STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	C 06/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	503 S 18TH ST LARAMIE, WY 82070

(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 observation, medical record review, and confirmed by staff interview, the facility failed to follow written physicians' orders for 1 of 13 sample residents (#31). The facility further failed to ensure quality control values for glucose testing were within acceptable limits for 1 of 3 resident units (unit #1). The findings were: 1. Review of admission orders for resident #31, signed by a physician on 3/23/09, revealed blood pressure was to be monitored every shift. However, review of the medical record revealed blood pressure was not being monitoring every shift. During an interview on 6/2/09 at 4:41 PM, the director of nursing (DON) confirmed blood pressure was not monitored every shift, even though there was a signed order for it. The DON explained that the nurse who filled out the admission orders sheet erroneously wrote that vital signs should be done every shift, which the physician did sign. According to the Wyoming State Nursing Practice Act July 2005 and Administrative Rules and Regulations November 2003, nurses shall practice under the direction of a physician. 2. Quality control logsheets for whole blood glucose testing on resident unit #1 were reviewed on 6/3/09. Logsheets for February, March, April, and May 2009 failed to include an acceptable range of values for control materials tested on a semi-automated glucometer. Interview with the	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 facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. 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. F281 The facility will provide or arrange services to meet professional standards. Correction: Ranges for the Quality Control testing on the Glucometers were added during the survey after the surveyor identified the issue. No resident was named Resident #31 has had "q shift BP's" discontinued. She has her blood pressure evaluated monthly and prn. Identification: Quality Control Glucometer testing logs were reviewed to identify issues and other logs that may not have ranges listed were also reviewed, no other issues were identified. Records of residents residing at facility were reviewed to identify any other residents who may not be getting their BP taken per MD order. Issues identified were corrected.	

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

Ron Nelson — Administrator — 6-24-09

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.

Accepted on 7/13/09 @ 855 Am w/ Ron Nelson, NHA.

Doc - 7/19/09 — 7/13/09

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F 281	Continued From page 1 DON on 6/3/09 at 3:10 PM revealed the acceptable range of control values should be written on the logsheet and used to determine if the glucometer was functioning correctly. A copy of the package insert for the control material was located in the unit #1 medication cart and an acceptable range of values was added to the quality control logsheets. Comparison of control values for lot number 43813 revealed 28 previously undetected instances in which results were outside the acceptable limits established by the manufacturer.	F 281	System: Licensed nurses have been in-serviced on provision/arrangement of the following services to meet professional standards, including ensuring ranges are included in Quality Control testing for the Glucometers and timely administration of physician orders, specifically blood pressures. Monitoring: The DON/Designee will conduct a review of the Glucometer testing logs 3 times weekly and prn to ensure Quality Control testing includes ranges and is completed appropriately. The DON/Designee will conduct a review of the treatment administration records 3 times weekly and prn to ensure BP's are completed per MD orders. The DON will provide follow up with the appropriate caregivers on identified problems, as deemed necessary. Identified issues will be tracked and trended and results will be included in the DON/designee's monthly QA&A report in order to ensure that correction is implemented, achieved, sustained and evaluated for its effectiveness. The DON is responsible for overall compliance.	7/19/09
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 provide care in accordance with the written plan of care for 1 of 13 sample residents (#42) and 1 non-sample resident (#13). The findings were: 1. Refer to F309 and F315 for details regarding the facility's failure to follow the care plan for resident #42. The care plan was not followed for toileting assistance, and the resident was incontinent of bowel and bladder.	F 282	F 282 The facility maintains that all residents that are able are toileted per their plan of care by the fact that they are clean, groomed, and without odor. Correction: Resident #42 is being toileted per her plan of care.	
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,	F 309		

