STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used in this document: ED- Executive Director ICC- Infection control coordinator DNS- Director of nursing services QAPI- Quality assurance and performance improvement	F 000		
F 170 SS=B	483.10(l)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to ensure residents routinely received mail on Saturdays. The findings were: Interview with the resident group on 8/10/10 at 3 PM revealed there was no mail service on some Saturdays because staff was not available to deliver it. Interview with the ED on 8/12/10 at 9:35 AM revealed passing out the resident's mail was assigned to the manager on duty for the weekend. Interview with the activity aide on 8/12/10 at 9:50 AM revealed she passed out the resident mail Monday through Friday. She stated the manager on duty was responsible to pass out the Saturday mail that came in; however, she confirmed this did not always happen. The activity aide stated "about fifty percent of the time" the Saturday mail was waiting first thing on Monday mornings to be distributed.	F 170	**RIGHT TO PRIVACY. SEND/RECEIVE MAIL DELIVERY** All residents have the potential to be affected by no mail service on Saturday. This facility will ensure mail service on Saturday through the Manager on Duty or designee who will be responsible for the delivery of mail to the residents. In the case that the mail is delivered late in the day, the Charge Nurse will be responsible for the service. The licensed nurses and mangers have been educated on the mail service policy on 9/2/2010 by the Activities Director. The Activities Director or designee will monitor the mail delivery slot on Mondays for any mail not delivered on Saturday and will report the results to the ED at the monthly QAPI committee meeting for three months then the committee will re-evaluate the need for continuance The ED will address non-compliance with appropriate corrective action.	9/5/10 9/26/10 ow 2:26 pm Per conversation with Jan Stacks 9/15/10

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

Executive Director 9/5/10

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.

This POC accepted 9/15/10 between the SE Admin. Jan Jansen, and Tony Madon. The 9/15/10 Completion date was added, agreed to by administrator.

9/10/10

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F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on review of resident council minutes, and resident and staff interviews, the facility failed to ensure 2 of 2 outstanding grievances brought forth by the resident council were addressed in a timely manner. The findings were: Review of resident council minutes for 5/26/10, 6/9/10, and 7/14/10 revealed there was a format used to identify grievances. This included any follow-up action that needed to be taken and the date the issue was resolved. The following concerns with two grievances were identified: a. Review showed that an issue related to the placement of two phones for resident use in common areas was raised during the May meeting. The phones were not easily accessible to residents. According to review of the July 2010 meeting minutes, the issue was not resolved and continued to be "In process." Interview with the resident group on 8/10/10 at 3 PM verified the phones had not been moved, and communication from staff related to the issue was lacking. Interview with the ED on 8/11/10 at 2:30 PM confirmed the issue was not resolved, and no further evidence of communication to the residents could be found related to resolving the issue.	F 244	**LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION** A meeting to discuss the lowering of the two phones for resident use and the choosing of the paint colors for the hallways was held with the resident council on 8/18/2010. The two phones were lowered to a height that is compatible for wheelchairs on 8/27/2010 by the Maintenance Director. The paint color choice was discussed at the resident council meeting held 9/2/10. Color choice will be brought to the council when the facility is ready to paint the walls. The Social Services Director (SSD) re-educated all staff on the Grievance Policy and Procedure on 9/2/2010. Grievances from residents, their families, staff members and visitors will be documented on the Kindred Healthcare, Inc. grievance form and forwarded to the SSD for investigation and follow up. The SSD will monitor the progress of the grievance resolution for timely completion and report the results to the ED monthly for one quarter at	9/5/10 9-26-10 ok 9-15-10

