Reviewed & approved w changes on pages 1, 6, 11, 12 & ate standard

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

PRINTED: 07/11/2006
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
	535027	Pg 1 of 2 v A. BUILDING after discussion w B. WING Bonnie Nemphley DON ov	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

7/26/06 @ 11:22 AM Linda Brown RN

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F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and caregiver interview, the facility failed to follow the written plan of care for 1 of 13 sample residents (#47). The findings were: Review of the care plan dated 5/18/06 showed resident #47 was supposed to receive nectar thickened liquids. During an interview on 6/28/06 at 1:55 PM, the registered dietitian (RD) stated the resident required thickened liquids based on the results from a swallowing study. The RD stated the care plan was current. The following concerns were identified regarding the facility's failure to follow the care plan: a. Observation on 6/27/06 at 9:50 AM revealed certified nurse aide (CNA) #1 answered the resident's call light. While in the resident's room, the CNA took a cup to the sink in the resident's bathroom and filled it with tap water. Without adding thickener, the CNA brought the cup of water to the resident and gave him/her a drink. Then the CNA left that cup of water on a table next to the resident. b. Observation on 6/28/06 at 10:07 AM showed CNA #1 filled a cup with tap water and placed it next to the resident (the water was not thickened). Interview with the CNA at that time revealed the resident was able to reach the water, and was able to independently drink fluids. The	F282	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations manual. The facility will continue to ensure that the written plan of care for residents is followed. A. A sign was posted 6/30/06 in the private bathroom of resident #47 stating that this resident is to be provided only thickened liquids. A container of thickener was placed in the resident's bathroom and at the bedside. B. Staff will be educated by the Director of Nursing (DON) at a staff meeting scheduled for 7/28/06 regarding the importance of following the plan of care summarized on the Certified Nursing Assistant (CNA) flow sheet. C. A staff inservice will be provided on 7/28/06 by the DON and a Registered Dietitian (RD) on the importance and proper use of thickened liquids for residents who require them. D. The DON will monitor for compliance. and present the results to the QA committee on a quarterly basis for at least one year. JUL 21 2006 added per phone request of DON 7/26/06	7/28/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeanne Kaiser, NHA | TITLE: Administrator | (X6) DATE: 7/20/06

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.

1309 Completion Date: The facility will continue to provide the necessary

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F 282	Continued From page 1 CNA stated there was a CNA care plan flow sheet which was updated everyday. Review of that care plan flow sheet provided by the CNA showed the resident was supposed to receive thickened liquids. c. Observation on 6/28/06 at 1:10 PM showed the resident was in his/her room, with a cup of water next to him/her. The water was not thickened. Interview with the resident's caregiver at that time revealed the resident "chokes" on water. The caregiver confirmed the water in the room was not thickened, and stated staff did not always thicken the water.	F 282		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and caregiver interview, the facility failed to provide thickened liquids during two observations for one of one sample residents (#47) with swallowing difficulties. The findings were: Review of a 5/18/06 fax communication to the physician from the registered dietitian (RD) showed resident #47 had swallowing difficulties.	F 309	The facility will continue to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A. A staff inservice will be provided on 7/28/06 by the R.D. on swallowing evaluations and the clinical implications of use of thickening agents for residents with swallowing difficulties. B. The DON will monitor C. See also the Plan of Correction for F282	7/28/06