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F 309	Continued From page 2 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 provide care to promote continence for 1 of 7 sample residents (#42) who were incontinent of bowel. The findings were: Review of the 3/11/09 care plan for resident #42 revealed staff were instructed to "assist to toilet...before and after meals." Observation on 6/2/09 revealed the resident was assisted to the toilet after breakfast at 8:35 AM. Continued observation revealed the resident was not offered the toilet or checked for incontinence before the lunch meal. After the lunch meal, at 12:45 PM (4 hours 10 minutes since the resident was last taken to the toilet), certified nurse aide (CNA) #1 transferred the resident to bed. The CNA checked the resident and stated the resident had been incontinent of bowel. On 6/2/09 at 12:55 PM the CNA stated, regarding the toileting schedule for this resident, that she normally took this resident to the bathroom after breakfast, because that's when the resident usually had a bowel movement. The CNA then stated she checked the resident for incontinence after lunch.	F 309	Identification: Residents who require assistance with toileting are at risk. The facility will do a record review of those residents residing at facility to identify residents who require assistance with toileting. The residents identified will be evaluated to ensure an effective toileting program is in place, including toileting times and that the care plan has been communicated to the CNA staff via the CNA ADL sheets. System: On or before the allegation of compliance the Director of Nursing/SDC will in-service CNA staff on the importance of timely toileting according to the plan of care. Monitoring: Licensed staff will monitor daily that residents are being toileted per the plan of care via random reviews of the CNAs providing ADL assistance. DON or designee with monitor the licensed staff and CNAs by frequently reviewing daily CNA worksheets/checklists ,CNA charting, and random observation until an acceptable pattern has been identified, then periodically to assess continued compliance. Identified issues will be reviewed in QA&A by the DON/Designee to ensure that the plan is implemented, sustained and evaluated for its effectiveness. The DON is responsible for overall compliance.	
F 311 SS=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.	F 311		7/19/09

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F 311	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide care to maintain or improve 1 of 8 sample residents (42) ability to use the toilet. The findings were: Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 3/16/09, revealed resident #42 required extensive assistance for toilet use. Review of the current care plan, dated 3/11/09, showed staff were instructed to "assist to toilet...before and after meals." Observation on 6/2/09 revealed the resident was assisted to the toilet after breakfast at 8:35 AM. However, observation on 6/2/09 at 12:45 PM revealed certified nurse aide (CNA) #1 transferred the resident to bed without assisting the resident to the toilet. The CNA then checked the resident for incontinence and changed the incontinence brief. During an interview on 6/2/09 at 12:55 PM, the CNA stated she assisted the resident to the toilet after breakfast, because that's usually when the resident had a bowel movement. The CNA stated she would "check and change" the resident after lunch, because the resident usually didn't have a bowel movement then.	F 311	F 309 Residents will receive and the facility will provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the plan of care. Correction; Resident # 42 is toileted so that she can move her bowels on the toilet resulting in her being continent vs. incontinent. Identification: Residents who require assistance with toileting are at potential risk. The facility will do a record review of those residents residing at facility to identify residents who require assistance with toileting. The resident identified will be evaluated to ensure an effective bowel management program is in place, including toileting times, issues identified will be corrected at that time System: On or before the allegation of compliance the Director of Nursing or Staff Development Coordinator will in-service staff on toileting residents per their plan of care. Residents will be assessed on admission, quarterly, annually and with significant changes in condition for their normal bowel habits and their toileting schedules. A 3-day bowel evaluation will be completed on admission and prn to establish normal bowel patterns. A care plan will be initiated to include interventions individualized to each resident based of his/her normal bowel and toileting times. Licensed staff will monitor daily that	
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff provided appropriate perineal (incontinence) care for 2 of 10 incontinent residents (#9, #34) who were dependent on staff for care. The findings were: Observation on 6/2/09 at 6:40 AM showed non-sample resident #9 was incontinent of urine and wore an incontinence pad. Certified nurse aide (CNA) #2 removed the wet pad by pulling it from back-to-front between the resident's legs, thus exposing the urethra to bacteria from the rectal area. The CNA then assisted the resident to the toilet. After the resident urinated, the CNA wiped the resident from back-to-front with toilet tissue, again transferring bacteria from the rectum to the urethra. She further failed to cleanse the resident's perineal area which had been in contact with urine from the wet pad. On 6/3/09 at 2:15 PM the CNA stated she was taught to perform perineal care from front-to-back. The CNA confirmed she did not thoroughly cleanse the resident's perineal area. She stated she only ever used toilet paper when providing incontinence care. Observation on 6/2/09 at 6:35 PM revealed CNA #3 provided peri-rectal cleansing for resident #8, who was incontinent of both urine and feces. Continued observation revealed the CNA put a clean disposable brief on the resident even though smears of feces remained on the resident's rectal area. Interview with the CNA at that time revealed the CNA did not realize the resident was not thoroughly cleansed. After the interview, the CNA cleaned the resident again and used four additional wipes before the feces	F 312	residents who are able are toileted through random observations of CNAs performing ADL cares. DON/ADON will monitor every month via random observation of CNAs providing ADL cares. Issues identified will be tracked and corrected at that time, trends will be presented in QA&A by the DON/Designee to ensure that the plan has been implemented, sustained, and evaluated for its effectiveness. The DON is responsible for overall compliance. F 311 The facility maintains that all residents that are able are toileted as evidenced by the fact that they are clean, groomed, and without odor. Correction: Resident #42 is being toileted per her plan of care. Identification: Residents who need assistance with toileting are at risk System: On or before the allegation of compliance the Director of Nursing or Staff Development Coordinator will in-service staff on the importance of timely toileting according to the plan of care. Monitoring: Licensed staff will monitor daily that residents are being toileted via random reviews with the CNAs. DON or designee with monitor the licensed staff and CNAs by frequently reviewing daily worksheets/checklists, CNA charting, and random observation until an	7/19/09

