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

PRINTED: 07/13/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535046	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER	777 AVENUE H POWELL, WY 82435

(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 throughout this document: ADLs= Activities of Daily Living CAA= Care Area Assessment CNA= Certified Nurse Aide DON= Director of Nursing Services MAR= Medication Administration Record MDS= Minimum Data Set LPN= Licensed Practical Nurse RN= Registered Nurse F= Fahrenheit Less commonly used abbreviations will be annotated in each deficiency.	F 000	F253 The facility shall provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1a. A. All housekeepers will be instructed to avoid deviating from the mixing protocol of cleaning solutions when cleaning resident rooms 103, 112, 216, 217, 218, 303, 304, 305, 307, 402, 404 and ALL resident rooms. B. All residents, visitors, and staff members have the potential to be affected by failure to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. C. Education will be provided to all Housekeeping staff regarding the need to avoid deviating from the mixing protocol of cleaning solutions when cleaning resident rooms. The Facilities Management Director or designees will conduct monthly inspections to ensure the resident floors are not discolored and or sticky.	
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 ensure 3 of 4 resident areas (North, South, and West) were clean, functional, and in good repair. The findings were: 1. Tour of the facility at 6 PM on 6/27/16 and again at 3:05 PM on 6/28/16 identified the following concerns: a. Eleven resident rooms (103, 112, 216, 217, 218, 303, 304, 305, 307, 402, 404) showed discolored bathroom linoleum that was sticky to the touch.	F 253		

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

Michelle Ostrander BSN, RN, MHA — 8/15/2016

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RECEIVED
WY Dept of Health
AUG 08 2016
Healthcare Licensing and Surveys

Accepted 8/15/16 by
Lori Russ 8/15/16
DOC = 8/14/16

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F 253	Continued From page 1 b. The bathroom floor in room 218 had 4 gaps in the seam; 2 of the gaps measured 5 inches long and the other 2 measured 2 inches long. The bathroom floor in room 303 had a gap that measured 6 inches long and room 304 had a gap that measured 5 inches long. All of these gaps created uncleanable surfaces. c. The sinks in resident rooms 207, 216, and 307 were slow to drain. d. Room 404 had a gash in the wall behind the headboard of the bed that measured 9 inches long which exposed the drywall and created an uncleanable surface. e. The carpet in the South common area and the hallways extending down the 100 hall and 200 hall of resident rooms showed large areas of discoloration. f. The carpet in the North common area and the hallways extending down the 300 hall and the 400 hall of resident rooms showed large areas of discoloration. 2. Interview with the director of facilities management at 9:20 AM on 6/30/16 revealed there was no plan in place at that time to replace/repair the bathroom floors and there was "a large backlog of work orders." In addition, he confirmed the stains in the carpet were not cleanable and the sticky floor was due to the housekeeper deviating from the mixing protocol of the cleaning solutions.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272	F 272 The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity using the resident assessment instrument (RAI) specified by the State. A. The CAA's for residents #2, #7, #55, and #58 can no longer be edited as they have been transmitted. Moving forward, CAA's for all residents, including residents #2, #7, #55, and #58 will be completed to include a comprehensive analysis, support, and justification regarding the decision to proceed with care planning. B. All residents have the potential to be affected by failure to complete comprehensive, accurate, standardized reproducible assessments of each resident's functional capacity using the RAI.	

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F 272	Continued From page 2 A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a comprehensive assessment was completed in a	F 272	F 272 C. All Interdisciplinary Team members will be educated on the importance of completing comprehensive, accurate, standardized reproducible assessments of each resident's functional capacity using the RAI. The Nursing Directors or designee will perform ongoing monthly audits to ensure that all CAA's are completed to include a comprehensive analysis, support, and justification regarding the decision to proceed with care planning. D. The Nursing Directors or designee will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 8/14/16	

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	535045	A. BUILDING _____ B. WING _____	06/30/2016

