PRINTED: 04/03/2006
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465157	A. BUILDING ______ B. WING ______	03/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLARD COUNTY CARE CENTER	150 SOUTH WHITE SAGE AVENUE DELTA, UT 84624

(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 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, it was determined that the facility did not ensure professional standards of quality were met. Specifically, facility nursing staff had not discarded insulin vials when indicated. Additionally, one insulin vial was not dated to identify when it had been opened. The insulin vials belonged to Residents 12, 13, and 14. Findings include: On 3/21/06, beginning at 7:40 AM, the surveyor asked the south hall charge nurse (a registered nurse) if she had administered insulin to any residents that morning. The charge nurse stated she had administered both Regular and NPH insulin to Resident 12 and 70/30 insulin to Resident 13. The surveyor asked to observe the insulin vials for Residents 12 and 13. The charge nurse obtained each of the vials from the mediation refrigerator located at the South Hall nursing station. The Regular insulin vial for Resident 12 had a tapped label with a date of "2/04/06". The NPH insulin vial for Resident 12 had no tapped label or date written on it. The 70/30 insulin vial for Resident 13 had a tapped label with a date of "2/06/06". On 3/22/06 at 7:10 AM, the surveyor asked the South Hall charge nurse if they could view all of	F 281 4/18/06 POC acceptable Completion date 5/5/06 (Brunbank RN)	F-281 Insulin vials for residents #12, 13, and 14 were discarded and replaced on 3/22/06. All new vials were dated (3/22/06) on the vial. Staff will be educated to policy "Use of Multidose Vials" and also on the procedure of checking vials for outdates prior to administration of medication. Training will be completed on 05/02/06. Checking for outdates on all open vials will be added to weekly charge nurse duties schedule. DON will check all open vials on 04/19/06 for outdates. DON will monitor monthly thereafter. DON will give verbal and written report of compliance at quarterly QA meeting on 6/28/06. She will report at QA meeting quarterly thereafter. See next page Utah Department of Health 761220 APR 14 2006 Bureau of Health Facility Licensing, Certification and Resident Assessment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy Schmid	Administrator	4-13-2006

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 281	Continued From page 1 the insulin vials currently being stored in the South Hall medication refrigerator. The surveyor observed Resident 12 ' s Regular and NPH insulin vials. The Regular insulin vial had tapped label with a date of " 2/04/06 ". The NPH insulin vial had no tapped label with a date. The surveyor observed Resident 13 ' s 70/30 insulin vial. The 70/30 insulin vial had tapped label with a date of " 2/06/06 ". On 3/22/06 at 7:15 AM, the surveyor asked the South Hall charge nurse what the tapped labels on the insulin vials indicated. The charge nurse stated the date on the labels identified when the insulin vials were opened. The surveyor asked the charge nurse why that date was necessary to know. The charge nurse replied that the insulin could only be used for three months after being opened. On 3/21/06 at 7:55 AM, the surveyor asked the North Hall charge nurse (a licensed practical nurse) if she had administered insulin to any residents that morning. The charge nurse stated she had administered Regular insulin to Resident 14. The surveyor asked to observe the Regular insulin vial for Resident 14. The charge nurse obtained the insulin from the mediation refrigerator located at the North Hall nursing station. The insulin vial had a tapped label with a date of " 2/03/06 ". On 3/22/06 at 8:00 AM, the surveyor asked the North Hall charge nurse if they could view all of the insulin vials currently being stored in the North Hall medication refrigerator. The surveyor observed Resident 14 ' s Regular insulin vial. The Regular insulin vial had tapped label with a	F 281	4/18/06 Per telephone call CDON Facility will have interim QA mtg on 4/26/06 prior to completion date for all tags of 5/5/06 VBarenbark RN	

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F 281	Continued From page 2 date of " 2/03/06 " . On 3/22/06 at 8:10 AM, the surveyor asked the North Hall charge nurse what the tapped labels on the insulin vials indicated. The charge nurse stated the date on the labels identified when the insulin vials were opened. The surveyor asked the charge nurse why that date was necessary to know. The charge nurse replied that the insulin could only be used for three months after being opened. On 3/22/06 at 3:30 PM, the surveyor requested from the Administrator a copy of the facility ' s policy regarding the use of multi-dose vials, including insulin. On 3/23/06 at 8:30 AM, the Director of Nursing (DON) provided the surveyors with a copy of the facility ' s policy titled, " Multi Dose and Single Dose Vials. " The policy instructions included, " . . . Multi-dose vials may be reused for 28 days. Multi-dose vials need to be dated when opened. " The Journal of Pharmacy Society of Wisconsin, July/Aug 2002, page 2 Insulin Storage and Stability, documented that potency loss may occur after the bottle of insulin had been in use for greater than one month. Specifically, Regular, 70/30, and NPH insulin is stable if used within 28 days after the seal was punctured, whether they were refrigerated or at room temperature. LillyDiabetes.com/product/insulin gives general information about the storage of insulin products. The recommended insulin storage for Regular, NPH and 70/30 insulin is 28 days. This information may be located at URL http://www.lillydiabewtes.com/product/insulin_faqs	F 281		

