STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155199		04/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE PARK VILLAGE	776 N UNION ST WESTFIELD, IN 46074

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 28, 29, 30, 31 and April 1 and 4, 2016 Facility number: 000106 Provider number: 155199 AIM number: 100266390 Census bed type: SNF: 10 SNF/NF: 94 Total: 104 Census payor type: Medicare: 13 Medicaid: 76 Other: 15 Total: 104 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed by 21662 on April 8, 2016.	F 0000	Dear Kim Rhoades, Please find the attached Plan of Corrections for the Health Recertification and State Licensure survey ID# 04W411 performed on March28,29,30,31, April 1, and 4, 2016. The provider respectfully requests that the2567 plan of correction be considered the letter of credible allegation and requests a desk review, in lieu of a Post Survey revisit. Sincerely, Zach Krumwied, HFA Executive Director Maple Park Village The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	
F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	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. Based on observation, interview and record review, the facility failed to ensure residents were treated with dignity and respect while assisting two residents to eat their meal in the 100 hall dining room (Residents #23 and #78). Findings include: On 3/28/2016 from 11:30 a.m., to 12:55 p.m., during the assisted dining room observation on 100 hall, Resident #23 was observed being assisted to eat by CNA #7. During this observation, CNA #7 would bring a bite of food to the resident's mouth without acknowledging what the food was and the resident was observed with wide open eyes as she jerked back in her chair. On 3/31/2016 from 12:10 p.m. to 12:55 p.m., Resident #23 and Resident #78 were observed in the 100 hall dining room and were being assisted to eat by CNA #6. As Resident #23 was being fed large bites of spaghetti on a fork she was observed with wide open eyes as she jerked back in her chair when the food was placed to her mouth. As CNA #6 alternated between Resident #23 and	F 0241	#1: Two Residents were listed as being affected by this deficient practice. Residents#23 and #78 were re-approached by the IDT and offered additional snacks/meal items to ensure that they received adequate nourishment. CNA #6 and CNA #7 were in-serviced on 3.31.2016 regarding treating residents with dignity and respect while assisting with meals and eating. #2: All Residents that receive assistance with meals or eating have the potential to be affected by this deficient practice. All Residents that receive assistance with meals or eating will be provided with care that treats them in a manner that promotes recognition of individuality, dignity, and respect while being assisted. Facility Nursing staff were in-serviced by the DNS/designee on or before 4.22.2016 in regards to ensuring Residents that receive assistance with meals or eating are treated in a manner that promotes recognition of individuality and also with dignity and respect while being assisted. #3: Facility Nursing staff were in-serviced by the DNS/designee on or before 4.22.2016 in regards to ensuring Residents that receive assistance with meals or eating are treated in a manner	04/22/2016

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	Resident #78, no conversation was attempted with the residents. Resident #78 also was observed to refuse a bite of spaghetti six times by keeping her mouth closed and shaking her head in a negative manner when the fork was put to her lips. CNA #6 did not verbally encourage the residents to take bites or tell the residents what the food was. During an interview on 3/31/16 at 12:28 p.m., the DNS (Director of Nursing Services) indicated the staff were to tell residents what they were offering the residents and were to interact with the residents while assisting them with their meal. The "Resident Rights" policy was provided by the DNS on 4/4/16 at 3:15 p.m. This current policy indicated the following: "POLICY: Upon admission to any facility, each resident (sic)/responsible party will receive a copy of the "Resident Rights"....." The "Resident Rights" policy was provided by the Benefits Administrator on 4/4/2016 at 3:30 p.m. This current policy indicated the following: "...(a) Dignity. The facility must promote		that promotes recognition of individuality, dignity, and respect while being assisted. All Nursing staff will complete the Feeding a Resident skills validation tool with the DNS/designee on or before 4.22.2016. The DNS/designee will perform rounds every meal to ensure compliance. #4: To ensure compliance, The DNS/Designee is responsible for the completion of the Resident meal and eating observation CQI audit tool weekly x 4 weeks, Monthly x6 months, and then quarterly until continued compliance is maintained for 2consecutive quarters. The results of these audits will be reviewed by the CQI committee and overseen by the ED. If a threshold of 100% is not achieved in an action plan will be developed to ensure compliance.	