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F 272	Continued From page 3 variety of areas for 4 of 15 sample residents (#2, #7, #55, #58). The findings were: 1. Review of the 5/10/16 annual MDS assessment for resident #2 showed the following areas that triggered which required a comprehensive assessment: Delirium, Cognitive Loss/Dementia, Visual Function, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, and Nutritional Status. The following concerns were identified: a. Review of the CAA for Delirium failed to show any analysis or justification for the decision not to care plan for delirium, showing "IDT [interdisciplinary team] does not care plan for delirium. Signs and symptoms of delirium are addressed immediately in the emergency room." b. Review of the CAA for nutritional status failed to show any analysis of the resident's actual or potential nutritional status problems such as current eating pattern, functional problems that affect the ability to eat, dental/oral problems, only stating "Under wt [weight] since admitted to care ctr [center]. [S/he] has maintained [his/her] weight fairly well however in the past 6 months w/o [without] significant wt [weight] changes." 2. Review of the 3/8/16 annual MDS assessment for resident #7 showed the following areas triggered for further assessment: Delirium, ADL Functional and Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Mood State, Falls, Nutritional Status, Dental Care, Pressure Ulcer, Psychotropic Drug Use and Pain. The following concerns were identified: a. Review of the CAA for Delirium failed to show any analysis or justification for the decision not to care plan for delirium, showing "IDT does	F 272		

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F 272	Continued From page 4 not care plan for delirium. Signs and symptoms of delirium are addressed immediately in the emergency room." b. Review of the CAA for Mood State failed to show any analysis of the resident's actual or potential mood problems, showing only that s/he had diagnoses of depression and anxiety, and an infection was causing the resident to feel tired. c. Review of the CAA for Falls showed no analysis of the resident's fall risk, such as health considerations that would increase the resident's risk for falling, showing only the resident's Morse fall score and the date of the resident's last fall. d. Review of the CAA for Psychotropic Drug Use failed to show any analysis of the resident's psychotropic drug use, showing only that the resident received psychotropic medications. 3. Review of the 5/2/16 admission MDS assessment for resident #55 showed the following areas triggered for further assessment: Cognitive Loss/Dementia, Visual Function, Communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Activities, Falls, Nutritional Status, Pressure Ulcer, and Pain. The following concerns were identified: a. Review of the CAA for Activities showed no analysis of the resident's activity needs, such as the resident's ability to participate in activities and what assistance might be needed for the resident to participate, showing only "The resident participated in little activities before admission" and noting that prior to admission the resident was putting puzzles together and watching movies. b. Review of the CAA for Falls showed no analysis of the resident's fall risk, such as health considerations that would increase the resident's	F 272		

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F 272	Continued From page 5 risk for falling, showing only the resident's Morse fall score. c. Review of the CAA for Pain failed to show an analysis of the resident's pain, such as diagnoses related to pain, or the resident's specific indicators of pain, showing only "The only time [s/he] appears to be in pain is during transfers in the Sara lift, but staff has reported that if they use the battery Sara lift vs. the manual [s/he] tolerates it very well and not in pain." 4. Review of the 4/28/16 admission MDS assessment for resident #58 showed the following areas that triggered for comprehensive assessment: Cognitive Loss/Dementia and Visual Function. Review of the CAAs for these triggered areas showed causes and risk factors were not shown and there were no conclusions drawn or evidence the data was analyzed to support the care plan decision. 5. Interview on 6/30/16 at 12:23 PM with RN #1 and RN #2 revealed more training was needed to ensure the CAAs were analyzed as required to ensure they were comprehensive.	F 272		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced		F323 The facility shall ensure hot water temperatures in resident bathrooms and showers do not exceed 110 degrees Fahrenheit A. Plumber's will install a mixing valve to correct the hot water issues noted on the North, South, West Units and Dining area. B. All residents, visitors, and staff members have the potential to be affected by failure to ensure hot water temperatures in bathrooms and showers do not exceed 110 degrees Fahrenheit.	

