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	535027	A. BUILDING _____ B. WING _____	C 09/25/2008

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 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and interview with a pharmacist, the facility failed to ensure staff maintained professional standards of practice related to medication administration for 1 (#14) of 15 sample residents. The findings were: According to the "Nursing Practice Act July 2005 and Administrative Rules and Regulations November 2003" for the Wyoming State Board of Nursing, nurses shall practice under the direction of a licensed physician. Failure to adhere to this standard was identified for the following resident: a. Medical record review showed that on 8/8/08 the physician ordered a two week trial of Megace 200 milligrams (mg) four times a day for resident #14. Further review of the record showed the following communication was faxed to the physician on 8/15/08: "...we have been holding [Megace] most of this week now." Review of the medication administration records showed staff held the medication on 8/11/08 at bed time as the resident was sleeping. Furthermore, the medication was not administered on 8/13/08 at 7 AM nor on 8/14/08 at 7 AM, 5:22 PM, and 7:05 PM due to "family request." The reason documented by the nurse for not giving the medication on 8/13/08 at 11 AM, 5:34 PM, and 7:07 PM and on 8/14/08 at 11 AM was "Not indicated." Further review of the record failed to reveal any evidence the physician was notified of the family's request not to give the medication or	F 281	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations manual. 1. The facility will continue to ensure that staff maintains professional standards of practice related to medication administration. 2. The primary nurse who is regularly assigned to the care of Resident #14 was provided 1:1 education regarding required notification to a resident's physician within 24 hours of any medication that has not been administered in accordance with the physician's order. 3. All licensed nursing staff will be educated regarding the requirement for physician's notification within 24 hours of any medication that has not been administered in accordance with the physician's order and that if any physician's order is questionable for any reason, the physician must be notified for clarification.	11/07/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

James Kaiser, NHA | Administrator | 10/16/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
Wyoming Dept of Health
OCT 17 2008

10/24/08 POC acceptable – P. Shino, RN

Office of Healthcare Licensing and Surveys

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F 281	Continued From page 1 of the nurse's decision not to administer the medication. On 9/24/08 at 3:20 PM the staff development coordinator confirmed there was no evidence the physician was notified and stated that he should have been. On 9/25/08 at 10:40 AM the director of nursing verified the physician should be notified immediately if a medication is held. b. According to physician orders signed on 8/27/08 the resident was to receive one half of a tablet of Remeron 7.5 mg and a whole tablet of Remeron 7.5 mg, both at bed time, for a total of 11.25 mg nightly. Review of the electronic medical record and interview with the pharmacist (A) on 9/24/08 at 10:35 AM revealed the order was incorrect. However, the order was not clarified by the nurse who noted it on 8/29/08. According to the sixth edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, 2004, "If a written order is...questionable for any reason, the physician must be notified for clarification."	F 281 (cont'd)	4. A representative sampling of medication administration records will be reviewed three times per week by the Staff Development Coordinator-RN, (SDC-RN) and compared to the corresponding physician's orders to ensure that medications are being administered as ordered. 5. A Quality Improvement (QI) indicator will be developed to monitor the medication administration compliance with physicians' orders, and the results reported to the organization-wide QI Committee, with subsequent referral to the organization-wide Pharmacy and Therapeutics (P & T) Committee on a quarterly basis for the next year. 6. The Director of Nursing (DON) will monitor.	
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the care plans for 2 (#9, #41) of 13 sample residents were followed. The findings were: 1. According to the 1/8/08 admission and 9/17/08	F 282	1. The facility will continue to ensure that the services provided by the facility are in accordance with the resident's written plan of care. 2. The staff members who are regularly assigned to provide care to Residents #9 and #41 were provided 1:1 education regarding the requirement for following the resident's written plan of care, to include toileting schedules.	11/07/08

