STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING ______ B. WING ______	C 01/31/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	**900 W 8TH ST** **GILLETTE, WY 82716**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	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 and staff interview, the facility failed to ensure a safe environment for residents in the bathing room of one of five resident neighborhoods. The findings were: Observation on 1/30/08 from 2:30 PM to 4:05 PM revealed the door to the bathing room in Neighborhood 5 was wide open. Observation of the whirlpool bathing tub located in the room revealed the back panel was removed, exposing the internal plumbing and electrical wiring of the tub. In addition, the wall mounted electric switch to the unit was in the open position. Finally, approximately 15 small metal fasteners (bolts, nuts, washers) used to attach the panel to the tub were on a four foot high shelf adjacent to the tub. Interview with licensed practical nurse #4 on 1/30/08 at 3:48 PM revealed the bathing tub had stopped working shortly after lunch and was being repaired by the maintenance department. Interview with the director of nursing on 1/30/08 at 5:00 PM revealed the exposed wiring and small metal fasteners represented a safety hazard to the residents.	F 323	F 323 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 will be accomplished by: On 1/30/08 from 2:30 p.m. to 4:05 p.m. it was observed that the door to the bathing room in NH 5 was open and the whirlpool tub was being worked on with the back panel removed exposing internal plumbing and electrical wiring of the tub. Corrective actions: 1. This deficiency was corrected the evening of 1/30/08 by the maintenance department. 2. Maintenance department will post "Out of Service" signs in areas where equipment is being worked on. In addition electric circuits to equipment will be disconnected until corrective maintenance has been completed. 3. Maintenance Department personnel will be educated on the importance of protecting residents from harm by using safe practices while working in the living environment of the residents. This training will be completed by March 16 and repeated annually. Staff Development Coordinator will maintain records of training sessions for the Maintenance Department. 4. The DON or designee will report the findings of quality monitoring to the QIC at the quarterly meeting for further review and recommendation	3/16/08 3/16/08
F 356 SS=B	483.30(e) NURSE STAFFING The facility must post the following information on	F 356		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlie K. Cealey — TITLE: Administrator — (X6) DATE: 2/22/08

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

FEB 26 2008

3/17/08 Changes made in agreement with Charlie Billey, Adm, Ramona Ensher, DON, [illegible], gm.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 356	Continued From page 1 a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure the nurse staffing data was posted in the required format and at the beginning of each shift. The findings were: Observation on 1/30/08 at 2:40 PM with registered nurse (RN) #1, clinical supervisor for	F 356	F 356 The facility will ensure that nurse staffing data will be posted on a daily basis with the following information included: The facility name, current date, resident census and the total number and actual hours worked by the following categories of licensed and unlicensed staff directly responsible for resident care per shift: - Registered Nurses - LPN's or LVN's - Certified Nurse Assistants (CNA's) This will be accomplished by: 1. Developing a template with the facility name and space for the date listed so each posting will include the name of the facility and the current date. 2. The actual hours worked will be posted at the beginning of each shift by the Charge RN beginning January 31, 2008. 3. Training to the above requirements for each Charge RN will be completed individually and re-education at nurses meeting on February 28, 2008. 4. The data will be monitored by DON for completion and tracked on a quality monitoring tool to be developed. 5. The DON or designee will report the findings of quality monitoring to the QIC at the quarterly meeting for further review and recommendations.	3/16/08 3/16/08

2/17/08 Changes made in agreement with Charlie Bailey, Asst Admin, Ramona Bushey, DON, and Tony Maddox, Surveyor
10:15 gpm

