STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/31/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide privacy during care for 1 (#42) of 13 sample residents. The findings were: Review of the 7/30/06 bowel and bladder program	F 164	The facility will ensure that each resident has the right to personal privacy and confidentiality of his or her personal and clinical records. This will be accomplished by: C.N.A.#22 was in-serviced by Education Specialist on 8/30/06 on privacy being provided when any personal care is being done on resident #42. Nursing assistants were inserviced by the Education Specialist on 9/15/06 on providing privacy during personal care for all residents. The Nurse Manager and Resident Care Manager will audit privacy issues monthly times three months, then quarterly, to assure compliance. The results of the audit will be reported to the quarterly Quality Improvement Committee by the Nurse Manager for review and recommendations. Nurse Manager will monitor for compliance.	08/30/06 09/15/06

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

X [signature] | X RN Facility Manager | X 10/30/06

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.

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F 164	Continued From page 1 progress note revealed resident #42 required assistance for toileting. Observation on 8/28/06 from 5:55 PM to 6:10 PM showed certified nurse aide (CNA) #22 assisted the resident into the bathroom in the resident's room. The aide then left the resident on the toilet, and left the room without closing the bathroom door, or the door to the resident's room. During this 15 minute observation the resident in the room next door was awake and moving about in his/her room. In addition, there was another resident who wandered in and out of the area. At 6:10 PM CNA #22 returned to check on the resident. Interview with the director of nursing on 8/30/06 at 4:35 PM confirmed she would expect at least one of the doors closed to ensure privacy for the resident.	F 164		
F 246 SS=D	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to individualize the physical environment to meet the needs of 3 (#56, #39, #52) of 13 sample residents. The findings were: 1. Observation on 8/28/06 at 4:56 PM showed resident #56 was seated in a wheelchair at a dining room table. The resident's torso was at least one foot from the table and his/her thighs	F 246	The facility will ensure the resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This will be accomplished by: 1. Resident #56 - PT/OT will screen resident for proper table height for eating. 2. Resident #39 - PT/OT will screen resident for proper table height for eating.	11/06/06 11/06/06

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F 246	Continued From page 2 were in contact with the bottom of the table. At 5:15 PM, the resident's arms were noted to be extended as s/he ate independently. At 5:22 PM the resident pulled the tray towards him/herself until approximately five inches of the tray was off the table. Additional observation during breakfast on 8/29/06 at 7:20 AM showed the resident was seated in a wheelchair at a dining room table. Again, the resident's torso was at least one foot from the table and his/her thighs were in contact with the bottom of the table. The resident's arms were extended as s/he ate independently. On 8/29/06 at 7:45 AM, certified nurse aide (CNA) #48 was questioned by the surveyor in regard to the resident's positioning during meals. The CNA commented, "We need a taller table or a shorter wheelchair." 2. Observation during the evening meal on 8/28/06 at 5:05 PM showed resident #39 was seated in a wheelchair at a dining room table. The wheelchair was positioned sideways to the table as the resident ate independently. At 5:10 PM the resident dropped a glass of juice between the table and the wheelchair. Observation of the resident during the evening meal on 8/29/06 at 5:10 PM showed s/he was seated in a wheelchair positioned sideways to the table. Interview with CNA #16 on 8/28/06 at 5:06 PM revealed, the resident was seated sideways, because the table was about 2 inches too low." 3. According to the 6/16/06 significant change Minimum Data Set (MDS) assessment for resident #52, s/he required supervision with transfers and and toilet use. Review of the resident's care plan dated 6/20/06 revealed "***high rise toilet seat*** Encourage routine	F 246	Continued from Page 2 A table of adjustable height was ordered. It arrived damaged. According to e-mail from company a new table is to be shipped on 10/24/06.	11/06/06
			3. Resident #52 - PT/OT screened resident for use of "high rise toilet seat". The toilet seat has been removed by Therapy. Care plan has been adjusted by Resident Care Manager to reflect the removal of toilet seat riser.	10/26/06
			Nursing staff in-serviced by Education Specialist on 9/15/06 on reporting of residents' need for adaptive equipment.	09/15/06
			Therapies will screen all residents for proper table height and report to Nurse Manager any problems.	11/06/06
			Resident Care Manager will audit quarterly the appropriateness of any adaptive equipment including table height and will report to Quality Improvement Committee the findings of the audit for review and recommend-ations. Nurse Manager will monitor for compliance.	