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F 282	Continued From page 2 quarterly Minimum Data Set (MDS) assessments, resident #9 was incontinent of bowel and bladder. Review of the care plan dated 9/17/08 showed staff were to toilet the resident before and after meals, at bed time, at 4 AM, and as needed. Observation on 9/23/08 revealed the resident was not toileted nor asked about using the toilet from 11:25 AM until 4:50 PM, a time period of 5 hours and 25 minutes. On 9/24/08 at 11:05 AM, the registered nurse (B) confirmed the care plan was current and that the length of time without toileting this resident was too long. 2. Review of the 2/29/08 annual and 8/15/08 quarterly MDS assessments revealed resident #41 was incontinent of bowel and bladder. Review of the care plan showed the resident was on a scheduled toileting program of before and after meals, at bed time, and as needed. Continuous observation on 9/24/08 showed the resident was not toileted, nor asked about using the toilet, from 10 AM until 2:10 PM. On 9/24/8 at 3:13 PM, the registered nurse (B) confirmed the care plan was current.	F 282 (cont'd)	3. All staff was educated at a staff meeting on 10/01/08 regarding the requirement for following the residents' written plan of care as provided to them by the information on their daily assignment sheets for the residents under their care. 4. The SDC-RN, the MDS Coordinator, and/or the DON will conduct at least weekly unannounced rounds on Residents #9 and #41, and a representative sampling of other residents on each unit to determine compliance with the residents' plan of care specific to toileting. 5. The information on care plans consistent with toileting will be developed into a QI indicator and reported to the organization-wide QI committee on a quarterly basis for the next year.	
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure 1	F 309	6. The DON will monitor 1. The facility will continue to ensure that each resident receives the necessary care and services to prevent bowel incontinence. 2. The Certified Nursing Assistant (CNA) assigned to provide care to Resident #41 was provided 1:1 education regarding the resident's plan of care for toileting to prevent bowel incontinence.	11/07/08

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F 309	Continued From page 3 (#41) of 10 sample residents received care and services to prevent bowel incontinence. The findings were: 1. Review of the 2/29/08 annual and 8/15/08 quarterly Minimum Data Set assessments revealed resident #41 was incontinent of bowel. Review of the bowel assessment showed the resident had a colostomy, but the seal failed up to seven times a week. Factors contributing to this failure were identified as an "extremely large hernia...near the colostomy" and the "chest on knees" position the resident assumed while sitting in the wheelchair. Further review of the assessment revealed "This posture makes it impossible for any stool leaving colostomy to enter bag." Review of the care plan showed the resident's scheduled toileting program was before and after meals, at bed time, and as needed. Continuous observation on 9/23/08 revealed the resident was not toileted, nor asked about needing to use the toilet, from 10 AM until 2:10 PM. During this period the resident remained in the knee/chest position from 1:20 PM until taken to the bathroom. When toileted at 2:10 PM, the certified nurse aide (C) stated the seal on the resident's colostomy had failed and fecal contents had leaked.	F 309 (cont'd)	3. All staff was educated at a staff meeting on 10/01/08 regarding the requirement for following the residents' plan of care to prevent bowel incontinence by adhering to the information provided on the daily assignment sheets for the residents under their care. 4. The SDC-RN, the MDS coordinator, and/or the DON will conduct at least weekly unannounced rounds on Resident #41, and a representative sampling of other residents on each unit to determine compliance with the residents' plan of care specific to preventing bowel incontinence. 5. The information gathered through these regular weekly rounds will be developed into a QI indicator regarding prevention of bowel incontinence, and reported to the organization-wide QI committee on a quarterly basis for the next year. 6. The DON will monitor.	
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315	1. The facility will continue to ensure that each resident receives the necessary care and services to prevent bladder incontinence.	11/01/08

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F 315	Continued From page 4 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to assure staff provided 1 (#9) of 10 sample residents with the necessary care and services to prevent urinary incontinence. The findings were: 1. According to the 1/8/08 admission and 9/17/08 quarterly Minimum Data Set assessments, resident #9 was incontinent of urine. Review of the care plan dated 9/17/08 showed staff were to toilet the resident before and after meals, at bed time, at 4 AM, and as needed. Observation on 9/23/08 revealed the resident was not toileted, nor asked about needing to use the toilet, from 11:25 AM until 4:50 PM, a time period of 5 hours and 25 minutes. Upon toileting the resident at the request of the surveyor at 4:50 PM, the certified nurse aides (D and E) confirmed the resident was incontinent of urine. On 9/24/08 at 11:05 AM, the registered nurse (B) stated that the extended length of time without toileting was too long a period for this resident.	F 315 (cont'd)	2. The Certified Nursing Assistants (CNA's) assigned to provide care to Resident #9 were provided 1:1 education regarding the resident's plan of care for toileting to prevent urinary incontinence. 3. All staff was educated at a staff meeting on 10/01/08 regarding the requirement for following the residents' plan of care to prevent bladder incontinence by adhering to the information provided on the daily assignment sheets for the residents under their care. 4. The SDC-RN, the MDS coordinator, and/or the DON will conduct at least weekly unannounced rounds on Resident #41, and a representative sampling of other residents on each unit to determine compliance with the residents' plan of care specific to preventing bladder incontinence. 5. The information gathered through these regular weekly rounds will be developed into a QI indicator regarding prevention of bladder incontinence, and reported to the organization-wide QI committee on a quarterly basis for the next year. 6. The DON will monitor.	
F 334 SS=C	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 334	Begins on Page 6	