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F 356	Continued From page 2 Neighborhoods 1 and 2, showed the nurse staffing data form was posted for the entire 24 hour period and lacked the name of the facility. The RN stated the information was posted before the supervisors left the previous day. However, no one would have changed the data had someone called in ill after the supervisors left. Furthermore, the RN stated she was unaware of all the information required to be posted.	F 356	by the DON and the Nursing Leadership Group	
F 371 SS=D	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must 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 routine cleaning for one of two nursing unit refrigerators in which resident food was stored. The findings were: Observation of the Neighborhood 5 resident food unit refrigerator on 1/28/08 at 4:44 PM, 1/29/08 at 9 AM and 3:43 PM, and again on 1/30/08 at 1:35 PM revealed a large frozen tan liquid spill in bottom of the freezer section. The spill covered half of the bottom of the refrigerator. Interview with the director of nursing (DON) on 1/30/08 at 2:10 PM revealed dietary was responsible for cleaning resident food refrigerators. On 1/30/08 at 2:13 PM, the dietary manager stated nursing staff were responsible for unit food refrigerators, not the dietary department. The manager further stated that if a policy and cleaning schedule existed, they would be in nursing. A second	F 371	F 371 The facility will ensure that food will be stored, prepared, distributed and served under sanitary conditions. This will be accomplished by: 1. A log will be developed for documenting the inspection and cleaning of refrigerators. "once a week by the night Shift Charge nurse or designated CNA 2. A quality-monitoring tool will be implemented by Clinical Supervisors to ensure refrigerators are inspected daily and cleaned weekly. Monitoring will be completed monthly and presented to DON or designee. 3/16/08 3. The DON or designee will report the findings of this monitoring tool to the QIC quarterly for further review and recommendations. 3/16/08	

3/17/08 10:45 Changes made in agreement with Charlie Bulkley, Admin, Ramona Bingham, DON, and Tony Bulkley, Surveyor.

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F 371	Continued From page 3 interview with the DON on 1/31/08 at 8:21 AM revealed nursing did not have a policy or cleaning schedule for the unit food refrigerators.	F 371	F 441 I. The facility will ensure that an infection control program designed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of disease and infection will be established and maintained. This will be accomplished by: 1. Data Collection worksheets will be modified to be the same throughout the facility. The Form to be used will be: Individual Infection Report from APIC Infection Control Kit Series. Clinical Supervisors will put data on monthly infection log from APIC. 2. Nursing staff will receive Education on correctly completing the form individually and at nurses meeting on February 28, 2008. 3. Clinical Supervisors will compile data and present data to DON who will track for facility. 4. Education of CNA's on appropriate practices (below waist is dirty) at CNA meeting February 22, 2008. 5. DON will maintain a consolidated summary of surveillance data for the facility. Antibiotic usage and prevalence of infection with organisms will be logged for quality relevant to infection control parameters. Residents with MDRO will have individual logs when positive and colonized. 6. Clinical Supervisors will review all records of culture and sensitivity reports for efficiency of antibiotic therapy then present findings to DON.	by the DON 3/16/08
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 worksheets, the facility failed to complete surveillance data collection for four of four months, train staff on the surveillance process, and maintain an active monitoring program to ensure staff compliance with infection control practices. The facility further failed to ensure staff used appropriate practices when assisting resident #100 with a bed pan during one of one observations of sample residents using a bed pan. The findings were: 1. The facility's infection control monthly surveillance worksheets were reviewed on 1/30/08 at 9:15 AM; the director of nursing (DON) was present during the review and provided an ongoing interview regarding the infection control program. The sample included four months, October 2007 through January 2008, and	F 441		

3/17/08 10:40 Changes made in agreement with Charlie Bailey, Andy, Ramona Bunker, DON, and Tony Trujillo, Surveyor.