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F 246	Continued From page 3 toileting." The following concerns were noted: Observation of the resident's toilet room on 8/29/06 at 1:03 PM and 8/31/06 at 7:10 AM revealed a high rise toilet seat was not attached to the toilet, nor visible in the immediate vicinity. Interview with registered nurse (RN) #24 on 8/31/06 at 7:55 AM confirmed the resident required a high rise toilet seat, but refused to use it. The RN further commented that she would have physical therapy evaluate because the resident was "awfully tall."	F 246		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE 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 adequate maintenance to ensure a comfortable interior in various areas of the facility. The findings were: Interview with the director of maintenance on 8/29/06 at 1:45 PM revealed he and one other employee were responsible for the up-keep and maintenance of five buildings on the grounds, and 29 acres of lawn. He further stated he or his co-worker would complete a walk through of the facility every day to identify areas that needed work. He also received work orders from various departments that were looked at on a monthly basis. He was aware of scraped walls and doors and stated that this winter the south wing would be done.	F 253	a. The entrance room door on room #313 has multiple scratches and gouges from wheelchairs entering the room. This area was sanded and repainted. b. The entrance wall near door in room #306 was damaged by wheelchairs. A wainscot was installed and painted to prevent further damage. The nursing staff was in-serviced on 10/26/06 on problem areas which receive damage from wheelchairs. c. Damaged wall/floor in smoking room. A thirty (30) inch wainscotting will be installed around the entire room to to prevent further damage to the wall. The floor tile will be stripped and re-waxed.	10/26/06 10/26/06 10/26/06 11/03/06 11/03/06

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F 253	Continued From page 4 Observation on all days of survey (8/28/06 through 8/31/06) revealed the following concerns with areas that required maintenance: a. The door on room #313 was scraped in two areas near the bottom. Both areas measured approximately four feet long. b. The inside wall under the light switch by the entrance of room #306 had an approximate 2 foot area of scraped paint. c. The smoking room on the south wing had an area on the wall under the mirror, approximately six feet long, of scraped paint. In addition, the floor in the smoking room was covered (too numerous to count) with burns from lit cigarettes. d. The door to a small wooden cabinet in the main dining room was broken off, the door was no longer attached, instead it was propped up in front of the cabinet. The cabinet was replaced on 8/29/06. e. A ceiling light cover was missing in the common area across from the therapy room on the south wing. The missing light cover was directly above the television. f. The bottom one-third of the right double exit door between the men's locked unit and the south unit was marred with multiple (too numerous to count) scrapes and gouges. g. The wood molding underneath the handrail next to resident room #320 was loose and pulled away from the wall. Interview and observation with the maintenance director on 8/29/06 at 1:45 PM revealed he was not aware of the missing light cover or the broken cabinet.	F 253	Continued from Page 4 d. The cabinet was replaced 8/29/06.	08/29/06
			e. The recessed light fixture in the south common area has been deleted from inventory. No repair parts are available. The fixture was dis-connected and removed on 10/27/06.	10/27/06
			f. The entry door damage on doors in south secure unit. These doors will be sanded, restained, and varnished.	11/03/06
			g. Molding damaged and pulled away from the wall. The molding next to resident room #320 was glued and secured to the wall.	10/26/06
			All areas will be put on the preventive maintenance inspection schedule and monitored by Maintenance. This will be monitored through Quality Improvement process.	
F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT	F 278	The facility will ensure the residents'	

