STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
TO: JANELLE CO LIN/CLIA	535039	A. BUILDING _____ B. WING POC accepted 11/1/07 jc	C 10/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, review of posted meal times, and staff and resident interviews, the facility failed to ensure residents were treated with dignity and respect during three of three meal observations. The findings were: The following concerns were noted regarding dignity in the small dining room: a. Observation on 10/8/07 at 5:30 PM revealed 12 to 15 residents ate their meals in a small dining room across from the central nurses' station. At 6:15 PM, certified nurse aide (CNA) #1 pulled a cart with a bus tub into the middle of the dining room and started clearing dirty dishes from tables where residents were finished and had left the dining room. In the process of clearing the tables, she scrapped left over food into the bus tub, and stacked the dirty dishes. The tables in the dining room and the bus tub cart were in close proximity to the seven residents who were still eating. Without asking the residents who were seated at the table, the CNA removed the tablecloth from beneath the beverages that two residents (#50 and #76) were still drinking. The tablecloth did not appear to be soiled and the residents did not request to have it removed. The two residents continued to consume their meal and beverages after the tablecloth was removed. b. Observation on 10/8/07 revealed the meal	F 241	F241 Dignity The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1. Dining room tables will be cleared of soiled tablecloths and used dishes and utensils when residents request or when all residents have exited the dining room. Charge nurses will monitor dining rooms during meals at least weekly to ensure clearing of tables occurs only when residents request or when residents have exited the dining room with special attention to resident #50 and #76. 2. The facility will order glasses and serve milk in glasses. Weekly audits will occur to ensure that residents are receiving milk in glasses, rather than in cartons. The audits will include residents #s 32, 16, 76, and 1. 3. The facility has formed a "dining room committee" and is working on the open dining situation. In the mean time residents are being consulted in resident counsel about their preferences for meal times. We are also informing residents to wait until closer to meal times to arrive at the dining room unless they want to wait for long periods of time. 4. All nursing staff will receive education regarding clearing soiled tablecloths, dishes, and utensils when residents request or when residents have exited the dining room. Education will also occur regarding	11/23/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cynthia K. Rankin RN, ED — TITLE — (X6) DATE: 11-1-07

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. POC accepted. Left message for Cynthia Rankin, ED on 11/1/07 @ 10AM. JL

NOV 05 2007 Janelle Corelin, CMRL

NOV 2

Wyoming Dept of Health

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F 241	Continued From page 1 trays for the small dining room arrived at 8:10 AM. At 8:30 AM, CNA #2 pulled the bus cart for the dirty dishes into the middle of the dining room and began clearing, scrapping, and stacking dirty dishes from the tables. Again this activity occurred in close proximity to the eight residents who were still eating. c. Observation on 10/11/07 at 1 PM revealed resident's #32, #16, #76, and #1 received milk in a carton. The residents were not provided with glasses for their milk so they drank the milk out of the cartons. Interview with the dietary manager on 10/11/07 at 11:30 AM revealed they routinely served the milk to residents in the paper cartons. According to the posted meal times located on the wall near the entrance to the main dining room, the evening meal was scheduled for 5:35 PM and the breakfast meal was at 7:50 AM. The following concerns were noted: a. At 5:30 PM on 10/8/07 there were residents seated waiting to be served meals at all 18 tables. Forty minutes later, at 6:10 PM, 22 unidentified residents seated at 9 of the 18 tables were still waiting to be served. The last resident was served in this dining room at 6:25 PM, 50 minutes after the posted meal time. b. At 8:15 AM on 10/9/07 the aides made their way around the dining room and obtained all of the residents' breakfast orders, including that of resident #60. At 8:20 AM 30 minutes after the posted meal time, the first meal was served. Resident #60 was the last resident to be served at 8:55 AM, which was 1 hour and 5 minutes after the posted serving time. d. Interview with resident #60 on 10/9/07 at 9:45 AM revealed s/he felt it was a long time to wait for the meal. She stated it was not unusual to have to wait so long.	F 241	serving milk in glasses and about adhering to the system for open dining so that residents are not pushed to the dining room early and then left there too long. This education will be completed on or before 11/25/2007 and will be conducted by the Director of Nursing. 5. A Performance Improvement Audit Tool will be utilized to conduct weekly observations. If any problem is noted immediate re-education and/or corrective action will take place. A member of Performance Improvement Committee will randomly observe meals weekly to ensure compliance with all above mentioned issues. 6. The Director of Nursing will report the results of these audits including any problems and/or trends at the monthly Performance Improvement Meeting for a period of no less than three months or until ongoing compliance had been achieved.	