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F 334	Continued From page 5 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and	F 334	1. The facility will continue to ensure that residents or their legal representatives are provided education on the benefits and potential side effects of the influenza vaccination prior to administering the vaccine, and provision of this education will be reflected in the residents' medical record. 2. Prior to immunization, each resident or their legal representative will be provided with a copy of an educational bulletin explaining the benefits and potential side effects of the influenza vaccination as published by the Centers for Disease Control, copy enclosed. A notation will be made in each resident's medical record regarding the provision of this resident education. 3. A policy will be developed outlining the facility practices utilized for influenza vaccination of residents. 4. A QI indicator will be developed to monitor the provision of resident education regarding the benefits and potential side effects of the influenza vaccination and the results will be reported to the organization-wide Infection Control Committee at the next two quarterly meetings. 5. The Director of Nursing will monitor.	11/01/08

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F 334	Continued From page 6 (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of medical records and facility policies and procedures, the facility failed to document resident education regarding influenza vaccination for six (#12, #18, #20, #41, #75, #76) of six residents. Further, the facility failed to develop written policies and procedures to ensure a safe and effective influenza immunization program. The findings were: 1. Review of immunization information in the medical records for six residents (#12, #18, #20, #41, #75, and #76) failed to show evidence the residents, or their legal representatives, were provided education on the benefits and potential side effects of influenza vaccination prior to administering the vaccine in October 2007. 2. The infection control nurse stated in an interview on 9/24/08 at 3:30 PM the facility relied upon a standing medical order as authority to provide resident immunizations. The standing			

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F 334	Continued From page 7 order prescribed the immunization on a seasonal basis, but did not provide information for residents regarding risks and benefits of the vaccination. 3. Interview with the facility staff development coordinator on 7/24/08 at 4:20 PM revealed the facility had not developed a uniform method for educating residents on the side effects or benefits of the influenza vaccination. She added the facility did not have written plans, policies, or procedures to govern its immunization program.			
F 356 SS=B	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356	1. The facility will continue to ensure that nurse staffing information is posted on a daily basis in a prominent place readily accessible to residents and visitors and updated at the beginning of each shift whenever changes occur. 2. The required nurse staffing information will be posted in the commons area of the facility in the same area as other public information postings, where it is readily accessible for viewing by residents and visitors. 3. The posted nurse staffing information will be revised at the beginning of each shift to reflect any changes that may occur after the information is posted. 4. The Administrator will monitor.	10/24/08

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F 356	Continued From page 8 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of posted nurse staffing information, and staff interviews, the facility failed to post the required information in a prominent place easily accessible to residents and visitors. In addition, the information was not posted at the beginning of each shift nor updated as scheduling changes occurred. The findings were: Observation on 9/24/08 at 3:55 PM showed the nurse staffing information was posted on a bulletin board by the time clock. Both were located away from areas reserved for resident care and activities. Review of the information revealed it was already posted for all three shifts. Furthermore, even though the schedule had changed, no changes were shown on the form for the past several days. Interview with the staff development coordinator at the time of the observation revealed the administrative assistant was responsible for posting the information. Interview with the administrative assistant (F) immediately after the observation confirmed she posted the information for the entire day and did not update it as scheduling changes occurred. In addition, the assistant stated she posted the staffing information on the last day she worked prior to a weekend and/or holiday; no other information was posted until her return.			
F 371 SS=F	483.35(i) SANITARY CONDITIONS			