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F 441	Continued From page 4 revealed the following concerns: a. The DON stated she received data collection worksheets from her three clinical supervisors, collectively representing all five units in the facility. The DON reported she sent a copy of the worksheets to the hospital infection control practitioner to be compiled in a monthly hospital-wide summary. However, the DON did not maintain a consolidated summary of surveillance data for the long-term care facility and had not established a mechanism to quantify relevant infection control parameters, such as prevalence of infections or antibiotic usage, threshold levels of diarrhea, residents with past cultures of multidrug-resistant organisms (MDROs), or information regarding residents colonized with MDROs. b. Two different versions of the monthly data collection worksheet were found in the facility's records. The DON stated she was unaware multiple forms were in use and acknowledged inconsistencies in the data elements collected on the two forms. c. Data collection forms were discovered to be incomplete or contained questionable information for all four months sampled: 1. Three of nine entries to indicate the probable onset of infection as "community, nosocomial, or chronic" were left blank in December 2007; three of 13 similar entries were blank on the November 2007 worksheets, as were nine of 20 entries for October 2007. 2. The facility's surveillance process included listing the organism or pathogen identified from microbiology culture. Worksheets for October 2007 failed to include culture results for three specimens submitted from Neighborhoods 1 and 2, and two similar omissions for the same month were discovered	F 441	Continued from Page 4 of 11 7. A staff training session will be conducted to educate nurses on the definitions of infection control terms community, nosocomial and chronic infections. These terms will be posted with infection control reporting forms. 8. The DON or designee will report finding of these monitoring tools to the QIC for review and recommendations. II. The facility will ensure the infection control program includes active monitoring that all staff utilize appropriate infection control practices such as hand hygiene. This will be accomplished by: 1. Clinical Supervisors will monitor non-nursing staff weekly on a random basis. 2. Clinical Supervisors will monitor nursing staff on hand washing hygiene during meal times. 3. A monitoring tool will be developed by the DON for both of the above. Clinical Supervisors will collect data and present to DON. 4. Staff Development Coordinator will present hand washing for all facility staff at All Staff Meeting on March 14, 2008. 5. Hand washing will be discussed at CNA and nurses' meeting monthly starting February 2008. 6. The DON or designee will report findings of these monitoring tools to the QIC for review and recommendations.	2/16/08

3/17/08 Changes made in agreement with Charlie Gulley, 10:15 Adm, Ramona Bushey, DON, and Tony Madden, Surveyor
am

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F 441	Continued From page 5 for Neighborhoods 3 and 4. 3. There was no evidence in the infection control records that culture and sensitivity reports from the laboratory were reviewed to assess the efficacy of antibiotic therapy. 4. The facility listed resident #27 twice on the January 2008 worksheet, even though the resident only had one active infection that month. d. Interview with the clinical supervisor for Neighborhoods 3 and 4, RN #5, on 1/29/08 at 2:20 PM revealed she used antibiotic therapy as the sole criteria for listing residents on the surveillance worksheet. The supervisor stated this was her understanding of the surveillance and data collection process. Interview with the clinical supervisor for Neighborhoods 1 and 2, RN #1, on 1/30/08 at 9:40 AM revealed she included not just residents receiving antibiotics, but also those with positive culture results and, in some cases, residents treated for signs and symptoms of infection without culture results. The DON acknowledged these inconsistencies in data collection on 1/30/08 at 10:10 AM and, further, agreed inconsistent data collection could potentially impact infection control statistics in the facility. e. Joint interview with the DON and RN #1 on 1/30/08 at 10:20 AM revealed confusion with regard to infection control terms such as "community-acquired", "healthcare-acquired", and "chronic" infections. Review of the facility's infection control policies and procedures on 1/30/08 at 10:25 AM failed to provide any further information to the staff on how to define or apply these terms. 2. The facility's infection control program failed to include evidence of active monitoring to ensure staff practiced appropriate infection control	F 441	Continued from page 5 of 11 III. The facility will ensure that resident #100 and all residents who use a bedpan receive appropriate infection control handling procedures of the bedpan before and after use. This will be accomplished by: 1. CNA #7 has been re-educated on the proper technique for handling of bedpans. All nursing staff will be re-educated on the proper handling of bedpans before and after resident use. This training will be conducted at the next CNA & Professional Nursing staff meetings scheduled in March. 2. Clinical Supervisors will monitor nursing staff on handling of bedpans when assisting residents. 3. A quality monitoring tool will be implemented to ensure care staff utilize the proper technique. Clinical Supervisors will collect data and present to DON. 4. The DON or designee will report findings of this monitoring tool to the QIC for review and recommendations.	3/16/08

by the DON and the nursing Leadership Team

3/17/08 Changes made in agreement with Charlie Gurley, Admin,
10/1/8 Ramona Burton, DON, and Tony Madsley, Surveyor.