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F 278	Continued From page 5 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure accurate documentation for 2 (#31, #23) of 2 sample residents and two (#50, #2) non-sample residents with non-pressure related wounds. The findings were:	F 278	Continued from Page 5 assessments will accurately reflect the resident status. This will be accomplished by: 1. Residents #23, #50, #2, #31's wound charting has been amended to "the term eschar has been inappropriately used when scab or dried drainage should have been used. 2. Wound/skin nurses were in-serviced on 8/30/06 by Nurse manager on the verbage of "eschar" in describing wounds. 3. Nurses in-serviced by Education Specialist on 10/25/06 in the usage of "eschar" when describing wounds/ wound healing. Nurse Manager will perform a quarterly audit for compliance. Nurse Manager will report to Quality Improvement committee results of audit for review and recommendations. Facility Manger will monitor for compliance.	08/30/06 08/30/06 10/25/06

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F 278	Continued From page 6 Interview with the director of nursing (DON) on 8/29/06 at 4:20 PM revealed the facility currently had four residents with healing pressure sores. The DON stated the residents all had stage I or stage II pressure sores. At that time, the surveyor asked the DON how many residents had unstageable pressure wounds with eschar, the DON replied, "None." Review of the wound book with the DON at that time revealed the use of the word "eschar" for residents with past wounds and for residents with current wounds. The DON stated the staff were using the term "eschar" in place of the word "scab." According to a picture and definition graph found for reference in the wound book, "eschar" was a full thickness, unstageable pressure sore. The treatment stated for eschar was debridement with an exception for intact heels. The definition did not address the use of the word for a healing, non-pressure related wound. The wound book also documented the following: a. Former resident #50 had scratched his/herself on the right elbow on 8/2/06. As the scratch healed, the facility documented the area was covered with "eschar." b. Resident #2 had a skin abrasion documented on 8/14/06 to the left elbow. Documentation on 8/23/06 showed "eschar present, healing slowly." c. Resident #31 received a skin tear on 8/17/06 which was treated with steri-strips (medical tape used to hold skin in place). The affected area was the right shin. Further review revealed on 8/23/06 the wound continue to resolve with "eschar present." d. According to the wound book, resident #23 scraped his/her left heel on the foot pedal of the wheelchair on 8/15/06. Documentation on 8/22/06	F 278		

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F 278	Continued From page 7 revealed the left heel had a slight amount of "eschar" without drainage. Observation of the resident's heel on 8/30/06 at 1:40 PM revealed the heel had dry brown colored crusty secretions which resembled a scab. According to Taber's medical dictionary, 19th edition, a scab is a crust of a cutaneous sore, wound, ulcer, or pustule formed by drying discharge.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to modify the plan of care for 1 (#24) of 1 unsample resident. The findings were:	F 280	The facility will ensure that the resident, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, will be allowed to participated in planning care and treatment or changes in care and treatment. This will be accomplished by: 1. Resident #24 - Resident Care Plan has been updated to reflect the "spitting" of food. Related diagnosis of dysphagia esophageal stricture and Alzheimers added to care plan. The Resident Care Managers/Minimum Data Set Nurses will review the twenty-four (24) hour report for any issues that need attention, and change the plan of care as necessary. A copy of the plan of care changes will be given to the Nurse Manager for review and instruction. Nursing staff was in-serviced on 10/25/06 regarding modification of plans of care for resident #24 and all residents as changes arise. Nurse Manager will report to Quality Improvement Committee. Facility Manager to monitor for compliance.	08/30/06 10/25/06

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F 280	Continued From page 8 Observation during the evening meal on 8/28/06 at 5:25 PM revealed resident #24 began spitting food on the floor. A second observation on 8/29/06 at 7:18 AM revealed the resident started spitting bread on the floor. At that time, certified nurse aide (CNA) #53, removed the resident's toast from the tray. The CNA then assisted the resident from the dining area to a recliner in the lounge. When asked, the CNA stated that once the resident started spitting, staff needed to remove him/her from the table and offer food at a later time. Review of the resident's medical record revealed a plan of care with a review date of 7/21/06. The plan failed to reveal an intervention to deal with the resident's spitting behavior. Review of the medical record showed a face sheet dated 11/9/04 which listed diagnoses which included dysphagia (difficulty swallowing) and esophageal stricture (narrowing of the esophagus) and Alzheimer's disease. Interview with the director of nursing on 8/29/06 at 4:08 PM revealed the intervention to stopped the spitting should have been in the plan of care.	F 280		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	The facility will ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This will be accomplished by: 1. Resident #39 - C.N.A.#48 was in-serviced on 8/31/06 by the Education Specialist regarding	08/31/06