9/8/10

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F 244	Continued From page 2 b. Review of the July meeting showed the residents desired to be involved in the selection of paint colors for the facility entrance and hallways. The plan of action for this issue showed the ED would involve residents in viewing the color choices for halls as able. The issue was listed as unresolved. Interview with a group of residents on 8/10/10 at 3 PM confirmed they had not been told about any plan or time frame to be presented with color choices for the walls. Interview with the ED on 8/11/10 at 2:30 PM confirmed he planned to involve the residents. He stated a time frame to involve the residents had not been established, and paint samples were not yet available. He further verified the plan was not effectively communicated back to the residents.	F 244	the QAPI meeting and then re-evaluate need for continuance. Report of grievance resolution will be presented at the bi-monthly Resident Council meetings. Non-compliance will be addressed by the ED at the QAPI for further corrective actions.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide maintenance and housekeeping to ensure 5 of 5 resident areas were comfortable, clean, and in good repair. The findings were: 1. Observation on 8/9/10 at 2 PM showed the floor of the television area by the back hall nurses station was un-swept with food crumbs and two dead flies. In addition, there were eight dead flies noted in the window sills of this resident area. During an observation on 8/12/10 at 9 AM, the dead flies remained in the window sills.	F 253	**HOUSEKEEPING & MAINTENANCE SERVICES** The television area by the back hall nurses station and the activity area were swept, mopped, and the dead flies removed from all areas on 8/13/2010. Health Services Group (HSG) re-educated all housekeeping staff on the proper cleaning techniques for all areas of the facility on 9/2/2010. The Housekeeping/Laundry Supervisor or designee will audit the facility common areas daily and	

9/15/10 9/26/10 ok 9-15-10

9/18/10 CM

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F 253	Continued From page 3 Observation on 8/9/10 at 3:40 PM showed there were seventeen dead bugs around the edges of the activity area walls. The next day 8/10/10 at 7:30 AM, observation showed the area had not been swept, and the dead bugs remained on the floor. In addition, the back hall and the south hall of the facility, which were not carpeted, had a dirt build-up around the perimeters of both halls. During an interview with residents on 8/10/10 at 3 PM, three of nine residents thought the floors in the facility were not clean enough. One of the residents mentioned an accumulation of dirt around the edges of the floor, and stated s/he had seen staff mop the floors without sweeping them first. 2. Random observations during the survey from 8/9/10 through 8/12/10 revealed the following locations had damaged doors or door frames: a. Room #1 ' s bathroom door. b. The emergency exit door near room #11. c. Room #17 ' s bathroom door. d. Room #19 ' s corridor door. e. Room #20 ' s corridor door. f. Room #27 ' s corridor door. g. Room #28 ' s corridor door. h. Room #45 ' s bathroom door. i. Room #47 ' s bathroom and corridor doors. j. Room #50 ' s bathroom door. 3. The following damage was also identified in resident areas during observations on 8/9/10 from 2:45 PM until 4 PM: a. The runner boards, located 18 inches from the floor throughout all five hallways, were scuffed, gouged, and faded. b. All five hallways had multiple scratches below the handrails, and were in need of touch up paint.	F 253	report the results to the ED at the monthly QAPI meeting for three months then will re-evaluate need for continuance. HSG will address all non-compliance and assess for corrective action. The edges around the tile floors cannot be cleaned by conventional means. Plans are in place to remove the dirty coving on the walls and replace it with new coving coinciding with the painting of the hallway walls and touchup of the runner boards, handrails, and baseboard covers. Cost estimates were received on 9/3 for the new coving. The hallway walls, coving, runner boards, handrails, and baseboard covers will be touched up and/or painted by 2/11/2011. The Maintenance Director or designee will monitor these areas daily to make repairs and touchups and will report the findings to the ED at the monthly QAPI meeting until completed. Health Services Group (HSG) will scrape off the dirty wax buildup and re-wax and buff the corners prior to the new coving installation.	9/26/10

