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 _____	04/01/2011

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 279 SS=F	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident and staff interview, it was determined that the facility failed to develop care plans to meet residents' needs. This failure was found for five of thirteen sample residents (#11, #9, #12, #7, and #3) and one of three closed sample residents (#14) who were at skin risk, had skin breakdown/pressure ulcers, experienced weight loss, and had falls. The findings included: 1. Record review for sample resident #11 evidenced that the resident was admitted to the facility from the hospital on 3/18/11. The	F 279	The facility will continue to ensure that comprehensive care plans are developed for each resident. 1. The Care Plan and staff care sheets (Kardexes) for Resident #11 will be revised to include skin care needs, risks, interventions and treatments. 2. The Care Plan and staff care sheets (Kardexes) for Resident #3 will be revised to include skin care needs, risks, interventions and treatments. 3. The Care Plan and staff care sheets (Kardexes) for Resident #7 will be revised to include any appropriate fall prevention interventions. 4. The Care Plan and staff care sheets (Kardexes) for Resident #9 will be revised to include clear liquids as tolerated, and interventions for any skin breakdown, monitoring of the skin, and weight loss. 5. The Care Plan and staff care sheets (Kardexes) for Resident #12 will be revised to include skin care needs, risks, interventions and treatments. 6. Resident #14 is deceased. 7. All residents' care plans will be updated with information affecting the care of the resident at the time that interventions are added or changed, and will reflect the resident's current functional status. Each resident's care plan is completely reviewed at least quarterly and upon any change in condition.	~~05/09/2011~~ 05/05/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
x Deanna Kaiser, NHA	x Administrator	x 04/28/2011

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.

Deanna Kaiser, NHA Administrator 05/04/2011

Per Conversation with CMS R.O.

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F 279	Continued From page 1 resident's diagnoses included right rib fracture, right hip fracture from a fall with ORIF (open reduction internal fixation), hypertension, hypothyroidism, and osteoporosis. a. Review of the medical record showed the resident was admitted from the hospital with skin breakdown which included a small decubitus in the gluteal fold. On 3/28/11 the documentation showed a decline in the wound and possible cellulitis. The wound nurse documented that the left gluteal area was very erythematous, measured 25 cm length and 9 cm width with light serous drainage. The area was also described as having cellulitis with ulceration in the inner aspect of gluteal fold, measuring 2 cm by 1.3 cm. b. Review of the resident's care plan dated 3/18/11 identified a problem of "pain for infection at surgical site and/or skin abrasions". The interventions listed were: "Observe bruises while healing, Apply topical cream to abrasions, dressings over staples until removed and then steri strips, and Document wound status". This also had a review dated 3/24/11 with no changes made. The plan of care did not address interventions to meet this resident's skin care needs and risks. The care plan did not include pressure reducing devices for chair or bed and turning/repositioning when being admitted with decubitus ulcer and skin issues from the hospital. The care plan was not updated when the cellulitis was identified to show the interventions to be provided. (Cross refer to F314) 2. Record review for sample resident #3 evidenced that the resident was admitted to the facility on 3/9/11. The resident's diagnoses included Alzheimer's, dementia, CAD (coronary	F 279	8. A representative sampling of residents' care plans and staff care sheets will be reviewed weekly by the Director of Nursing and Staff Development Coordinator to ensure that residents with identified needs, including skin care, nutritional intake, and fall prevention, have that information reflected on their Care Plan and staff care sheets (Kardexes), and that the information reflects the resident's current functional status. 9. The information from the review of residents' care plans will be developed into a Quality Improvement indicator, and the results will be reported by the Director of Nursing on a quarterly basis to the Medicine/Critical Care Committee with oversight by the organization-wide Quality Improvement/Performance Improvement Committee until resolved. 10. The Director of Nursing will monitor.	

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F 279	Continued From page 2 artery disease), hypertension, diabetes, left leg weakness, and history of urinary tract infection. a. Review of the "LTCC Nursing Notes" showed the resident developed a blister on the right heel on 3/15/11, six days after admission. b. Review of the "Active Pressure Wound Audit" provided by the DON (Director of Nursing) showed resident #3 had a facility acquired pressure sore on the right heel. c. Review of the resident's care plan dated 3/9/11 revealed interventions to meet this resident's skin care needs and risks were not addressed until 3/22/11, when a problem of "skin breakdown" was added. The plan of care did not address the development of pressure sore on the resident's heel until seven days after it was found. The plan of care did not address the need for a nursing assessment and monitoring of the resident's feet (diabetic)before or after the heel wounds were identified. (Cross refer to F314) 3. Record review for sample resident #7 evidenced that the resident was admitted to the facility on 3/19/08. The resident's diagnoses included dementia, depression, left hemiparesis, osteoarthritis, recent bladder stones, chronic urinary infections, and BPH (benign prostatic hypertrophy). The resident was identified by the facility to be at risk for falls and had a fall documented on 2/5/11. a. Review of the "Care Plan" sheet identified a problem of "Risk for falls" dated 2/11/11. The goal listed no falls and the review was dated May 2011. The interventions were blank with no interventions listed. The area under follow up	F 279		

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F 279	Continued From page 3 listed a fall date of 2/5/11. There was no evidence interventions were assessed and/or altered in an attempt to prevent further falls. b. The Minimum Data Set (MDS) Coordinator confirmed on 4/1/11, during the exit conference, that the resident's care plan was incomplete. 4. Record review for resident #9 revealed that the resident was admitted on 12/28/10 with diagnoses that included normal pressure hydrocephalus, pituitary tumor, hypertension, falls, dementia, glaucoma, and stroke. a. Review of the resident's "LTCC SBAR" (per staff this was pre-admission assessment) dated 12/27/10 (one day prior to admission) revealed that the resident was assessed to have no skin wounds, a Braden scale of 13, normal skin, and no wound care, to independently eat a regular diet, and to weigh 178 pounds. b. Review of the resident's 2/9/11 significant change MDS assessment evidenced that the resident was totally dependent and required one or two plus staff for the Activities of Daily Living (ADLs) of bed mobility, dressing, eating, personal hygiene, and bathing. The resident's ADLs of transfer, walk in room and in corridor, locomotion on unit and off unit, and toilet were coded as did not occur. The assessment indicated that the resident's weight was 184 pounds, the resident had not experienced any weight loss, had a feeding tube, and received 51 % or more of the total calories through the tube feeding. No pressure ulcers were noted on this assessment or on the admission assessment.	F 279		

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F 279	Continued From page 4 c. Review of the resident's nutritional assessments/notes dated 1/29/11, 2/8/11, 2/28/11, and 3/30/11 revealed that the resident had a feeding tube inserted (2/7/11) and had experienced significant weight loss. The resident had not been weighed so the weight loss was not identified until 2/24/11 when the first weight since the admission weight was done. Additionally, this weight loss was not addressed by the Diet Technician until 2/28/11 (17 days after the resident's tube feeding was started). (Refer to F325 for specifics on nutrition). d. Review of the resident's "Pressure Ulcer, Stage Two Orders" and skin breakdown documentation provided to the surveyor evidenced the following skin breakdowns: 1/8/11 - right buttocks not measured, Xenaderm ointment, apply BID (twice a day) and PRN (as needed) 1/18/11 - right and left buttocks 1/27/11 - right buttock had large purplish area - very close to breakdown 1/29/11 - left buttock red spots 2/15/11 - open right buttock. e. Review of the resident's Care Plan (last dated update was 2/10/11) and nurse and nurse aide care sheets (referred to as Kardexes by some staff) evidenced that the resident's significant weight loss after entering the facility was not addressed. The care plan listed the GT (gastrostomy tube) and tube feeding for nutrition/hydration. Neither the nurse or nurse aide sheets indicated that the resident was to have clear liquids as tolerated (as noted in the nutritional notes).	F 279		

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F 279	Continued From page 5 f. Review of the resident's Care Plan (last dated update was 2/10/11) and nurse and nurse aide care sheets (referred to as Kardexes by some staff) evidenced that the resident's ongoing skin breakdown was not addressed. The Care Plan noted the resident's heels were to be floated, he/she was on a turning schedule, and a waffle air mattress was to be used. The nurse care sheet did not list interventions for any skin breakdown or monitoring of the skin. The nurse aide care sheet noted that the resident was to be turned every 2 to 3 hours when in bed and to have a Baxter pad and an air mattress. (Note: On 1/27/11, nurse A charted that the Baxter pad was to be removed as it "negates the value of the winged therapy mattress as well as the new waffle mattress..") 5. Record review for resident #12 evidenced that the resident was admitted 1/19/11 with diagnoses that included anemia, dementia, chronic diarrhea, hypertension, hypothyroidism, osteoporosis, chronic obstructive pulmonary disease, and insomnia. a. Review of the resident's physician orders evidenced "Pressure Ulcer, Stage Two Orders", dated 2/4/11, listing a Stage two pressure ulcer on the right buttock. The following orders related to the resident's actual skin breakdown: "Nursing Orders: Change position every 1-2 hours Use turn sheet to present shearing Do not rub red areas Encourage diet and fluid intake Treatment: "Xenaderm" ointment, apply BID and PRN	F 279		

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F 279	Continued From page 6 Pressure reducing devices: (none marked by physician) Medications: (none marked by physician) Referrals: (none marked by physician)." b. Review of the resident's wound tracking documentation (3/4/11 - 3/8/11, 3/14/11, 3/15/11, 3/21/11, and 3/29/11) revealed that the resident had two or three small open areas on the right buttock. c. On 3/31/11 starting at 9:28 AM, the following observation was made with nurse O: Resident #12's right inner buttock had two small open areas and the area surrounding the open areas was red. The nurse and Certified Nurse Aide (CNA) P indicated that the redness was a normal color of the resident's buttocks. The nurse applied Xenaderm. d. Review of the resident's Care Plan dated 1/27/11 and nurse and nurse aide care sheets (referred to as Kardexes by some staff) evidenced that the resident's ongoing skin breakdown was not addressed. 6. Closed record review for resident #14 evidenced that the resident was admitted to the facility on 1/6/06 and had diagnoses that included chronic obstructive pulmonary disease, hypertension, osteoporosis with compression fractures, cervical kyphosis, hypothyroidism, panic attacks, anxiety, and recurrent urinary tract infections.	F 279		

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F 279	Continued From page 7 a. Review of the nursing notes revealed that on 1/28/11, the MDS Coordinator noted that "...has been declining physically with poor intakes and loss of abilities. An area on ___(his/her) bottom that started out as a cyst of some kind has developed an unstagable area that is not over a bony prominence but has characteristics of deep tissue damage. Wound Care nurse has initiated a KCI First Step mattress overlay and ___(resident's name) is not to sit in ___(his/her) recliner or wheelchair until this area is resolved. Will do a Significant Change MDS. Area is open to air with Xenaderm twice a day. On a turn schedule." b. Record review for the resident including physician visits and orders, wound charting from November, 2010 through January, 2011, and nursing notes evidenced that the resident's pressure ulcers continued to deteriorate and the possible cyst area worsened and had begun draining, causing a potential for infecting the open pressure ulcers. The specialized mattress (First Step) was placed on the bed on 1/28/11. At this time the resident was restricted to bed, except for lift transfers to the bathroom. The wound notes mention the resident's declining condition, including not eating and the plan to involve dietary. There was no evidence to show that the "nice pads" in the recliner were appropriate, effective pressure reducing/relieving cushions or that the pads had been assessed to meet the individual resident's needs. There was no evidence of a nutritional assessment or of nutritional interventions or a diet change/modification, including supplements, added after the resident's skin condition began deteriorating and the resident had decreased meal intake. There was no evidence that	F 279		

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F 279	Continued From page 8 different treatment options other than Xenaderm were considered as the resident's skin condition deteriorated. (Refer to F314 for details related to the pressure ulcers) c. Review of the resident's Care Plan (last dated update was 12/23/10) and nurse and nurse aide care sheets (referred to as Kardexes by some staff) evidenced that the resident's ongoing skin breakdown was not addressed as such. No problem of skin breakdown was listed on the Care Plan. Under Dressing, there was an approach to turn every 2 hours when in bed (dated 1/11/11). The Care Plan had the following additions related to skin and positioning: Appliances - 1/11/11 partial lift prn 1/31/11 KCI (mattress) Mobility - 1/28/11 KCI w/bedrest with bathroom privileges; no wheelchair, recliner 1/19/11 turn schedule every 2 hours when in bed Toileting - 1/11/11 check and change every 2 hours at noc 1/31/11 dri flow pad The nurse care sheet dated 1/28/11 had the following additions related to the resident's skin issues hand written in: No attends; just Dryflows; Turn; KCI airbed; BR with BRP only The nurse care sheet dated 1/28/11 had the following printed information related to the resident's skin issues :	F 279		

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F 279	Continued From page 9 Wound care - coccyx; Turn schedule in bed. The nurse aide care sheet dated 1/28/11 had the following printed information related to the resident's skin issues. Toilet AC (before meal)/check and change every two hours at noc; turn every 2 hours when in bed. Review of these three forms failed to show an overall care plan that addressed the resident's current plan of care related to the resident's pressure ulcers, on the resident's buttocks and foot. The nurse aide sheet did not indicate that the resident was on bedrest with bathroom privileges only and was to wear slippers, not shoes. The nurse's sheet did not describe the wound care or frequency. Additionally, the Care Plan and care sheets had not been updated to show the resident's significant declines in ADL functioning. The resident did not have a comprehensive care plan based on assessment of the resident's status.	F 279		
F 314 SS=G	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.	F 314	The facility will continue to ensure that appropriate and timely interventions are implemented to prevent the development of new pressure ulcers, prevent the decline of existing pressure ulcers, and/or to treat the ulcers once they develop. 1. Resident #11 had surgical intervention on 04/07/2011 for her existing wound, and is recovering very well. Resident #11 is receiving ongoing treatment with a wound vacuum, and has pressure relieving devices in the bed and wheelchair. The Care Plan and staff care sheets for Resident #11 include appropriate information regarding wound care and treatment.	~~05/09/2011~~ 05/05/2011 JMK

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F 314	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident and staff interview, it was determined that the facility failed to implement appropriate, timely interventions to prevent the development of new pressure ulcers, prevent the decline of existing pressure ulcers, and/or to treat the ulcers once they developed for seven of thirteen sample residents (#11, #9, #12, #13, #5, #4, and #3) and one of three closed sample residents(#14). The findings included: Reference According to "Pressure Ulcers in Adults: Prediction and Prevention", U.S. Department of Health and Human Services, Clinical Practice Guideline, Number 3, "Any person at risk for developing a pressure ulcer should avoid uninterrupted sitting in any chair or wheelchair. The individual should be repositioned, shifting the points under pressure at least every hour or be put back to bed if consistent with overall patient management goals." According to "Pressure Ulcer Treatment", U.S. Department of Health and Human Services, Clinical Practice Guideline, Number 15, the resident should have an individually prescribed seat cushion which will relieve or reduce pressure on bony prominences. Support surface and positioning needs should be assessed and reviewed regularly and determined by results of skin inspection, patient comfort, ability, and general state. Covering these support services with bed linens, towels or incontinent pads decreases their effectiveness for pressure relief.	F 314	2. The acquired blister on the right heel of Resident #3 has healed, and ongoing monitoring of the resident's feet is being conducted. An intervention has been added to the Care Plan and staff care sheets to moisturize the feet of Resident #3 on a daily basis, and off-load heels when in bed. Pressure relieving devices have been placed in the bed and wheelchair. The Care Plan and staff care sheets for Resident #3 include appropriate information regarding wound care and treatment. 3. An intervention has been added to the Care Plan and staff care sheets to moisturize the feet of Resident #9 on a daily basis, and to off-load heels when in bed. A pressure-relieving cushion was placed in the wheelchair of Resident #9 and the Care Plan and staff care sheets revised to include this information. 4. Residents #12, #13, #5, and #4 will all be re-assessed for skin integrity and appropriate treatment interventions developed to address identified skin issues, including pressure-relieving devices and other appropriate preventive devices. 5. Resident #14 is deceased. 6. All residents who have, or are at risk for, skin breakdown will be regularly assessed and provided appropriate preventive care and treatment for their skin care needs, including pressure-relieving devices, and the care and services will be documented in the residents' medical record, on the resident's care plan, and on the staff care sheets. 7. An electronic notification system has been developed to promptly advise the interdisciplinary care team, including the Registered Dietitian, regarding any resident with active skin problems and/or receiving wound care and services.	