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F 241	Continued From page 2 e. Confidential resident interviews conducted during the days of survey (10/8/07-10/11/07) revealed three residents who confirmed they often had to wait a long time to be served meals in the main dining room.	F 241		
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, medical record review and staff interview, the facility failed to ensure side rails were evaluated for safety for one (#60) of three sample residents who used side rails. The findings were: Observation on 10/8/07 at 5:30 PM revealed resident #60 was in bed watching television. The bed was equipped with two full side rails that were in a raised position. Review of the 9/5/07 annual Minimum Data Set (MDS) assessment showed the resident was totally dependent on staff for bed mobility and did not utilize the bed rails for mobility or transfers. No devices or restraints were coded for this resident on the MDS assessment. The following concerns were noted related to the use of side rails for this resident: a. The two side rails attached to the resident's bed had gaps in the bars that could potentially result in a limb being entrapped.	F 323	F323 483.25 (h) ACCIDENTS AND SUPERVISION The facility will 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. 1. Resident #60 had a safety assessment completed on 10/29/07 for ½ side rails Physical therapy completed a safety screen for resident # 60's ½ side rails on 10/29/07. Resident uses the side rails to assist with repositioning in bed. Resident has signed a consent for ½ side rails on 10/29/07 after reviewing the risks of side rails. 2. An audit will be conducted to ensure all residents with side rails have completed safety assessments. This audit will be conducted by the Director of Nursing and will be completed on or before 11/25/07. 3. All nursing staff will be re-educated regarding the risks and benefits of using side rails and the appropriate use of restraints. This education will take place on or before 11/25/07 and will be conducted by the Director of Nursing. 4. A member of the Performance Improvement Committee will utilize a Performance Improvement Audit Tool to conduct weekly audits to ensure all residents have safety assessments completed for residents with side rails. Any problems noted during the audits will result in re-education and/or corrective action.	11/25/07

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F 323	Continued From page 3 b. Medical record review revealed there had been no safety assessment for the use of these rails. c. Interview with the director of nursing on 10/10/07 at 1:50 PM revealed the side rails were used for security. She further stated the facility had been using the rails on the resident ' s bed for approximately three weeks.	F 323	5. The Director of Nursing or designee will report the results of the audits including any problems and/or trends at the monthly Performance Improvement Meeting for a period of no less than three months or until ongoing compliance has been achieved.	
F 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (I) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures	F 334	F 334 483.25 (n) INFLUENZA AND IMMUNIZATION The facility will develop policies and Procedures that ensure that -- 1. Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; 2. Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; 3. The resident or the resident's legal representative has the opportunity to refuse immunization; and 4. The resident's medical record includes documentation that indicates, at a minimum the following. (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility will develop policies and Procedures that ensure that --	11/25/07

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F 334	Continued From page 4 that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure education	F 334	(1) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (2) Each resident is offered a pneumococcal immunization, each resident has already been immunized; (3) The resident or the resident's legal representative has the opportunity to refuse immunization; and (4) The resident's medial record includes documentation that indicated, at a minimum the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) The the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (5) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. 1. Residents #s 7,12,23,31,35,41,42,49, 50,54,56,60,64 and 66 did receive their immunizations prior to 10/12/07 without documented evidence of education. 2. The Infection Control Nurse or designee will document education provided to residents and/or residents' legal representatives regarding risks and benefits of immunizations on	

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F 334	Continued From page 5 was documented for 14 of 14 sample residents (#7, #12, #23, #31, #35, #41, #42, #49, #50, #54, #56, #60, #64, #66) who were immunized against influenza and/or pneumococcal infections. The findings were: Medical record review showed residents #7, #12, #23, #31, #35, #41, #42, #49, #50, #54, #56, #60, #64, and #66 had received the influenza and/or pneumonia immunizations in the facility since October 1, 2006. However, the records failed to show whether or not these residents or their representatives had received any education concerning the risks and benefits of these immunizations prior to receiving them. Interview with the infection control nurse on 10/10/07 at 3 PM revealed the education was provided but not documented as required.	F 334	a resident education form starting 10/12/07. The resident education form will be kept in the resident's medical record. 3. A member of the Performance Improvement Committee will utilize a Performance Improvement Audit Tool to conduct weekly audits to ensure that immunization education is being documented on the resident education form and placed in the resident record. Any problems noted during the audits will result in re-education and/or corrective action. 4. Education will be provided to the nursing staff regarding educating and documentation of education to all residents that receive immunizations. This education will take place on or before 11/25/07 and will be conducted by the Director of Nursing. 5. The Director of Nursing will report the results of the audits including any problems and/or trends at the monthly Performance Improvement Meeting for a period of no less than three months or until ongoing compliance has been achieved.	
F 356 SS=B	483.30(e) NURSE STAFFING The facility must post the following information on 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	F 356	F356 483.30 (e) NURSE STAFFING 11/25/07 The facility will post the following information on a daily basis: -Facility name. -The current date. -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. Certified nurse aides. -Resident census.	11/25/07