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F 312 F 315 SS=D	Continued From page 5 was completely removed. 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 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide care to promote continence for 1 of 8 sample residents (#42) who were incontinent of bladder. The findings were: Review of the 3/11/09 care plan for resident #42 revealed staff were instructed to "assist to toilet...before and after meals." Observation on 6/2/09 revealed the resident was assisted to the toilet after breakfast at 8:35 AM. Continued observation revealed the resident was not offered the toilet, or checked for incontinence, before the lunch meal. After the lunch meal, at 12:45 PM (4 hours 10 minutes since the resident had been taken to the toilet), certified nurse aide (CNA) #1 transferred the resident to bed. The CNA checked the resident, and stated s/he was incontinent of bladder. Interview with the CNA on 6/2/09 at 12:55 PM revealed the toileting schedule she followed for this resident consisted of taking the resident to the bathroom after breakfast and then	F 312 F 315	acceptable pattern has been identified, then periodically to assess continued compliance. Identified issues will be reviewed in QA&A by the DON/Designee to ensure plan is implemented, sustained and evaluated for its effectiveness. The DON is responsible for overall compliance. F312 The facility maintains that residents are receiving appropriate peri-care Correction: Residents # 9 is receiving peri care appropriately, the CNA who provided peri care inappropriately during survey has been re-educated Resident #34 is receiving peri care appropriately, the CNA who provided peri care inappropriately during survey has been re-educated. Identification: Residents who are incontinent and require assistance with peri care are at risk. System: On or before the allegation of compliance the Director of Nursing or Staff Development Coordinator will in-service the RNs, LPNs and CNAs on how to perform appropriate peri care. Monitoring: Licensed staff will monitor daily that residents are given appropriate peri care through random observations of CNAs performing peri care. DON/ADON will monitor every month via random observation of CNAs providing peri	7/19/09

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F 315 F 323 SS=D	Continued From page 6 checking the resident for incontinence after lunch. 483.25(h) ACCIDENTS AND SUPERVISION 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. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide adequate monitoring to prevent accidents for 1 of 4 sample residents (#31) with a history of falls. The findings were: Review of the 3/27/09 admission Minimum Data Set (MDS) assessment showed resident #31 fell in the past 30 days. The following concerns were identified: a. Review of the 3/16/09 "fall risk review tool" showed areas where blood pressure and orthostatic hypotension were to be assessed were left blank. On 6/2/09 at 1:45 PM, registered nurse (RN) #1 took the resident's blood pressure. When the resident was lying down, the blood pressure was 114/62; when the resident stood, it dropped to 92/60. b. Review of nursing notes showed on 5/15/09 the resident stated, "I got dizzy and fell." According to the nurse, the resident's blood pressure was 90/48. The nurse notified the physician, who ordered that the Toprol (blood pressure medication) be withheld on 5/16/08. Review of progress notes showed on 5/18/09 the	F 315 F 323	care. Issues identified will be tracked and corrected at that time, trends as well as infection control reports will be presented in QA&A by the DON/Designee to ensure that the plan has been implemented, sustained, and evaluated for its effectiveness. The DON is responsible for overall compliance. F315 The facility assures that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Correction; Resident #42 has her toileting needs addressed in her care plan and on the CNA ADL sheets and CNAs have been educated on toileting residents per the care plan. Identification: Residents who require assistance with toileting are at risk. Residents who are incontinent will be evaluated to ensure toileting and/ or incontinence care needs are addressed and to ensure services are provided to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Care plans will be reviewed/ revised at that time. CNA ADL sheets will be reviewed and revised at that time if indicated System: Upon admission residents are assessed for incontinence as well as level of ADL assistance required utilizing the nurses	7/19/09