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F 314	Continued From page 11 ___According to the CMS (Centers for Medicare and Medicaid) RAI (Resident Assessment Instrument) Version 3.0 Manual, : Unstageable Slough and/or Eschar is "Known but not stageable related to coverage of wound bed by slough and/or eschar; full thickness tissue loss; base of ulcer covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed". This is to be coded as M0300F. Reference for Xenaderm This combination product is used on skin wounds and ulcers to help relieve pain and help healing. Trypsin is an enzyme that helps to break up and remove dead skin and tissue. Balsam Peru is a mild antiseptic that helps prevent bacteria from growing and may also help the growth of skin cells. Castor oil is added to protect and soothe the affected area. This product may also reduce the odor from some wounds. How to use Xenaderm Top This medication is for use on the skin only. Avoid contact with eyes. Wash your hands before and after applying this medication. Apply a thin layer to the affected area, usually at least 2 times daily or as directed by your doctor. If your doctor has directed you to clean the affected area, clean it before applying this medication. Leave unbandaged or apply a dressing as directed by your doctor. To remove the medication, wash gently with water. If you are unsure about how to clean the affected area or apply this medication, consult your doctor. 1. Record review for sample resident #11 evidenced that the resident was admitted to the facility from the hospital on 3/18/11. The	F 314	8. Qualified nurses will measure wounds stage II and above on a weekly basis and document the information in the resident's medical record. 9. Education will be provided to the nursing staff regarding the assessment for risk of pressure sores and appropriate treatment for identified issues. 10. An interdisciplinary Wound Care team has been developed comprised of a Certified Wound Care Registered Nurse, the Director of Nursing, the Staff Development Coordinator, the Registered Dietitian, the MDS/Resident Assessment Coordinator, and the Rehabilitation Services Director/Physical Therapist. This team meets on a weekly basis and reviews all residents who are at risk for developing skin breakdown, as well as those residents currently receiving treatment for wounds and other skin problems. (See Attached) Interventions and preventive measures are determined, treatment progress is reviewed, and the information is documented in the resident's medical record. The resident's care plan and staff care sheets are revised to reflect any changes in the plan of care. 11. The care and treatment of residents with pressure sores, and the services provided to prevent pressure sores will be regularly monitored by the Director of Nursing and developed into a Quality Improvement indicator. The results of the monitoring will be reported to the Medicine/Critical Care Committee and the organization-wide Quality Improvement/Performance Improvement Committee on a quarterly basis. 12. The Director of Nursing will monitor.	

LTCC WOUND CARE PREVENTION AND TREATMENT

WEEK OF: **YEAR: 2011**

Name	Braden Score	Active Wound? Y N	Site and Description of Wound	Treatment	Nutrition Intervention	Seating	Mattress	C.P. & Kardex updated

F314

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 _____	04/01/2011

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F 314	Continued From page 12 resident's diagnoses included right rib fracture, right hip fracture from a fall with ORIF (open reduction internal fixation), hypertension, hypothyroidism, and osteoporosis. a. Review of the patient report summary sheet dated 3/18/11 also identified the resident as having type II diabetes. The skin assessment on this form noted the resident as having bruising. The "wound care" was documented as "Blisters on gluteal crease upper area." Another "LTCC SBAR" sheet dated 3/18/11 identified the resident's Braden (skin risk assessment) as "19". The wounds were documented as "blisters at folds and tape blister on right thigh". However, the resident had a Standing order sheet started on admission for "Pressure Ulcer Stage Two Orders". [Note: The Braden Scale is a rating scale from 6-23. A lower Braden Scale Score indicates a lower level of functioning and, therefore, a higher level of risk for pressure ulcer development. A score of 19 would indicate that the patient is at low risk, with no need for treatment at this time.] b. Review of the "Discharge Summary" from the hospital included, "He/she had some small traction blisters at the tape on his/her hip which was noted when dressing changed on postoperative three. ...He/she did develop some superficial decubiti in his/her sacral region while in the hospital. This was just stage I with some slight blistering and the nurses monitored it with DuoDerm ..." [Note: Information faxed to surveyor following the survey had a correction which noted DuoDerm	F 314		

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F 314	Continued From page 13 was not used in the hospital. The facility reported it was Xenaderm.] c. Observations of resident #11 were made on 3/30/11 at 9:40 AM when nurse G provided wound care. The resident was in the bathroom when nurse G entered the room. The nurse washed her hands, donned gloves and provided peri care before the wound treatment. The resident stood to have his/her buttocks cleansed. The nurse picked up a package of disposable wipes opened them with a key and removed the wipes to do cares. The resident told the nurse that he/she was told not to let anyone use wipes on his/her bottom due to his/her skin condition. The nurse stated, "These wipes don't have anything allergic in them" and proceeded to wipe the resident's buttocks. [Note: The physician orders on admission stated, "No wet wipes/use H2O & soap ONLY". The wipes that were used did contain Aloe Vera and lanolin.] The resident had a large area of erythema/redness over the left buttock with redness extending into the gluteal fold and blistering along the left gluteal fold. When the top of the gluteal fold was separated, a quarter size area of black eschar was observed. The nurse removed her gloves, washed her hands, donned gloves and applied Xenaderam to the entire buttocks including the gluteal fold. The nurse reported that the resident was started on an antibiotic due to the area having an infection. The nurse staged the wound as a "Stage II". The resident complained of pain during the perineal care and wound treatment when the inflamed area was touched. The incision area on the resident's right hip was healed which demonstrated the resident's healing process.	F 314		

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F 314	Continued From page 14 [Eschar is described as thick, leathery, frequently black or brown in color, necrotic (dead) or devitalized tissue that has lost its usual physical properties & biological activity.] d. Resident interview on 3/30/11 following the wound cares revealed the resident was not provided timely interventions which included a pressure relief surface for the wheelchair and recliner. The resident stated, "They gave me this scalloped pad yesterday for my wheelchair" and pointed to a two inch egg crate foam pad he/she was sitting on. "They had a blue plastic pad in my wheelchair that was hard as a rock first when my bottom got sore. I complained because it hurt to sit on. Before that I didn't have anything in my wheelchair. I didn't think my bottom was sore when I came in but it is really sore now. The wound nurse told me they should not use those wipes on my bottom just a warm cloth but some staff just don't listen. I had a sore on my coccyx a long time ago but it healed. I know they started my antibiotics yesterday (3/29/11) for the infection and I don't know what to do because I'm supposed to be going home soon". e. Review of the "LTCC nursing notes" provided included the initial notes on admission dated 3/18/11 to 3/31/11. The notes included: 3/18/11 - "Wounds/TX: 3 surgical sites with staples and dressings, bruises on R (right) leg internal and external and on pubic area, and skin abrasions on left buttocks and right hip from wipes/tape". 3/22/11- the notes identified open area on coccyx which was not measured.	F 314		

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F 314	Continued From page 15 3/27/11 - (9 days later) next documentation on the wounds in the gluteal fold stated, "Resident's coccyx very red and warm to touch has scab in coccyx fold. E-mail sent to (name) wound care". 3/28/11- "Up to toilet. Wound in gluteal fold draining seroserous fluid. Wound warm to touch. Cleaned with wet towels. Applied Xenaderm". 3/28/11 - "Res. was seen by wound care nurse, (name). Note faxed to MD requesting atb therapy for possible cellulitis". The wound nurse documented that the left gluteal area was very erythematous, measures 25 cm length and 9 cm width with light serous drainage. The area was also described as having cellulitis with ulceration inner aspect of gluteal fold 2 cm by 1.3 cm. 3/29/11 The notes showed the resident was seen by the physician and a new order was written to consult wound care and start resident on Keflex 500 mg three times a day for ten days. 3/30/11- "Roho cushion place to seat in resident's recliner". f. Review of the physician progress notes dated 3/29/11 stated, "Called to see for red sore buttocks. Pt. had a 2nd degree decubiti in (hospital) which over the weekend significantly increased in size with surrounding erythema and a deep Stage III ulcer... Decubiti ulcer over coccyx with surrounding cellulitis. P (plan) antibiotics and wound care". g. Review of the resident's care plan dated 3/18/11 identified problem of "pain for infection at surgical site and/or skin abrasions". The	F 314		

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F 314	Continued From page 16 interventions listed were: "Observe bruises while healing, Apply topical cream to abrasions, dressings over staples until removed and then steri strips, and Document wound status". This also had a review date of 3/24/11 with no changes made. The plan of care did not address interventions to meet this resident's skin care needs and risks. The care plan did not include pressure reducing devices for chair or bed, turning/repositioning, ulcer care or wound cares when being admitted with decubitus ulcer and skin issues from the hospital. The care plan was not updated when the cellulitis was identified to show the interventions provided. Review of the resident's care sheets used for nurses and aides were also reviewed. The nurses sheets included, "dressing to R hip, wipe/tape burns buttocks/hip and Medicare assessment". It also listed FSBS (fasting blood sugars) four times a day. The sheet had not been updated to show cares when the coccyx was very red and warm to touch and scab in coccyx fold. The aides care sheets included, "NO WET WIPES/USE H2O & Soap ONLY, and tape sensitivity." h. Interview with nursing staff who did not want to be identified reported that they had been told not to stage wounds or document sizes of wounds. "We've been told that the wound nurse is supposed to be the one documenting on the wounds." Also that the wound care nurses came from the hospital when referrals were made on skin issues per the policy and procedure. The nurses confirmed that resident #11's wound care was twice a day by nursing with only limited documentation of the observation made during	F 314		

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F 314	Continued From page 17 wound care. i. In a follow up interview with the resident on 3/31/11 at 10:30 AM, the resident complained of increased pain. The resident reported he/she had requested another pain pill and could not tolerate sitting in the recliner due to pain from the "sores on my tail bone". j. Review of the "Wound Care" policies and procedures with a revised date of 4/06 included a protocol for the hospital and long term care. It addressed surgical and traumatic wounds, rashes including rash of perineum and rectal areas and pressure ulcer protocol and standing physician order sheets for Stage I, II, III and IV breakdown. All areas addressed "Complete wound care documentation". Resident #11's had a standing order sheet started on admission 3/18/11 for "Pressure Ulcer Stage Two Orders". This sheet identified the treatment of Xenaderm ointment BID and PRN. It did not address any pressure reducing devices nor where the measurements of the area were to be documented. k. Interview on 3/30/11 with the DON (Director of Nursing) confirmed that resident #11's nursing notes and the wound documentation were incomplete and plan of care did not address this resident's skin care needs. The DON reported she was trying to get the skin documentation to be more consistent by having the wound care nurses documenting skin breakdown. They were currently working on revising the wound policy and procedure. However, the wound care nurses were only listed as referrals on complicated wounds. This resulted in a lack of wound	F 314		

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F 314	Continued From page 18 assessments and inconsistent documentation. The facility failed to ensure a resident having pressure sores received necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. 2. Record review for sample resident #3 evidenced that the resident was admitted to the facility on 3/9/11. The resident's diagnoses included Alzheimer's, dementia, CAD (coronary artery disease), hypertension, diabetes, left leg weakness, and history of urinary tract infection. a. Review of the admission MDS (minimum data set) assessment dated 3/25/11 identified the resident as being at risk for pressure ulcers and having ongoing Stage II pressure ulcers on admission. b. Review of the standing order sheet for pressure ulcers Stage II identified the resident having pressure ulcers on the right and left gluteus. It noted the measured areas on the right as 1.0 cm x .9 cm, and on the left as .3 cm x .4 cm. c. Resident #3 was observed on 3/30/11 when nurse G was doing wound care. The resident was seated in the recliner with his/her feet elevated. The resident was wearing a slipper sock with the right heel resting on the foot rest. The nurse reported the open areas on the resident's bottom had healed but the resident had developed a blister on his/her right heel after admission. The nurse removed the resident's right sock and checked the right heel. The resident had a quarter size discolored area on the right heal. The nurse reported the area was a blister but is now	F 314		

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F 314	Continued From page 19 drying. The area was described as looking like a dried blood blister which is improving. d. Review of the "LTCC Nursing Notes" included: 3/9/11 (admission) - "He/she wears orthopedic shoes. He/she wears left ankle AFO for foot drop. Today feet are without any skin breakdown ...The left ankle problem is related to central spinal cord damage ... " 3/15/11- The documentation showed the blister on the right heel was found by the bath aide six days after admission. 3/16/11- It indicated the area on the resident's right heel was referred to Wound Care and interview with the resident's spouse reported the resident had breakdown on his/her right heel before. e. Review of the "Active Pressure Wound Audit" provided by the DON showed resident #3 had a facility acquired pressure sore on the right heel. f. Review of the resident's care plan dated 3/9/11 revealed interventions to meet this resident's skin care needs and risks were not addressed until 3/22/11 when the problem of "skin breakdown" was added. It identified skin breakdown Stage II on the left and right gluteus which were present on admission and the right heel as an "unstaged intact blister". The plan of care did not address the development of the pressure sore on the resident's heel until seven days after it was found. The plan of care did not address the need for a nursing	F 314		

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F 314	Continued From page 20 assessment and monitoring of the resident's feet (diabetic) before or after the heel wounds were identified. 3. On 3/31/11 at 9:25 AM, in an interview with the Director of Nursing (DON), the surveyor requested to have her or a nurse view the skin of residents' (#4, #12, #13, #9, and #5) who currently have or have had pressure ulcers. The DON stated that the nurses could do that. On 3/31/11 starting at 9:28 AM, the following observations were made with nurse O: a. Resident #9 was lying in bed on his/her back without his/her heels floating. When the resident was turned to each side after the nurse unfastened the resident's incontinent brief, his/her back and buttocks were red. The resident's heels and feet were dry and had peeling skin. The resident was lying on a Waffle Mattress Overlay. The nurse placed pillows under the resident's legs, but the resident's heels were still not off the mattress. Additionally, there was no pressure relieving/pressure reduction cushion observed in the resident's wheelchair. During the survey time, the resident was observed at various times to be seated in his/her wheelchair. b. Resident #12's right inner buttock had two small open areas and the area surrounding the open areas was red. The nurse and Certified Nurse Aide (CNA) P indicated that the redness was a normal color of the resident's buttocks. The nurse applied Xenaderm. When asked if measurements of the open areas were done, the nurse revealed that "nurses don't measure wounds".	F 314		

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F 314	Continued From page 21 c. Resident #13's was observed while standing in the sit to stand lift. No open areas were observed on the resident's buttocks. When the resident's left heel was observed, two red areas which did not blanch were found on the bottom of the foot. The staff were not aware of the areas, but suggested the areas might be from the resident's slippers. Additionally, the resident's chair did not have any pressure relieving or reducing devices in it. d. At 9:50 AM, the nurse left the Special Care Unit (SCU). CNAs P and Q transferred resident #5 into bed from his/her high backed wheelchair, using the maxi lift. The resident's heels were checked and found to have no skin breakdown. At 9:55 AM when nurse O came into the resident's room, the resident's back and buttocks were observed and found to have no skin breakdown. Additionally, the resident's wheelchair was observed to have no pressure relieving or reduction devices in place. e. On 3/31/11 at 10:15 AM, resident #4's skin was observed with nurse C. The resident's left heel had dry skin. The back, outer side of the right heel had a black, dry area which the nurse identified as a scab. There was peeling skin on the heel. The resident's right upper buttock had several small purplish/black areas and the buttock was light red. The left upper buttock had two small purplish/black spots on it. These areas were not observed to be open. The resident stated that these were really improved and that he/she used Vasolex Ointment on the areas. There was a cushion in the resident's wheelchair, which he/she identified to be an "air cushion", but it was not a pressure relieving/reduction device.	F 314		

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F 314	Continued From page 22 4. Record review for resident #9 revealed that the resident was admitted on 12/28/10 with diagnoses that included normal pressure hydrocephalus, pituitary tumor, hypertension, falls, dementia, glaucoma, and stroke. a. Review of the resident's "LTCC SBAR" (per staff this was pre-admission assessment) dated 12/27/10 (one day prior to admission) revealed that the resident was assessed to have no skin wounds, a Braden scale of 13, normal skin, and no wound care, to eat a regular diet independently, and to weigh 178 pounds. b. Review of the resident's LTCC Nursing Assessment form dated 12/29/10 noted that the resident's Braden Scale score was 22 (low risk for skin breakdown) when it was completed on 12/28/10. c. Review of the resident's "LTCC Nursing Notes" revealed a note dated 1/27/11 and written by nurse A. "Recommendation: A waffle mattress was began today. Will also be removing ____(his/her) Baxter pad as it negates the value of the winged therapy mattress as well as the new waffle mattress as well as it is allowing more heat to build in the perianal area. Have also added two more pillows to keep ___(his/her) heels up and for better support when on ___(his/her) side." d. Review of the resident's 2/9/11 significant change Minimum Data Set (MDS) assessment evidenced that the resident was totally dependent and required one or two plus staff for the Activities of Daily Living (ADLs) of bed mobility, dressing, eating, personal hygiene, and bathing. The resident's ADLs of transfer, walk in room and	F 314		