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	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...." 3.1-3(t)			
F 0314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure staff washed their hands according to their policy and procedure during a pressure ulcer dressing change for 1 of 1 resident being observed for pressure ulcer dressing change (Resident #35). Finding includes: Resident #35's record review was completed on 3/31/16 at 9:13 a.m.	F 0314	#1: One Resident was listed as being affected by this deficient practice. Resident#35's dressing was removed and replaced utilizing the proper infection control procedures to prevent the spread if infection. Res #35's referenced area on her was healed on 4.5.2016. RN #8 and CNA #12 were in-serviced on 4.1.2016regarding proper hand-washing and glove use. #2: All Residents that receive treatment or services related to pressure sores have the potential	04/22/2016

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	Diagnoses included, but were not limited to, Lewy bodies Alzheimer's disease and Parkinson's disease. An "IDT [Interdisciplinary] Weekly Update Skin Events-[Name of Company] Pressure Wound Skin Evaluation Report" dated 3/23/16 at 1:14 p.m., indicated the pressure ulcer was located on the coccyx. The pressure ulcer was an existing wound present on admission. The original date was 3/4/16, as a Stage II (Partial thickness loss of dermis, which presented as a shallow open ulcer with a red pink ulcer bed without slough. May also have presented as an intact or open/ruptured serum filled blister). The most severe tissue type was Granulation (pink-red moist tissue that filled an open wound when it began to heal). The wound measured 2.0 x 1.0 x 0.1 cm (centimeters). The wound color was pink granulation with scant amount serosanguineous drainage. The periwound was normal. An "IDT Weekly Update Weekly Skin Event-[Name of Company] Pressure Wound Skin Evaluation Report" dated 3/30/16 at 1:07 p.m., indicated the pressure ulcer was located on the coccyx. It was an existing wound present on admission. The original date was 3/4/16. The wound was now staged as a Stage III		to be affected by this deficient practice. All Residents that receive treatment or services related to pressure sores will receive care utilizing proper infection control procedures to prevent the spread if infection. All facility Nursing staff were in-serviced by the DNS/designee on or before 4.22.2016in regards to ensuring that all Residents that receive treatment or services related to pressure sores are receiving care with proper hand-washing and glove use. #3: All facility Nursing staff were in-serviced by the DNS/designee on or before 4.22.2016in regards to ensuring Residents that all Residents that receive treatment or services related to pressure sores are receiving care with proper hand-washing and glove use. All facility Nursing staff will complete a Hand-washing and Glove use skills validation with the DNS/designee on or before 4.22.2016. The DNS/designee will perform rounds every shift to ensure compliance. #4: To ensure compliance, The DNS/Designee is responsible for the completion of the Hand-washing and Glove use CQI audit tool weekly x 4 weeks, Monthly x 6 months,and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee and overseen by the ED. If a	

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	pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle was not exposed. Slough may be present, but does not obscure the depth of tissue loss. May include undermining and tunneling). The most severe tissue type was slough (Necrotic or avascular in the process of separating from viable tissue. Usually soft, moist, and light in color, may be stringy). The wound measured 2.0 x 0.6 x 0.1 cm. The wound color was approximately 25% white slough and 75% pink granulation with scant amount serous drainage. The periwound was normal. On 3/31/16 at 3:15 p.m., RN #8 and CNA #12 were observed completing a pressure ulcer dressing change to Resident #35's coccyx pressure ulcer. CNA #12 assisted during the dressing change while RN #8 performed the dressing change. RN #8 sat her dressing supplies on a bedside table on top of a barrier. CNA #12 donned clean gloves. RN #8 performed hand hygiene at the resident's bathroom sink for a total of 21 seconds. After performing hand hygiene she went out to her cart to get another size box of gloves. She returned to the room and performed hand hygiene at the resident's bathroom sink for a total of 20 seconds, then donned clean gloves. CNA #12 removed		threshold of 100% is not achieved in an action plan will be developed to ensure compliance.	