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F 356	Continued From page 6 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 on all days of the survey and staff interview, the facility failed to ensure accurate nurse staffing information was posted in an area readily accessible to residents and visitors. The findings were: Observation on 10/8/07, 10/9/07, and 10/11/07 revealed there were two areas in the facility where the nurse staffing information was posted. The following concerns were noted with the content of the posted information: a. There was a board with nurse staffing information posted in the secure care unit, which was up-to-date. However, this location was not readily accessibly to visitors and residents because the unit was locked and could not be accessed without keying in a code or getting assistance from a staff member. b. Nurse staffing information posted in a conference room was not current as it showed information dated 9/30/07. In addition, the area was not readily available to residents and visitors. There were two doors into the conference room: one was an entrance from the business office and the other door opened into a corridor.	F 356	The facility will post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: -Clear and readable format. -In a prominent place readily accessible to residents and visitors. The facility will 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 will maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. 1. The nurse staffing boards have been placed in the two main entrance hallways and are easily accessible to residents and visitors. These staffing boards contain current staffing information. Completion date: 10/24/07 2. The staffing clerk or designee will update the nurse staffing boards daily and as changes occur over the course of the day. 3. A member of the Performance Improvement Committee will conduct daily audits to ensure the nurse staffing boards are maintained in easily accessible areas with current staffing information. A Performance Improvement Audit tool will be utilized for these audits. Any problems identified as a result of the audits will result in immediate re-education and/or corrective action. 4. The Director of Nursing or designee will report the results of the audits including any problems and/or trends noted for a period of no less than three months or until ongoing compliance has been achieved.	

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F 356	Continued From page 7 However, when the corridor door was closed, observation revealed the door automatically locked.	F 356		
F 368 SS=E	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 observation, review of posted meal times, and interviews with staff and residents, the facility failed to ensure each resident was offered a nourishing snack despite an elapsed time in excess of 14 hours between the evening and morning meals. The findings were: The following problems were identified in regard to meal times and bedtime snacks: a. Review of posted meal times near the entrances to the main dining room and small dining room showed 7:50 AM for breakfast and 5:35 PM for dinner, which was an elapsed time of	F 368	F 368 483.35 (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 will be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility will 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. 1. The dietary staff will stock a food and beverage cart every evening with substantial (carbohydrate/protein) snacks to offer every resident at bedtime. This will occur on or before 11/25/07. 2. All nursing staff will receive re-education regarding importance and requirements of offering bedtime snacks. This education will occur on or before 11/25/07. 3. The charge nurses will monitor offering and delivery of bedtime snacks of all residents. A member of the Performance Improvement Committee will perform weekly audits to ensure all residents are offered bedtime snacks. Any problems noted will result in immediate re-education and/or corrective action.	11/25/07

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F 368	Continued From page 8 14.25 hours between these two meals. b. Observation on 10/8/07 at 7:30 PM revealed the first meal served in the main dining room occurred at 5:50 PM. On 10/9/07 the first morning meal was served at 8:20 AM. The span between meal times was actually 14.5 hours. c. Confidential interviews with six residents on 10/08/07 and 10/11/07, revealed they were not usually offered a bedtime snack. d. Interview with certified nursing assistant (CNA) #3 on 10/10/07 at 3:55 PM, and CNA #4 on 10/10/07 at 3:56 PM verified that not all residents were offered bedtime snacks. Both CNAs reported that snacks were provided for any resident who had diabetes or anyone who requested a snack.	F 368	4. Any concerns and/or trends will be reported at the monthly Performance Improvement Meeting by the Director of Nursing for a period of no less than three months or until ongoing compliance has been achieved.	
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 one of one observation, staff interview, and review of policies and procedures, the facility failed to ensure safe thawing practices were followed or that vents and other equipment in the food production area were adequately cleaned. The findings were: Observation in the kitchen on 10/9/07 between 10:20 AM and 11 AM revealed the following concerns: a. At 10:20 AM two plastic containers labeled	F 371	**F 371 Sanitary Conditions – Food Prep & Service** The facility will store, prepare, distribute, and serve food under sanitary conditions. 1. The preparation tables and the hood vents are on a regular cleaning schedule to ensure that they are acceptably clean at all times. The hood vents were cleaned prior to the surveyor's exit on 10/11/07. The shelves have been cleaned also. 2. The dietary staff will receive re-education regarding adhering to the cleaning schedule and the policy regarding safe thawing of food. The kitchen manager on or before 11/25/07 will conduct this education.	11/25/07

