed hands on the eating surface of the tables and shoulders and backs of non-sample residents #11, #20 and #55. Interview with the dietary staff (#1) after the	F 441	9) The Director of Nursing and the Director of Nutrition Services will monitor.	

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F 441	Continued From page 12 observation confirmed she should have washed her hands before touching the tables and residents.	F 441		