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F 323	Continued From page 6 by: Based on observation, resident and staff interview, and review of facility logs, the facility failed to ensure hot water temperatures at end-use points were maintained at a safe temperature in 4 of 4 resident areas (North unit, South unit, West unit, Dining Hall). The findings were: 1. Observation of the South unit on 6/28/16 showed the following: a. At 9:07 AM the temperature of the bathroom sink hot water in room 106 measured 130 degrees F. b. At 9:15 AM the temperature of the bathroom sink hot water in room 111 measured 132 degrees F. c. At 9:17 AM the temperature of the bathroom sink hot water in room 110 measured 130 degrees F. d. At 9:45 AM the temperature of the shower hot water in the South shower room measured 122 degrees F before dropping to 110.1 degrees F. 2. Observation of the North unit on 6/28/16 showed the following: a. At 9:34 AM the temperature of the bathroom sink hot water in room 413 measured 127 degrees F. 3. Observation of the Dining Hall on 6/30/16 showed the following: a. At 10:39 AM the hot water temperature at the sink in the public women's bathroom measured 129.7 degrees F. 4. Review of facility domestic hot water temperature logs showed the following:	F323	C. Education will be provided to all Plant Operations staff regarding the need to ensure hot water temperatures in bathrooms and showers do not exceed 110 degrees Fahrenheit and to take immediate corrective action to prevent risk or actual from burning if the temperature is beyond 110 degrees. The Facilities Management Director or designee will perform audits weekly to ensure the temperatures do not exceed 110 degrees Fahrenheit and maintain documentation of corrective action taken at the time a temperature exceeds 110 degrees Fahrenheit if applicable. D. The Facilities Management Director will aggregate monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	8/14/16

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F 323	Continued From page 7 a. On 5/11/16 at 7:46 AM, the hot water temperature in "North Nourishment" measured 127.3 degrees F. b. On 5/11/16 at 7:51 AM, the hot water temperature in "West Dining" measured 132.2 degrees F. c. On 5/18/16 at 1:42 PM, the hot water temperature in "303" measured 127.5 degrees F. d. On 5/18/16 at 1:46 PM, the hot water temperature in "eye wash room west" measured 121.8 degrees F. e. On 5/18/16 at 1:49 PM, the hot water temperature in "202" measured 124.0 degrees F. f. On 5/25/16 at 8:30 AM, the hot water temperature in "Room 208" measured 127.1 degrees F. g. On 6/15/16 at 9 AM, the hot water temperature in "N. Nourishment" measured 141.1 degrees F. h. On 6/15/16 at 9:04 AM, the hot water temperature in "W. Tub Room" measured 136.4 degrees F. i. On 6/15/16 at 9:07 AM, the hot water temperature in "S. Nourishment" measured 133.8 degrees F. j. On 6/22/16 at 7:17 AM, the hot water temperature in "West Dining" measured 126 degrees F. k. On 6/29/16 at 9:10 AM, the hot water temperature in "South Nourishment" measured 126.6 degrees F. l. On 6/29/16 at 9:12 AM, the hot water temperature in "Dinning [sic]" measured 122.8 degrees F. m. On 6/29/16 at 9:15 AM, the hot water temperature in "North 500" measured 123.7 degrees F. 5. Interview with a group of 11 residents on	F 323		

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F 323	Continued From page 8 6/28/16 beginning at 10 AM revealed the hot water temperature in the facility fluctuated, with one resident stating s/he had been shocked while taking a shower because the water would get very hot suddenly. The resident further stated the water was "hot enough to burn you." 6. Interview with bath aide #1 on 6/28/16 at 2:19 PM revealed the hot water temperature in the South shower room fluctuated greatly, and she tried to keep showers at a lower temperature so as not to harm residents. 7. Interview with bath aide #2 on 6/28/16 at 12:09 PM revealed the hot water in the North shower room fluctuated, and she could often feel on her own skin the water had gotten too hot. 8. Interview with the director of facilities management on 6/29/16 at 2:32 PM revealed the facility became aware the hot water temperatures were too high on 4/8/16 after an employee communicated a concern about the temperatures. Since that time, the facility had been moving through the process of soliciting bids and gaining Board approval for the plumbing work necessary to fix the problem. However, the facility had not put any interventions into place in the meantime to ensure resident safety, and the hot water temperatures had continued to be high. He further stated the facility had turned the heat down on the hot water the morning of 6/29/16, and had been able to reduce the hot water temperatures at end-use points.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive	F 328		