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F 281	Continued From page 3 .jsp?reqNavId=5.9	F 281		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, it was determined that the facility did not ensure that for 1 of 11 residents randomly selected for Medication Pass observation, the resident was free of significant medication errors. Specifically, a facility registered nurse did not provide guidance to Resident 15 with regard to proper administration of a Metered Dose Inhaler (MDI). Findings include: Resident 15 was admitted to the facility on 3/01/04, his diagnoses included: chronic obstructive pulmonary disease, depression, pulmonary fibrosis and dementia. On 3/21/06 at 7:20AM, a facility registered nurse was observed preparing medications for Resident 15. The registered nurse handed resident 15 a Combivent MDI, for which the resident was to receive two puffs. The resident shook the Combivent MDI and took two puffs in rapid succession, less than five seconds apart. While Resident 15 was self administering the Combivent MDI, the registered nurse was at the bedside. The registered nurse provided no	F 333	F-333 Resident # 15 will be educated by DON on Manufacturers specifications for usage of MDI per product information by April 28, 2006. Resident will demonstrate and verbalize correct self administration to DON. All licensed nursing staff will be educated on correct use of MDI per manufacturers specifications on April 27, 2006. DON will observe administration of MDI by nursing staff monthly. Verbal and written report will be given by DON at quarterly QA meeting on 6/28/06 and quarterly thereafter.	

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F 333	Continued From page 4 guidance to Resident 15 with regard to the proper adminstration of the medication. On 3/22/06 at 12:02 PM, the same facility registered nurse was observed preparing medications for Resident 15. The registered nurse handed resident 15 a Combivent MDI, for which the resident was to receive two puffs. The resident shook the Combivent MDI and took two puffs in rapid succession, less than five seconds apart. While Resident 15 was self administering the Combivent MDI, the registered nurse was at the bedside. The registered nurse provided no guidance to Resident 15 with regard to the proper adminstration of the medication. On 3/22/06 at 4:00 PM, an interview was held with the Administrator and a different facility registered nurse. The surveyor requested a copy of the facility ' s policy regarding the administration of inhaled medications. The surveyor asked both the Administrator and the registered nurse if they were aware of any guidelines regarding the time interval between doses of inhaled respiratory medications such as Combivent MDI. Both the Administrator and the registered nurse were unaware of any such guidelines. The surveyor asked the registered nurse if she had ever been assigned to administer medications, including Combivent MDI to Resident 15. She replied that she had on several occasions and that Resident 15. The surveyor requested a copy of the manufacturer ' s product insert for Resident 15 ' s Combivent MDI. The registered nurse retrieved this information for the surveyor and acknowledged she had not been aware that there must be a one-minute interval between doses of the Combivent MDI, as the	F 333		

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F 333	Continued From page 5 product insert instructs. On 3/22/06 at approximately 4:30 PM, the Director of Nursing informed the surveyor that the facility ' s policy regarding inhaled respiratory medications included guidance to follow the manufacturer ' s specifications, and in the case of the Combivent MDI to wait one minute between doses. On 3/22/06 at 4:30 PM, the registered nurse, who had been observed preparing medications for Resident 15 on 3/21/06 and 3/22/06, approached the surveyor and stated she had just learned something about Combivent MDI. The registered nurse stated she had learned that if multiple doses of Combivent MDI were being administered, there must be at least two minutes between doses. She stated she was the first she had known about this guidance. A review of the manufacture ' s specifications regarding the preparation and administration of Combivent MDI included the following: Combivent Inhaler package insert, " . . . 6. Wait one minute and SHAKE the inhaler again . . . for each inhalation prescribed by your physician. "	F 333		
F 371 SS=E	483.35(h)(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:	F 371	F-371 (a) Dietary personnel will be educated on appropriate handling of food on 04/20/06. Dietary employees will not contact exposed, ready to eat food with their hands. Suitable utensils such as spatulas, tongs and other dispensing equipment will be utilized.	