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F 315	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to assure staff provided treatment and services to attain or maintain as much bladder continence as possible for 2 (#56 and #39) of 9 sample residents who were incontinent of urine. The findings were: According to the quarterly Minimum Data Set (MDS) assessment dated 6/23/06 resident #39 was occasionally incontinent of bowel (once a week) and incontinent of urine (multiple daily episodes). In addition, the resident was assessed as requiring extensive assistance with transferring and toilet use. Interview with certified nurse aide (CNA) #48 on 8/30/06 at 1 PM revealed the resident resided outside of the men's locked unit; however, he routinely came into the locked unit at noon to eat lunch. When questioned at that time regarding incontinence care, the CNA said all cares for the resident were provided by the CNAs on the south unit; "All we do is keep [resident #39's name] occupied." The following concerns were identified with the coordination of incontinence care: Following lunch on 8/30/06 at 1 PM, CNA #48 pushed the resident in his wheelchair into the television room. The CNA asked the resident if he wanted to watch a movie. The resident nodded. At 2:15 PM, CNA #20, who who worked on the south unit, entered the television room and asked the resident if he wanted to go to his room. The resident refused stating he wanted to watch the movie. At 2:50 PM the movie ended; however, the resident remained in the television room. At	F 315	Continued from Page 9 following toileting schedule requiring resident to return to his/her unit after meals for toileting and other cares. Care Plan for toileting will instruct to follow B&B recommendations as posted. 2. Resident #56 - Resident expired 10/25/06. C.N.A. #16 was in-serviced by Education Specialist on 8/31/06 regarding following toileting schedule. All nursing staff will be inserviced by Education Specialist on following written toileting programs for residents. Resident Care Managers/MDS Nurses will do a random audit for compliance on residents who have written toileting program. Results of audit will be reported to Quality Improvement Committee for review and recommend-ations. Nurse Manager will monitor for compliance.	08/31/06 11/06/06

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F 315	Continued From page 10	F 315		

3:30 PM (3.5 hours since the resident entered the locked unit), CNA #22 who worked on the south unit, entered the television room and asked the resident if he wanted to go back to his room; the resident agreed and the CNA wheeled the resident back to his room.

Interview with CNA #22 on 8/30/06 at 3:45 PM revealed she had changed the resident's brief and the resident had been incontinent of urine. When asked about the resident's toileting plan, the CNA stated the resident was to be toileted before and after meals. The CNA further commented the resident should have been toileted earlier.

Review of the resident's individualized bowel and bladder management program dated 6/14/06 revealed, "Toilet q [every] 2 - 2 1/2 hours while awake..."

According to the significant change MDS assessment dated 6/23/06 for resident #56, s/he was frequently incontinent of bowel (2-3 times a week) and incontinent of urine (multiple daily episodes). In addition, the resident was assessed as requiring extensive assistance with transferring and toilet use. The following concerns were identified:

Review of the resident's individualized bowel and bladder management program dated 7/31/06 revealed the resident was to be toileted between 4:30 - 5:00 PM. Continuous observation of the resident on 8/28/06 between 4:20 PM and 7:07 PM showed the resident was not approached by staff to be toileted. Observation at 7:07 PM (2 hours and 47 minutes since the observation began) revealed the resident was taken to the toilet by CNA #16. Interview with the CNA at 7:14 PM revealed the resident was incontinent of urine. Further interview with the CNA revealed the