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F 314	Continued From page 23 in corridor, locomotion on unit and off unit, and toilet were coded as did not occur. No pressure ulcers were noted on this assessment or on the admission assessment. e. Review of the resident's physician standing order sheet (listed as "Pressure Ulcer, Stage Two Orders") and dated 1/8/11 revealed the following orders related to actual skin breakdown: "Nursing Orders: Change position every 1-2 hours Use turn sheet to present shearing Do not rub red areas Encourage diet and fluid intake Treatment: 'Xenaderm' ointment, apply BID and PRN Pressure reducing devices: (none marked by physician) Medications: (none marked by physician) Referrals: (none marked by physician)." f. Review of the resident's "Pressure Ulcer, Stage Two Orders" and skin breakdown documentation provided to the surveyor evidenced the following skin breakdowns: 1/8/11 - right buttocks not measured, Xenaderm ointment, apply BID (twice a day) and PRN (as needed) 1/18/11 - right and left buttocks 1/27/11 - right buttock had large purplish area - very close to breakdown 1/29/11 - left buttock red spots 2/15/11 - open right buttock.	F 314		

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	535027	A. BUILDING _____ B. WING _____	04/01/2011

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F 314	Continued From page 24 g. On 3/29/11 at 9:25 AM, in an interview with nurse G, she indicated that the resident was receiving Xenaderm to his/her open area on the buttocks. h. No wound tracking was found to show that the facility routinely monitored, measured, or assessed the resident's skin breakdowns. Nor was there any documentation to show that nutritional interventions were considered to address the resident's skin breakdown. i. Review of the resident's "LTCC Nutritional Assessment" forms revealed an assessment by the Registered Dietitian (RD) dated 1/29/11. There was no evidence that the RD was aware of the Stage II pressure ulcer or of any significant weight loss. The next three nutritional notes were documented by the Diet Technician (DNT) on 2/8/11, 2/28/11, and 3/30/11 and did not show any awareness of the resident's skin breakdowns. (Refer to F325 for specifics related to the resident's nutritional status). j. On 3/31/11 at 3:10 PM, in an interview with Registered Dietitian (RD), she revealed that weights were generally done on a monthly basis. When asked about how she was notified when residents have skin breakdown, she commented that the notification was not good. She remarked that she has to search through the documentation to find needed information. She confirmed that she did not always receive nutrition referrals for consultations with residents who had wound (skin breakdowns). k. On 3/31/11 at 4:47 PM, in an interview with the Administrator, Director of Nursing, and nurse A,	F 314		

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F 314	Continued From page 25 the concerns about weight loss and skin breakdown and the RD's involvement were discussed. The concerns that the RD expressed about the communication and lack of a system of notification were included in this discussion. I. Review of the resident's Care Plan and nurse and nurse aide care sheets (referred to as Kardexes by some staff) evidenced that the resident's ongoing skin breakdown was not addressed. The Care Plan noted the resident's heels were to be floated, he/she was on a turning schedule, and a waffle air mattress was to be used. The nurse care sheet did not list interventions for any skin breakdown or monitoring of the skin. The nurse aide care sheet noted that the resident was to be turned every 2 to 3 hours when in bed and to have a Baxter pad and an air mattress. The nurse aide directions on the care sheet to turn the resident every 2 to 3 hours and for the resident to use the Baxter pad did not match the resident's current plan or orders. 5. Closed record review for resident #14 evidenced that the resident was admitted to the facility on 1/6/06 and had diagnoses that included chronic obstructive pulmonary disease, hypertension, osteoporosis with compression fractures, cervical kyphosis, hypothyroidism, panic attacks, anxiety, and recurrent urinary tract infections. a. Review of the resident's 1/11/11 history and physical examination revealed that the physician noted "...has had some skin breakdown and ___(he/she)is being followed by wound care. Xenaderm is being used on them. Last time I saw ___(him/her)on November 30 ___(he/she) had	F 314		

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F 314	Continued From page 26 what looked like maybe an inclusion cyst left iliac crest . Apparently that is improving. It has never opened up. Wound care will continue to follow." b. Review of the resident's physician orders revealed the following orders related to wound care: 10/9/10 (telephone order) - Xenaderm BID (twice a day) and prn, change from prn, to L (left) buttock, coccyx area. 11/15/10 (telephone order) - Change Xenaderm to prn (as needed) 1/28/11 (telephone order) - One First Step mattress; turn schedule please, no chair @ present, bedrest with BRP (bathroom privileges) c. Review of the resident's Wound Condition & Care Reports revealed the following: Note: Starting in 11/10, an area on the left iliac crest was noted by the physician to possibly be an inclusion cyst. The wound charting contained information about this area, noting it to be an ecchymotic area, small hard area, or a small eschar scab on the iliac crest or on the buttocks. The wound charting was confusing about the actual site and/or wound being described in each note. The pressure ulcers in the following charting notes appeared to relate to areas other than that of the possible cyst. 11/15/10 - Open areas are healed at this time. Xenaderm changed to prn; GEO, pillow under legs while in bed. 11/29/10 - Small pinpoint open area on R (right)	F 314		

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F 314	Continued From page 27 buttock, Xenaderm being used. ____(name) WC (wound care) here this am to look at lesion, nursing to use Xenaderm on it, Dr. ___ (name) called, will be over sometime this week to look at it. Several notes in December, 2010 described as R buttock or buttock, area remains open, Xenaderm applied, purplish/pink color. 12/29/10 - Two superficially opened areas noted to have 3 blisters on buttocks. 1/1/11 - Buttocks, not measured, superficial. 1/4/11 - Right foot 2nd toe, 0.1 x 0.1 cm, superficial, small blister on right foot 2nd toe, GEO, pillow under legs while in bed, Braden 19, doctor not notified, will wear slippers instead of shoes. 1/4/11 - Right buttock, not measured, superficial, two small superficial open areas. 1/5/11 - R gluteal/small L glut., 2 cm L x 1 cm W, superficial, Stage II noted, beefy red tissues, no fibrin, Xenaderm being applied, very small stage II on L gluteal, drainage - light serous, causes - pressure/possible decrease in nutrition, discussed w/staff, Will continue to monitor areas, appropriate treatment w/Xenaderm to all areas BID/PRN. Pt sits on nice pads when in chair, staff stated she has been eating less lately, may need more assist w/eating/encouragement (wound nurse) 1/10/11 - R gluteal w/2 cm round Stage II pressure ulcer, L gluteal w/no open area today. Open area to L hip/buttock is .3 cm L x .6 cm W x	F 314		

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F 314	Continued From page 28 sup D, no changes, but just below this area is deep tissue injury w/non-open deep purple area measuring 4 cm L x 1 cm W, new from last week, drainage - light serous, causes - pressure/new area from unknown etiology, pt is very fragile....discussed air bed options w/___ (MDS coordinator), but would make it difficult to elevate HOB (wound nurse) 1/13/11 - blister on toes, approx .1 cm, superficial, these 2 areas on tops of 2 and 3rd are white and do not blanch well, pressure/new area 1/13/11 - buttocks, not measured, superficial, three superficial open areas, one large and two small 1/27/11 - rt gluteal fold, 0.7 cm L x 0.4 cm W, superficial, Stage II w/Xenaderm on and pink wound bed - noted closed area above that appears red but healing. (Note: lt gluteal, 4.2 cm L x 3.0 cm W, unknown/slough, odor before debrided, causes - pressure vs trauma) (?? if this is previously described cyst) Pt resting on back in bed, turned to MRT side for assessment and cares. Attends w/large amount serosanguinous drainage from Lt gluteal wound. RN debrided dark slough from surface or wound that did relieve odor. Continue w/Xenaderm to aide in debridement and healing. Continue to debride as able at wound RN visits. Then schedule with no pressure to Rt gluteal area. No chair unless able to offload area. (wound nurse) 1/28/11 - l hip, peri wound area is red and puffy. Inner area of wound has layer of black eschar that looks like it is sinking down into wound about 0.4 cm deep, odor - foul	F 314		

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F 314	Continued From page 29 1/28/11 - rt gluteal fold, not assessed today, left hip, not measured today, wound w/thick fibrin and red peri-wound about 1 cm band. Pt to bed on first step mattress, pt on recliner sleeping and slouched to left side so sitting directly on wound. First step placed on bed and when set up pt was transferred to bed, pt not to sit on chair/recliner/wheelchair until healing. can be taken to toilet via standing lift. Pt turned to rt side to offload lt hip and legs elevated/separated w/foam pillows, now on turn schedule. d. Review of the nursing notes evidenced that on 1/26/11, nurse O charted "Resident's L hip decub is draining brown/yellow, foul smelling drainage. ___(name) wound nurse notified per e-mail." e. Review of the nursing notes revealed that on 1/28/11, the MDS Coordinator noted that "...has been declining physically with poor intakes and loss of abilities. An area on ___(his/her) bottom that started out as a cyst of some kind has developed an unstagable area that is not over a bony prominence but has characteristics of deep tissue damage. Wound Care nurse has initiated a KCI First Step mattress overlay and ___(resident's name) is not to sit in ___(his/her) recliner or wheelchair until this area is resolved. Will do a Significant Change MDS. Area is open to air with Xenaderm twice a day. On a turn schedule." f. On 3/31/11 at 4:47 PM, in an interview with the Administrator, she verified that the resident did not have any wound culture results. g. On 3/31/11 at 5:28 PM, in an interview with the MDS Coordinator, she confirmed the following wound information related to the progression of	F 314		

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F 314	Continued From page 30 the resident's skin condition: 11/30/10 - physician identified possible cyst on left iliac crest 12/5/10 - wound nurse noted small eschar 12/26/10 - two areas with skin problems 1/5/11 - wound nurse noted both left hip and gluteal and right gluteal skin issues 1/10/11 - deep tissue injury identified. The Coordinator verified that a GEO mattress was in place until the First Step mattress was implemented. Additionally, she confirmed that pressure reducing/relieving chair devices were not in place for this resident. h. On 3/31/11 at 3:10 PM, in an interview with the Registered Dietitian (RD), she was asked about resident #14's nutritional plan. She thought that maybe the resident had received Arginaid. Review of the resident's physician orders and of the record failed to show that the resident had been started on any supplements or that the skin breakdown had been assessed by the RD. In summary, the resident's pressure ulcers continued to deteriorate and the possible cyst area worsened and had began draining, causing a potential for infecting the open pressure ulcers. The specialized mattress (First Step) was placed on the bed on 1/28/11. At this time the resident was restricted to bed, except for lift transfers to the bathroom. The wound notes mention the resident's declining condition, including not eating and the plan to involve dietary. There was no	F 314		

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F 314	Continued From page 31 evidence to show that the "nice pads" in the recliner were appropriate, effective pressure reducing/relieving cushions or assessed for the individual resident. There was no evidence of a nutritional assessment or of nutritional interventions or change of diet, including supplements, added after the resident's skin condition began deteriorating and the resident had decreased meal intake. There was no evidence that different treatment options other than Xenaderm were considered as the resident's skin condition deteriorated. The facility was requested to provide any documentation related to the care and treatment of the resident's pressure ulcers, including nutritional interventions, assessments, etc. The week following the survey the facility sent additional documentation on the wound assessment, nursing notes, and physician information. This information was reviewed. [Note: The record review findings were based on hard copy medical record review and documentation requested and provided by the facility staff from their electronic record system. The facility had some documentation kept hard copy and some electronic.]	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	The facility will continue to ensure that the resident environment remains as free of accident hazards as possible, and each resident receives adequate supervision and assistance to prevent accidents. 1. Resident #10 is deceased as of 03/31/2011. Staff member N was counseled on 04/04/2011 regarding not providing intake to residents.	~~05/09/2011~~ 05/05/2011

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F 323	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined that the facility failed to ensure that the environment was as free of accident hazards as possible. This was related to: 1) Care of a resident who was at risk for choking (residents #10 and #5), 2) Entrapment risk with the use of assistive devices (residents #19 and #20), 3) Accessible chemicals, and 4) Medication left on table in Special Care Unit (SCU). The findings included: Choking Risk 1. Record review for resident #10 evidenced the resident had diagnoses that included end stage Parkinson's Disease, incontinence, insomnia, migraine headaches, history of urinary tract infection, and dehydration/sepsis. a. Review of the resident's nursing notes revealed the following notes related to the resident's difficulty swallowing or choking: 3/22/11 - "Has had noted difficulty swallowing this noc, having to swallow several times in order to get a small amount of fluid down.." 3/23/11 - "Choking episode after dinner. Cup of tuna salad left in room which ___(he/she) was feeding ____(himself/herself). Day LPN (Licensed Practical Nurse) suctioned Res. Encouraged Res to cough. Was able to clear. Recommend supervision while Res eating due to increased difficulties swallowing." b. Review of the resident's Care Plan and nurse	F 323	2. Staff assigned to the care of resident #5 has received education by the Staff Development Coordinator/Registered Nurse regarding the importance of having the head of the wheelchair elevated when providing intake to the resident. The Care Plan and staff care sheets have also been updated to reflect this information. 3. All staff will receive education regarding proper positioning of residents during the provision of food and/or fluids. 4. The upper side rails on the beds of Residents #19 and #20 were modified on 04/19/2011 with a cover that will prevent possible entrapment, and the lower side rails were removed. The gaps between the side rails and the mattress on the beds of Resident #19 and #20 will be filled with a pad to prevent the possibility of entrapment. 5. All beds with side rails were measured on 04/06/2011 to ensure the side rail zones are safe as per Food and Drug Administration (FDA) guidelines. Side rails that do not meet zone safety measurements will be removed, secured so that they cannot be used, or modified with devices to meet safety requirements. 6. An evaluation form was developed (See attached) and a process implemented on 4/26/2011 to assess the safety of assistive devices/side rails currently in use to ensure they meet safety standards. All residents who utilize side rails will be evaluated using this process to ensure the safety of the devices and the residents' use of them. 7. The Care Plans and staff care sheets for Resident #19 and Resident #20, and any other residents who use side rails, will be updated to address the use of side rails.	

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F 323	Continued From page 33 and nurse aide care sheets (identified by some staff as kardexes) revealed that the resident was identified to be an "aspiration risk: keep HOB (head of bed) elevated". c. On 3/30/11 at 8:35 AM, resident #10 was observed sitting up in bed with his/her tray of puree textured food and three cups of liquids with lids placed on the over-the-bed table, directly in front of the resident. The resident appeared to be sleeping. No staff were in the room with the resident. d. On 3/30/11 at 8:40 AM, staff member N came into the room and indicated that she was going to give the resident a massage. She was observed to attempt to feed resident #10 a spoonful of puree texture food. The resident refused to open his/her mouth. Next the staff member gave the resident a drink of juice. The resident coughed several times after choking on the fluid. The surveyor left the room when the resident stopped coughing. Soon after that, the staff member was observed to come to the nurses' station and request assistance for the resident who was choking. Nurse G was observed to enter the room and suction the resident. At 9:00 AM, staff N was observed in the hallway and she indicated that the resident had received a massage. e. On 3/30/11 at 9:08 AM, in an interview with Certified Nurse Aide (CNA) D, she revealed that staff member N was not a CNA or licensed staff member but part of a massage service that the Hospital had available. f. On 3/30/11 at 5:05 PM, in an interview with the Administrator, the Director of Nursing (DON), and nurse A, they verified that staff member N was	F 323	8. The chemicals stored in the storage room located across from Room #18 were removed on 04/22/2011 and relocated into a locked storage room. 9. Locks were placed on 04/26/2011 on the cupboard space under the sinks of the kitchen located next to the main dining room, the kitchen located next to the second floor dining room, and any other areas accessible to residents where chemicals may be stored. 10. Staff education will be provided to nursing staff that provide care to resident #25 regarding the requirement for supervision of medication administration. 11. The electronic medication administration record of Resident #25 will be noted to include information that medications are not to be left for self-administration without direct supervision. 12. All residents who have been assessed to not be safe for self-administration of medications will have a notation in their electronic medication administration record that medications cannot be left for the residents in an unsupervised manner, including at their table. This assessment will include residents whose table mates are not safe for self-administration of medications. 13. Education will be provided to all nursing staff regarding each resident's assessment for safety of self-administration of medications, to include not leaving medication at the table of any resident who is not assessed as being safe for self-administration of medications, and any resident who has a table mate who has been assessed to be unsafe for self-administration of medications.	