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F 309	Continued From page 2 The physician ordered a swallowing evaluation. Review of the 5/25/06 barium swallowing evaluation note written by the speech therapist revealed the resident had trace amounts of barium that penetrated into the airway. There was penetration with thin liquids; therefore, the speech therapist recommended the resident continue with nectar thickened liquids. Review of the radiology report for that same swallowing study showed "...a small amount of laryngeal penetration is also observed with thin liquids..." Review of orders noted on 6/19/06 showed the physician ordered nectar thickened liquids for the resident. Review of the care plan dated 5/18/06 showed the resident was supposed to receive nectar thickened liquids. During an interview on 6/28/06 at 1:55 PM, the RD stated the resident required thickened liquids based on the results from the swallowing study. The following concerns were identified: a. Observation on 6/27/06 at 9:50 AM revealed certified nurse aide (CNA) #1 answered the resident's call light. While in the resident's room, the CNA took a cup to the sink in the resident's bathroom and filled it with tap water. Without adding thickener, the CNA brought the cup of water to the resident, and gave the resident a drink. Then the CNA left that cup of water on a table next to the resident. b. Observation on 6/28/06 at 10:07 AM showed CNA #1 filled a cup with tap water and placed it next to the resident (the water was not thickened). Interview with the CNA at that time revealed the resident was able to reach the water, and was able to independently drink fluids. The CNA stated there was a CNA care plan flow sheet which was updated everyday. Review of that care plan flow sheet provided by the CNA showed the	F 309		

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F 309	Continued From page 3 resident was supposed to receive thickened liquids. c. Observation on 6/28/06 at 1:10 PM showed the resident was in his/her room, with a cup of water next to the resident. The water was not thickened. Interview with the resident's caregiver at that time revealed the resident "chokes" on water. The caregiver confirmed the water in the room was not thickened, and stated staff did not always thicken the water.	F 309		
F 323 SS=E	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 and staff interview, the facility failed to provide a safe environment for residents in two of three resident areas. The findings were: 1. Observation on 6/27/06 at 9:19 AM and again on 6/28/06 at 4:12 PM revealed the electric cord for an ARJO lift battery charger was plugged into an electrical outlet directly behind the East nurses' station. Wrapped around the plug was a piece of cotton tape on which was written "do not unplug." The tape had come loose and dropped between the plug and the electric wall outlet, coming into direct contact with the metallic prong on the plug. Interview with RN #1 on 6/28/06 at 4:12 PM confirmed the tape represented a fire hazard.	F 323	The facility will continue to ensure that a safe environment is provided for residents. 1. The tape on the electric cord for the Arjo lift battery charger was removed 6/28/06 2. The faulty lock on the wall cabinet in the second floor bathing room will be repaired or replaced 3. The three vertical panels covering the base board heaters in the main dining room will be repaired. 4. The spray bottle under the sink in the second floor laundry room was removed 6/29/06. 5. Monthly environmental rounds will be conducted by the Infection Control Nurse and an Environmental Services Supervisor on a monthly basis to identify items that may constitute accident hazards. A report of the findings of these rounds will be provided to the DON, who will develop a Quality improvement (QI) monitoring system and report the findings and corrective actions to the organization-wide Environment of Care Committee every other month for at least the next 12 months. 6. The DON will monitor.	8/10/06

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F 323	Continued From page 4 2. Observation on 6/26/06 at 3:48 PM and again on 6/28/06 at 4:10 PM revealed one of four wall cabinets in an unlocked residents' bathing room on the second floor had a faulty locking mechanism. The cabinet door was closed but the locking mechanism did not work. Inside the cabinet were several razors, metal nail clippers and files, and a 16 oz. bottle of 70% isopropyl alcohol. Interview with LPN #1 on 6/28/06 at 4:15 PM confirmed the cabinet locking mechanism was not working properly. 3. Observation on 6/27/06 at 8:13 AM and again on 6/28/06 at 4:40 PM revealed three vertical panels covering the base board heaters in the main dining room were not flush with the adjoining panels. The exposed sharp edges jutted out approximately 2 inches from the heater. Interview with the administrative assistant on 6/28/06 at 4:45 PM confirmed the edges represented a safety hazard to anyone brushing up against the panels. 4. On 6/27/06 at 9 AM observation on the second floor revealed a room with an open door marked "laundry room." Under the sink in an unlocked cabinet was a spray bottle of "Highly Concentrated All Purpose Cleaner." The spray bottle had the following cautionary statement "...caution- may be harmful if swallowed...keep out of reach of children..."	F 323		