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F 371	Continued From page 6 Based on observations of breakfast being served and a kitchen inspection, it was determined that the facility staff did not consistently store and distribute food under sanitary conditions. Findings included: 1. On 3/21/06 at 7:45 AM, in the North Hall dining area, breakfast was observed being served from a portable serving cart. The food server was observed to place biscuits and bacon on to the plates that were to be served to the residents. The food server was not using a kitchen utensil to handle the food. The food server was also observed to touch the diet tray cards, condiments, milk cartons, and yogurt cartons. Additionally, staff were observed to use the same tray repeatedly to deliver resident meals. Staff were observed to set the tray on dining tables and return the tray to the food server for the next resident's meal. 2. On 3/22/06 at 7:50 AM, in the North Hall dining area, breakfast was observed being served from a portable serving cart. The food server was observed placing French toast on the plates that were to be served to the residents without using a kitchen utensil to handle the food. The food server also touched the tray cards and used a pair of scissors to open a condiment. This occurred after another staff member had assisted a resident use the same scissors. 3. On 3/22/06 at 8:15 AM, in the South Hall dining area, the food server was observed to use a spatula to place French toast on plates that were to be served to the residents. She was then observed to repositioned the toast on the plates	F 371	Dietary manager will observe meal serving on each neighborhood By 04/28/06. Manager will continue To monitor monthly thereafter Verbal and written report of compliance will be given at quarterly QA meeting on 06/28/06 by dietary manager. Manager will report quarterly to QA committee meeting thereafter. (b) Jello/Pudding in walk in cooler was covered and dated with preparation date on 03/20/06. Dietary personnel will be educated on appropriate covering and marking of prepared food items on 04/20/06. Dietary Manager will do checks of walk-in cooler weekly to monitor for correct storage and marking of prepared food items. Verbal and written report of compliance will be given at quarterly QA meeting on 06/28/06 by dietary manager. Manager will report quarterly to QA committee meeting thereafter.	

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F 371	Continued From page 7 with the same gloved hand that was used to touch menu cards. A second food server was observed to place bacon on an individual resident's plate with a gloved hand. She was then observed to remove the bacon and French toast from the plate and placed them back into the warming containers with the same gloved hand that were used to touch milk cartons, serving containers, juice glasses, unwrapped straws and serving trays. 4. During the initial tour of the kitchen on 3/20/06 at 2:30 PM, it was observed in the walkin refrigerator that a tray of jello/pudding was not covered and it did not have a preparation date.	F 371		
F 428 SS=E	483.60(c)(1) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, it was determined that facility staff failed to ensure that the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist. This occurred for 10 of 11 sampled residents. (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10.) Findings include: Resident 1 was admitted to the facility on 8/1/05 and resided in the facility throughout the month of	F 428		

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F 428	Continued From page 8 December 2005. A review of resident 1's drug regimen reviews revealed no documentation to suggest the resident's medications were reviewed by a licensed pharmacist for the month of December 2005. Resident 2 was admitted to the facility on 8/4/03 and resided in the facility throughout the month of December 2005. A review of resident 2's drug regimen reviews revealed no documentation to suggest the resident's medications were reviewed by a licensed pharmacist for the month of December 2005. Resident 3 was admitted to the facility on 12/5/05 and resided in the facility throughout the month of December 2005. A review of resident 3's drug regimen reviews revealed no documentation to suggest the resident's medications were reviewed by a licensed pharmacist for the month of December 2005. Resident 4 was admitted to the facility on 11/18/05 and resided in the facility throughout the month of December 2005. A review of resident 4's drug regimen reviews revealed no documentation to suggest the resident's medications were reviewed by a licensed pharmacist for the month of December 2005. Resident 5 was admitted to the facility on 8/4/04 and resided in the facility throughout the month of December 2005. A review of resident 5's drug regimen reviews revealed no documentation to suggest the resident's medications were reviewed by a licensed pharmacist for the month of December 2005.	F 428	Contracted Pharmacist was educated to requirement of reviewing all resident's drug regimes each month including those cited: Residents 1,2,3,4,5,6,7,8,9, and 10 on 04/05/06. Pharmacist will review all resident drug regimes by 04/28/06. Pharmacist will continue to monitor monthly thereafter. DON will audit all charts before month end April, May, and June to insure that pharmacist visit was made. Pharmacist will be contacted and reminded if visit has not been made. DON will audit random charts monthly thereafter. Verbal and written report will be given by DON at quarterly QA meeting on 06/28/06. DON will report quarterly to QA committee thereafter.	