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F 323	Continued From page 7 interdisciplinary team (IDT) discussed the resident's fall. The IDT documented "we are continuing to monitor the resident's blood pressure. If it continues to be low, we will contact [his/her] physician." However, review of the medical record showed the last documented blood pressure was on 5/17/09. During an interview on 6/2/09 at 4:25 PM, the director of nursing (DON) confirmed a lack of blood pressure monitoring after the fall. The DON stated the IDT did not determine what would be considered a low blood pressure, nor did they decide how often the blood pressure should be monitored.	F 323	comprehensive admission assessment. Residents will be assessed continually through the RAI process. When a resident is identified as incontinent and/ or requires assistance with toileting he/ she will be evaluated by a licensed nurse in order to determine the reason for incontinence and, if appropriate, a bladder retraining program will be initiated. The care plan will address the resident's toileting/ incontinence care needs. The IDT will update the plan of care and communicate to the nursing staff the suggested toileting plan/ incontinent care plan. On or before the date of alleged compliance, the Director of Nursing or Staff Development Coordinator will in-service the nursing staff on the urinary management practice guidelines as it relates to toileting vs. incontinent care. Monitoring: Licensed staff will monitor daily that residents are being toileted via random reviews with the CNAs while they provide ADL cares. DON/designee will monitor licensed staff and CNAs by frequently reviewing daily CNA documentation and random observation until an acceptable pattern has been identified, then periodically to assess continued compliance. Identified issues will be reviewed in QA&A by the DON/designee to ensure that the plan is implemented, sustained and evaluated for its effectiveness. The DON is responsible for overall compliance.	
F 371 SS=F	483.35(i) SANITARY CONDITIONS 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 and staff interview, the facility failed to ensure employees practiced appropriate hand hygiene during 1 of 3 meal observations. The facility further failed to ensure proper storage and labeling of opened food containers in the dry goods and refrigerated storage areas. The findings were: 1. On 6/3/09 at 11:38 AM dietary aide #1 was observed washing her hands; the aide washed for less then 5 seconds and used her bare hands to	F 371		7/19/09

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F 371	Continued From page 8 turn off the water faucets. The aide then donned gloves and prepared trays for the lunch meal. While serving food, dietary aide #1 was observed to scratch her face and neck, repeatedly adjust her hair net and glasses, and pull on her left ear and earring. From 11:40 to 12:20 (40 minutes) the aide handled slices of bread and dinner rolls, positioned food on residents' plates with her thumbs and fingers, and wiped down the serving counter with a paper towel. At no time during the observation did the employee wash her hands or change gloves. Instructions posted above the hand washing sink instructed employees to wash their hands for at least 10 seconds and to use paper towels to turn off faucets after washing. The dietary manager (DM) stated in interview on 6/4/09 at 8:40 AM his expectation was that dietary staff wash their hands properly and frequently when preparing and serving food. Section 2-301.12 of the 2005 United States Food Code requires kitchen personnel to vigorously wash their hands for at least 10-15 seconds and use paper towels to run off water facets at the handwashing sink to avoid recontaminating clean hands. The Code further requires employees to wash their hands after touching bare human body surfaces. 2. The following food storage concerns were observed during the initial tour of the food storage areas on 6/2/09 at 6:20 AM: a. One of six boxes of dried potatoes and one of eight boxes of cream of rice cereal in the dry storage area were opened and exposed to the environment. Neither of the opened boxes were covered or wrapped to prevent contamination, and neither was labeled with the date the packaging had been opened.	F 371	F323 The facility will assure that each resident receives adequate supervision and assistive devices to prevent accidents. Correction: Resident #31 has been evaluated by the IDT for prevention of accidents, including falls. The IDT has determined that the current interventions should include her blood pressure is monitored every month and prn Identification: The facility identified other residents having the potential for accidents, including falls, through record reviews of the resident's most recent assessment for risk for falls. Fall risk reviews are completed on admission, quarterly, annually, and with significant change in status. The residents identified with high risk for falls will be reviewed by the Interdisciplinary Team to include evaluation of current preventative interventions. Resident care plans will be updated and will reflect any assessed needs. System: Using the fall risk review tool, residents will be screened on admission, quarterly, annually, and with significant change in status for risk for falls by licensed nurses. For resident's identified at high risk for falls, the licensed nurse completing the review will initiate a plan of care. During IDT meetings, the IDT team will then review/implement/revise the care plans of those residents identified by the fall risk review to be at high risk for falls and, thus, assure that	