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F 368 SS=B	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, review of policies and procedures, and review of internal documentation, the facility failed to assure staff offered snacks at bedtime to residents on one of three units. The findings were: On 6/27/06 at 3 PM confidential interviews with three residents who resided on the East unit revealed they were not offered snacks at bedtime. Interview with registered nurse (RN) #3 on 6/28/06 at 4:30 PM verified snacks were only offered to diabetic residents and to those residents who received a snack pre-labeled with their name. The RN specifically stated she had not seen snacks offered to all residents on the East unit. Interview with certified nurse aide (CNA) #2 on 6/28/06 at 5:15 PM revealed the	F 368	The facility will continue to ensure that all residents are offered bedtime snacks. A. Evening snacks will be offered to all residents and documented when given. a specific staff member will be assigned this duty on a regular basis on the daily assignment sheet. B. The policy on nourishments will be revised to reflect this practice. C. The offering of evening snacks to all residents will be monitored daily by the charge nurses, and the documentation of the snacks will be monitored by the DON on a weekly basis to ensure compliance. D. Results of the monitors will be presented to the QA Committee on a quarterly basis for at least one year. added per request of DON 7/26/06	8/10/06

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F 368	Continued From page 6 CNAs were to document on the snack list if they offered residents a snack. At that time, review of the "LTCC East Snack List" with the CNA revealed the column for bedtime snacks was blank. According to the facility's 11/19/91 policy and procedure, "Serving Between Meal & Bedtime Snacks," snacks were provided "to serve the resident with extra nourishment to provide energy" and "to provide adequate nutrition..."	F 368		
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, staff interview, and record review, the facility did not ensure food was stored or prepared under sanitary conditions. Equipment used for food preparation and food storage was not maintained in a clean, sanitary condition and handwashing facilities in one location did not have a sanitary system in place for the disposal of paper towels. In addition, the facility failed to sanitize the ice machine. The findings were: 1. Observation in the main kitchen on 6/26/06 at 4 PM, 6/27/06 at 0910,and 6/28/06 at 3:30 PM revealed the following sanitation concerns: a. The knife on the manual can opener had an accumulation of dried food residue on its blade. The same build up was seen at all three	F 371	The facility will continue to ensure that food is stored, prepared, distributed, and served under sanitary conditions A. The manual can opener was washed on 6/28/06. The cooks on both the morning and afternoon shifts have been educated by the Director of Nutrition Services to ensure that the manual can opener is washed and sanitized on a daily basis at the end of their shift. B. The front exteriors of the stacked ovens were cleaned on 6/29/06. The ovens will be placed on a regular cleaning schedule to ensure they are cleaned inside and out on a monthly basis. C. The sprinkler heads located directly above the fryer and steam-jacketed kettles were cleaned 6/29/06, and are in the process of being replaced. These sprinkler heads will be placed on a regular cleaning schedule to ensure they are cleaned whenever indicated and at least on a monthly basis. D. A trash can with a foot pedal lid will be purchased and placed by the handwashing sink in the cold food preparation area. E. The policy and practice regarding maintaining ice machines will be revised to include quarterly sanitizing with an EPA-registered disinfectant suitable for use on ice machines.	8/14/06

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F 371	Continued From page 7 observations. On 6/28/06 at 3:30 PM the director of the dietary department noted and verified the dried food accumulation on the can opener's knife blade. b. The front exteriors of the stacked ovens, including all knobs, dials, and switches, were coated with a heavy layer of grease and dust. The ovens were in the same condition during all three observations. On 6/28/06 at 3:30 PM the director of the dietary department noted and verified the soiled condition of the ovens. c. The sprinkler head located directly above the fryer and steam-jacketed kettles had visible strands of dust particles adhering to its surface. It appeared exactly the same on all observation dates. On 6/28/06 at 3:30 PM the director of the dietary department noted and verified the soiled condition of the sprinkler head. d. A large, plastic trash barrel with a lid that required manual removal was located next to the handwashing sink in the cold food preparation area. Staff had to remove and replace the lid of the can with their hands in order to dispose of the towels after each episode of handwashing. On 6/28/06 at 3:30 PM, when this concern was expressed to the director of the dietary department, she commented that there was supposed to be a trash can with a lid operated by a foot pedal in that area. However, direct observation of this handwashing station at that time showed there was no other type of container in this work area for employees engaged in food preparation to use for paper towel disposal after washing their hands. 2. Interview with the director of the dietary department on 6/26/06 at 4:20 PM revealed the department did not have a policy for cleaning and	F 371	F. The Dietary Supervisor and/or Director of Nutrition Services will make monthly rounds of the food service areas to ensure that sanitary conditions are maintained. The findings of these rounds will be incorporated into a Quality Improvement study and reported to the organization-wide Environment of Care Committee on a quarterly basis for at least the following 12 months. G. The Director of Nutrition Services will monitor.	