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F 315	Continued From page 11 resident was to be toileted every two hours. The CNA stated he came on duty at 1:30 PM and did not remember when this particular resident had last been toileted.	F 315		
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of material safety data sheets (MSDS), the facility failed to ensure hazardous chemicals were not available to residents in two areas of the facility. In addition, the facility failed to ensure the main dining room was free from trip hazards. The findings were: Observation on 8/28/06 at 2:28 PM revealed a closet labeled "staff members only" in the north wing near room #238. The closet was equipped with a padlock. However, the lock was undone. Inside the closet on a shelf were two spray bottles containing solutions. One bottle was about one quarter full of a clear liquid, and had no label except for an orange sticker reading "hazardous material." The other spray bottle was approximately three quarters full of a blue liquid. This bottle had "omega" written on it. There were no staff members in the area, just resident #29. Review of the 7/14/06 significant change Minimum Data Set assessment showed this resident was moderately impaired for cognitive skills and decision making. According to the MSDS for "Omega," it is an eye and skin irritant,	F 323	The facility will ensure that the resident environment remains as free of accident hazards as is possible. This will be accomplished by: 1. Housekeeping Manager removed all chemicals from unlocked closet and unused pod on 8/28/06. Housekeeping staff in-serviced by Housekeeping Manager on 8/28/06 on the importance of all chemicals being appropriately labeled and secured. Housekeeping Manager/designee will do monthly audits to ensure compliance and report to Quality Improvement Committee for review and recommendations. 2. Resident #38 - Oxygen tubing placement in dining room evaluated, oxygen tubing replaced with a fourteen (14) foot cannula by Education Specialist on 8/31/06 to allow for better placement of tubing within floor cord cover to keep tubing on the floor for resident/employee safety. Resident expired 10/22/06	08/28/06 08/28/06 08/31/06

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F 323	Continued From page 12 and "if ingested...contact a physician immediately." Observation on 8/28/06 at 4:58 PM revealed a bottle labeled "Ultra Spray" on a shelf in the hallway across from room #336. The one gallon bottle was about half full, and had an orange sticker on it that read "hazardous material." According to the MSDS for "Ultra Spray," it is an eye and skin irritant and not for ingestion; "Do not induce vomiting...call a physician immediately." Interview with the housekeeping supervisor on 8/30/06 at 2:10 PM confirmed all chemicals were to be locked up if not being used by the staff. She also stated the bottles should be labeled to show the content. Observation in the main dining room on 8/29/06 at 5:26 PM revealed the oxygen concentrator for resident #38 was located next to a wall. About 6 feet of oxygen tubing was between the oxygen concentrator and the resident's table; the oxygen tubing was not touching the floor. While walking between the wall and the table, the surveyor almost tripped on the clear tubing. Further observation in the main dining room on 8/30/06 at 12:55 PM and 8/31/06 at 7:50 AM, revealed approximately 6 feet of the resident's oxygen tubing between the oxygen concentrator and the resident's table. The center section (approximately 1 ft. in length) of the tubing was in direct contact with the floor; the remainder was suspended above the floor. Interview with LPN #14 on 8/31/06 at 7:50 PM confirmed the oxygen tubing was a potential trip hazard and should not hang above the floor.	F 323	Continued from Page 12 Nursing staff in-serviced on 10/25/06 and 10/26/06 by Education Specialist on the placement of oxygen tubing in common areas to prevent accidents. All WRC staff to monitor for possible safety issues with oxygen tubing and report issues to nursing staff. Nurse Manager will report to Quality Improvement of any issues reported. Facility Manager to monitor for compliance.	10/25/06 10/26/06
F 363 SS=D	483.35(c) MENUS AND NUTRITIONAL ADEQUACY	F 363	The facility will ensure that the menus	