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F 371	Continued From page 9 b. A one gallon container of Worcestershire sauce, half-full from previous use, had sticky sauce residue on the outer surface of the container. Dried brown residue was also observed on the handle, lid, and on the tray beneath the container. c. A one gallon container of ranch salad dressing was observed in the walk-in refrigerator, 1/3 full from previous use. The outer surface of the container and lid were sticky with spilled dressing. The dressing residue was also on the shelf beneath the salad dressing container. d. One of three containers of scrambled egg mix and one of two containers of chopped cole slaw had been previously opened and stored in refrigerated storage. Neither container was dated. e. Seven thawed commercial milk shakes were observed in a double-door, reach-in refrigerator. An additional 15 thawed shakes were observed in a plastic milk crate in the facility's walk-in refrigerator. Written instructions on individual cartons indicated the product had a 14 -day expiration period from the date it was thawed. However, none of the shakes were labeled with a thaw date or a post-thaw expiration date. Interview with dietary aide #2 on 6/2/09 at 7:10 AM revealed shakes were removed from the freezer as needed for resident use and kept in a milk crate. She stated the crate should be labeled with the thaw date, but "...someone must have forgot." Interview with the DM on 6/2/09 at 3:30 PM revealed it was the department's policy that all food containers be dated when opened and any remaining food be stored in a closed container. He confirmed the facility's process for dating thawed commercial milk shakes as a batch. He further verified the absence of dating for the products previously noted.	F 371	appropriate interventions are identified risk and in place. In addition, resident falls will be documented, reported, assessed and care planned by the interdisciplinary team (IDT) to prevent repeat falls or falls resulting in significant injury. The interdisciplinary team will review resident falls within 24 to 72 hours to evaluate circumstances and probable cause for the fall utilizing the post fall review. The IDT will then modify or implement a care plan and treatment approach, including addressing any identified need for interventions and/or adequate supervision to prevent falls resulting in injury or prevent repeat falls. On or before the allegation of compliance Staff will be in-serviced by the Director of Nursing or SDC on the importance of provision of adequate supervision and implementation of interventions including blood pressures if recommended. Monitoring: Charge nurses will monitor for residents receiving supervision and application of interventions via care rounds. Members of the IDT will assist in monitoring by conducting administrative rounds to ensure residents are receiving supervision and application of interventions. The DON/Designee will review resident treatment administration records three times weekly and prn to ensure blood pressures are evaluated per physicians' orders. In addition, the DON/designee will oversee the 24-hour reporting system through administrative	

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	535043	A. BUILDING _____ B. WING _____	C 06/04/2009

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F 371	Continued From page 10 Section 3-302.11 (A) (4) of the 2005 United States Food Code requires food be stored in packages, covered containers, or wrappings to prevent contamination. Further, section 3-501.17 (B) of the Code requires refrigerated food containers be clearly marked at the time the original container is opened.	F 371	rounds and fall reporting. The DON / designee will report identified trends to the QA&A Committee monthly to ensure that the plan is implemented, sustained, and evaluated for it's effectiveness. Follow up will be conducted as indicated by appropriate disciplines of the IDT. The DON is responsible for overall compliance.	
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of infection control surveillance data, the facility failed to ensure staff used appropriate infection prevention practices during 2 of 10 observations of resident care. The facility further failed to completely and accurately track infections among residents. The findings were: 1. Observation on 6/2/09 at 12:45 PM revealed certified nurse aide (CNA) #1 transferred resident #42 to bed and subsequently discovered the resident had been incontinent of bowel and bladder. The CNA was observed to roll the resident onto his/her right side and the CNA removed the resident's soiled brief. The CNA	F 441	F371 The facility will store, prepare, distribute and serve food under sanitary conditions. Correction: No specific resident was identified Identification: Residents that reside at the facility are at potential risk. System: On or before the allegation of compliance the Dietary Manager/designee will in-service the dietary staff on procedures for sanitation to include; food storage, dating and labeling, and proper hand washing and gloving techniques Monitoring: The Dietary Manager/designee will monitor compliance through weekly and prn kitchen observation rounds. Issues identified will be reviewed by the Dietary manager/designee at QA&A monthly to ensure plan has been implemented, sustained and evaluated for effectiveness. The Dietary Manager is responsible for overall compliance.	7/19/09