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F 323	Continued From page 34 not a CNA and that massage therapists were not licensed in the State. 2. Review of resident #5's 3/21/11 History and Physical Examination evidenced that the resident had diagnoses that included Parkinson's Disease, dementia, muscle contractures, depression, behavioral issues, coronary disease, and gastroesophageal reflux disease. Observation, staff interview, and record review of the resident's 3/5/11 quarterly MDS assessment verified that the resident required total care with his/her Activities of Daily Living, including bed mobility, transferring, and eating. On 3/30/11 at 7:50 AM, resident #5 was observed seated in his/her reclining high back wheelchair in the common area. CNA T was feeding the resident. The head of wheelchair was only slightly elevated. The resident was chewing repeatedly on each bite. Starting at 8:15 AM, the resident was coughing occasionally during the meal. Entrapment Hazards Reference for Professional Standards of Practice for bed rail-related entrapment deaths/injuries: Bed rail-related entrapment deaths and injuries can occur in the elderly population, who are often at risk due to limited mobility, psychoactive or sedative medications, confusion, sedation, restlessness, lack of muscle control, size and physical deformities. Death by asphyxiation or injuries to the resident's extremities can occur when the resident becomes caught between the mattress and the bed rail; the headboard and the bed rail; or getting his or her head/extremity stuck	F 323	14. Regular hazard surveillance rounds will be conducted on a quarterly basis by the Staff Development Coordinator, the Director of Nursing, the Infection Control Coordinator, and the Director of Plant Operations to monitor resident care areas for the identification and correction of any accident hazard areas or practices. The checklist (See Attached) utilized for these rounds will be revised to include observations of positioning of residents during intake, side rail safety, storage of chemicals, and any medications left in unsafe areas. Any observations of hazardous areas or practices will be immediately resolved and one-to-one staff education provided at that time. 15. The results of the quarterly hazard surveillance rounds will be developed into a Quality Improvement Indicator and reported by the Director of Nursing on a quarterly basis to the Environment of Care Committee with oversight by the organization-wide Quality Improvement/Performance Improvement Committee. 16. The Director of Nursing will monitor.	

F323

WEST PARK LTCC – **Comprehensive Side Rail Evaluation**

Date_____ **REASON** ____ ADMISSION ____ RE-CHECK _____ SIGNIFICANT CHANGE

	Bed Mobility		**Ambulation**
	Able to turn self in bed		Ambulates per self unassisted
	Able to turn independently to right side		Ambulates with assist of ___1 staff ___2 staff
	Able to turn independently to left side		Ambulates with assistive device
	Uses a side rail to turn self		Unsteady/unbalanced
	Needs assist of one to turn		Impaired gait
	Needs total assist to turn		Non ambulatory
	Uses a side rail to assist while staff turn resident	**Sitting**	
	Attempts to crawl out of bed		Able to sit without support
	Can/does use call light		Falls forward
	Uses a side rail to sit up in bed		Falls backward
	Uses a side rail to get out of bed		Falls sideways: ___to the left; ___to the right
	Fear of falling		Other:
	Used to define spatial parameters		

MUSCLE CONTROL

___Paralysis ___RUE ___RLE ___LUE ___LLE ____POOR TRUNK SUPPORT

___Weakness

___Other **Please explain**_____

Able to get out of bed per self without problems ___Yes ___No **Comments**_____

Attempts to arise/ambulate unescorted ___Yes ___No **Comments**_____

History of falls ___Yes ___No **Comments**_____

Mental Status: ___Cognitively aware ___Cognitively impaired ___Intermittent confusion

May attempt to climb over side rail ___Yes ___No Abnormal Lab Work/MIC _____

Orthostatic Hypotension present ___Yes ___No Abnormal Rad/CT _____

Medications which may affect balance or mobility _____

_____

Medication concerns_____

_____

ASSESSMENT OF SIDE RAILS

____Full Length ____3/4 Length

____Half Length ____1/4 Length

____Split Rail ____Alt. Split Rail

See Page 2 for Examples

Zones Measured? ___Yes ___ No

___ Zones Pass ____Zones Fail

Resident/Family Interview

Can the resident participate in their plan of care?	___Yes	___No
Does the family participate in the plan of care?	___Yes	___No
Does the resident request to use side rail?	___Yes	___No
Education to resident regarding side rail use?	___Yes	___No
Does the family request use of the side rail?	___Yes	___No
Education to family regarding side rail use?	___Yes	___No

*** ZONE MEASUREMENT FAILURE REQUIRES RAIL MODIFICATION FOR SAFETY ***

Modifications made to side rail: _____

How will the use of a side rail assist the resident? _____

_____

_____

_____

_____

Eval Continued on Page 3

STICKER

Purpose of side rail: _____ Positioning _____ Increase self mobility _____ Holds bed controls
_____ Define bed parameters _____ Restraint (proceed to Restraint Assessment)

Time of Side Rail Use _____At all times _____Turn & Reposition only _____Transfers

F323

Risk vs. Benefit analysis and Tracking Information

_____

_____

_____

_____

Date educational pamphlet provided _____ Consent form signed? ____Yes _____ No

Physician's order ___Yes ___No Added to Care Plan ___Yes ___No

_____ _____

Date Nurse Signature

IDT RECOMMENDATIONS FOR SIDE RAIL USE_____

_____

_____

Signatures _____ _____ _____

_____ _____ _____

SIDE RAIL QUARTERLY UPDATES

Date_____ Is assessment current? ___Yes ___No

Changes: _____

_____

_____

Care Plan updated? _____Yes _____No

Nurse Signature_____

Date_____ Is assessment current? ___Yes ___No

Changes: _____

_____

_____

Care Plan updated? ___Yes ___No

Nurse Signature_____

Date_____ Is assessment current? ___Yes ___No

Changes: _____

_____

_____

Care Plan updated? ___Yes ___No Nurse Signature_____

F323

F323

LTCC SIDE RAIL LOG UPDATED: _____

Resident Name	Type of Rail In Use	Purpose: (If it constitutes a restraint, a consent and MD order must be obtained)	Date of Side Rail Assess-ment	Measure-ments of bed on file?	Modification Made if Un-safe	Care Plan Update	Nurse Report Sheet Update	C.N.A. Kardex Update	Restraint Consent & MD order signed?

#323, #441

LTCC EOC/IFC ROUNDS CHECKLIST

DATE: LOCATION/UNIT: REVIEWER:

No.	SURVEILLANCE ITEM	MET	UNMET	COMMENTS/CORRECTIVE ACTION
I.	**Nursing Service**			
A.	Equipment (i.e. bedpans, urinals, basins) are clean and properly stored			
B.	Resident's wheelchairs, walkers, and other assistive devices are clean			
C.	Dirty utility rooms contain only dirty items, are free of excess clutter & door is closed			
D.	Medical supplies are stored in designated area which is clean, uncluttered & free of sources of environmental contamination (dust, soiled linen, garbage, etc.)			
E.	Clean & sterile supplies are protected /covered. No sterile equipment w/expired date.			
F.	Glucometer solutions date not expired. Test strips not expired. Glucometer is clean. No medications are transported/stored on glucometer cart.			
G.	Medications are not left at dining tables where other residents are able to obtain.			
H.	Residents properly positioned during provision of intakes			
I.	Nebulizers rinsed after each use and cleaned as per policy			
J.	Humidifiers cleaned routinely as per policy			
K.	Nurses hand washing monitored for accuracy of when done as well as procedure			
II.	**Infection Control Practices**			
A.	Isolation protocols are being followed as indicated			
B.	PPE are readily available. Staff use PPE appropriately			
C.	Specimen containers are clearly labeled; are transported in biohazard bag			
D.	Specimens are held in a designated area. Specimen refrigerators are clearly labeled and are not used for food, drink, or medications			
III.	**Medication Handling**			
A.	Medications have not passed expiration dates. Med vials are dated when opened.			
B.	Medications are stored in accordance with package directions. Meds are stored separately by route of administration (e.g. oral meds not stored with topical creams)			
C.	Containers used to hold supplies/materials for multiple residents (solutions, ointments, etc.) are protected, clean and maintained aseptically to reduce cross-contamination between residents.			
D.	Medication refrigerator temps <41F. Refrigerator contains only meds – no food			
E.	Med carts and med cart drawers are clean & tidy. Locked when unattended			
F.	Juice/food on med carts is covered; kept cold if sitting out longer than 4 hours			
G.	Computer screen is locked if unattended			
IV.	**Sharps/Needles Handling**			
A.	Needles are deposited uncapped into sharps containers			
B.	Sharps containers are properly stored and no more than 2/3's full			

#323, #441

V.	**Tube Feeding**			
A.	Administration tubing is marked and dated; changed every 24 hours			
B.	Feeding syringe is marked, dated and properly stored			
C.	Feeding solution is correct for date, rate, and solution used			
A.	Catheter bag and tubing ins positioned properly; not on the floor.			
B.	Separate, marked, clean graduates are available for each resident			
VII.	**Ostomy/Wound Care**	**MET**	**UNMET**	**COMMENTS/CORRECTIVE ACTION**
A.	Solutions are marked, dated and properly stored			
B.	Syringes & other equipment (basins, etc.) is marked, dated & properly stored			
VIII	**Oxygen/Respiratory Therapy**			
A.	O2 tubing is changed routinely by CP. O2 signs are posted appropriately			
B.	O2 tubing is placed in plastic bag when not in use. Nebulizer tubing/mask is appropriately stored when not in use			
IX.	**Linen Handling**			
A.	Clean linen carts are covered. The linen room door is closed			
B.	Linen barrels are not located near the clean cart. Linen barrels are not in hall during mealtimes. Soiled linen barrels are covered and not more than 2/3's full			
C.	Soiled linen is bagged at the site, and not placed on the floor, chair, etc. Linen is held away from the employee's clothing			
X.	**Shower/Tub Room**			
A.	Tub is clean, and cleaned between each resident as per policy			
B.	Shower chair is cleaned between resident as per policy			
C.	Shower and tub cleaning supplies are properly stored/secured			
D.	No electrical device is in close proximity to water.			
XI.	**Food/Pantry**			
A.	Pantry/kitchen area is clean, including range top, burners, ovens, and hoods			
B.	Resident refrigerators are clean; freezer defrosted, no staff food being stored			
C.	Food is covered, labeled and dated in refrigerator. No outdated food			
D.	Resident refrigerator temps are < 41F			
E.	Ice dispensers are clean. A schedule for cleaning has been established			
XII.	**Handwashing Facilities**			
A.	Sinks are clean and free of clutter. Contaminated equipment is not soaked, rinsed or cleaned in handwashing sinks			
B.	Soap is available at all handwashing sinks. Alcohol-based handrub is available in appropriate areas. Soap & handrub dispensers are filled when empty & are operational			
C.	Paper towels are available at all handwashing sinks			

#323, #441

XIII	General Cleanliness			
A.	Environment is dust-free			
B.	Environment is odor-free			
C.	There is a cleaning schedule for equipment and environmental surfaces			
D.	Equipment, furnishings, countertops, etc. are visibly clean and dust-free			
E.	Window blinds and curtains are clean and dust-free			
F.	Bathrooms are clean and odor-free			
G.	Light fixtures and clean and insect-free			
H.	No evidence of insects or pests			
I.	Floors are clean			
J.	Ventilation grills are clean and dust-free			
K.	Waste containers are empted daily			
L.	Cleaning products are labeled and stored appropriately			
M.	Staff refrigerator clean and without outdated items			
N.	No chemicals under sinks, or areas locked / chemicals secured. > #323			
XIV	**Safety**	**MET**	**UNMET**	**COMMENTS/CORRECTIVE ACTION**
A.	Handrails are securely fastened to walls			
B.	Hazardous items, sharp objects, etc. are not left unsecured			
C.	Baseboard heaters are in good repair; nothing is loose, open, damaged.			
D.	No electrical device is in close proximity to water.			
E.	Siderails meet standards of use, safe sizing, and padded where needed. > #323			

Comments: _____

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	535027	A. BUILDING _____ B. WING _____	04/01/2011

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

(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 323	Continued From page 35 in the bed rail. Both split and full rails have the potential to cause fall-related injuries as well as entrapment. Additionally fall-related injuries or injuries to extremities can occur when confused/disoriented residents climb over the top of side rails or get an arm or leg entrapped. Placement of air pressure mattresses (either overlay air mattresses placed on top of a regular mattress or beds with built-in air mattresses) alters the space between the mattress and the rail when the mattress compresses as the resident shifts his/her weight on the bed. FDA (Food and Drug Administration) is recommending less than 4 ¾ inches (120 mm) for the head breadth dimension for the population vulnerable to entrapment. See FDA Safety Alert: Entrapment Hazards with Hospital Bed Side Rails August 23, 1995 and Joint Commission on Accreditation of Healthcare Organization: Sentinel Event Alert, Issue 27, September 6, 2002. U.S. Food and Drug Administration Updated October 31, 2006 entitled, "The Hospital Bed Safety Workgroup (HBSW) is a partnership among FDA, the medical bed industry, national health care organizations, patient advocacy groups, and other federal agencies (Centers for Medicare & Medicaid Services, Consumer Product Safety Commission, and the Veterans Administration). Its goal is to reduce the risk of side rail entrapment in hospital beds. Between January 1, 1985 and January 1, 2006, FDA received 691 incidents of patients caught, trapped, entangled, or strangled in hospital beds. The reports included 413 deaths, 120 nonfatal injuries, and 158 cases where staff needed to intervene to prevent injuries. Most patients were frail, elderly or confused.	F 323		

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F 323	Continued From page 36 This guidance provides recommendations for manufacturers of new hospital beds and for facilities with existing beds (including hospitals, nursing homes, and private residences)..." The guidance also included, "... assess an individual patient's needs when using a side rail; and consulting with the hospital bed manufacturer and their facilities ' risk managers..." Side rail Usage: 1. On 3/28/11 at 3:10 PM, an initial tour of the first floor, with residents in rooms (1 to 30) was completed with staff A. There were residents' beds observed to have assistive devices, some of which included side rails. There were different types of half side rails available for use on the head and foot end of the beds. Staff A reported that there were only a few residents who used the side rails as enablers. The one type of side rail had three spaces within the rail itself large enough to pose a risk for potential entrapment. This type of rail was noted on resident #19's bed. 2. During the environmental tour on at 3/31/11 at 2:00 PM with maintenance staff and the DON (Director of Nursing), the side rail issue was addressed. The two side rails at the head of resident #19's bed were elevated. The DON confirmed the half side rails at the head end of the bed contained the controls for the bed and were being used. Additionally, the side rails at the foot end of the bed were not to be used but were accessible for use. These side rails had three spaces within each side rail which measured approximately 6 ½ inches in width and 8 ½ inches in height. The same type of side rails were also identified for resident #20. The	F 323		

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F 323	Continued From page 37 surveyor demonstrated her concern by passing her head through the inherent gap in the 3 sectioned side rail. There were also gaps noted between the side rail and the mattress. 3. In an interview with the DON, during the environmental tour on at 3/31/11 at 2:00 PM, she reported she was not aware of the issues with those types of devices and would be checking all side rails. The facility has a process to review residents with side rails to address if the device being used was a restraint. However, the facility did not have a process to assess the safety of the assistive devices/side rails currently in use. 4. Record review for resident #19 and #20 included: a. Resident #19's diagnoses included CHF (congestive heart failure) COPD (chronic obstructive pulmonary disease) , hypothyroid, constipation, and history of elbow fracture. The nurse aide care sheet instructed the CNAs not to leave the resident alone in the bathroom, apply right arm brace for comfort, and identified the resident at high risk for falls. The nurse aide care sheet did not address the use of the side rails or assistive devices. b. Resident #20 diagnoses included, dementia, osteoporosis, COPD (chronic obstructive pulmonary disease), and history of TIA (Trans ischemic attack), and aneurysm with shunt. The nurse aide care sheet identified the resident as a partial lift and use of wheelchair and at moderate risk for falls. The nurse aide care sheet did not address the use of the side rails. There was no indication that the current side rails	F 323		