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F 363	Continued From page 13 Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of the menu and diet manual, the facility failed to follow the diet guidelines to meet the nutritional needs of 5 (#17, #27, #31, #33, #43) of 5 residents who received a pureed, no concentrated sweets diet. The findings were: Observation of the preparation of the evening meal on 8/29/06 at 3:44 PM revealed cook #1 added approximately one pint of half-and-half (equal portions of whole milk and cream) to the pureed cheese omelet and toast. Interview with the cook at that time revealed she was pureeing food for 15 residents. The cook further commented she always added half-and-half to pureed items such as eggs. Interview with the assistant dietary manager on 8/30/06 at 3:44 PM revealed 5 (#17, #27, #31, #33, #43) of the 15 residents who received pureed food also had a physicians orders for "no concentrated sweets." At that time the assistant dietary manager provided a copy of the facility's "no concentrated sweets" diet which was titled "limited concentrated sweets" in the facility's diet manual. According to the "Simplified Diet Manual, 9th edition, Iowa Dietetic Association" the limited	F 363	Continued from Page 13 will: 1. Meet the nutritional needs of residents in accordance with the Food and Nutrition Board of the National Research Council, National Academy of Science; 2. Be prepared in advance; and 3. Be followed. This will be accomplished by: Dietary staff was in-serviced by Dietition on 8/31/06 regarding the appropriate/inappropriate liquids used in the process of making pureed foods. When an appropriate liquid for pureeing a food is to be a milk product, 2% milk will be used. The Dietary Manager will conduct a weekly audit on the preparation of pureed foods for two months. The Dietary Manager will report results of audit to Quality Improvement Committee for review and recommendations. Facility Manager will monitor for compliance.	08/31/06

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F 363	Continued From page 14	F 363		

concentrated sweets diet was to be "used when a moderate calorie restriction is desirable for weight management. This plan may be appropriate for some people with diabetes whose blood sugars stay within desirable with minimal diet modifications." The diet manual further documented the limited concentrated sweets diet limited the amounts of concentrated sweets and high fat foods." The manual listed "whole milk, chocolate milk and sweetened flavored yogurt" as milk products that were to be served on a limited basis. Half-and-half was not listed as an allowed item.

Review of the menu for the week of 8/27/06 - 9/2/06 revealed eggs were served five of the seven days. Interview with the assistant dietary manager on 8/31/06 at 7:40 AM confirmed half-and-half was utilized by dietary staff during the preparation of food served on a pureed diet, such as with pureed eggs.

Interview with the registered dietitian on 8/31/06 at 8 AM confirmed two of the residents receiving a pureed, no concentrated sweets diet were on planned weight loss programs (#33, #43), and three residents (#17, #27, #31) had the diagnosis of diabetes.

Review of the 6/9/06 quarterly MDS assessment for resident #43 showed s/he was on a planned weight change program. A physician's order dated 5/8/06 revealed the resident was to receive a NCS (no concentrated sweets) pureed diet. Review of the 5/31/06 dietary progress note showed the resident weighed 235 pounds. The 8/24/06 dietary progress note showed a weight gain of two pounds with a weight of 237 pounds.

Interview with the registered dietitian on 8/31/06

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F 363	Continued From page 15 at 7:45 AM confirmed routinely adding half-and-half to foods was not necessarily appropriate; particularly for those residents on a planned weight loss program.	F 363		
F 371 SS=E	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 assure refrigerated food items were maintained at the proper temperature and stored in a manner to prevent cross contamination. The findings were: Observation on 8/29/06 at 7:10 AM revealed the refrigerator at the south nurses' station was used to store resident food, including milk. The thermometer located inside the refrigerator showed a temperature of 50 degrees Fahrenheit (F). Interview with the director of nursing on 8/29/06 at 7:18 AM revealed the temperature was too high, and she would have maintenance come look at it. Interview with the maintenance director on 8/29/06 at 1:45 PM revealed the thermometer being used was inaccurate. Observation of two thermometers placed in the refrigerator at this time confirmed the faulty thermometer read 60 degrees F while another electric thermometer read 40 degrees F. Review of the August 2006 temperature log for this refrigerator showed 23 days the temperature was recorded at 46 degrees	F 371	The facility will ensure the storage, preparation, distribution, and serving of food under sanitary conditions. This will be accomplished by: 1. The thermometer in the refrigerator at the south nurses' station was replaced by the Maintenance Department on 8/29/06 2. The refrigerator temperature logs will include the parameters for food safety - five (5) degrees celsius or forty-one (41) degrees F. or less. 3. Nurses will adjust the refrigerator regulator to ensure temperatures are within the written parameters. 4. A policy/procedure will be written by Education Specialist regarding the storage of employee's food with residents' food, and will be posted on refrigerators. Nursing staff was in-serviced by Education Specialist on 10/25/06 on the monitoring of refrigerator temperatures, on submitting a repair request to the Maintenance Department and on any temperatures	08/29/06 11/06/06 11/06/06 10/25/06