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F 428	Continued From page 9 Resident 6 was admitted to the facility on 2/22/05 and resided in the facility throughout the month of December 2005. A review of resident 6's drug regimen reviews revealed no documentation to suggest the resident's medications were reviewed by a licensed pharmacist for the month of December 2005. Resident 7 was admitted to the facility on 1/7/04 and resided in the facility throughout the month of December 2005. A review of resident 7's drug regimen reviews revealed no documentation to suggest the resident's medications were reviewed by a licensed pharmacist for the month of December 2005. Resident 8 was admitted to the facility on 6/9/03 and resided in the facility throughout the month of December 2005. A review of resident 8's drug regimen reviews revealed no documentation to suggest the resident's medications were reviewed by a licensed pharmacist for the month of December 2005. Resident 9 was admitted to the facility on 3/29/04 and resided in the facility throughout the month of December 2005. A review of resident 9's drug regimen reviews revealed no documentation to suggest the resident's medications were reviewed by a licensed pharmacist for the month of December 2005. Resident 10 was admitted to the facility on 8/23/05 and resided in the facility throughout the month of December 2005. A review of resident 10's drug regimen reviews revealed no documentation to suggest the resident's medications were reviewed by a licensed	F 428		

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F 428	Continued From page 10 pharmacist for the month of December 2005. An interview was held with the facility's Director of Nursing (DON) and the Administrator on 3/22/06 at 2:15 PM. Both the DON and Administrator stated that the facility's contracted pharmacist did not conduct a drug regimen review for any residents for the month of December 2005.	F 428		
F 429 SS=F	483.60(c)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities to the attending physician and the director of nursing. This REQUIREMENT is not met as evidenced by: Based on interviews with the Director of Nursing (DON) and record review, it was determined that between April 2005 and March 2006, facility staff failed to ensure that the pharmacist reported any irregularities to the attending physician and the DON. Additionally, for 2 of 11 sampled residents, facility staff did not act on the pharmacist's recommendations. (Resident identifiers 4 and 10.) Findings include: 1. Resident 4 was an 84 year old male admitted to the facility on 11/18/05 with the diagnoses of osteoarthritis, anxiety due to smoking cessation, congestive heart failure, hypertension and confusion. During a review of resident 4's Pharmacy Review	F 429	F-429 Physician orders were obtained for labs recommended by pharmacist for resident # 4 on 04/13/06. physician orders were obtained for labs recommended by pharmacist for resident # 10 on 04/13/06. Pharmacist was educated on 04/05/06 as to facility expectation of a written monthly report to DON of all irregularities found, and any recommendations from monthly drug review. Pharmacist will deliver written report of April review to DON by May 5, 2006. DON will review report and forward to individual physicians for review of comments and recommendations for their patients. DON will follow-up on June 5, 2006 and document that recommendations were addressed by physician. DON will continue to audit and follow above procedure monthly. DON will give verbal and written report of compliance at quarterly QA meeting on 06/28/06. DON will give reports quarterly to QA committee thereafter.	

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(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 429	Continued From page 11 form located in his clinical record, it was documented that the Pharmacist recommended in November 2005 to "Consider checking labs as (patient) is on diuretic therapy." Also, in January 2006, the Pharmacist recommended, "May consider checking labs - no record in chart (and patient) on diuretic therapy." A review of resident 4's clinical record determined that he did not have any lab results or physician orders for lab work to be completed. 2. Resident 10 was an 89 year old female admitted to the facility on 8/23/05 with the diagnoses of osteoarthritis, senile with depressive features and anxiety, congestive heart failure and dementia. During a review of resident 10's Pharmacy Review form located in her clinical record, it was documented that the Pharmacist recommended in January 2006 to "Consider checking Hg A1C (a lab test used primarily used to identify the plasma blood glucose concentration over time)." Also, in February 2006, the Pharmacist recommended, "Consider checking (Hg)A1C." These two recommendations were not reported to the attending physician nor the DON. Resident 10's medical record contains no documentation to suggest this laboratory test was completed or deemed unnecessary by the resident's attending physician. 3. An interview was held with the DON on 3/21/06 at 3:25 PM, and again on 3/23/06 at 8:30 AM. The DON stated, at both meetings, that the facility's contracted pharmacist had not submitted a pharmacy report to the DON or to attending	F 429		