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	the resident's pants and brief and turned her onto her right side and RN #8 removed her dressing off her coccyx. RN #8 removed her gloves and performed hand hygiene at the resident's bathroom sink for a total of 18 seconds, then donned clean gloves. She prepared the resident's dressing supplies and cleaned the resident's wound, then removed her gloves. She performed hand hygiene at the resident's bathroom sink for a total of 19 seconds, then donned clean gloves. RN #8 placed a dressing over the resident's wound. RN #8 removed her gloves and performed hand hygiene at the resident's bathroom sink for a total of 25 seconds, then donned clean gloves. She finished Resident #35's dressing change. She removed her gloves and performed hand hygiene at the resident's bathroom sink for a total of 13 seconds, then donned clean gloves and placed a dated piece of tape on the resident's dressing. She removed her gloves and performed hand hygiene at the resident's bathroom sink for a total of 11 seconds. CNA #12 finished getting the resident dressed, then removed his gloves and performed hand hygiene at the resident's bathroom sink for a total of 14 seconds. RN #8 and CNA #12 did not perform hand hygiene by washing their hands with their right palms over their left dorsums with interlaced fingers and vice versa, their			

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	backs of their fingers to their opposing palms with fingers interlocked, rotational rubbing of left thumbs clasped in their right palms and vice versa and rotational rubbing, backwards and forwards with clasped fingers of right hands in left palms and vice versa during any of the times they performed hand hygiene to ensure good friction was used. During an interview on 3/31/16 at 3:39 p.m., RN #8 indicated she should have washed her hands for 40-60 seconds. During an interview on 3/31/16 at 3:45 p.m., CNA #12 indicated he had washed his hands prior to coming into the room to provide care for the resident. He indicated he should wash his hands for 40 seconds to one minute. He indicated he thought he had washed his hands long enough. A current policy titled "Hand Hygiene" dated 2/2010 with a revise date of 12/2015, indicated "...HAND WASHING:.. Wash hands when visibly soiled! Duration of the entire procedure: 40-60 seconds... 3. Wet hands with water 4. Apply enough soap to cover all hand surfaces 5. Rub hands palm to palm 6. Right palm over left dorsum with interlaced fingers and vise versa 7. Palm to palm with fingers interlaced 8. Backs			

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	of fingers to opposing palms with fingers interlocked 9. Rotational rubbing of left thumb clasped in right palm and vice versa 10. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vise versa 11. Rinse hands with water 12. Use clean towel; dry hands thoroughly with a single use towel 13. Use towel to turn off faucet 14. Your hands are now safe... Five moments for Hand Hygiene: Before touching a patient...." 3.1-40(a)(2)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview and record review, the facility failed to ensure staff performed perineal care according to their policy and procedure for a	F 0315	#1: One Resident was listed as being affected by this deficient practice. Resident #71received additional complete personal care/services to prevent urinary tract infections that included the	04/22/2016

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	resident with a history of Urinary Tract Infections for 1 of 3 residents observed for perineal care (Resident #71). Finding includes: On 3/31/2016 at 11:01 a.m., after CNA #3 and CNA #2 transferred Resident #71 into bed, Resident #71's personal care was observed. The resident's recliner chair's seat was observed wet. After the resident was positioned and undressed for personal care, CNA #2 was observed to swipe down each side of the resident's groin and then below the abdominal fold two times. No cleansing of the labia area was observed. After the resident was turned, her personal care was completed, and she was transferred back to her recliner chair. On 4/01/2016 at 4:38 p.m., Resident #71's clinical record was reviewed. The resident's diagnoses included, but were not limited to, Alzheimer disease, Type 2 diabetes, and retention of urine. The annual minimum data set assessment, dated 2/17/2016, indicated the resident was cognitively impaired and required extensive assist of two persons for toileting and was always incontinent of bladder. The physician's order, dated 8/1/2015,		cleansing of the labia on 3.31.2016. Res #71'Srecliner was cleaned and sanitized. CNA #2 was in-serviced on 4.1.2016regarding the proper perineal care policy and procedure. #2: All Residents have the potential to be affected by this deficient practice. All Residents will receive proper and complete perineal care. All facility Nursing staff were in-serviced by the DNS/designee on or before 4.22.2016 in regards to performing proper and complete perineal care. #3: All facility Nursing staff were in-serviced by the DNS/designee on or before 4.22.2016 in regards to performing proper and complete perineal care. All facility Nursing staff will complete a perineal skills validation with the DNS/designee on or before 4.22.2016. The DNS/designee will perform rounds every shift to ensure compliance. #4: To ensure compliance, The DNS/Designee is responsible for the completion of the Perineal care CQI audit tool weekly x 4 weeks, Monthly x 6 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee and overseen by the ED. If a threshold of 100% is not achieved in an action plan will be developed to ensure compliance.	