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F 441	Continued From page 6 practices, such as hand hygiene. Interview with the DON on 1/30/08 at 10:30 AM revealed the facility assessed hand hygiene as part of the competencies for direct care nursing staff. She stated she was not aware of an on-going assessment to monitor hand hygiene among non-nursing staff such as housekeeping, maintenance operations, activities, or dietary. The DON further stated employee practices and hand hygiene during meals was not routinely monitored. The DON acknowledged the activities staff provided food or snacks during some resident activities and, further, reiterated her expectation that hand hygiene was important when serving food or assisting residents to eat. 3. Observation on 1/28/08 at 4:30 PM revealed resident #100 was lying in bed and certified nurse aides (CNAs) #3 and #7 were in the room. The resident had been incontinent and requested to use the bedpan. The following concerns were noted: a. CNA #7 washed her hands, put on gloves, and placed the bedpan on the floor next to the resident's bed. b. The CNA performed incontinence care for the resident, then picked the bedpan up off the floor and placed it under the resident. Interview with that Neighborhood's clinical supervisor, RN #5, on 1/30/08 at 2:30 PM revealed, "It is never appropriate to put a bedpan on the floor except in an emergency." Interview on 1/31/08 at 8:21 AM with the DON confirmed the expectation was that the bedpan be placed on the bed, never on the floor, because the floor was considered dirty.	F 441		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION	F 444		

3/17/08 10 [illegible] Changes made in agreement with Charlie [illegible], [illegible], [illegible] Bushy, DON, and [illegible] [illegible] [illegible]

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F 444	Continued From page 7 The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff practiced appropriate hand hygiene while assisting residents at two of two meal observations. The findings were: 1. Certified nurse aide (CNA) #8 was observed feeding resident #83 during the evening meal served on 1/28/08. The observation began at 5:30 PM and ended at 5:51 PM. During this time period, the CNA repeatedly touched her face, hair, and common environmental surfaces while assisting the resident. At the outset of the meal, she repositioned the resident's wheelchair, touching both arm rests and one of the push handles. The CNA also used her hands to feed the resident a sandwich and to break up crackers added to the resident's soup. During the meal, the CNA left the table to refill a drinking glass for the resident. While doing this, she touched several environmental surfaces in a serving kitchen, including a refrigerator handle, a lock and chain around the handle, and a stock container of fluid. In addition, the CNA ran her hand along the countertop. Three other staff members were observed to touch these same surfaces during the meal. The CNA returned to the resident's table carrying the drinking glass with her fingers and thumb over the rim of the glass. Once at the table, the CNA again picked up the resident's sandwich, utensils, and napkin while assisting him/her to eat. At no time during the 21 minute	F 444	F 444 contact c residents #83 and #61 and The facility will ensure that staff washes their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This will be accomplished by: 1. Each staff member will carry alcohol-based hand hygiene products and use it when appropriate. 2. Staff will be re-educated on proper handling of dishes (not on rim of dish) at CNA and nurses' meetings in February. 3. Monitoring tool will be developed and Clinical Supervisors will collect data and present to DON. 4. The DON or designee will report findings of these monitoring tools to the QIC for review and recommendations.	3/16/08 by the DON and the Nurse Leadership Team 3/16/08

3/17/08 10:40 Changes made in agreement with Charlie Bailey, Admr, Ramona Bailey, DON, and Tony Maddox, Surveyor.

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F 444	Continued From page 8 observation did the CNA wash her hands or use a hand hygiene product. 2. During the breakfast meal on 1/29/08, CNA #6 was observed to assist resident #61 with his/her food. During the 13 minute observation, 7:45 AM to 7:58 AM, the CNA repeatedly rubbed her face, scratched her head, rubbed the back of her hand across her mouth, and rubbed her right eye with the fingers of her right hand. She used both hands to feed the resident and handled utensils, transferred a drinking glass between hands while holding the glass by the rim, and added condiments to the resident's coffee cup. At no time during the observation did the CNA wash her hands or use a hand hygiene product. 3. Interview with the director of nursing (DON) on 1/30/08 at 9:12 AM revealed her expectation that staff wash their hands prior to assisting at resident meals and any time they left the table to perform other tasks. The DON further stated alcohol-based hand hygiene products were available to all staff to use when appropriate.	F 444		
F 465 SS=D	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe and clean environment for kitchen staff. The findings were: Periodic observations in the kitchen, beginning on	F 465	F 465 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. This requirement is not met as evidenced by (1) two of 10 ceiling light fixture covers were cracked with pieces missing. In addition one was not tightly closed. (2) An upright refrigerator in the middle of the kitchen has an exposed condenser motor on top of the unit which was encrusted with dust and dirt. This will be accomplished by:	