9/15/10 9/26/10 ok DW 9-15-10

9/26/10 ✓ ok DW approved 9/15/10 at 2:24 pm by telephone call/Pam Stark

9/18/12

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F 253	Continued From page 4 c. The hallway between the front and back nurses' stations had scuffed and scratched baseboard heaters with obvious paint missing the entire length of the baseboard covers. d. The front light switch cover in room #17 was cracked. e. In room #22, the bathroom sink had eight screw holes between the sink and mirror. f. Across from room #45, the corners of both sides of the hallway were gouged and scuffed from the floor level to 2 feet high. g. In room #48, near the headboard of bed B, the wall was gouged 18 inches across. h. Across from the back nurses' station, the corner of the two intersecting hallways was gouged and scuffed from floor height to 3 feet high. During an interview with the ED on 8/12/10 at 8:10 AM, he stated housekeeping had recently been outsourced and the number of hours reduced. Upon being presented the findings of the survey concerning failures in housekeeping, the ED stated that housekeeping may be understaffed, and stated he was responsible to monitor housekeeping. In addition, the ED stated the facility needed repairs and maintenance to doors and hallways.	F 253	Rooms #1, 17, 19, 20, 27, 28, 45, 47, and 50 will have their doors repaired or replaced by 2/11/2011. The front light switch cover in room #17 was replaced 8/30/2010. The screw holes in room #22 were patched and painted on 8/30/2010. The wall in room #48 which was gouged has been repaired and painted. The Maintenance Director or designee will monitor the facility for any necessary repairs to be completed and report the repairs to the ED at the monthly QAPI meeting until completed.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329	**DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** Resident #21 has had a physician contraindication noted for a GDR of Seroquel, Ativan, and Zoloft on 9/1/2010. The resident's medical records have been audited and any resident requiring a GDR contraindication note by a physician for a GDR have	9/26/10

9/26/10 ont 9/25/10

9/8/10

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SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 15TH STREET RAWLINS, WY 82301

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F 329	Continued From page 5 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary medications for 2 of 10 sample residents (#13, #21). The findings were: 1. Review of the monthly summary and Gradual Dose Reduction (GDR) reviews for resident #21 showed s/he was evaluated for the medications Seroquel, Ativan and Zoloft (all psychotropic medications) on 5/4/10, 6/1/10, and 7/12/10. Each of these reviews showed the resident did not have any physician contraindication for GDRs for any of the three medications. Review of the monthly summaries showed the Ativan and Zoloft were started on 9/12/09 and the Seroquel was started on 10/14/09. Interview with the DNS on 8/11/10 at 2:10 PM verified a GDR was not attempted on these medications since they were	F 329	had this documentation added to their medical records as of 9/1/10. The admitting physicians have had a copy of the CMS 483.25(l) regulation and the Kindred Healthcare, Inc. Policy and Procedure delivered to them on 9/2/2010. The LN staff were re-educated on the regulation and Policy and Procedure by the SDC on 9/2/2010. The Health Information Manager (HIM) has developed a tickler file and will alert physicians when a GDR evaluation is required for a resident on a psychotropic medication. The HIM will ensure that the evaluation is completed in a timely manner and placed in the resident's medical record. All non-compliance will be reported to the ED and the MD at the monthly QAPI meeting for six months for any appropriate corrective actions. Resident #13 has had an assessment related to TD as recommended by the pharmacist completed on 8/3/10 and 8/18/10 and placed in his/her medical record.	9-26-10 9-15-10

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F 329	Continued From page 6 started although there were not any contraindications for GDR noted by the physician. 2. Review of the medical record for resident #13 showed the resident had received daily doses of Seroquel since December 2009. Review of the 7/2/10 and 8/3/10 medication regimen review by the pharmacist showed a recommendation for the facility to complete an assessment related to tardive dyskinesia (TD), a possible side effect of the medication affecting the nervous system. Review of the medical record showed the assessment had not been done. In an interview on 8/10/10 at 4:30 PM, the DON revealed staff were unable to find evidence of any any assessment having been done related to TD.	F 329	The LN have been re-educated on the need for an assessment related to TD for residents on medications where it is a side effect on 9/2/10 by the SDC. The MDS Coordinator or designee will complete an assessment related to TD for all newly and re-admitted residents who receive daily doses of a medication with TD as a side effect and place it in the resident's medical record. A tickler file will be developed to ensure timely re-assessments per Kindred Healthcare, Inc. Policy and Procedure by the MDS Coordinator. The HIM or designee will audit the charts monthly for three months for compliance and report the results to the ED at the monthly QAPI meeting. Non-compliance will be addressed by the ED for appropriate corrective actions.	9/2/10 9-26-10 9-15-10
F 441 SS=H	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	F 441	**INFECTION CONTROL, PREVENT SPREAD, LINENS** Residents #1, #2, #3, #4, #5, #6, #8, #12, #16, #28, #33, #34, #35, #38, #42 were named as being affected by the facility's failure to ensure an	9/2/10 9-26-10 9-15-10