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	was Macrobid 100 mg two times per day for seven days for a urinary tract infection. The physician's order, dated 8/6/2015, was Levaquin 500 mg one time per day for seven days for a urinary tract infection. The laboratory result for a urine with culture and sensitivity, dated 8/2/2015, indicated the urine was positive for blood, leukocytes, and bacteria. The culture indicated the growth of greater than 100,000 of proteus mirabilis. A current policy titled "Perineal Care"dated 2/2010 with a revised date 3/2012, provided by the Director of Nursing Services (DNS) on 3/31/16 at 5:00 p.m., indicated "Procedure Steps:..2. Provide for privacy. 3. Wash hands...7. Fill wash basin with warm water and have resident check temperature. 8, Assist resident to spread legs and lift knees if possible. 9. Wet and soap folded wash cloth. 10. NOTE: If resident has catheter, check for leakage, secretions or irritation Gently wipe catheter from meatus downward for approximately four inches. Do not rewipe catheter...11. Obtain clean wash cloth. Wet, soap and fold wash cloth. Females: 12. Separate labia and wash urethral area first. 13. Wash between and outside labia in downward strokes. 14. Alternate from side to side-wipe from front to back and from center of			

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	perineum outward. 15. Use a clean area of the wash cloth with each wipe. Do not rewipe area, unless using a clean area of the wash cloth. Change wash cloth as needed. (Proceed to #20)...20. Change water in basin, With a clean wash cloth, rinse area, thoroughly in the same direction as when washing. 21. Gently pat area dry in same direction as when washing...23. Wet and soap wash cloth...25. Change water in basin, With a clean wash cloth, rinse area, thoroughly in the same direction as when washing. 26. Gently pat area dry in same direction as when washing...." 3.1-41(a)(2)			
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure proper cleaning of equipment, failed to ensure beard restraint was worn for 1 of 1	F 0371	#1: Two Residents were listed as being affected by this deficient practice. Residents #49 and #81 were provided with new ice and refreshments during subsequent	04/22/2016

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	employee (Cook #9), failed to ensure hands were washed when indicated for 1 of 1 employee (Cook #9) and failed to ensure ice was passed in a sanitary manner for 2 of 2 residents observed. This deficient practice had the potential to affect 5 of 9 residents who receive pureed diets as well as for 34 of 34 residents who received ice and fluids during the lunch meal service in the main dining room. Findings include: The kitchen tour was completed on 3/28/16 at 9:56 AM with the Certified Dietary Manager (CDM). During the tour the following was observed: 1. On 3/28/16 at 10 a.m., Cook #9 was observed standing at the food prep table with a full beard and no beard restraint. On 3/31/16 at 2:45 p.m., Cook #9 was observed walking through the kitchen by the steam table and food prep area without a beard restraint. 2. The mixer had dried debris on it and CDM indicated at that time it should have been cleaned yesterday. 3. The walk in refrigerator had dried red		meals with staff utilizing proper sanitary manner. CNA #5 was in-serviced on 4.4.2016 regarding the proper ice passing procedure policy and procedure. Cook #9 received and in-service and disciplinary action related to the proper use of hair restraints and hand-washing/glove use on 4/5/2016. The mixer referenced as having dried debris on it was cleaned and covered on 3/28/2016 after the tour was completed. The walk-in refrigerator floor was cleaned on 3/28/2016 after the tour was completed. #2: All Residents have the potential to be affected by this deficient practice. A facility audit was performed by the ED/Designee on or before 4.22.2016 to ensure that all ice scoops were stored and utilized in a sanitary manner and that all Dietary staff were utilizing appropriate hair restraints and hand-washing/glove use procedures. A kitchen inspection was performed on4.1.2016 to ensure that kitchen equipment was stored in a clean and sanitary manner. The ED/designee will perform daily rounds to ensure compliance. #3: All facility staff were in-serviced by the ED/Designee on or before 4.22.2016 in regards to proper use and storage of ice scoops. All dietary staff were in-serviced by the ED/designee on or before 4.22.2016 in regards to the proper use of hair restraints. All	