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F 371	Continued From page 16 F or higher. The temperature log included instructions on proper temperatures for storing vaccines; however, there were no instructions on appropriate temperatures related to food storage. According to Food Code 2005, U.S. Public Health Service, 3-501.16: "Potentially Hazardous Food (Time/Temperature Control for Safety Food), Hot and Cold Holding. Potentially hazardous food (time/temperature control for safety food) shall be maintained: (2) At a temperature specified in the following: (a) 5 degrees Celsius or 41 degrees F or less;" The following concerns were noted in the men's locked unit: Observation on 8/29/06 at 1:55 PM with certified nurse aide (CNA) #11, showed resident food items such as snacks, cartons of milk, and cans of soda were stored in the unit refrigerator. At that time, the CNA removed a plastic bag and stated, "I know my food is not supposed to be in here." The CNA said the bag contained food items brought from her home. Observation on 8/30/06 at 1 PM with CNA #48 revealed a plastic jug containing water was in the unit refrigerator along with resident food items such as milk and cans of soda. The CNA removed the jug and stated, "This should not be in here." The CNA further commented the jug was hers and she brought it from her home. Interview with the assistant dietary manager on 8/30/06 at 1:10 PM revealed there was no written policy; however, the expectation was that staff would store their food in the employee dining room refrigerator.	F 371	Continued from Page 16 outside the parameters for food and vaccines. Nurse Manager will monitor storage of staff food and review temperatures monthly and report results to Quality Improvement Committee for review and recommendations. Facility Manager will monitor for compliance.	
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an	F 441	The facility will ensure to establish and maintain and infection control	

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F 441	Continued From page 17 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 and staff interview, the facility failed to assure proper infection control measures were followed in the men's locked unit in an effort to prevent the transmission of disease and infection. At the time of the survey, 10 residents received services in the unit. The findings were: Observation in the men's locked unit on 8/28/06 at 5:30 PM, and again at 5:46 PM, showed resident #43 independently maneuvered his wheelchair to a garbage can in the dining area. The resident leaned over, took a soiled paper cup out of the garbage can, and spit in the cup. The resident then placed the soiled cup back into the garbage can. Even though certified nurse aide (CNA) #16 was in the immediate area during both observations, no staff intervention occurred. Interview with the infection control nurse on 8/30/06 at 3:40 PM confirmed the CNA should have intervened. Observation in the men's locked unit on 8/28/06 at 6:13 PM revealed CNA #16 swept the floor in	F 441	Continued from Page 17 program designed to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of disease and infection. This will be accomplished by: 1. Resident #43 - Garbage can has been removed as there are other garbage cans available that are not easily accessible to residents. C.N.A. #16 in-serviced by Education Specialist on 08/31/06 on monitoring residents and intervening when there are infection control issues, and the proper placement of dustpan Nursing staff will be in-serviced on 11/18/06 by Education Specialist on intervening when residents' actions are an infection control issue. Random audits will be performed by Resident Care Managers and results of audits will be reviewed by Quality Improvement Committee for any recommendations. Nurse Manager will monitor for compliance.	10/26/06 08/31/06 11/06/06