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F 371	Continued From page 9 as containing sliced sweetened strawberries were seen sitting in a pan of standing water. Although the pan was in a sink, there was no water running. At the time of the observation, dietary aide #1 stated the strawberries were thawing. Review of an undated policy and procedure revealed foods could be thawed under "cold running water." The word "running" was underlined. Interview with the dietary manager and dietitian on 10/10/07 at 1 PM confirmed the water was supposed to be running in order to safely thaw frozen foods. b. Two food preparation tables were equipped with a lower shelf used to store clean pans and other small kitchen equipment. Both of these shelves were soiled with dried on food and splatters of dried on liquids. In addition, there was a thick build-up of grease and dust on the hood vents directly above the range. Interview with the dietary manager and dietitian on 10/10/07 at 1 PM confirmed the shelves were to be cleaned whenever something was spilled on them, and the vents were last cleaned in July 2007.	F 371	3. A member of the Performance Improvement Committee will audit the completion of the cleaning schedule weekly to ensure that the equipment is being cleaned according to schedule and that the schedule is frequent enough to assure acceptable cleanliness. Safe thawing of food will also be monitored weekly by a member of the Performance Improvement Committee. Any problems noted will be addressed immediately by re-education and/or corrective action. 4. The results of the Performance Improvement Audits will be reported at the monthly Performance Improvement Committee meeting; any trends and/or problems will be reported as well. This will continue for a period of no less than three months or until ongoing compliance has been demonstrated.	11/25/07
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. 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.	F 425	F425 483.60 (a),(b) PHARMACY SERVICES The facility will provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in 483.75 (h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. The facility will provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 10/11/2007

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F 425	Continued From page 10 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure expired medications were not available for administration in one of three medication carts and in one of two medication rooms. Findings were: Observation on 10/10/07 at 2:50 PM at the central nurses' station revealed following concerns: a. Observation in the medication room revealed a box containing 24 vials of Xopenex 1.25 milligrams (mg) with an expiration date of 9/07. A 120 milliliter (ml) bottle of Doxepin 10 mg/ml had no visible expiration date, and a sodium phosphate enema, 4 1/2 ounces had an expiration date of May 2007. b. Observation of a medication cart revealed it contained a one pint bottle of guaifenesin with an expiration date of 9/07. c. Interview with registered nurse #1 and licensed practical nurse #1 verified these findings.	F 425	and biologicals) to meet the needs of each resident. The facility employs or obtains the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. 1. The box of 24 vials of Xopenex 1.25 milligrams with an expiration date of 9/07, bottle of 120 milliliters of Doxepin 10 mg/ml, and a sodium phospate enema, 4 ½ ounces were destroyed on 10/10/07. 2. The nurse managers inspected all medication rooms and medication carts on 10/10/07 to ensure that expired medications were not available for administration. 3. A licensed nurse has been assigned to inspect all medication rooms and medication carts and remove all expired medications weekly. 4. The Pharmacist Consultant and/or a member of the Performance Improvement Committee will conduct weekly audits of medication rooms and medication carts utilizing a Performance Improvement audit tool. Any problems identified as a result of the audits will result in immediate re-education and/or corrective action. 5. The Director of Nursing will report the results of the audits including any Problems and/or trends noted at the monthly Performance Improvement Meeting for a period of no less than three months or until ongoing compliance has been achieved.	
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.	F 465		

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F 465	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure floors in the kitchen area were clean. The findings were: Observation in the dry food storeroom on 10/9/07 at 10:20 AM revealed an accumulation of dried food, dirt and grease that had built up along the juncture of the flooring and walls beneath the shelving units. In addition, the flooring at the two entrances located between the dining room and kitchen were soiled with a build up of an unidentifiable black substance. A similar black substance had also accumulated on the floor of the entrance to the dietary manager's office. Interview with the dietitian and the dietary manager on 10/10/07 at 1 PM revealed this was a build up of dirt, grease and food that was not effectively cleaned with a broom and mop. They stated it would take a machine to get it cleaned.	F 465	**F 465 Other Environmental Conditions** The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1. The entire kitchen floor, including the dry storage room and the entrances between dining room and kitchen and the entrance to the dietary manager's office will be thoroughly cleaned on or before 11/25/07. 2. A regular cleaning schedule will be established to ensure that the floor in the kitchen is maintained in an acceptably clean condition. 3. A member of the Performance Improvement Committee will monitor the cleanliness of the kitchen floor weekly to ensure that it is clean. 4. Education will be provided to the dietary staff regarding maintaining the cleanliness of the kitchen floor. This education will take place on or before 11/25/07 and will be conducted by the kitchen manager. 5. The results of the Performance Improvement Audits will be reported at the monthly Performance Improvement Committee meeting; any trends and/or problems will be reported as well. This will continue for a period of no less than three months or until ongoing compliance has been demonstrated.	11/25/07