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	debris on the entrance floor. 4. On 03/28/16 at 11:21 a.m., Cook #9 had touched the edge of the garbage can lid with his gloved hands twice. Cook #9 removed the gloves he had on and without washing his hands, donned a new pair of gloves to get eight pieces of bread bread out for the pureed diets. On 4/1/16 at 1:25 p.m., the CDM indicated, at that time that Cook #9 should have removed his gloves and washed his hands before handling the bread. The Retail Food Establishment Sanitation Requirements dated November 13, 2004, indicated, "...410 IAC 7-24-129 When to wash hands Sec. 129. (a) Food employees shall clean their hands and exposed portions of their arms as specified under section 128 of this rule immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and the following: (6) After handling soiled surfaces, equipment, or utensils...." 5. On 03/28/2016 at 12:11 p.m., CNA #5 was observed scooping ice from the ice bucket into a glass. She placed the ice		dietary staff were in-serviced by the ED/Designee on or before 4.22.2016 in regards to proper hand-washing and glove use related to food handling and preparation. All dietary staff were in-serviced by the ED/Designee on or before 4.22.2016 in regards to the policy and procedure for cleaning and maintaining of kitchen equipment. #4: To ensure compliance, The ED/Designee is responsible for the completion of the Hair Net use CQI audit tool, the Ice Scoop use and storage CQI audit tool, and the Kitchen Equipment sanitation CQI audit tool weekly x 4 weeks, Monthly x 6months, and then quarterly until continued compliance is maintained for 2consecutive quarters. The results of these audits will be reviewed by the CQI committee and overseen by the ED. If a threshold of 100% is not achieved in an action plan will be developed to ensure compliance.	

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	scoop in the bucket and poured iced tea into the glass and delivered it to Resident #49. She returned to the ice bucket, picked up the scoop from within the bucket and scooped ice into a glass, then placed the ice scoop horizontally in the bucket on top of the ice. She poured iced tea into the glass and delivered it to Resident #81. The CNA did not wash or sanitize her hands after delivering the iced tea to Residents #49 and #81. During an interview on 04/04/2016 at 1:15 p.m., the ED (Executive Director) with the Dietary Manager in attendance, indicated the facility had no specific handwashing policy for the meal service. Additionally, the ED indicated he believed while the staff were in "The Zone" (meaning clean and sanitary dining room work area where ice, cups and fluids were located) it was acceptable to leave the ice scoop in the ice bucket when ice and liquids were distributed to the residents during meals. A current policy titled "[Name of Company] Handling Clean Equipment and Utensils" original date 02/02 and revised date 07/15, provided by the ED on 04/04/2016 at 1:20 p.m., indicated, "POLICY: Clean equipment and utensils will be handled in a way to prevent contamination...1. When handling			

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	cleaned and sanitized equipment and utensils, the staff will avoid touching the parts that will come into contact with food or mouth.... " A current policy titled "[Name of Company] Cleaning Ice Machine and Scoop" Original date 02/02 and revised date 05/06, provided by the ED at 1:38 p.m., indicated "POLICY: The ice machine and equipment (scoops) will be cleaned on a regular basis to maintain a clean, sanitary condition...8. Store ice scoop beside or on top of the machine in a clean non-porous container that allows water to drain off (and not pool around the scoop)...." The Retail Food Establishment Sanitation Requirements dated November 13, 2004, indicated, "...410 IAC 7-24-129 When to wash hands Sec. 129. (a) Food employees shall clean their hands and exposed portions of their arms as specified under section 128 of this rule immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and the following: (6) After handling soiled surfaces, equipment, or utensils...." 3.1-21(i)(3)			

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F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.			