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F 323	Continued From page 38 that were observed in use had been assessed for potential entrapment hazard with the space/gaps inherent in the resident's bed (mattress, side rails foot/head board). Chemical Hazards: 1. On 3/28/11 at 3:10 PM, an initial tour of the first floor was completed with staff A. A storage room located across from room 18 was unlocked. The room had metal shelving with bottles of hand sanitizer at eye level. The bottles had "Warning Labels" which identified risks associated with indigestion and eye exposure. This room was located by the door going into the special care area. Staff A reported the secure unit was not a locked unit and at times the doors to the unit were left open. This increased the potential of wandering residents walking in the area and accessing the room with chemicals. 2. On 3/30/11 at 3:25 PM, observations were made in the kitchen located next to the main dining room. There were open doors which entered from the dining room side and the hall side. The doors to the cupboard space under the sink did not lock; several containers of chemicals were stored in this space. 3. On 3/30/11 at 3:35 PM, observations were made in the kitchen located next to the second floor dining room. At the time of the observation the two doors which entered this area were not locked. The doors to the cupboard space under the sink had a lock, but it did not appear to lock. There were several containers of chemicals were stored in this space. At the time of the	F 323		

CENTERS FOR MEDICARE & MEDICAID SERVICES

FEB A 2011

OMB NO. 0938-0391

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F 323	Continued From page 39 observation, dietary staff member V entered the area. She revealed that she locks the lock every night but that the lock is broken. She verified that there were chemicals stored under sink. Medication left unattended on Special Care Unit On 3/29/11 at 12:30 PM, the meal service was observed on the Special Care Unit (SCU). Observation evidenced that resident #25 stood up and walked around the end of the table to assist resident #26 who was not eating. There was a cup of medications left next to resident #25's drink glasses. The cup was within reach of another resident, who was seated next to resident #25's chair.	F 323		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to timely assess, evaluate, and implement nutritional interventions	F 325	The facility will ensure the timely assessment, evaluation and implementation of nutritional interventions in order to maintain acceptable nutritional parameters. 1. A new nutrition assessment was conducted on 04/25/2011 (copy attached) on Resident #9 and the results added to the resident's Care Plan and staff care sheets, including nutritional interventions for any subsequent weight loss or skin breakdown, and the provision of clear liquids as tolerated. Resident #9's weight and skin integrity will be closely monitored by the Registered Dietitian. 2. An electronic notification system has been developed to promptly advise the interdisciplinary care team, including the Registered Dietitian, regarding any resident with active skin problems and/or receiving wound care and services.	05/04/2011 05/04/2011 jmk Not attached to public copy d/t HIPAA. JMC 5-9-11

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F 325	Continued From page 40 in order to maintain acceptable nutritional parameters for one of sixteen sample residents (#9). There was no evidence that the facility assessed the resident's nutritional status or reweighed the resident timely when he/she experienced significant physical declines, including not eating, and/or implemented nutritional interventions for the resident's weight loss or skin breakdown. At the time the feeding tube was placed on 2/7/11, the resident was not reweighed and the resident's documented skin breakdowns were not included in the nutritional assessment. The findings included: Reference: 2005 American Dietetic Association, Scope of Dietetics Practice Framework, Standards of Practice in Nutrition Care for the Registered Dietitian (RD) " STANDARD 2: NUTRITION DIAGNOSIS The registered dietitian identifies and describes an actual occurrence, risk of, or potential for developing a nutrition problem that the registered dietitian is responsible for treating independently. Rationale: At the end of the assessment step, data are clustered, analyzed and synthesized. This will reveal a nutrition diagnostic category from which to formulate a specific nutrition diagnostic statement. A nutrition diagnosis changes as the client response changes, whereas a medical diagnosis does not change as long as the disease or condition exists. There is a firm distinction between a nutrition diagnosis and a medical diagnosis. The main difference between the two types of diagnoses is that the nutrition diagnosis does not make a final conclusion about the identity and cause of the underlying disease. A client may have the medical	F 325	3. Nutrition Assessments will be updated within four days of the identification of any resident with skin breakdown or significant weight loss, and nutrition interventions developed to address the skin breakdown, weight loss, or any other nutrition issues identified through the assessment process. The nutrition interventions will be reflected in the resident's Care Plan and staff care sheets, and the nutrition care of these residents will be monitored on a weekly basis by the Registered Dietitian or Diet Technician. 4. Residents with significant weight loss will be weighed weekly, and the Registered Dietitian and/or Diet Technician will monitor these weights and develop nutrition interventions to address significant weight loss. 5. The nutrition assessments and Care Plans for all residents with skin breakdown or significant weight loss will be reviewed and revised if needed to ensure the skin breakdown or weight loss is addressed with appropriate nutrition interventions. 6. An interdisciplinary Nutrition Committee has been developed comprised of the Registered Dietitian, Director of Nursing, Staff Development Coordinator/ Registered Nurse, and Resident Assessment/MDS Coordinator. This committee meets on a weekly basis to review all residents with skin breakdown and/or significant weight loss, and develop appropriate nutrition interventions to address these issues. The residents' Care Plans and staff care sheets are updated at that time to include any new interventions, and documentation will be entered into the residents' medical record to reflect any changes in the nutrition plan of care.	

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F 325	Continued From page 41 diagnosis of "Type 2 diabetes mellitus"; however, after performing a nutrition assessment, the RD may determine a nutrition diagnosis(es) with nutrition diagnostic labels for example, "excessive energy intake" or "excessive carbohydrate intake". In the community or public health setting the nutrition diagnosis may relate to a population based condition (food safety and access) rather than a medical diagnosis. Examples of nutrition diagnostic labels may then be "intake of unsafe food" or "limited access to food". The nutrition diagnosis(es) demonstrates a link to setting realistic and measurable expected outcomes, selecting appropriate interventions and tracking progress in attaining those expected outcomes." " STANDARD 3: NUTRITION INTERVENTION The registered dietitian identifies and implements appropriate, purposefully planned actions designed with the intent of changing a nutrition-related behavior, risk factor, environmental condition, or aspect of health status for an individual, target group, or the community at large. Rationale: Nutrition intervention involves a) selecting, b) planning and c) implementing appropriate actions to meet clients' nutritional needs. The selection of nutrition interventions is driven by the nutrition diagnosis and provides the basis upon which outcomes are measured and evaluated. An intervention is a specific set of activities and associated materials used to address the problem. The registered dietitian may actually perform the interventions, or may delegate or coordinate the nutrition care that others provide. All interventions must be based on scientific principles and rationale and when available grounded in a high level of quality research (evidence-based interventions). The	F 325	7. The Registered Dietitian will develop the information from the weekly monitoring of residents with skin breakdown and/or weight loss into a Quality Improvement indicator, which will be reported to the organization-wide Performance Improvement/Quality Improvement Committee on a quarterly basis by the Director of Nutrition Services/Registered Dietitian. 8. The Director of Nutrition Services/Registered Dietitian will monitor.	

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F 325	Continued From page 42 registered dietitian works collaboratively with the client, family, caregiver or community to create a realistic plan that has a good probability of positively influencing the nutrition diagnosis/problem. This client driven process is a key element in the success of this step, distinguishing it from previous steps that may or may not have involved the client to this degree of participation." According to the CD-HCF (Consultant Dietitians in Health Care Facilities) Pocket Resource for Nutrition Assessment 2001 Revision, page 2, a "Nutrition assessment is a comprehensive approach completed by the dietetic professional to define nutrition status which employs medical history, nutrition intake, nutrition history, medication, physical examination, anthropometric measurements and laboratory data. Nutrition assessment includes interpretation of data from the screening process. The assessment process includes a review of other disciplines' data that may affect the assessment process such a physical therapy, occupational therapy, speech therapy, etc. It includes the organization and evaluation of information to declare a professional judgment. Nutrition assessment precedes a care plan, intervention and evaluation." [Note: The record review findings were based on hard copy medical record review and documentation requested and provided by the facility staff from their electronic record system. The facility had some documentation kept hard copy and some electronic.] Record review for resident #9 revealed that the resident was admitted on 12/28/10 with	F 325		

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F 325	Continued From page 43 diagnoses that included normal pressure hydrocephalus, pituitary tumor, hypertension, falls, dementia, glaucoma, and stroke. a. Review of the resident's "LTCC SBAR" (per staff this was pre-admission assessment) dated 12/27/10 (one day prior to admission) revealed that the resident was assessed to have no skin wounds, a Braden scale of 13, normal skin, and no wound care, to eat a regular diet independently, and to weigh 178 pounds. b. Review of the resident's Patient Notes evidenced a note dated 2/3/11 and written by nurse B. The note documented "...To date ..... full Code and aggressive measures. ... became acutely ill 1/26/11 with renal failure ...Has been refusing food and fluids due to weakness, fatigue, personal choice related to confusion. ..." c. Review of the resident's 2/9/11 significant change Minimum Data Set (MDS) assessment evidenced that the resident was totally dependent and required one or two plus staff for the Activities of Daily Living (ADLs) of bed mobility, dressing, eating, personal hygiene, and bathing. The assessment indicated that the resident's weight was 184 pounds, the resident had not experienced any weight loss, had a feeding tube, and received 51 % or more of the total calories through the tube feeding. No pressure ulcers were noted on this assessment or on the admission assessment. d. Review of the resident's physician orders revealed the following orders related to nutrition: 12/28/10 - Regular diet Standing Admission Orders - "Tube Feedings:	F 325		

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	535027	A. BUILDING _____ B. WING _____	04/01/2011

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F 325	Continued From page 44 specifics per individual resident, through dietary &/or attending physician" and "Weight...monthly" (Note: There was no TF present at the time of admission.) Order summary with Physician name stamp only with no date (print date 3/24/11): "Diet TF Osmolite 1.5 60 cc/hr flush w/H2O 180 cc q 4 hr" e. Review of the Weight Book for the East Unit evidenced the following weights for resident #9: 1/11 - 184 pounds (recorded on MDS assessment with Assessment Reference Date of 1/1/11) 2/11 - 161.3 pounds (noted on LTCC Doctor Rounds sheet as having been done on 2/24/11) (significant weight loss of 12.3 % from previous documented weight) 3/11 - 162.5 pounds (noted on LTCC Doctor Rounds sheet as having been done on 3/14/11). f. Review of the resident's "Pressure Ulcer, Stage Two Orders" and skin breakdown documentation provided to the surveyor evidenced the following skin breakdowns: 1/8/11 - right buttocks not measured, Xenaderm ointment, apply BID (twice a day) and PRN (as needed) (noted by nurse on 1/16/11) 1/18/11 - right and left buttocks 1/27/11 - right buttock had large purplish area - very close to breakdown 1/29/11 - left buttock red spots 2/15/11 - open right buttock. g. Review of the resident's "LTCC Nutritional Assessment" forms evidenced the following assessments:	F 325		

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F 325	Continued From page 45 1/29/11 - written by RD (Registered Dietitian): total assistance with feeding; swallowing and chewing problems with acute illness; weight 184 pounds (no ideal or usual body weight listed); needs 2050 (KCal for basal needs), protein needs 83 - 100 (grams), 2090 (cc - cubic centimeters fluid); no oral or fluid intake noted; no weight changes noted; decubitus none; laboratory values - albumin 2.7, BUN 33, Sodium 151, Potassium 3.0, H/H 11.1/33; regular diet with prn pm (afternoon) or HS (bedtime) supplements. "..Currently with acute illness, poor intakes, needing full assistance with eating. ... is willing to have feeding tube placed, waiting to see if illness improves. Current issues with chewing and swallowing, was fine prior to illness. Nutritional dx: suboptimal po (oral) intake r/t (related to) current illness. Interventions: regular diet, food/beverages per resident preference and acceptance, feeding assistance. Monitors: intakes, weight." (Note: This was the first evidence of RD involvement with this resident's nutritional evaluation.) 2/8/11 (day after tube placement) - written by DNT (Diet Technician): "Res has recently had virtually no p.o. intake following period of acute illness. Lack of intake appears to have been in relation to a combination of factors including weakness, fatigue, and confusion. Diagnoses as failure to thrive 2/7/11. .....decided that tube feeding was desired. PEG tube was placed 2/7/11. Res' ht: 5'10", wt: 184 pounds at most recent weight. Estimated nutrient needs determined to be 1680 - 2100 kcals, 67-84 gpro, 2100-2520 cc H2O. Recommendation made, and order received for Osmolite 1.5 at 60 cc/hr continuous per pump, and 180 cc H2O flushes q 4 hours. Formula/flushes as ordered provide	F 325		

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F 325	Continued From page 46 2160 kcals, 89 g/pro, and 2166 cc free H2O. These orders appear adequate to meet ___ (his/her) estimated needs. Will monitor ___(his/her) weight, tolerance, and labs as available, and request TF/Flush adjustments as needed." 2/28/11- written by DNT: "Res shows a significant weight decline of 12.3 % x 1 mo. Current weight is 161.2 pounds. Weight loss very likely occurred before tube feeding was placed. TF continues to be provided as Osmolite 1.5 at 60 cc/hr, with 180 cc H2O flushes every 4 hours. In addition, ___(he/she) is now allowed clear liquids. Will resques Res be weighed again in 2 weeks to ascertain that weight decline was prior to tube feeding. Will monitor closely." 3/30/11 - written by DNT: "Res shows a weight loss of 9.7 %x 3 mo. However, this loss occurred before tube feeding placement. Weight is now stable. Was weighted 3/14, as stated would be done in previous note. Feb 161.2, Mar 162.3. It appears appropriate and adequate to meet ___(his/her) needs. Also is now receiving a clear liquid diet. Will continue to monitor." h. Review of the resident's Care Plan and nurse and nurse aide care sheets (referred to as Kardexes by some staff) evidenced that the resident's significant weight loss after entering the facility was not addressed. The care plan listed the GT and tube feeding for nutrition/hydration. Neither the nurse or nurse aide sheets indicated that the resident was to have clear liquids as tolerated (as noted in the DNT's nutritional notes). i. On 3/31/11 at 3:10 PM, in an interview with Registered Dietitian (RD), she revealed that	F 325		

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F 325	Continued From page 47 weights were generally done on a monthly basis. When asked about how she was notified when residents have skin breakdown, she commented that the notification was not good. She commented that she has to search through the documentation to find needed information. She confirmed that she did not always receive nutrition referrals for consultations with residents who had wound (skin breakdowns). The RD was asked about the 23 pound weight loss that resident #9 had experienced. She commented that the resident had dramatically stopped eating and it took a while for the family to decide on the placement of a gastrostomy tube (g tube). The RD said that in previous system (Meditech) there was a notification, but that jRaven (Resident Assessment Instrument software) did not provide that. She verified that she was involved with completing Section K (Nutrition) of the Minimum Data Set (MDS) and with care planning for this Section of the assessment. She stated that weight loss should be on the resident's care plan. j. On 3/31/11 at 4:47 PM, in an interview with the Administrator, Director of Nursing, and nurse A, the concerns about weight loss and skin breakdown and the RD involvement were discussed. The concerns that the RD expressed about the communication and lack of a system of notification were included in this discussion.	F 325		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	The facility will ensure that food is stored, prepared, and distributed in a manner that minimizes the potential for the spread of food-borne illness.	05/09/2011 05/05/2011 JMK

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F 371	Continued From page 48 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to store, prepare, and distribute food in a manner that minimized the potential for the spread of food-borne illness. The findings included: 1. On 3/28/11 starting at 4:17 PM, during an initial kitchen tour conducted in the presence of the Dietary Manager (DM), the observations were made: a. The three compartment sink was identified as the sinks which were used to wash the pots and pans. The sanitizer information was posted above the sink and revealed that OASIS 146 - Multi-Quat Sanitizer was being used by the facility. The strips to be used to verify the sanitizer strength were identified as QT- 40 and the acceptable range was listed as 150 - 400 parts per million (ppm). The DM was asked to check the strength of the sanitizer. The color of the strip appeared to show the ppm were 100 (not strong enough to sanitize adequately). The type of strip used to check the water was a QT-10, which the DM verified was the only type that they currently had. b. In the dry storage room, there were seven cans of chocolate Ensure sitting on the shelf. These cans were dented. The DM verified that the cans	F 371	1. Dietary staff will check the sanitizer strength of water in the sanitizing sink each time it is filled by using the correct strip (QT-40) and following the directions posted by Eco Lab, the provider of the testing product. This test will be done when the water is no more than 75 degrees, and the results recorded on a log in the pots and pan area. 2. The Food Service Supervisor will monitor the compliance of this testing. 3. The dietary stock person will examine all food before putting it on the shelves and will notify the Food Service Service Supervisor of any dented cans. The Food Service Supervisor will examine the cans and dispose of any that may be unsafe, and document when this occurs. 4. There will be a consistent system of labeling food that leaves the kitchen with an easily understandable expiration date. All food will be clearly labeled with a complete expiration date, as per this example: EXP: 4/29/11. 5. The cupboard doors in the kitchen located next to the main dining room were cleaned on 4/20/2011, and the open bag of potato chips sitting on the three shelf cart in the dry storage room was disposed of on 04/01/2011. 6. A staff inservice will be conducted by the Director of Nutrition Services/Registered Dietitian on 05/04/2011 to further educate staff regarding proper procedure for testing the sanitizer strength of the water in the sanitizing sink, disposal of any dented canned products, labeling or disposal of opened food, labeling of expiration dates on food products, and maintaining cleanliness of food service areas.	