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F 441	Continued From page 18 the dining area. As the CNA swept, he placed the soiled dustpan between the handrail and the wall. Interview with the infection control nurse on 8/30/06 at 3:40 PM confirmed this was a violation of proper infection control practices.	F 441		
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to assure staff followed proper handwashing procedures in an effort to prevent the spread of infection and disease. The findings were: The following concerns with handwashing were observed in the men's locked unit: a. Observation on 8/28/06 at 5:10 PM showed resident #39 dropped a cup containing juice on the floor. Certified nurse aide (CNA) #33 wiped up the spilled juice. Then, without washing or sanitizing her hands, the CNA put on gloves and assisted resident #39 with his meal. b. Observation on 8/28/06 at 5:46 PM revealed CNA #16 removed a meal tray from the table after an unidentified resident finished eating and placed the tray in the mobile cart. The CNA then removed his gloves and without washing or sanitizing his hands, assisted resident #56 with his meal. c. Observation on 8/28/06 at 5:48 PM showed	F 444	The facility will ensure that staff will wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This will be accomplished by: a. Education Specialist in-serviced C.N.A.#33 on 08/31/06 regarding the proper clean up of spills and policy/ procedure of handwashing. b/c. Education Specialist in-serviced C.N.A.#16 on 08/31/06 on policy/ procedure for handwashing with emphasis on between residents handwashing and handling of food. d. C.N.A.#53 (should be #48) in-serviced by Education Specialist on 9/01/06 on policy/procedure for handwashing with emphasis on between resident handwashing. e. C.N.A. #24 in-serviced 8/29/06 by Education Specialist on handwashing policy/procedure. Nursing Staff in-serviced by Education Specialist on 09/15/06 on handwashing policy/procedure with	08/31/06 08/31/06 09/01/06 08/29/06 09/15/06

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F 444	Continued From page 19 CNA #16 took a bag of garbage into the soiled utility room, then without washing or sanitizing his hands, picked up 3 unused cartons of milk and placed the cartons in the resident's refrigerator. d. Observation on 8/29/06 at 7:43 AM revealed CNA #53 used a washcloth to cleanse the face of resident #52. Then, without changing gloves or washing or sanitizing her hands, the CNA attained another washcloth and cleansed the face of resident #53. Observation on 8/28/06 at 4:47 PM showed CNA #24 came out of resident room #306 with a bag of garbage in her hands. She discarded the garbage bag in a garbage can near the soiled utility room. Then without washing or sanitizing her hands, she assisted resident #62 in the hallway and re-arranged his/her sweater. Interview on 8/30/06 at 3:40 PM with the infection control nurse confirmed the CNAs did not follow proper handwashing procedures in the aforementioned examples. Review of the facility policy, "Handwashing/Hand Hygiene" revised March 2003, revealed: "The use of gloves does not replace handwashing." The policy also documents handwashing should occur, "After handling items potentially contaminated with blood, body fluids, or secretions." In addition, the policy documents that an alcohol based hand rub can be used if hands are not visibly soiled "... before direct contact with residents ...after contact with resident's intact skin...and after removing gloves."	F 444	Continued from Page 19 emphasis on areas of concern addressed on survey. Alcohol-based, hand-sanitizer dispensers for staff have been added to each unit by the Houseekeeping Manager on 9/18/06. Infection Control Nurse/Education Specialist will perform random audits on hand washing. Results of audit will be presented quarterly to the Quality Improvement committee for review and recommendations. Nurse Manager and nursing staff to monitor for compliance.	09/18/06
F 445 SS=D	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and	F 445	The facility will ensure that personnel handle, store, process, and transport	

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F 445	Continued From page 20 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to assure linens were properly handled in the men's locked unit to prevent the spread of infection. At the time of the survey, 10 residents received services in the unit. The findings were: Observation in the men's locked unit on 8/29/06 at 7:50 AM showed certified nurse aide (CNA) #48 placed two soiled clothing protectors and a soiled washcloth on the handrail outside of resident room #323. At 7:54 AM (four minutes later), the CNA removed the linens and took the items into the soiled utility room. Interview with the infection control nurse on 8/30/06 at 3:40 PM confirmed handling soiled linens in this manner violated proper infection control practices. Review of the facility policy "Laundry/Linen," revised December 2003, revealed "Handle all soiled linen as though it is potentially infectious."	F 445	Continued from page 20 linens so as to prevent the spread of infection. a. C.N.A.#48 was inserviced by Education Specialist on 8/31/06 on the proper handling of soiled laundry/ linen per policy/procedure. Nursing staff was inserviced by Education Specialist on 10/26/06 on the handling of soiled laundry/linen. Infection Control Nurse/Education Specialist will conduct random audits on staff handling of soiled laundry/ linen. Results of audit will be submitted to Quality Improvement Committee for review and recommend-ations. Infection Control Nurse will monitor for compliance.	08/31/06 10/26/06