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	(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure infection control practices were followed during perineal care for 3 of 3 residents observed during personal care (Residents #10, #63 and #71) Findings include: 1. On 4/1/16 at 11:25 a.m., CNA #1 was observed doing perineal care for Resident #10 who had an incontinent episode of urine and stool. After completing perineal care, CNA #1 proceeded to wipe the stool off Resident #10. He removed his gloves, then he applied new gloves and continued to provide personal care to Resident #10 without performing hand hygiene in between changing gloves. On 4/1/16 at 2:00 p.m., Resident #10's clinical record was reviewed with diagnoses including, but not limited to, dementia without behavioral disturbances, constipation and anemia. During an interview on 4/4/16 at 1:24 p.m., CNA #3 indicated if a resident had a bowel movement, you were to do rectal care, apply new gloves, and complete	F 0441	#1: Three residents (#10, #63, #71) were listed as being affected by this deficient practice.Residents #10, #63 and #71 received subsequent perineal care with the proper infection control practices. Resident#71's and #63's room and belongings were cleaned and replaced or sanitized. CNAs #12, #1, #3, #2, #4 were in-serviced on4.1.2016 regarding proper perineal care, hand-washing, and glove use. #2: All Residents have the potential to be affected by this deficient practice. All Residents will be provided with perineal care utilizing proper infection control practices. All facility Nursing staff were in-serviced by the DNS/designee on or before 4.22.2016 in regards to proper perineal care and hand-washing/glove use #3: All facility Nursing staff were in-serviced by the DNS/designee on or before 4.22.2016in regards to proper perineal care and hand-washing/glove use. All Nursing staff will complete a skills validation with the DNS/designee on or before 4.22.2016regarding proper perineal care. The DNS/designee will perform audits daily to ensure that proper infection control procedures are performed during perineal care.	04/22/2016

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	personal care. During an interview on 4/4/16 at 1:30 p.m., CNA #1 indicated when you provide perineal care to a resident, who had a bowel movement, you provide perineal care, remove the gloves, perform hand hygiene, and apply new gloves to finish personal care. 2. On 3/31/16 at 10:45 a.m., CNA #4 washed her hands and donned gloves. CNA #4 grabbed wipes to provide peri care to the resident. CNA #4 wiped the bowel movement off the resident's bottom. CNA #4 tucked the soiled wipes beneath the resident's dirty brief. CNA #10 took clean wipes with the same gloved hands and cleansed beneath her abdominal folds and in the labial area. CNA #10 helped hold the resident on her side while CNA #3 removed the dirty brief, then helped secure the clean brief. On 3/31/16 at 10:52 a.m., CNA #4 pulled up the residents pants to put them on. CNA #4 pulled up the residents sheet, blanket and repositioned the resident's head onto the pillow with the same gloved hands. CNA #4 opened the resident's cabinet drawer to put the wipes back in the drawer, grabbed the resident's stuffed animals and positioned them underneath the resident's arms on both sides. On 3/31/16 at 10:58 a.m., CNA #4 grabbed the resident's comb and was		#4: To ensure compliance, The DNS/Designee is responsible for the completion of the perineal care CQI audit tool weekly x 4 weeks, Monthly x 6 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters.The results of these audits will be reviewed by the CQI committee and overseen by the ED. If a threshold of 100% is not achieved in an action plan will be developed to ensure compliance.	