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F 441	Continued From page 11 placed the soiled brief directly on the resident's bed, partially on the resident's pillow. When the CNA rolled the resident back over to his/her back, the soiled brief was under the resident's left shoulder. The CNA then pulled the brief out from under the resident's shoulder, and placed it into a garbage bag. During an interview on 6/4/09 at 8:10 AM, CNA #1 stated soiled briefs should only be put into a garbage bag. 2. On 6/2/09 at 8:53 AM CNA #4 assisted resident #62 to the toilet. The CNA stated the resident was incontinent of urine prior to the transfer. After placing the resident onto the toilet, the unbuckled end of the CNA's gait belt fell into the resident's wet brief. After assisting the resident, and without cleansing the gait belt, the CNA placed the belt around her waist and went to assist other residents. At 10:35 AM that morning, the CNA confirmed the belt touched the inside of the resident's brief and that she did not clean it before using it again. 3. The director of nursing (DON), also serving as the infection control practitioner (ICP), stated in interview on 6/3/09 at 6:20 PM her expectation was that soiled briefs not be placed on resident beds, chairs, bedside tables, or other areas with the potential to spread infectious material. She stated the correct practice required placing soiled briefs directly into a garbage bag. 4. The facility's infection control surveillance logsheets for January through May 2009 were reviewed on 6/4/09 at 9:15 AM; the DON/ICP was present during the review. The following concerns were noted while reviewing the surveillance data: a. Of 82 residents listed on the infection surveillance log, 69 (84%) entries failed to	F 441	F 441 The facility will maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. Correction: The ADON has been assigned as the Infection Control (IC) nurse and the DON is the back up. The IC program is established in the facility. The CNA observed during survey providing improper peri care and placing the soiled briefs at the head of the residents bed has be re-educated on the proper way to dispose of soiled briefs to prevent cross contamination. Identification: Rounds were made in the facility to identify any infection control issues. System: On or before the allegation of compliance the DON will in-service the Administrative staff on the facility's IC program to include surveillance, complete data collection, isolation implementation, and preventing the spread of infections. The DON/designee will review the IC report including identified trends with the medical director during the QA process monthly. The RNs, LPNs and CNAs were re-educated on the proper way to perform peri care and dispose of soiled briefs to prevent cross contamination	

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F 441	Continued From page 12 indicate whether resident specimens were submitted for culture. b. Of 8 entries indicating specimens were submitted for culture, 4 (50%) failed to include a culture result. c. Five of 82 (6%) resident entries failed to include comments on treatment, antibiotic usage, or clinical outcome. d. The surveillance log failed to track infections and antibiotic treatment to resolution and, therefore, prevented the association of findings to develop trends and intervention strategies. The DON/ICP stated in interview on 6/4/09 at 9:50 AM that the surveillance program was undergoing revision. She confirmed the lack of relevant information, stating there had been a change in staff responsible for data collection.	F 441	Monitoring: According to company protocol, infections will be tracked and trended through surveillance, complete data collection, isolation implementation, and preventing the spread of infections. Trends, outbreaks and/or issues concerning infection control program will be reviewed by the DON/designee in the monthly QA process to ensure plan has been implemented, sustained, and evaluated for its effectiveness Licensed staff will monitor daily that residents are given appropriate peri care and soiled briefs are properly disposed through random observations of CNAs performing peri care. DON/ADON will monitor every month via random observation of CNAs providing peri care. Issues identified will be tracked and corrected at that time, trends as well as infection control reports will be presented in QA&A by the DON/designee to ensure plan has been implemented, sustained, and evaluated for its effectiveness. The DON is responsible for overall compliance.	7/19/09