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F 371	Continued From page 8 sanitizing the ice machine that was located in the kitchen. According to the director of the dietary department, the maintenance department was responsible for this particular piece of equipment and all cleaning and sanitizing was done by that department. Information provided by the maintenance department showed they used a product called "Nu Calgon," which is a phosphoric acid product. According to materials published by the Nu-Calgon manufacturer at www.nucalgon.com, this product is specifically formulated for inhibiting scale in ice machines and other equipment. It is not identified as a detergent or a sanitizer. According to the Morbidity and Mortality Weekly Report for June 6, 2003/52(RR10);1-42, Guidelines for Environmental Infection Control in Health-Care Facilities: ice machine cleaning and sanitation is a Category II recommendation, which means implementation is supported by clinical or epidemiologic studies, or a theoretic rationale. Ice Machines and Ice, part IX, F states that ice machines must be cleaned and disinfected on a regular basis. "An EPA-registered disinfectant suitable for use on ice machines or storage chests should be used in accordance with label instructions."	F 371		

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F 426 SS=E	483.60(a) PHARMACY SERVICES - PROCEDURES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to assure sample resident #47 did not receive expired medications from one of three medication carts. In addition, random observation of that same cart showed other expired medications were available for resident use. The findings were: Observation of the second floor medication cart on 6/28/06 at 4:40 PM revealed the following medications had expired: a. A 300 tablet bottle of Aspirin 81 milligrams (mg) for resident #47 was approximately one half full and expired on 4/06. At the time of the observation, licensed practical nurse (LPN) #1 confirmed the expiration date and stated Aspirin from that bottle was routinely administered to the resident. b. A tube of Hydrocortisone Cream 0.5%, expired March 2005. c. Two tubes of Lamisil 1%, one expired 5/05 and the other 4/06. d. A tube of Betameth/Clotrimazole 1%/0.05%, expired 5/06. e. A tube of Povidone Iodine 10%, expired 2/06. At the completion of the observation, LPN #1	F 426	The facility will continue to provide pharmaceutical services to meet the needs of each resident A. The 300 tablet bottle of aspirin with expiration date of 4/06 was disposed of on 6/28/06. B. The tube of Hydrocortisone Cream 0.5% with an expiration of March 2005 was disposed of on 6/28/06. C. The two tubes of Lamisil 1% with expirations of 5/05 and 4/06 were disposed of on 6/28/06. D. The tube of Betameth/Clotrimazole with an expiration of 5/06 was disposed of on 6/28/06. E. The tube of Povidone Iodine 10% with expiration of 2/06 was disposed of on 6/28/06. F. The D.O.N. will designate a nurse to regularly inspect the medication carts on a monthly basis for expired medications, and dispose of any items that will expire within that month, and report the findings to the D.O.N. (See attached monitoring form.) This will be in addition to inspections conducted by pharmacy staff of the medication rooms. G. The findings of the monthly inspections of the medication carts will be developed into a Quality Improvement study and reported to the organization-wide Pharmacy and Therapeutics committee on a quarterly basis for at least the following 12 months. H. The D.O.N. will monitor	7/24/06