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F 371	Continued From page 9 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of cleaning lists, the facility failed to maintain one range hood, four refrigerators and three range surfaces in a sanitary manner. In addition, the facility failed to follow the Food Code standard for preventing food contamination by utilizing separate food areas for employees and residents. These failures were identified in four of four kitchen units used for food service for seventy-two residents. The findings were: 1. Observation of the second floor kitchen unit on 9/23/08 at 10:40 AM revealed the following unclean areas: a. The hood above the range had dust and strings of lint. b. Food crumbs and areas of burned food were on the burner trays and range surface. c. Small black particles of dirt were scattered throughout the lower shelf on the refrigerator door. d. The freezer tape that secured the upper shelves of the refrigerator door had dust and lint on the exposed sticky side of the tape. e. Food crumbs and spilled juices were on the refrigerator shelves and in the refrigerator	F 371	1. The facility will continue to ensure that food is stored, prepared, distributed and served under sanitary conditions, and that separate food areas are maintained for employees and residents. 2. The second floor kitchen unit range surface and burner trays, range hood, and refrigerator-freezer will be thoroughly cleaned by 10/17/08 and at least weekly thereafter. 3. The first floor range surface and burner trays will be thoroughly cleaned by 10/21/08 and at least weekly thereafter. 4. The unwrapped ear of corn in the east nursing station kitchen unit refrigerator was removed on 9/25/08. The refrigerator will be thoroughly cleaned by 10/21/08 and at least weekly thereafter. 5. The secure unit kitchen refrigerator-freezer will be thoroughly cleaned by 10/21/08 and at least weekly thereafter. 6. A policy and procedure will be developed to outline the various departments' responsibilities and duties to ensure that unit kitchens are regularly maintained in a sanitary manner.	11/07/08

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F 371	Continued From page 10 freezer. f. Specks of dried spilled juices were scattered on some of the unopened containers of juice and supplements. Further observation of the second floor kitchen unit on 9/25/08 at 8:45 AM (two days later) revealed the unclean areas remained as observed on 9/23/08 at 10:48 AM. 2. Observation of the first floor unit kitchen unit on 9/23/08 at 2:40 PM revealed food crumbs and areas of burned food on the burner trays and range surface. Further observation on 9/25/08 at 8:55 AM revealed the unclean burner trays and range surface remained as observed on 9/23/08 at 2:40 PM. 3. Observation of the nursing east station kitchen unit on 9/23/08 at 3 PM revealed the lower refrigerator compartment contained an unwrapped and unlabeled ear of corn enclosed in the husk surrounded by loose fibers of corn silk. Further observation revealed food crumbs and spilled juices were on the refrigerator shelves and in the refrigerator freezer. Observation on 9/25/08 at 9:20 AM revealed the refrigerator and refrigerator freezer remained as observed on 9/23/08 at 3 PM. 4. Observation of the secure unit kitchen unit on 9/23/08 at 2:50 PM revealed chocolate chip pieces, Styrofoam pieces, plastic bag ties, spilled juices and small masses of spilled ice cream were scattered throughout the refrigerator freezer. Further observation revealed there was dried food, spilled juices and crumbs on all of the refrigerator shelves. 5. Review of August and September kitchen	F 371 (cont'd)	7. Staff education was provided at a staff meeting on 10/01/08 regarding the requirement that staff food not be co-mingled with resident food. 8. The maintenance of a sanitary environment for the storage, preparation, distribution and serving of food on the unit kitchens will be monitored through regular environmental rounds conducted by the SDC-RN and the Infection Control Coordinator on a quarterly basis. The results of these rounds will be reported to the Environment of Care committee by the DON on a quarterly basis. The minutes of the Environment of Care committee are provided to the organization-wide QI Committee for their review on a quarterly basis. 9. The DON will monitor.	

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	535027	A. BUILDING _____ B. WING _____	C 09/25/2008

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F 371	Continued From page 11 cleaning lists revealed no system for ensuring the facility's four kitchen units were maintained in a clean manner. Interview with the dietary manager on 9/24/08 at 9:20 AM confirmed the lack of a system. The dietary manager stated sometimes the nursing staff cleaned the kitchen units, sometimes the dietary staff did it and other times the housekeeping staff did it, but no one was designated as responsible for cleaning and no one was assigned the responsibility for overseeing that it was done. As of 9/25/08 at 11 AM, the facility was unable to provide the requested policy and procedures for cleaning the kitchen units. 6. Review of the 2005 U.S. Public Health Service Food Code, 3-307.11 revealed, "Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306." The following concerns were identified regarding the facility's failure to follow the above Public Health Service Food Code: a. Observation of the nursing east station kitchen unit refrigerator on 9/23/08 at 3 PM revealed a plastic bag of food, container of yogurt, plastic container of food, partially wrapped sandwich and bottle of juice and water labeled with a staff's person's name were co-mingled with residents' supplements and juices. Further observation revealed the food labeled with staff names did not have information or dates that indicated when the food should be discarded. b. Observation of the secure unit kitchen unit on 9/23/08 at 10:40 AM revealed plastic containers and bags of foods labeled with staff names were co-mingled with residents' nutritional supplements, sandwiches, juices, milk, ice cream, sodas, coffee, tea, applesauce and			