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F 371	Continued From page 49 were too dented to use and tossed them into the trash. c. In the walk-in freezer, there was a large undated and unlabelled plastic bag of chicken. The DM verified that this was chicken breast and that the bag should be labelled and dated. 2. On 3/29/11 from 2:10 PM to 2:40 PM, in an interview with an Eco Lab staff member and the DM, the use of the sanitizer in the three compartment sink was discussed. The Eco Lab representative stated that the test strip approved by the FDA (Food and Drug Administration) for use with the sanitizer was QT- 40, which has the added 150 ppm value marked on the strip. He indicated that 200 ppm, which is approximately 1/4 ounce per gallon, is acceptable and that the water should be checked at room temperature. a. Review of the printed literature which was posted above the three compartment sink noted that the sanitizer level should be checked in a temperature range of 65 - 75 degrees Farenheit (F). The Eco Lab representative verified that if the test strips were used when the hot water was first run into the sanitizing sink, the ppm would indicate a higher value. b. The DM and dietary staff member S showed the surveyor the log book where the staff document the sanitizer level. The recordings were mostly 200 - 300 ppm. c. Dietary staff member R was observed running hot water into the rinse sink while the sanitizer sink was filling. The Eco Lab staff member revealed that this method of filling the sinks would not allow for the proper filling of the sanitizing sink	F 371	7. Twice per week the Food Service Supervisor will check the food preparation, serving, and storage areas to identify any dented cans, open and/or unlabeled food, and will dispose of any unsafe products. During these rounds, the Food Service Supervisor will also identify any areas or equipment needing cleaning, and ensure that those areas are immediately cleaned. 8. The information on testing of proper sanitizer strength, disposal of dented cans, disposal of open and/or unlabeled food, proper labeling of expiration dates, and cleanliness of food preparation areas will be developed into a Quality Improvement monitor and reported on a quarterly basis by the Director of Nutrition Services/Registered Dietitian to the organization-wide Quality/Performance Improvement Committee. 9. The Director of Nutrition Services/Registered Dietitian will monitor	

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F 371	Continued From page 50 since the device worked on an aspirator principle. d. The Eco Lab representative used numerous test strips, cooled the water to the proper temperature to verify the amount of sanitizer present, and determined that the sanitizer was too low. He made adjustments, increasing the amount of sanitizer to an acceptable level when the water was room temperature. He discussed the need to educate the dietary staff with the DM, dietary staff member S, and the surveyor. 3. On 3/30/11 at 1:53 PM, observations were made in the kitchenette in the Special Care Unit (SCU). The under counter drawers had red splatters in them. In the refrigerator there were 14 thawed Sysco Shakes which were labelled with different designations (X3-30; Ex 4-2; 4-9) and three thawed Magic Cups marked "X3". The cartons for the shakes indicated that these were to be used in 14 days after thawing; the Magic Cups were to be used in five days after thawing. At the time of the observation, CNA U was asked to explain what the "X3-30" meant on the shake carton. She responded "30 days maybe." 4. On 3/30/11 at 2:00 PM, observations were made in the kitchenette on the East Unit at the nurses station. In the refrigerator there were two thawed Magic Cups marked X3. At the time of the observation, CNA J was asked to explain what the "X3" meant on the Magic Cup. She did not provide a response. Nurse A was present and she referred the question to CNA D, who said that 4/3 meant 4/3 (April 3rd). CNA D indicated that she monitors the refrigerator contents and knows that the dietary staff come daily to fill and replace items.	F 371		

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F 371	Continued From page 51 5. On 3/30/11 at 3:25 PM, observations were made in the kitchen located next to the main dining room. The cupboard doors were sticky to touch and there were streaks of dried liquids which had run down some of the cupboard doors. In the dry storage room, there was an open bag of potato chips sitting on a three shelf cart.	F 371		
F 441 SS=F	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.	F 441	The facility will ensure that an Infection Control Program is designed and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1. Resident #1's infection was resolved as of 03/24/2011. 2. Resident #21's infection was resolved as of 03/26/2011. 3. The Infection Control Log and Surveillance Data collection forms were revised on 04/25/2011 to more completely track infection information including when cultures were done, what interventions were initiated, and what the outcomes were. (Copies Attached) 4. A policy was developed on 04/25/2011 regarding cleaning of nebulizer equipment. (Copy Attached) All staff will be educated by the Infection Control Coordinator or Staff Development Coordinator regarding the proper procedure for cleaning of nebulizer equipment in accordance with this policy. 5. Resident #10 is deceased as of 03/31/2011, and no other residents are currently using a humidifier or suction equipment. 6. A General Equipment Cleaning policy (copy attached) was initiated on 04/25/2011 by the Infection Control Coordinator and provided to all staff.	05/09/2011 05/05/2011 SMK

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F 441	Continued From page 52 (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 record review, observation, and staff interview, it was determined that the facility failed to implement an infection control program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. The facility's Infection Control Program failed to provide complete and follow-up information related to individual residents. The findings included: INFECTION CONTROL PROGRAM 1. Review of the "Infection Control Program" with the ICC (Infection Control Coordinator) from the hospital on 3/31/11 at 9:30 AM revealed she was responsible for the infection control program in the facility. She revealed she would gather information from the long term care staff and shift reports. She was tracking the residents with infections on a tracking log. At the end of the month she reviewed all lab sheets and physician orders with residents receiving antibiotics. The log sheets for four months December 2010, January 2011 February 2011, and March 2011 were reviewed. The logs did not consistently show when cultures were done or show dates when residents were place in isolation or when interventions were stopped. The examples included:	F 441	7. A policy was developed on 04/25/2011 regarding cleaning of humidifiers. (Copy Attached) All staff will be educated by the Infection Control Coordinator or Staff Development Coordinator regarding the proper procedure for cleaning of humidifiers in accordance with this policy at the time a humidifier is placed into use. 8. A policy was developed on 04/25/2011 regarding cleaning and maintenance of general respiratory equipment, (Copy Attached) which includes suction equipment. All staff will be educated by the Infection Control Coordinator or Staff Development Coordinator regarding the cleaning of suction equipment in accordance with this policy. 9. A hand hygiene video sponsored by the New England Journal of Medicine was assigned for the viewing of all staff, and a follow-up inservice and post-test (Copy Attached) regarding proper hand washing was provided to staff by the Director of Nursing on April 20, 2011. 10. A staff inservice will be provided regarding standard precautions and contact precautions, to include specific information pertaining to the care of Residents #1, #21, #19, #5, #27, #9, #12, and #13, as well as the entire resident population. 11. A laundry detergent product will be sought with effective properties against multi drug-resistant organisms at a water temperature not exceeding 110 degrees. In the event such a product is not available, a hot water booster will be installed on the nursing unit washing machines to increase the water temperature to at least 120 degrees, which is the temperature at which the current detergent product is effective.	

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F 441	Continued From page 53 a. Resident #1 was identified with having recurring C-diff (Clostridium difficile) infections. The resident had a positive stool culture on 2/8/11 with isolation precautions were started. On 2/18/11 stool culture was negative and isolation was discontinued. On 3/7/11 the stool culture showed C-Difficile with toxin A&B and on 3/23/11 a stool culture was negative. The log sheet listed resident #1 with an infection on 3/11/11 and noted "Contact Isolation". This was four days after the resident was having diarrhea and positive culture. The infection control program failed to ensure timely tracking and follow-up to ensure appropriate measures were in place to prevent the spread of infections and maintain a record of incidents and corrective actions taken. [Clostridium difficile (C-diff) is a spore-forming, gram-positive anaerobic bacillus that produces two exotoxins: toxin A and toxin B. It is a common cause of antibiotic-associated diarrhea (AAD).] b. Resident #21 was identified by staff A during the initial tour on 3/28/11 at 3:10 PM to be in isolation. An isolation cart was outside the resident's room and the resident was identified as being in "Droplet Precautions". Review of the tracking logs by the ICC showed the resident having a UTI 2/11/11 and nausea with elevated temperature on 2/25/11. There was no indication of when or why the resident was put in "Droplet Precautions". c. The log for February 2011 also showed a GI (gastro intestinal) outbreak with 23 residents listed as having NVD (nausea, vomiting and	F 441	12. The Infection Control Coordinator will make weekly rounds to visually observe the aseptic techniques of staff in hand washing, linen handling, equipment use, oxygen provision, nebulizer and suction equipment maintenance and humidifier cleaning, including care provided to Residents #19, #5, #27, #9, #12, #13 and #4. 13. Information from the Infection Control rounds will be developed into a Quality Improvement indicator and the results reported to the Infection Control Committee and the organization-wide Quality/Performance Improvement Committee on a quarterly basis by the Infection Control Coordinator. 14. The Infection Control Coordinator will monitor.	

F441

Infection Control Log Location_____ Date/Month/Year_____

Date of ID	*Pt number*	*Patient Name*	*ADM date*	*Diagnosis /Procedure*	*Culture/ concern*	*Intervention*	*Outcome*	*Comments*

F441

INFECTION CONTROL SURVEILLANCE DATA[1]

NAME_____ROOM_____AGE_____SEX_____

PRECAUTIONS:_____
(For patient cares, transport, employees)
SYMPTOMS/DIAGNOSIS_____

NOTED BY:_____(name & title)
ADMIT DATE_____DATE SYMPTOMS NOTICED_____DATE RESOLVED_____
PHYSICIAN NOTIFIED(date)_____TIME:_____
Medications:_____

REPORT COMPLETED BY:_____(name & title) DATE_____

****

URINARY TRACT: ( ) Chronic Cath UTI ( ) None or New Cath UTI ( ) Post-op

****

Chronic Catheterization
(Select 3)
( ) Fever 100.2 or change
( ) Dysuria
( ) Flank Pain
( ) Change color/character
( ) Confusion new/change of
( ) New/increased incont.
( ) Urine + Leukocytes
( ) Urine culture positive

Non or New Cath
(Select 2)
( ) Fever 100.2 or change
( ) Dysuria
( ) Flank Pain
( ) Change color/character
( ) Confusion new/change of
( ) New/increased incont.
( ) 10 WBC urinalysis
( ) Urine culture positive

HYDRATION
( ) Dry mucous membranes
( ) Cracked lips
( ) Dark Urine
( ) Dry Skin
( ) Trouble Swallowing
( ) Refuses fluids

PREVIOUS 24 HOUR FLUID INTAKE_____

****

RESPIRATORY TRACT: ( ) URI ( ) LRI ( ) INFLUENZA ( ) Ventilator Pt. ( ) Post-op

****

Upper Respiratory
( ) Coryza
( ) Pharyngitis
( ) Ear, nose, throat
(Inflammation, sore throat, Rhinorrhea, cold, earache)

( ) Mastoiditis
( ) Sinusitis
-No allergy at time

Influenza
( ) Headache, chills, myalgias, fever 100.2 F

Lower Respiratory
( ) Rales
( ) Ronchi
( ) Decreased breath sounds

****(Select 1 above plus)****

****(Select 2 below)****
( ) New increased cough
( ) Purulent sputum
( ) Fever 100.2 F or change
( ) Increased respirations to 25/min or greater
( ) Pleuritic chest pain
( ) Confusion new or change of
( ) Tachypnea

****(Single selection)****
( ) CXR + pneumonia or possible infiltrate

---

[1] TURN INTO INFECTION CONTROL COORDINATOR / DESIGNEE

F441

****

SPECIAL SKIN ( ) SST ( ) FS ( ) HS ( ) HZ

****

Skin/Soft Tissue (SST)

( ) Not decubiti
( ) Cellulitis
( ) Heat
( ) Redness
( ) Pain/tender
( ) Swelling

( ) Fungal skin (FS)

( ) Herpes Simplex (HS)
vesicles from a papular rash with or without itching/pain

( ) Herpes Zoster (HZ)
Vesicles from papular rash with or without itching/pain by Dermatomes

****

Wound (Decubitus) ( ) WI-D

****

( ) New wound at pressure point
( ) Wound increase by 50% after admission
( ) Purulent drainage stage II_IV
( ) Fever 100.2 F or change
( ) Confusion new or change of

****

Gastrointestinal Tract ( ) **GI**

****

( ) More than 2 episodes of vomiting in 24 hour period
( ) Diarrhea: acute onset liquid stools lasting 12 hours or more - foul or unusual odor.

****(Select 2)**** **OR** ****( ) Known enteric pathogen****

( ) Nausea
( ) Vomiting
( ) Abdominal pain
( ) Diarrhea

****

Eye/Conjunctivitis ( ) **Eye**

****

****(Select 1)****

( ) New drainage
Mucopurulent
( ) Redness/itching/pain/conjunctiva
( ) Scleral redness/itching/pain
-no trauma or allergy

****

Other ( ) **GU** ( ) **IV** ( ) **Central Line** ( ) **SWI** ( ) **Bacteremia**

****

( ) Genitourinary
( ) Vaginal - Yeast infection foul drainage / odor
( ) Penile - Drainage / cellulitis
( ) IV site
( ) Central Line
( ) SWI - Surgical wound infection
( ) Bacteremia / Sepsis

( ) Chills ( ) Fever ( ) Decreased BP
( ) Rigors ( ) Temp 101.2 F
( ) Primary origin (P) ( ) Secondary origin (S)

WestPark HOSPITAL
CODY, WYOMING

F441

POLICIES AND PROCEDURES

SUBJECT: Maintenance & Routine Cleaning of Nebulizers in LTCC	INITIATION DATE: 04/20/2011	POLICY #
OWNER: Eileen Dudek, R.N., D.O.N., LTCC	EFFECTIVE DATE:	
	DATE REVISED:	PAGE 1 of 1
APPROVAL:	MANAGER / DIRECTOR	DATE
Infection Control Coordinator; T Karter RN		
Cardiopulmonary Director		
Infection Control Committee		
ADMINISTRATION NAME / TITLE	SIGNATURE	DATE
Douglas A. McMillan, CEO		

PURPOSE: Nebulizers will be assigned to specific residents then cleaned & sanitized on routine basis for prevention of infections & to aid in the maintenance of a healthy environment for all residents of LTCC.

POLICY: It is the intent of the LTCC to maintain nebulizers in clean and infection free condition while they are in daily use by residents.

PROCEDURE: Nebulizers will be kept clean daily and will be thoroughly cleaned weekly.

<u>After each use:</u>

1. Remove the mask or mouthpiece and T-shaped elbow from the cup of the nebulizer machine. Remove the tubing and set it aside. (The tubing should not be washed or rinsed).
2. Rinse the mask or mouthpiece and T-shaped elbow in warm running water for 30 seconds. (Use distilled or sterile water for rinsing if possible.)
3. Shake off excess water and air dry on a clean paper towel.
4. Put the mask or mouthpiece and the T-shaped elbow, cup, and tubing back together, and connect the device to the compressor. Run the nebulizer machine for 10 to 20 seconds to dry the inside of it.
5. Disconnect the tubing from the compressor. Make sure every part of the nebulizer machine is dry before storing it.
6. Place cover over compressor.