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F 328	Continued From page 9 proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure oxygen therapy was monitored to ensure proper treatment for 1 of 6 sample residents (#35) who used oxygen. The findings were: 1. Review of the 4/11/16 quarterly MDS assessment showed resident #35 had received oxygen (O2) therapy. Review of the active June 2016 physician orders showed an order for oxygen as needed to keep saturation levels above 90%. The following concerns were identified: a. Review of the medical record failed to show oxygen saturation levels were monitored regularly. b. Review of the nursing progress notes from April 2016 to June 2016 showed 5 entries when the nurse documented the resident was placed on O2 due to saturation levels in the 80's. c. Interview with the DON on 6/29/16 at 3:15 PM verified he was unable to find additional monitoring, and the O2 saturation levels should be monitored daily to ensure the resident received oxygen as needed.	F 328	F 328 The facility will ensure that oxygen therapy will be monitored to ensure proper treatment. A. All nursing staff will be instructed to ensure that oxygen saturations will be monitored as ordered by physician's orders for resident #35. B. All residents receiving oxygen therapy have the potential to be affected by failure to monitor oxygen saturation levels regularly. C. All nursing staff will be educated on the importance of following physician orders to keep saturation levels above 90% at the nurses/CNA meeting in August. This has been added as a treatment for the nurses to monitor oxygen levels every shift. The Nursing Directors, or designee, will perform ongoing monthly random audits to ensure that nursing staff are monitoring oxygen levels per physician orders. D. The Nursing Directors will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 8/14/16	

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F 329 SS=E	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 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 drugs for 3 of 11 sample residents (#14, #43, #58) who used psychotropic medications. The findings were: 1. Review of the 12/31/15 medication regimen review (MRR) showed resident #14 used medications which were scheduled to have GDRs	F 329	F 329 The facility shall ensure that the drug regimen for residents who use psychotropic medications will be free of unnecessary drugs. A. All pharmacists will be instructed to ensure that a Gradual Dose Reduction (GDR) will be attempted or contraindicated for residents #14, #43, and #58. B. All residents have the potential to be affected by failure to ensure that GDRs are done regularly. C. All pharmacists will be educated to complete GDRs regularly and as per their schedules. The Pharmacy Director, or designee, will perform ongoing monthly random audits to ensure the Gradual Dose Reductions are being completed. D. The Pharmacy Director will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 8/14/16	

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F 329	Continued From page 11 (Gradual Dose Reduction). The pharmacist showed on this review when the medications were due for GDRs. The following concerns were identified: a. The GDR for Olanzapine (antipsychotic) was due in December 2015, Alprazolam (sedative/hypnotic) and Venlafaxine (antidepressant) were due in January 2016. Review of the medical record failed to show a GDR was attempted or contraindicated for these medications. b. Review of the MRRs dated 2/28/16 and 4/9/16 showed Trazodone (antidepressant) was due for a GDR in April 2016. Review of the medical record failed to show a GDR was attempted. c. Review of the June 2016 physician orders showed active medications for the resident included: Olanzapine 5 mg AM and PM, Alprazolam 0.25 mg twice daily with an additional 0.5 mg PRN (as needed), Venlafaxine 150 mg daily, and Trazodone 50 mg at bedtime. d. Interview with the DON at 8:45 AM on 6/30/16 verified a GDR had not been attempted related to these medications for this resident. 2. The MRR dated 6/6/16 for resident #43 revealed a GDR for Temazepam (sedative/hypnotic) was due in January 2016. Review of the medical record failed to show an attempted GDR. Review of the June 2016 physician orders showed the resident's active medications included Temazepam 15 mg at bedtime. Interview with the DON at 8:45 AM on 6/30/16 verified the last time this resident had an attempted GDR for Temazepam was on 2/17/2015. 3. Review of the 3/28/16 MRR showed resident	F 329		

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F 329	Continued From page 12 #58 was receiving the antidepressant fluoxetine 5 mg daily on admission (9/24/15). The pharmacist documented the first GDR for this drug was due in April 2016. Review of the 4/29/16 MRR showed the fluoxetine was changed in April 2016 to 10 mg daily, and the next GDR was due in October 2016. Review of the 4/22/16 physician order showed the medication dose was not changed, the resident continued to receive fluoxetine 10 mg 0.5 tab by mouth daily. Review of the June 2016 MAR showed the resident was receiving the 5 mg dose daily. Interview with the DON on 6/30/16 at 10:30 AM verified there was no evidence a GDR for the fluoxetine had been attempted since admission.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (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 sanitary requirements were met in 1 of 1 kitchens. The findings were: 1. Observation on 6/27/16 at 5:20 PM showed a bucket containing sanitizer solution was sitting in a food disposal sink. The sink was not clean;	F 371	F 371 The facility will ensure sanitary requirements are met in the kitchen. A. All Dietary staff will be instructed regarding the need to not place buckets containing sanitizer solution in dirty food disposal sinks, to ensure that all food items have gone into the disposal, and to also ensure that the bucket is cleaned/sanitized before moving it from a dirty area to a clean area. A. All Dietary staff will be instructed regarding the need to keep wet wiping cloths in the sanitizer solution instead of on the counter where she worked. In addition, dietary staff #2 will be instructed regarding the need to not have wet wiping cloths on carts being used to transport food to the service line.	