3/17/08 Changes in agreement with Charlie Dulley, Admin, Ramona Bayless, DON, and Tony Bradley, Surveyor.
10:15

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F 465	Continued From page 9 1/28/08 at 2:48 PM through 1/31/08 at 9:48 AM, revealed two of ten ceiling light covers were cracked with pieces missing. In addition, one of the covers was not firmly attached to the lighting unit and was hanging loosely away from the ceiling. Furthermore, an upright refrigerator was standing in the middle of the kitchen. The refrigerator had an exposed condenser motor on the top of the refrigerator which was encrusted with dust and dirt. Interview with the kitchen manager on 1/30/08 at 10:48 AM confirmed the two ceiling light covers needed repaired or replaced. The kitchen manager was unaware of the accumulated dirt surrounding the condenser motor and agreed the area around the motor "should be cleaned and enclosed."	F 465	Continued from page 9 of 11 1. Plan of correction is to order new light cover fixtures for all kitchen lights that are cracked, or otherwise in disrepair. New fixtures covers will be ordered by 2/25/08 and installed immediately upon receipt. Further, all light cover fixtures will be observed to ensure that they are clean, fit tight and are in good repair. Surveillance to be completed by 3/10/08. 2. The condense motor was cleaned and maintained on 1/30/08. This unit will have a cover designed installed that is designed for this model of refrigerator to allow heat to dissipate and air flow to move around the condenser by 3/16/08.	3/16/08
F 468 SS=D	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to securely attach five handrails to the wall of the Special Care Unit (SCU). The findings were: Periodic observations from 1/29/08 at 3:48 PM through 1/31/08 at 9:00 AM revealed the following handrail sections were loosely attached to the wall in the SCU hallway: a. An eight foot length opposite the dirty linen closet. b. An eight foot length next to the dirty linen closet. c. An eight foot length at the hall corner next	F 468	4. The DON or designee will report the findings of quality monitoring to the QIC at the quarterly meeting for further review and recommendations. 3. Lights & fixtures, and the condense motor for the refrigerator will continue to be included in the Plant Operation Preventative Maintenance Plan.	

3/17/08 10/18 Changes in agreement with Charlie Bulley, Adm., Ramona Bushey, DON, and Tony Markley, Surveyor. CB

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
	535022	A. BUILDING ______ B. WING ______	C 01/31/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 468	Continued From page 10 to the resident community room. In addition, an approximate 8 inch end piece was missing from this rail, further destabilizing the hand rail. d. An eight foot length next to the SCU entry door. e. A two foot length next to the dirty linen closet. Interview with licensed practical nurse #2 while in the SCU on 1/29/08 at 3:50 PM verified the handrails were unsafe and should be fixed. Interview with the facility maintenance manager on 1/30/08 at 2:48 PM confirmed the handrails were unstable.	F 468	F 468 The facility will ensure all handrails, equipped on both sides of the corridor, will be firmly secured to the wall. This requirement was not met as evidenced at five locations on Neighborhood 2 were identified where the handrails were lose. This will be accomplished by: 1. The handrails identified as lose have been properly secured to the wall. In addition, all handrails in the facility will be inspected to ensure they securely attached to the wall and meet all code requirements. All work and surveillance to be completed by 3/1/08. Handrail inspections will continue to be included in the Plant Operation Preventive Maintenance plan. 2. The DON or designee will report the findings of quality monitoring to the QIC at the quarterly meeting for further review and recommendations.	3/1/08

3/17/08 10:15
Changes in agreement with Charlie Smiley, Adm, Kamona Bradley, DON, and Tony [illegible], Surveyor
G.M.