<u>Once a Day:</u>

1. Remove the mask or mouthpiece and T-shaped elbow from the cup of the nebulizer machine. Remove the tubing and set it aside. The tubing should not be washed or rinsed.
2. Wash the mask or mouthpiece and T-shaped elbow with a mild dishwashing soap and warm water.
3. Rinse under a strong stream of water for 30 seconds. (Use distilled or sterile water if possible.)
4. Shake off excess water. Air dry on a clean paper towel.
5. Put mask or mouthpiece and T-shaped elbow, cup, and tubing back together and connect the device to the compressor. Run the nebulizer machine for 10 or 20 seconds to dry the inside of the nebulizer.
6. Disconnect the tubing from the compressor.
7. Place cover over the compressor.

<u>Weekly:</u> Cardiopulmonary staff replaces the equipment on a weekly basis.

DATE REVIEWED										
INITIALS										

WestPark HOSPITAL
CODY, WYOMING

F441

POLICIES AND PROCEDURES

SUBJECT; Equipment Cleaning General Infection Prevention Policy	INITIATION DATE:	POLICY #:
OWNER: Infection Control Coordinator Theresa Karter, RN	EFFECTIVE DATE:	
	DATE REVISED: 04/25/2011	PAGE 1 of 5
APPROVAL:COO; L. Barsness, RN	MANAGER / DIRECTOR	DATE
LTCC Director of Nursing		
Infection Control Committee		
ADMINISTRATION NAME / TITLE	SIGNATURE	DATE
Douglas A. McMillan, CEO		

I. Purpose/Expected Outcome:

A. To ensure patient safety through proper infection prevention measures.

II. Definitions:

A. **Hospital approved disinfectants** –Based on EPA registered scientific based claims. Federal law requires all applicable label instructions to be followed. (e.g. use-dilution, shelf life, storage, material compatibility, safe use and disposal).

B. **Categories of Medical Equipment**

1. **Critical**—Critical items confer a high risk for infection if they are contaminated with any microorganism. Objects that enter sterile tissue or the vascular system must be sterile. Examples include surgical instruments, cardiac and urinary catheters, implants and ultrasound probes used in sterile body cavities.
2. **Semi-critical**—Semi-critical items contact mucous membranes or non-intact skin. These items require high-level disinfection using chemicals cleared by the Food and Drug Administration (FDA). Examples include respiratory therapy and anesthesia equipment, some endoscopes, laryngoscope blades, esophageal manometry probes, cystoscopes, anorectal manometry catheters, and diaphragm fitting rings.
3. **Non-critical**—Non-critical items are those that come in contact with intact skin but not mucous membranes. Intact skin acts as an effective barrier to most microorganisms. "Virtually no risk has been documented for transmission of infectious agents to patients through non-critical items (VII.D.)
   a. **Patient care items**—These items are considered low risk and may be decontaminated where they are used. Examples include bedpans, blood pressure cuffs, crutches and computers. Note that hand hygiene should be practiced in accordance with policy.
   b. **Environmental Surfaces**—To be cleaned per Environmental Service policies in context with area or surface being cleaned. Examples are bed rails, bedside tables, furniture and floors.

III. Policy:

A. Care of equipment and environment are maintained to prevent transmission of infectious agents to patients/residents.

B. Equipment is to be cleaned with a hospital approved disinfectant according manufacturers recommendation.

IV. Procedure/Interventions:

A. **Patient Care Equipment**

1. Single use items are to be disposed of after use in proper receptacles. **(ALL EMPLOYEES)**
2. Reusable equipment is not used for the care of another patient until it has been properly cleaned with a hospital-approved disinfectant and allowed to air dry or is cleaned in accordance with the manufacturer's recommendations.

DATE REVIEWED										
INITIALS										

a. Unit-based patient care equipment (EKG machines, wheel chairs, procedure chairs, exam tables/stretchers, IV poles, computers) are to be cleaned between patients and when visibly soiled. **(ALL EMPLOYEES)**
b. Nursing unit based EKG and Telemetry monitors and cables are cleaned with disinfectant and allowed to air dry between patients. **(UNIT STAFF)**
c. The following equipment is cleaned on a regular basis by department staff and when item is visibly soiled with a hospital-approved disinfectant and allowed to air dry or is cleaned in accordance with the manufacturer's recommendations:
   i. Electronic or tympanic thermometers, pulse oximeters, blood glucometer units
   ii. Vital signs machine
   iii. Doppler, fetal monitors, infant warmers
   iv. Mobile Computer Units
   v. Patient slider boards, exercise/therapy equipment
   vi. Wheel Chairs, walkers and lifts, commodes
   vii. Portable X-ray units and Cardio-Pulmonary equipment
   viii. Portable Medication Carts, Treatment Carts
   ix. Laundry and Food Carts are cleaned on a regular basis by department staff.
d. Remove non-disposable equipment from patient room at time of discharge or when no longer needed and place in soiled utility room for cleaning.
e. **ALL EMPLOYEES are responsible for proper cleaning of equipment in their respective departments.**
f. Patient care equipment will be cleaned prior to being stored in a Clean Utility Room.
g. Store clean and sterile supplies in Clean Supply Areas which are physically separate from contaminated supplies.

3. The sterility of packages is event related. Remove from storage and discard all sterile disposable items that have been opened for any reason, damaged or are otherwise contaminated.
4. **Mobile Computer Devices:** Use Cavi-Wipes or PDI Wipes or Dispatch sprayed on cloth.
   Weekly: Use canned air to remove dust, dry particles etc. from keyboard
   Mobile devices/carts, including key board and mouse are cleaned:
   a. Between patients
   b. When visibly soiled
   c. At least every 24 hours
5. **Toy Cleaning**:
   a. Clean and disinfect all non-machine washable toys between patients and when visibly soiled. **(Dept Staff)**
   b. Discard any toy that cannot be cleaned or disinfected.
      i. Cloth toys which are not washable.
      ii. Metal toys with rusted parts.
      iii. Wooden toys with rough finish or splintered areas.
      iv. Plastic toys that have cracks or sharp edges.
      v. Paper toys or books that become contaminated.

B. **Eye Wash Stations:**
   1. Eye wash stations with bottled water:
      a. Dept. staff will change water every 30 days
      b. Discard water in bottles and rinse well with warm tap water.
      c. Refill with sterile water
   2. Eye wash stations attached to sink/faucet.
      a. Dept. staff will run water for 3 minutes once a week to flush out line.
      b. Report any signs of corrosion to Maintenance Department.

C. **Ice Machines/Water**
   1. Utilize an ice machine to pass filtered water and ice to patients whenever possible.
   2. Ice should be distributed in a container to patients'/residents rooms to fill water containers.
      a. **Do not bring patient water/ice container from Patients/Residents room to ice machine.**
   3. Patients are not to go to the ice machine to get ice or water for themselves.
   4. Employees should use only clean glasses and cups when obtaining ice.

D. **Linen and Laundry Services**
   1. Clean linen must be covered or wrapped to prevent contamination during transport and stored linen must be protected until linen is distributed to patient room.
   2. Handling of soiled linen:
      a. **ALL soiled linen is to be bagged prior to transport in halls. Do not overfill laundry bags.**
      b. Place bagged linen into laundry hampers provided in each patient care area. Keep laundry bags/hampers closed when not in use.
      c. Facility Linen and Resident clothing with blood or body fluids requiring rinsing prior to laundering: *Always wear gloves when handling soiled linen.
         i. Place soiled linen in **clear trash bag.** (complete the cleaning of patient and environment)
         ii. Take bagged laundry to dirty utility room.
         iii. Put on gloves and other PPE and rinse out linen in hopper.
         iv. Place rinsed laundry in appropriate laundry bags.
         v. Remove gloves and PPE and wash hands.

E. **Staff Food and Drink**
   1. **Staff is not allowed to have open drinks or food in patient care areas. Covered drinks are permitted.**
   2. Perishable food items, specific for staff consumption is to be refrigerated in refrigerator designated for staff use only.
   3. **Refrigerators**
      a. Refrigerators will be maintained in a sanitary condition and at a temperature that meets the accepted standard of safety for items requiring refrigeration.
      b. Food refrigerators should contain only food, properly wrapped or placed in properly closed containers. Single serve food and beverage items should be discarded after one use. **No partially used, single serve containers can be left in a public, patient use refrigerator.**
      c. All perishable food and beverages should be dated, and disposed of at expiration date specified. It is recommended that all non-commercially prepared and packaged items be disposed of after 3 days.
      d. Medicine or drug refrigerators should be kept solely for the purpose of storing medicines that require refrigeration according to the manufacturer's instructions. Sealed food items (apple sauce, pudding, ensure) that are used for the purpose of adding medication for administration to patient requiring crushed medicines may be kept in the medication refrigerator until opened. Once opened, these items must be kept in an insulated cooler with ice packs in the med preparation area and disposed of at the end of each shift.
         i. Temperature for medication refrigerators are kept by the Pharmacy Department.
      e. Blood refrigerators should contain only blood and blood products.
      f. Specimen refrigerators should contain only specimens. Specimens must be properly secured and should be labeled appropriately to include date and time collected.
      g. Temperatures on refrigerators used for patient consumption products in patient care areas should be checked and recorded daily to ensure proper temperature control. (Exception: when department/unit is closed)
         i. Temperature control log sheet should be posted, indicating date, time, temperature reading, and initials of persons who checked reading.
         ii. The temperature of food refrigerators should be maintained between 33° F and 41°F.
         iii. The temperature at which drugs are kept in medication refrigerator should be maintained between 36°F (2°C) and 46°F (8°C).
         iv. Specimen refrigerators kept at 36°F (2°C) to 46°F (8°C).
         v. If temperature reading is identified as being out of range, thermostat should be adjusted. If repeat readings (x2) indicate temperatures above or below ranges listed above, Plant Operations (Maintenance Dept.) must be notified immediately.
      h. Cleaning
         i. All refrigerators in each unit/department should be defrosted and cleaned using a hospital-approved disinfectant, at least once a month or on a more frequent basis as indicated.
         ii. It is the responsibility of Nutrition and Food Service Department to clean the facility patient food refrigerators on a regular scheduled basis. This includes the refrigerator in the IPU Nutrition room.

iii. Responsibility for cleaning department based refrigerators remains with the Department Directors designated staff.
iv. All spills should be wiped up as they occur and or observed, to maintain cleanliness, on an ongoing basis.

4. **Plants and Flowers in Patient Care Areas**
   a. Potted plants and fresh flowers are not allowed in neutropenic patient rooms, in PACU, MBU & Nursery and should be restricted from other areas caring for immunocompromised patients. Special considerations and approaches are followed for LTC Residents.
5. **Admissions**
   ALL ADMISSIONS
   a. A face mask will be placed on all Patients presenting to this facility reporting illness with a cough. Outpatients will be asked to wear this mask while in this facility.
   b. Patients admitted into the ER reporting illness with cough will wear a mask and staff caring for the ER patient will follow Droplet Precautions.
   c. Patients admitted into the IPU with lower respiratory tract illness of unknown origin will be placed on Droplet Precautions and Patient will remain in Droplet Precaution Isolation, following the 2007 CDC Duration Guidelines.
6. **Visitors**
   a. Visitors are to be discouraged from visiting if they exhibit signs or symptoms of infection (e.g. cough, runny nose, fever).
   b. At certain times of the year, due to the prevalence of communicable diseases in the community, visitation may be limited. Signs will be posed in the entrance lobby areas and next to elevators during these periods.
   c. Visitors are to be encouraged to perform hand hygiene before and after visiting patients and practice Cough Etiquette.
   d. Visitors are to be encouraged to wear PPE as applicable (Nursery, Isolation rooms, etc.)

7. **2-Step Procedure for Cleaning Blood or Body Substance Spills**
   a. Clean/disinfect blood or body fluid spills right away with Dispatch or Omega disinfectant.
   b. Cleaning up Spills:
      i. Always wear gloves
      ii. Spray Dispatch or Omega disinfectant onto the spill and let sit for 2-3 minutes
      iii. Soak up spill using paper towels. Dispose of paper towels and gloves in **clear trash bag.**
         (i) If there is free flowing – dripping blood/body fluid on cleaning towels use the hazardous waste (red) bags for disposal of items.
      iv. Put on gloves.
      v. Re-apply Dispatch or Omega disinfectant.
      vi. Wipe with paper towels.
      vii. Throw the paper towels and gloves in regular trash.
      viii. Wash your hands.

   c. Each department is responsible to have disinfectant spray bottles AND **clear trash bags** and red trash bags in their area.
   d. GERMICIDAL WIPES AND OTHER PRE MOISTENED TOWELS ARE NOT ACCEPTABLE CLEANING AGENTS FOR BLOOD AND BODY FLUID SPILLS.
   e. Facility Linen and Resident/Patient Clothing with blood or body fluids requiring rinsing prior to laundering: (grossly bloody, BM or vomit)
      i. Always wear gloves when handling soiled linen
   f. Place soiled linen in **clear trash bag.** (Complete the cleaning of patient and environment) then:
   g. Take bagged laundry to dirty utility room.
   h. Put on gloves and other PPE and rinse out linen in hopper.
   i. Place rinsed laundry in appropriate laundry bags.
   j. Remove gloves and PPE and wash hands.

V. References:

A. HCPro IC Manual for Hospitals and Long Term Care Facilities. 2006 ICP Associates, LLC.
B. Centers for Disease Control and Prevention. Guidelines for Environmental Infection Control in Health Care Facilities: Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). MMWR 2003; 52 (no.RR-10); 1-48. Full text available at www.cdc.gov/ncidod/hip/enviro/guide.htm.
C. Centers for Disease Control and Prevention. Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008.
D. Weber DJ, Rutala WA. Environmental issues and nosocomial infections. In: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008.

WestPark HOSPITAL
CODY, WYOMING

F441

POLICIES AND PROCEDURES

SUBJECT: Maintenance and Routine Cleaning of Humidifiers	INITIATION DATE: 04/20/2011	POLICY #
OWNER: Eileen Dudek, R.N., D.O.N., LTCC	EFFECTIVE DATE:	
	DATE REVISED:	PAGE 1 of 1
APPROVAL:	MANAGER / DIRECTOR	DATE
Infection Control Coordinator: T. Karter, RN		
ADMINISTRATION NAME / TITLE	SIGNATURE	DATE
Douglas A. McMillan, CEO		

PURPOSE: Humidifiers will be cleaned and sanitized on a routine basis for the prevention of infections and to aid in the maintenance of a healthy environment for all residents of LTCC.

POLICY: Humidifiers will be discouraged from use in resident rooms. Residents/families who insist on bringing a humidifier to the facility will have it cleaned and disinfected per policy.
It is the intent of the LTCC to maintain humidifiers in clean and infection free condition while they are being used in resident rooms.

PROCEDURE: The humidifier will be cleaned on a routine weekly basis with clean tap water.
The humidifier will be disinfected once a month.

Weekly Cleaning:
1. Empty the water from the holding receptacle.
2. Use mild dish soap and warm water.
3. Clean the holding receptacle.
4. Rinse thoroughly with clear water.
5. Wipe off the sides of the receptacle.
6. Refill with cool clean tap water.

Monthly Disinfecting:
1. Remove receptacle from resident room to the main bath.
2. Clean receptacle first, as stated above.
3. Fill receptacle with water.
4. Add 1 tsp. liquid chlorine bleach for every gallon of water.
5. Allow solution to set for 30 minutes. Occasionally swish around while soaking.
6. Pour the solution carefully down the drain.
7. Rinse the receptacle several times well with clear water.
8. Refill with cool clear water.

Changing Filters: The resident's family member will be expected and reminded to bring and replace the filters for humidifiers, as per manufacturer of individual humidifiers suggestion.

RELATED FORMS:

REFERENCE:

DATE REVIEWED										
INITIALS										

WestPark HOSPITAL CODY, WYOMING

F441

POLICIES AND PROCEDURES

SUBJECT; Cleaning and maintenance of General Respiratory Equipment in LTCC	**INITIATION DATE: 4/25/11**	**POLICY #:**
OWNER: Director of LTCC Nursing, Eileen Dudek, RN	**EFFECTIVE DATE: 4/25/11**	
	DATE REVISED:	**PAGE 1 of 2**
APPROVAL: Administrator of LTCC, Jeanne Kaiser	**MANAGER / DIRECTOR**	**DATE**
Infection Control Coordinator: Theresa Karter, RN		
Infection Control Committee		
ADMINISTRATION NAME / TITLE	**SIGNATURE**	**DATE**
Douglas A. McMillan, CEO		

PURPOSE:

WPH LTCC Suction or oxygen equipment is assigned to a specific patient for use during the resident's need for such.