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F 371	Continued From page 13 there were pieces of raw chicken visible which had not gone into the disposal. At 5:25 PM dietary staff #1 refilled the sanitizer bucket with fresh solution and moved the bucket to a food preparation counter. The dietary staff failed to clean/sanitize the bucket prior to moving it out of the contaminated disposal sink. According to Food Code 2013, U.S. Public Health Service: 4-602.11 "(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned: "...(5) At any time during the operation when contamination may have occurred." 2. Observation on 6/29/16 at 11:10 AM showed dietary staff #2 was preparing food on a food preparation counter. A wet wiping cloth was located on the counter where she worked. As she completed her task, the dietary staff member picked up the wet towel from the counter and wiped down the area. In addition, a wet wiping cloth was observed on 6/29/16 at 11:34 AM on a cart being used to transport food to the service line. According to Food Code 2013, U.S. Public Health Service: 3-304.14 " ...(B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114; " 3. Interview with the dietary manager on 6/29/16 at 12:30 PM verified wet towels were to be kept in the sanitizer solution. Further, he verified the bucket with sanitizer solution should not be in the dirty sink.	F 371	F 371 B. All residents have the potential to be affected by failure to ensure sanitary requirements are met. C. All dietary staff members will be educated on the importance to maintain sanitary conditions. The Nutrition Director or designee will perform ongoing monthly audits to ensure compliance. D. The Nutrition Director or designee will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 8/14/16	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441 F 441 SS=D	Continued From page 14 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441 F 441	F 441 The facility will ensure the infection control program is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. A. All Nursing staff will be instructed regarding the need to clean and sanitize hands before and during assisting residents at meal time. B. All residents have the potential to be affected by failure to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. C. All nursing staff will be educated on the importance of handwashing and the handwashing policy at the nursing and CNA/NSA meetings in August. The Nursing Directors, or designee, will perform ongoing monthly random audits to ensure that all nursing staff and NSAs are washing hands before and in between assisting residents at meal time.	

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F 441	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure effective hand hygiene practices were implemented during 2 of 2 meal observations. The findings were: 1. Observation on 6/28/16 at 12:01 PM showed nutrition support assistant (NSA) #1 was passing meal trays and fluids to the residents seated in the dining room. The NSA touched his face and glasses multiple times and wiped his nose with a Kleenex. The NSA then went to the table, cut up food and fed resident #42 his/her lunch. The NSA did not perform hand hygiene prior to feeding the resident. 2. Observation on 6/28/16 at 12:10 PM showed CNA #1 feeding resident #11. The CNA then wiped a second resident's mouth with a napkin and returned to feeding the first resident. The aide did not perform any hand hygiene between residents. 3. Observation on 6/29/16 at 5:36 PM showed CNA #2 waiting at the food service counter. The aide was touching the counter, her clothes, and reaching into her pockets. The aide then returned to the table to feed resident #11. The aide did not perform hand hygiene prior to feeding the resident. 4. Interview with the infection prevention nurse on 6/30/16 at 9:05 AM confirmed hands were to be cleansed before serving and feeding residents, when feeding multiple residents, and after	F 441	F 441 D. The Nursing Directors will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 8/14/16	

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F 441	Continued From page 16 touching their own (employee) face, clothes or blowing the nose. 5. Review of the policy and procedure titled "Hand Washing" revised 6/13, showed "1. When to wash hands:...d. After coughing, sneezing, using a handkerchief or disposable tissue... l. After engaging in other activities that contaminate the hands."	F 441		