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	combing and touching the resident's hair. At that time, CNA #4 indicated she should have removed her gloves and washed her hands after cleaning up the bowel movement. 3. On 3/31/2016 at 11:01 a.m., Resident #71's personal care was observed. With gloved hands, CNA #3 and CNA #2 transferred the resident from her recliner into her bed utilizing the Hoyer lift. The resident's seat of her recliner was observed to be wet and did not have an incontinent pad in her chair. After the resident was positioned in her bed, she was rolled from side to side to undress and remove the resident's brief. Next, CNA #2 with the same gloved hands was observed to wipe down each side of her groin and below her abdominal fold 2 times. After the resident was rolled to her side, CNA #2 cleansed the rectal area. With the same gloved hands, CNA #2 and CNA #3 redressed the resident with a new brief and a pair of pants and transferred her back with the Hoyer lift to her chair. The seat of her chair was observed dry, but had not been cleansed or disinfected prior to the resident being transferred back into the chair due to it was wet when the resident was transferred out of it earlier. CNA #2 removed her gloves, donned a new pair of gloves and proceeded to remake the resident's bed. CNA #3 removed her			

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	gloves, dispensed the paper towel with the lever, and washed her hands. During this handwashing observation, the dispensed towel was observed to continually touch the CNA's uniform. This towel was used to dry her hands. CNA #2 was observed to handwash and with her wet hand, dispensed the paper towel by pulling on the lever, and then, dried her hands with the same towel. A current policy titled "Perineal Care"dated 2/2010 with a revised date 3/2012, provided by the Director of Nursing Services (DNS) on 3/31/16 at 5:00 p.m., indicated "Procedure Steps:..2. Provide for privacy. 3. Wash hands...7. Fill wash basin with warm water and have resident check temperature. 8, Assist resident to spread legs and lift knees if possible. 9. Wet and soap folded wash cloth. 10. NOTE: If resident has catheter, check for leakage, secretions or irritation Gently wipe catheter from meatus downward for approximately four inches. Do not rewipe catheter...11. Obtain clean wash cloth. Wet, soap and fold wash cloth. Females: 12. Separate labia and wash urethral area first. 13. Wash between and outside labia in downward strokes. 14. Alternate from side to side-wipe from front to back and from center of perineum outward. 15. Use a clean area			

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	of the wash cloth with each wipe. Do not rewipe area, unless using a clean area of the wash cloth. Change wash cloth as needed. (Proceed to #20)...20. Change water in basin, With a clean wash cloth, rinse area, thoroughly in the same direction as when washing. 21. Gently pat area dry in same direction as when washing...23. Wet and soap wash cloth...25. Change water in basin, With a clean wash cloth, rinse area, thoroughly in the same direction as when washing. 26. Gently pat area dry in same direction as when washing...." A current policy titled "HAND HYGIENE" dated 2/2010 with a revised date 12/2015, provided by the Director of Nursing Services (DNS) on 3/31/16 at 5:00 p.m., indicated "...HAND WASHING...Wash hands when visibly soiled!..Duration of the entire procedure: 40-60 seconds... 3. Wet hands with water 4. Apply enough soap to cover all hand surfaces 5. Rub hands palm to palm 6. Right palm over left dorsum with interlaced fingers and vise versa 7. Palm to palm with fingers interlaced 8. Backs of fingers to opposing palms with fingers interlocked 9. Rotational rubbing of left thumb clasped in right palm and vice versa 10. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vise versa 11.			

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	Rinse hands with water 12. Use clean towel; dry hands thoroughly with a single use towel 13. Use towel to turn off faucet 14. Your hands are now safe... Five moments for Hand Hygiene: Before touching a patient, Before Clean/Aseptic procedure, After body fluid exposure risk, After touching a patient, After touching patient surroundings...." A current policy titled "Gloves" dated 2/2010 with a revised date of 3/2012, provided by the Executive Director on 4/1/16 at 10:50 a.m., indicated "Procedure Steps: 1. Wash hands 2. Put on gloves...4. Perform procedure...8. Dispose of gloves in waste basket (Note: Use care to not contaminate hands.) 9. Wash hands...." 3.1-18(l)			