9/2/10

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F 441	Continued From page 7 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of policies and procedures, training documentation, and review of surveillance records, the facility failed to maintain an infection control program to prevent, minimize and control the risk for infections and communicable diseases. The program failed to ensure an unknown number of staff who were documented as being ill with nausea and diarrhea were adequately monitored and tracked to prevent transmission of infection. This failure resulted in harm to 15 of 44 residents (#1, #2, #3, #4, #5, #6, #8, #12, #16, #28, #33, #34, #35, #38, #42) who were either confirmed with a diagnosis of norovirus or had documented signs and symptoms of gastrointestinal illness over a ten-day period. The findings were: 1. Review of the facility's infection control program information showed the facility reported an outbreak of gastrointestinal illness to the	F 441	unknown number of staff who were documented as being ill with nausea and diarrhea were adequately monitored and tracked to prevent transmission of infection and cannot be corrected. All residents have the potential to be affected by this. The new SDC has been educated and orientated on the Kindred Healthcare, Inc. Policies, Procedures and Forms for infection control and infectious disease spread prevention by a District Director of Clinical Operations on 9/1/10. The staff has been educated on the process of calling in ill and how their illness will be tracked and monitored by the SDC who will be responsible for screening them prior to returning to work under the guidelines of the Policy and Procedure regarding the employee Return to Work Policy following an illness and the spread of infectious diseases on 9/2/10 by the SDC. New infections will be documented and tracked per Kindred Healthcare, Inc. Policy and Procedure regarding the facilities	9/15/10 9-26-10 9-15-10

9/15/10

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F 441	Continued From page 8 physicians, state survey agency and state epidemiologist on 6/15/10. Review of the medical records for residents #5 and #88 revealed both tested positive for norovirus on 6/22/10. On 8/10/10 at 3:30 PM, the DNS stated she was unsure about the specific measures implemented during the gastrointestinal outbreak that lasted for ten days (6/15/10 - 6/24/10). The DNS further stated the nurse who was responsible for the infection control program during the outbreak was no longer a facility employee and remaining records lacked clear information. According to the policy: "Infection Surveillance Procedures (PRO 56002)", the facility's surveillance procedures were to include the following: "... 5. Collect data on individual cases weekly that included at least: the unit on which the infection was present, whether the infection was nosocomial or community-acquired, site of the infection, risk factors present, type of transmission precaution instituted, and infectious organism. 6. Compare the data to the previous week to identify increases in the number of infections by unit, site, and organism. 7. Investigate the causes of increases and institute controls appropriate to the causes. 8. Calculate the prevalence rates (expressed as %) monthly..." According to the facility's Infection Control Program Root Cause Analysis policy (POL 003-01), the analysis must "identify changes that could be made in systems and processes, through either redesign or development of new systems or processes that would reduce the risk of such events occurring in the future." Review of the surveillance records for that time period and documentation of the event revealed the following concerns with the facility's infection control	F 441	surveillance procedures. Surveillance will include systematic data collection of resident and staff infections, analysis of trends and causes, and determination of intervention effectiveness. The SDC will implement proper precautions per Kindred Healthcare, Inc. Policy and The Dept. of Health guidelines. Visual compliance with the prevention of the spread of infectious disease of all staff will be completed by the SDC and/or designee. The data collection and Root Cause Analysis reports will be presented by the SDC to the ICC/QAPI monthly meeting for one year and appropriate procedure and policy actions will be developed and implemented at that time. The DNS or designee will audit the IC log for compliance to Kindred Healthcare, Inc. Infection Control Policy weekly until four consecutive months of 100% compliance is achieved then monthly for one year with the results reported to the ED at the monthly QAPI meeting and	9-26-10 9-15-11