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F 426	Continued From page 10 confirmed the expiration dates and stated the medications itemized in b, c, d, and e were available for resident use. According to the facility's policy and procedure, "Medication area inspections," last reviewed 2/14/05, monthly inspections of the three wings of the nursing home would be conducted "to determine that all medications are in date and usable..." Further review showed, "Outdated, adulterated, or otherwise unusable medications will be immediately removed from the area..."	F 426		
F 431 SS=D	483.60(d) LABELING OF DRUGS AND BIOLOGICALS Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This REQUIREMENT is not met as evidenced by: Based on random observation and staff interview, the facility failed to assure all medications in one of three medication carts were labeled in accordance with currently accepted professional principles. The findings were: Random observation of the second floor medication cart on 6/28/06 at 4:40 PM revealed a tube of medication with the manufacturer's name, DuoDerm Hydroactive Gel, inscribed on it. A label was attached, but it was completely blank. At the time of the observation, licensed practical nurse	F 431	The facility will continue to ensure that drugs and biologicals used will be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. A. The D.O.N. will designate a nurse to regularly inspect the medication carts on a monthly basis to determine that all drugs and biologicals are properly labeled and have a visible expiration date. (See attached monitoring form.) The results of the inspections will be reported to the D.O.N., who will include the information as part of a Q.I. study that will be reported to the organization-wide Pharmacy and Therapeutics committee on a quarterly basis for at least the following 12 months. B. The D.O.N. will monitor. C. The DuoDerm Hydroactive Gel's a label was discarded. added per request of DON 7/26/06	7/24/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(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 431	Continued From page 11 (LPN) #1 verified the blank label. The LPN stated she had no idea which resident used the medication. In addition, the label covered the expiration date.	F 431		
F 444 SS=D	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 review of policies and procedures, the facility failed to assure staff completed handwashing as required for one sample (#39) and two non-sample (#17, #20) residents. The findings were: According to the facility's policy and procedure, "Hand Hygiene/Handwashing," last revised 7/15/05, handwashing interrupts the "transmission of infectious organisms by the hands of healthcare workers," prevents "cross contamination during patient care," and "is the single most important means of preventing the spread of infection." Further review of the policy revealed wearing gloves "is not a substitute for handwashing/hand hygiene", and hand hygiene "is to be performed: After removing gloves. Gloves must be changed...when moving from a contaminated site to a clean site." The following instances where staff failed to implement this policy after the provision of perineal	F 444	The facility will continue to ensure that staff are required to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. A. The Registered Nurse/Staff Development Coordinator (RN/SDC) conducted a 1:1 inservice on 6/30/06 with Certified Nursing Assistant (CNA) #5 regarding the requirement to wash hands between glove changes when performing direct resident cares. B. The RN/SDC conducted a 1:1 inservice on 6/30/06 with CNA #8 regarding the requirement to wash hands between glove changes when performing direct resident cares. C. A staff inservice will be provided on 7/28/06 regarding handwashing, to include the requirement for handwashing between glove changes. A post-test (See attached form) will be required to be completed by all direct patient care staff to determine comprehensive knowledge of handwashing. D. The D.O.N. will monitor. and present results to the QA Committee on a quarterly basis for at least one year. added per request of DON 7/26/06	8/11/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

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F 444	Continued From page 12 (incontinence) care were identified: a. Observation on 6/27/06 at 7:55 AM showed certified nurse aide (CNA) #5 provided perineal care for resident #17 and removed her gloves. However, the CNA failed to cleanse her hands before re-gloving and rinsing the resident's dentures. The CNA then helped the resident insert the dentures into his/her mouth. b. On 6/27/06 at 8:15 AM, CNA #5 completed perineal care for resident #20 and removed her gloves. The CNA failed to cleanse her hands before re-gloving and inserting dentures into the resident's mouth. c. At 9:40 on 6/28/06, observation showed CNA #8 assisted resident #39 into the bathroom and removed the wet incontinence brief. The CNA changed her gloves but failed to cleanse her hands before brushing, and then helping the resident insert, his/her top dentures. Interview with the infection control coordinator on 6/28/06 at 2:30 PM revealed her expectation was that staff would remove their gloves after providing perineal care, was their hands, and re-glove. The coordinator verified that handwashing was absolutely necessary.	F 444		