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F 371	Continued From page 12 puddings in the refrigerator. Further observation revealed the food labeled with staff names did not have information or dates that indicated when the food should be discarded. c. Interview with the administrator on 9/25/08 at 10:50 AM revealed the facility had a separate refrigerator for staff and staff should have used the staff refrigerator.			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview with the pharmacist, the facility failed to ensure irregularities were identified and reported for 1 (#41) of 13 sample residents. The findings were: Review of physician orders and the medication administration records showed resident #41 had received Seroquel (antipsychotic) 25 milligrams (mg) since 12/13/06 and Remeron (antidepressant) 30 mg since 4/16/07. Even though a dose reduction had not been attempted, review of the monthly medication regimen reviews since 8/28/07 showed the medications were not identified and reported as irregularities. Interview with the pharmacist (A) on 9/24/08 at 4:10 PM	F 428	1. The facility will continue to ensure that the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist, and that any irregularities are reported to the attending physician and the director of nursing. 2. The physician for Resident #41 was notified on 9/29/08 of the irregularity in this resident's medication regimen regarding the medications Seroquel and Remeron, and has determined that the current regimen is still appropriate to meet this resident's medical needs. 3. The licensed pharmacist who conducts the facility's monthly drug regimen reviews has been provided with copies of the most current regulations specific to identifying and notifying the resident's physician regarding any irregularities.	11/07/08

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F 428	Continued From page 13 revealed he was unaware of the requirement to identify and report, to the physician and director of nursing, the lack of an attempted dose reduction for either medication.	F 428 (cont'd)	4. During the monthly drug regimen reviews, the licensed pharmacist will identify any medication orders that are appropriate for a gradual dose reduction and will report these as irregularities for review and response by the resident's physician. 5. The monthly drug regimen reviews will be monitored by the Chief Pharmacist and reported as a QI indicator to the organization-wide Pharmacy and Therapeutics Committee on a quarterly basis. A copy of the report will be provided to the organization-wide QI Committee on a quarterly basis for their review and oversight.	
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure appropriate hand hygiene practices were followed during one of two meals observed. The findings were: Staff assistance during the dinner meal was observed on 9/25/08 from 5:50 PM to 6:21 PM. Certified nurse aide (G) assisted residents #17 and #41 with their dinner. The CNA was observed chewing her fingernails on both hands on four occasions during the 31 minute observation. Interspersed with her nail biting, the CNA assisted resident #17 by opening his/her drink containers, touching a straw at the end placed into the resident's mouth, and holding the resident's hand. She cut food on resident #41's plate by holding a piece of chicken with her left hand while cutting it into smaller pieces with a fork in her right hand. The CNA twice moved residents' drink glasses by placing her fingers over the drinking surface of the glass. At no time during the observation did the CNA wash her hands. During an interview on 9/24/08 at 4:10 PM, the	F 444	1. The facility will continue to ensure that staff washes their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. 2. Staff was educated at a nursing staff meeting on 10/01/08 regarding the need to practice appropriate hand hygiene during meal service, including not chewing fingernails and not touching the resident's food or drinking surface of utensils unless appropriate hand sanitation can be assured	11/01/08

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F 444	Continued From page 14 infection control nurse stated he expected staff to comply with hand hygiene standards when assisting residents with their meals. He further stated staff should not place their fingers in their mouths when providing assistance to residents and, if inadvertently did so, should immediately wash their hands.	F 444 (cont'd)	3. The unit charge nurses will monitor the appropriateness of hand washing during meal service, and will report their observations to the SDC-RN on a weekly basis. The information gathered from the weekly observations will be developed into a QI indicator and reported by the DON to the organization-wide Infection Control Committee on a quarterly basis. The minutes of the Infection Control committee are provided to the organization-wide QI Committee for their review on a quarterly basis. 4. The Staff Development Coordinator-RN will monitor.	