8/12/11

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F 441	Continued From page 9 program and failure to follow its policies: a. Review of dated and undated information showed residents, #1, #2, #3, #4, #5, #6, #8, #12, #16, #28, #33, #34, #35, #38 and #42 were "sick" during the norovirus outbreak. According to this data, 15 of 44 (34%) residents at the facility during the outbreak presented with signs or reported symptoms of gastrointestinal illness. Based on review of the dated information, the following progression of illness could be determined: Six residents (#1, #3, #6, #28, #34 and #42) had nausea, vomiting and/or diarrhea on 6/15/10; two additional residents (#4, #16) had diarrhea on 6/16/10; and two more residents (#5, #38) had diarrhea on 6/17/10. The facility's infection control records were incomplete and lacked evidence of systematic data collection, analysis of trends and causes, or a system to determine the effectiveness of interventions that were implemented. b. Information regarding employees showed one or more employees in the dietary and nursing departments had gastrointestinal symptoms on 6/15/10, 6/16/10, 6/17/10 and 6/18/10, and were either too ill to come to work or had to be sent home. Information regarding trends, the identity and number of ill employees, and system for ensuring compliance with the "return to work" policy was lacking. Interview with the ICC on 8/11/10 at 11:06 AM revealed there were no cultures collected for any of the ill employees. The ICC stated a root cause investigation related to the outbreak was lacking. c. An 6/18/10 attendance roster showed ancillary and nursing staff attended a training program titled "Handwashing." The 6/15/10 and 6/16/10 note written by the previous infection control	F 441	corrective actions taken where appropriate.	9-26-10 9-15-10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 08/12/2010

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F 441	Continued From page 10 nurse showed housekeeping and nursing staff were given instructions about using Virex solution to "clean railings, doorknobs and things in patient rooms." However, there was no evidence that the facility monitored staff compliance with the infection control instructions. d. In an interview on 8/12/10 at 10 AM, the DNS stated a root cause analysis for the norovirus outbreak should have been incorporated into the infection control case study action plan report, but the facility failed to do this. Review of the infection control case study action plan, completed on 6/22/10, showed the facility census was 44 when an outbreak occurred on 6/15/10. However, the type of outbreak, number of residents affected and information about procedures for assessing staff compliance and efficacy of the action plan was not included in the case study action plan. e. Additional review of the facility's infection control program included a review of the May, June and July 2010 weekly surveillance records for eye, urinary tract, wound, yeast and other infections. The records were incomplete in one or more areas of data collection and there was no evidence of analysis of data, no documentation of prevalence rates, investigations, or actions taken as a result of the data collected. f. The infection control records lacked documentation to show how infection control activities would be integrated into the facility's overarching QAPI program. Interview with the ED on 8/12/10 at 9:05 AM revealed the facility did not collect data or conduct audits related to the infection control outbreak in June 2010.	F 441		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		

9/8/10

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F 520	Continued From page 11 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure an effective QAPI program was being implemented. The findings were: Interview with the ED on 8/12/10 at 9:05 AM revealed there was not a QAPI program at the time of the survey. The ED stated there was some data being collected related to pain, incontinence, and restraint use; however, there was nothing being done with the data. In addition,	F 520	**COMMITTEE-MEMBERSHIP/MEET QUARTERLY/PLANS** The facility has established a QAPI committee to meet CMS guidelines and held a meeting on 8/20/10. The members consist of the Executive Director, DNS, SDC, Social Services Director, Activities Director, Nutrition Services Director, Health Services Group Manager, Maintenance Manager, Business Office Manager, Payroll and Benefits Coordinator, and Medical Director. The committee members were educated on the Kindred Healthcare, Inc. PI policy and procedure on 8/20/10 by the ED at the QAPI meeting. Issues were identified and action plans developed by the respective department manager to be implemented, monitored, and data collected as to the plans effectiveness to correct the identified quality deficiency. These results will be presented to the ED at the monthly QAPI meeting for one year where corrective actions, changes, and recommendations by	9/15/10 9-20-10 QM 9-15-10

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F 520	Continued From page 12 the ED stated there were no past meeting minutes to be reviewed, and a committee needed to be established. Furthermore the ED revealed there were no data or audits related to infection control, including the norovirus outbreak that affected residents and staff in June 2010.	F 520	the QAPI committee will be discussed and implemented. Data collected related to pain, incontinence, and restraint use was discussed and it was determined that these areas are in substantial compliance and will be monitored to maintain compliance.	9-24-10 9-15-10

9/8/10