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465157	A. BUILDING _____ B. WING _____	03/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLARD COUNTY CARE CENTER	150 SOUTH WHITE SAGE AVENUE DELTA, UT 84624

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F 429	Continued From page 12 physicians since April 2005. During the 3/23/06 interview, the DON stated the facility did not have a system in place for nursing staff to go back into the individual clinical records and retrieve any recommendations written by the Pharmacist. The DON also stated she had not known the pharmacist's schedule for coming to the facility to do the drug regimen reviews.	F 429		
F 430 SS=F	483.60(c)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interviews with the Director of Nursing (DON) and record review, it was determined that between April 2005 and March 2006, the facility did not receive reports of potential drug irregularities from their consultant pharmacist. Consequently, the facility was unable to ensure that potential drug irregularities were acted upon by the attending physician and the DON. Findings include: The facility's consultant pharmacist did not submit potential drug irregularities to the attending physician and the DON. Cross-Refer F-429. An interview was held with the facility's DON on 3/23/06 at 8:30 AM. The DON stated that the facility contracted pharmacist had not submitted a pharmacy report to her or the attending physicians since April 2005. The DON stated that	F 430	Pharmacist was educated on 04/05/06 as to facility expectation of a written monthly report to DON of all irregularities found, and any recommendations from monthly drug review. Pharmacist will deliver written report of April review to DON by May 5, 2006. DON will review report and forward to individual physicians for review of comments and recommendations for their patients. DON will follow-up on June 5, 2006 and document that recommendations were addressed by physician. DON will continue to audit and follow above procedure monthly. DON will give verbal and written report of compliance at quarterly QA meeting on 06/28/06. DON will give reports quarterly to QA committee thereafter.	

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F 430	Continued From page 13 the facility staff did not review the pharmacist's notes after each monthly medication reviews were completed and therefore, could not ensure that recommendations were acted upon. The DON explained that prior to April 2005, the pharmacist would submit the reports directly to her and that she would send the information directly to the attending physicians. The DON stated this has not occurred since April 2005, and that she was not certain why the pharmacist stopped sending the reports.	F 430		
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 observations of staff providing resident cares, it was determined that facility staff did not consistently wash their hands or use sanitizing gels after direct resident contact for which hand washing was indicated. Findings include: On 3/21/06 at 7:20 AM, a South Hall nurse was observed during medication pass. The registered nurse was observed to administer medications to three residents. As the nurse administered medications to these three residents, she was observed to touch the medication cups after the	F 444	F-444 Nursing staff will be educated as to appropriate hand washing protocols as indicated by acceptable professional practice, including hand washing or use of sanitizing gel before and after gloving and after any contact with resident or contaminated items on May 2, 2006. DON will observe one med pass on each neighborhood by May 30, 2006. A verbal and written report will be given by DON at quarterly QA meeting on June 28, 2006. DON will continue to observe monthly and give quarterly reports to QA committee.	

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F 444	Continued From page 14 residents had handled the cups and brought the cups to their mouths. Between residents, the nurse did not wash her hands, either with soap and water or sanitizing gel. On 3/21/06 at 8:00 AM, a North Hall nurse was observed administering medications to four residents. The nurse was observed to prepare one resident ' s medication, placing the medications in a medication cup. She was then observed to deliver the medication cup to the resident, hand the cup to the resident, and then take the cup back from the resident after the resident had placed the cup to their mouth. The nurse was observed to go back to the medication cart and repeat these steps for each of the four residents. The nurse did not wash her hands with soap and water or use sanitizing gel between resident contact for these four residents. On 3/22/06 at 12:02 PM, a South Hall nurse was observed checking blood glucose levels of two residents, preparing and administering insulin to one resident, and administering inhaler medication to one resident. The nurse was observed to be wearing gloves with each of these tasks. Additionally, the nurse was observed to change her gloves between residents. However, the nurse did not wash her hands with soap and water or sanitizing gel between resident contacts.	F 444		

MILLARD COUNTY CARE CENTER
IHC A Service of Intermountain Health Care

150 South White Sage Ave.
Delta, UT 84624
(435) 864-2944
(435) 864-3483 FAX

April 13, 2006

To Whom It May Concern:

This is our written credible allegation of compliance for all federal regulations. The date for alleged completion of compliance is May 5, 2006.

Sincerely,

Nancy Schmid

Nancy Schmid
Administrator