Tubing and attachments are checked daily for integrity and cleanliness, but cleaned and replaced, if necessary, AT LEAST weekly. This will address/ prevent build up dirt, resident misuse, cross-contamination, and the potential of the equipment harboring pathogens during patient care use..

PROCEDURE:

- Nursing personnel responsible for sanitizing and cleaning equipment shall:
  - Be thoroughly knowledgeable of the cleaning methodology specified by the manufacturer, state regulations and/or company policy;
  - Be aware of the hazards which may be associated with use of the de-germing agent including inhalation of vapors and avoidance of dermatological contact;
  - Comply with cleaning and tagging of equipment as cleaned and ready for use.
  - Disinfect equipment in a manner that minimizes splashing, spraying or creating droplets which might transfer blood or other potentially infectious materials from the equipment to the cleaner.
- Equipment that is heavily soiled shall be prewashed because the disinfectant may not be powerful enough to penetrate thick deposits of blood or other potentially infectious materials.
- All disposable accessories and parts should be replaced at least weekly but also when the appearance of built up dirt, excretions a/o visible blood is seen. Those parts with visible blood and excretions should be placed in a biohazard bag and the suction canister MUST NOT BE OPENED, but discarded intact into a biohazard waste bag/container.
- All equipment shall be processed in accordance with the manufacturer's guidelines using an EPA approved hospital-grade germicidal cleaner.

DATE REVIEWED										
INITIALS										

- West Park Hospital LTCC shall only use disinfectant products which meet company standards (a hospital-grade germicidal cleaner, which the product manufacturer claims to be effective against tuberculosis bacteria and the AIDS and Hepatitis B, C, D viruses).

Handling, cleaning, and Storage of Dirty Equipment:

- Dirty equipment is kept covered and stored in the dirty equipment receiving area. Then the equipment must be cleaned, with an approved EPA cleaner utilizing appropriate PPE during the cleaning process. Once completed, the unit should be covered with a bag and labeled CLEAN- This label must include the DATE the CLEANING was done. Then it can be removed and placed in the CLEAN Utility Room

- Contaminated equipment must be removed from the immediate resident area, covered upon discovery, and taken to a dirty utility room. In that setting the responsible cleaner MUST don PPE for self protection before proceeding to;

1. Remove/disconnect all contaminated disposable items and place them in a Bio Hazard bag.
2. Clean all surfaces with an EPA approved disinfectant with cloth or paper towels
   Ethyl or isopropyl alcohol (70% to 90%)
   Phenolic germicidal detergent
   (dilute per label)
   Iodophor germicidal detergent
   (dilute per label)
   Quaternary ammonium germicidal detergent (dilute per label)
   Household bleach (sodium hypochlorite 5.25%
   1,000 ppm available chlorine= 1: 50 dilution
3. Once completed, the unit should be covered with a clean, clear plastic bag and labeled CLEAN. This label must include the DATE the CLEANING was done.
   The cleaned equipment can then be moved to the CLEAN Utility Room since is it ready for the next use.

RELATED FORMS:
Receiving Equipment Policy

REFERENCE:
Medical Consultants Network, INC

F441

Entered 4-22-11 DE

WEST PARK LONG TERM CARE CENTER
STAFF MEETING & INSERVICE
APRIL 20, 2011

TOPIC: Customer Service
PRESENTER: Dawn Garrison
TIME: .75
OBJECTIVES To provide education + understanding of WPH's Customer service goals

TOPIC: Handwashing
PRESENTER: Eileen Dudek RN
TIME: .25
OBJECTIVES To increase knowledge of points of care + service when handwashing is required by professional standards

Attendee name (PLEASE PRINT LEGIBLY)

Cherry Jenson	Patti Wallace-CNA	
Jennifer Paxton	Mary Dessen	
Jerrica Patterson	Melodye Trusty	
Michael Perkins	Ann Pasek/c	
[illegible]	PE WHITE	
R. Mallon	Sharon Medley	
Marion Smith Ingram CNA	AGNES C PARKER	
Ellen Burbank RDCSG	Paula Perez	
Patti Mucci	Kristie Hoffert	
Carolyn Stanfill	[illegible]	
Randy Mittleider	Henry McCoy CNA	
Bertha Brandon LPN	Danielle Turner	
Shellie Bouchard-Hermans		
Tiana Grill	TIANA GRILL	
Jo Walker	Amy Potter	
Pamela Bass		
Vicky Goodman		
Donna Zubik	Patricia Everett	
Ruth Vaughan		
Shelly Kindt		
Colleen Kindt		
Becky Peterson		
Peg Pink Pace		
Eileen Dudek		
[illegible]		
[illegible]		

1/04 EDUCATIONAL PROGRAMS SIGN IN SHEET.doc

F441

LTCC HANDWASHING POST-TEST

1. When you remove your gloves what should you do?

2. Name three (3) contaminated surfaces.

3. Briefly describe Standard Precautions.

4. State three (3) appropriate times to wash your hands.

F-441

Hand Hygiene (HH) Compliance Monitoring Form

Unit: _____ Date: _____

Observer: _____ Time: _____

A	B	C	Dd	E	F	G
TYPE OF STAFF OBSERVED	HH Opportunities	Gloves used Properly	Type of Procedure/Care Observed	Compliance HH a/o glove use	%Compliance	Comments
TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	
RN CNA MD						

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 _____	04/01/2011

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

(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 54 diarrhea). The log did not address corrective actions that were taken. Infection Control Issues 2. The infection control issues identified by observation, record review and staff interview during survey included: cleaning of resident equipment (suction machines, humidifiers, nebulizer machines for breathing treatments), adequate processing of laundry items (clothing protectors and resident personal clothing), and proper handwashing. a. During the initial tour on 3/28/11 and all days of survey, nebulizer machines with tubing attached were noted to be sitting on a table in the main lounge area on the first floor by the nurses station. Staff was observed to place residents at the table and start their breathing treatments without cleaning of the equipment before or after treatments. 1) Interview with staff F on 3/30/11 revealed she was not aware of a policy or procedure for cleaning of the nebulizer equipment. 2) On 3/31/11 during the environmental tour the DON confirmed she was not aware of a policy and procedure for cleaning of the nebulizer equipment or if the manufacturers cleaning instructions were being followed by staff. 3) Observations included resident #19 who was one of the residents observed on all days of survey receiving the nebulizer treatments in the lounge. Review of the infection control logs identified resident #19 being treated for an upper respiratory infection on 1/24/11, 2/15/11 and	F 441		

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 _____	04/01/2011

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

(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 55 3/26/11 (during the survey). 4) On 3/29/11 at 11:30 AM and on 3/30/11 at 8:42 AM and 11:50 AM, observations of the East Unit common area where the television was located, evidenced one table with two nebulizer set-up sitting on the table. These devices were observed at numerous times throughout the survey and they remained uncovered on the table. Residents were observed to receive treatments at this table. Staff were requested to provide manufacturer's cleaning instructions for the equipment. None were given to the surveyor. The facility failed to ensure proper cleaning and storage of equipment which has the potential to cause respiratory infections. REFERENCE from Respiratory Therapist website: general cleaning of a nebulizer machine: Regular cleaning of your nebulizer machine helps prevent germs and bacteria that can cause respiratory infection. "Follow the manufacturer's instructions for cleaning and storage of your nebulizer machine." The cleaning of the machines will included cleaning after each use, once a day and once or twice a week cleaning. After each use: 1. Remove the mask or mouthpiece and T-shaped elbow from the cup of your nebulizer machine. Remove the tubing and set it aside. The tubing should not be washed or rinsed. 2. Rinse the mask or mouthpiece and T-shaped elbow in warm, running water for 30 seconds. Use distilled or sterile water for rinsing, if	F 441		

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F 441	Continued From page 56 possible. 3. Shake off excess water and air dry on a clean cloth or paper towel. 4. Put the mask or mouthpiece and T-shaped elbow, cup, and tubing back together, and connect the device to the compressor. Run the nebulizer machine for 10 to 20 seconds to dry the inside of it. 5. Disconnect the tubing from the compressor. Make sure every part of the nebulizer machine is dry before storing it. 6. Place a cover over the compressor. Once every day: 1. Remove the mask or mouthpiece and T-shaped elbow from the cup. Remove the tubing and set it aside. The tubing should not be washed or rinsed. 2. Wash the mask or mouthpiece and T-shaped elbow with a mild dishwashing soap and warm water. 3. Rinse under a strong stream of water for 30 seconds. Use distilled or sterile water if possible. 4. Shake off excess water. Air dry on a clean cloth or paper towel. 5. Put the mask or mouthpiece and T-shaped elbow, cup, and tubing back together and connect the device to the compressor. Run the nebulizer machine for 10 to 20 seconds to dry the inside of the nebulizer. 6. Disconnect the tubing from the compressor.	F 441		

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F 441	Continued From page 57 Place a cover over the compressor. Once or twice a week: This included a rinse under a strong stream of water for 30 seconds, a soak for 30 minutes in a solution of one part distilled white vinegar and two parts distilled water and a rinse the nebulizer parts again under warm, running water for one minute or rinse with distilled or sterile water. b. Humidifiers: On 3/29/11, 3/30/11, and 3/31/11, observations made in resident #10's room revealed that a humidifier was in use. There was no evidence to show when the humidifier was cleaned. As noted above, the facility did not have the manufacturer's instructions for cleaning the humidifiers. The cleaning guidelines instruct users to follow the guidelines recommended by the manufacturer, to keep humidifiers free of harmful mold, fungi and bacteria. Humidifiers having dirty reservoirs and filters can quickly breed bacteria and mold. The use of dirty humidifiers can be especially problematic for people with asthma and allergies, but even in healthy people humidifiers have the potential to trigger flu-like symptoms or even lung infections when the contaminated mist or steam is released into the air. c. Suction Equipment: On 3/29/11, 3/30/11, and 3/31/11, observation in resident #10's room revealed that a suction canister contained cloudy liquid with a top layer of pink on it. The amount increased each day. There was no evidence to show that the canister was being cleaned or that it had been emptied,	F 441		

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F 441	Continued From page 58 cleaned, or changed. d. Handwashing: 1) During the initial tour on 3/28/11, nurse A identified resident #5 as being in contact isolation with a rash on his/her scalp. A bedside stand which contained isolation supplies was sitting outside the resident's room. There was no sign to identify the type of isolation or the precautions that should be used when caring for this resident. Review of the resident's nurse and nurse aide care sheets (identified by some staff as kardexes) information evidenced that both forms contained "contact precautions - scalp". Review of resident #5's 3/21/11 History and Physical Examination evidenced that the resident had diagnoses that included Parkinson's Disease, Dementia, muscle contractures, depression, behavioral issues, coronary disease, and gastroesophageal reflux disease. The physician noted "...has had some skin breakdown on ___(his/her) head, which really looks like boils and furuncles. I am going to get the wound care nurses involved. ...has multiple furuncles on the back of ___(his/her) neck toward the left side. There is no drainage. They all look fairly scabbed over.." On 3/29/11 at 9:25 AM, in an interview with nurse G, she stated that resident #5 was to receive cream to his/her head for the treatment of staph (staphylococcal), which had not been cultured. The nurse confirmed that the resident was on contact isolation. On 3/29/11 at 5:05 PM, two Certified Nurse Aides	F 441		

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F 441	Continued From page 59 (CNAs) (L and M) were observed, in the SCU common area, repositioning resident #5 in his/her geri-chair without gloves on. In order to do this, the CNAs both reached under the resident's lower body and under his/her neck/shoulders and lifted the resident upward toward the top of the geri-chair. After the repositioning was completed, CNA L went to the kitchenette and poured a glass of orange juice and delivered it to another resident without performing hand washing. CNA M went directly to another resident's room and began providing care without performing hand washing. 2) On 3/29/11 at 5:00 PM, observation during a medication pass evidenced nurse C prepared and gave resident #27 an insulin injection. She took the resident to his/her room, laid the insulin pen on the resident's bed, gave the injection, and then returned the pen to the medication cart without cleaning it. 3) On 3/30/11 at 8:15 AM, observation during a medication pass revealed nurse G prepared and administered resident #9's medication via gastrotomy tube. She checked the placement of the tube, using a stethoscope, which she laid on the resident's bed. After the administration of the medication, the nurse picked up the stethoscope and was not observed to clean it. 4) On 3/31/11 starting at 9:28 AM, residents #9, #12, and #13's buttocks, back, and/or heels were observed with nurse O. The nurse and CNA P touched these residents in order to turn and reposition them during the observation. The nurse did not wash her hands between the observations of the residents or before leaving the third resident's room.	F 441		

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F 441	Continued From page 60 5) On 3/31/11 at 10:15 AM, resident #4's buttocks, back, and heels were observed with nurse C. The back, outer side of the right heel had a black, dry area which the nurse identified as a scab. There was peeling skin on the heel. The resident's right upper buttock had several small purplish/black areas and the buttock was light red. The left upper buttock had two small purplish/black spots on it. After the nurse assisted the resident during this observation, no hand washing was done. e. Interview with the Infection Control Coordinator on 3/31/11 at 9:30 AM revealed she was not aware of how this equipment was being cleaned or monitored or that the manufacturer's guidelines were being used to ensure proper cleaning of equipment. She reported that an inservice was completed on 3/16/11 which included proper hand hygiene, C-diff, and resistant infections. f. During the environmental tour on at 3/31/11 at 2:00 PM with maintenance staff and the DON (Director of Nursing), the facility identified two small rooms which each had a washer and dryer. There was one room in the SCU (special care unit) and the other on the second floor. Staff reported that these wash areas were used for the residents who wanted to do their own personal laundry and for washing clothing protectors for all the residents. The maintenance staff reported that the water feeding these areas was 110 degrees which was not as hot as the main laundry at 160 degrees. Staff was not aware if the current laundry detergent being used in the small laundry areas was effective with the lower water temperatures. The DON reported they would contact "Ecolab" to ensure the proper detergent	F 441		

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F 441	Continued From page 61 /enzyme with the lower water temperature used was effective with multidrug-resistant organisms in the facility. Reference: CDC (Center for Disease Control) Antimicrobial Resistance - Multi-drug Resistant Organisms in Non-Hospital Healthcare Settings: They are bacteria and other microorganisms that have developed resistance to antimicrobial drugs. ... MRSA (Methicillin Resistant Staphylococcus aureus) and VRE (Vancomycin-resistant enterococci) are the most commonly encountered multidrug-resistant organisms in patients residing in non-hospital healthcare facilities. Non-hospital healthcare facilities can safely care for and mange these patients by following appropriate infection control practices. Current prevention methods is an ongoing investigation. No single prevention approach is likely to work alone. Careful handwashing is important for prevention of spread of many infections including Staph aureus..." Clostridium difficile (C-diff) is a spore-forming, gram-positive anaerobic bacillus that produces two exotoxins: toxin A and toxin B. It is a common cause of antibiotic-associated diarrhea (AAD). Transmission: C. difficile is shed in feces. Any surface, device, or material (e.g., commodes, bathing tubs, and electronic rectal thermometers) that becomes contaminated with feces may serve as a reservoir for the C. difficile spores. C. difficile spores are transferred to patients mainly via the hands of healthcare personnel who have touched a contaminated surface or item. Prevention in hospitals and other healthcare settings: "Use antibiotics judiciously,	F 441		

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F 441	Continued From page 62 Use Contact Precautions: for patients with known or suspected C. difficile-associated disease: Place these patients in private rooms. If private rooms are not available, these patients can be placed in rooms (cohort) with other patients with C. difficile-associated disease. Perform Hand Hygiene using either an alcohol-based hand rub or soap and water. If your institution experiences an outbreak, consider using only soap and water for hand hygiene when caring for patients with C. difficile-associated disease;alcohol-based hand rubs MAY NOT be as effective against spore-forming bacteria. Use gloves when entering patients ' rooms and during patient care. Use gowns if soiling of clothes is likely. Dedicate equipment whenever possible..." CONTINUE THESE PRECAUTIONS UNTIL DIARRHEA CEASES Implement an environmental cleaning and disinfection strategy: Ensure adequate cleaning and disinfection of environmental surfaces and reusable devices, especially items likely to be contaminated with feces and surfaces that are touched frequently. Use an Environmental Protection Agency (EPA) -registered hypochlorite-based disinfectant for environmental surface disinfection after cleaning in accordance with label instructions; generic sources of hypochlorite (e.g., household chlorine bleach) also may be appropriately diluted and used. (Note: alcohol-based disinfectants are not effective against C. difficile and should not be used to disinfect environmental surfaces.)	F 441		