

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155331	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/04/2012
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3405 N CAMPBELL RD VALPARAISO, IN 46385
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 26, 27, 28, 29, and 30, 2012 and December 3 and 4, 2012</p> <p>Facility number: 000224 Provider number: 155331 AIM number: 100267700</p> <p>Survey team: Regina Sanders, RN-TC Shannon Pietraszewski, RN (November 26, 27, 28, 29, and 30, 2012 and December 3, 2012) Jan Kulik, RN (November 26 ,2012)</p> <p>Census bed type: SNF: 21 SNF/NF: 75 Total: 96</p> <p>Census payor type: Medicare: 24 Medicaid: 56 Other: 16 Total: 96</p> <p>These deficiencies reflect State findings cited in accordance with 410</p>	F0000	<p>I respectfully request consideration for paper compliance. I have forwarded additional supportive documentation via fax today (12-17-12 at 3:00 p.m.) to 1-317-233-7494. Please reference the attached 2567 as "Credible Allegation of Compliance" for our annual survey conducted on November 26-December 4, 2012. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws. Please feel free to contact us should you have any questions. Thank you. Amber Janeczko, Executive Director</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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	IAC 16.2. Quality review completed on December 6, 2012 by Bev Faulkner, RN			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents received the necessary care and services related to assessments of a dialysis shunt (access for dialysis) for 1 of 1 resident reviewed for dialysis (Resident #72) and failed to ensure a medication was administered through a gastro-tube (feeding tube) for optimal therapeutic benefit, related to a stomach medication (Prevacid) being given without stopping the feeding for 1 of 2 residents observed for gastro-tube techniques (Resident #1).</p> <p>Findings include:</p> <p>1. During an observation on 11/28/12 at 1:42 p.m., Resident #72 had a dressing on his right forearm. The resident indicated it was an access for dialysis. He indicated the staff checked the area, "sometimes." The resident indicated he received dialysis on Tuesday, Thursday, and Saturday.</p>			F0309	<p>F 309 SS=D 1. The AV access fistula for resident #72 was assessed for a thrill and bruit on 12/03/12 with no abnormal findings. Assessments are ordered ongoing each shift. On 11/30/12, the MD for resident #1 was advised of the Prevacid administration and an order was received to change the time of administration of the Prevacid dose to allow the enteral gastric tube feeding to remain off 30 minutes before and after administration of the medication. 2. No other residents have an AV fistula access for dialysis. A listing of all residents ordered PPIs was developed and audited by Care pharmacy and the DON to ensure that all PPIs are administered on an empty stomach. All residents with PPIs have orders to administer on an empty stomach. 3. Licensed nurses will be inserviced by the Staff Development Coordinator or designee by 12/28/12 on the need to assess AV access fistulas of dialysis residents each shift to ensure the presence of a thrill and bruit. Inservicing by the Staff</p>		12/28/2012

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	<p>Resident #72's record was reviewed on 12/03/12 at 10:38 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and end stage renal disease.</p> <p>A Quarterly Minimum Data Set Assessment (MDS), dated 10/25/12, indicated the resident's cognition was intact.</p> <p>A care plan, dated 11/16/12, indicated the resident received dialysis three times a week week. The approaches included to check the shunt site for signs and symptoms of infection, pain or bleeding daily and as needed and to monitor the shunt site by palpating for the thrill (vibration) and listen for the bruit (swishing sound) every shift and to notify the physician of absence of the thrill or bruit.</p> <p>There was a lack of documentation in the Nurses' Notes to indicate the resident's thrill and bruit had been assessed from 10/05/12 at 7:08 a.m. through 10/15/12 at 11:06 a.m.; 10/15/12 at 11:06 a.m. through 10/27/12 at 7:17 a.m.; 10/27/12 at 7:17 a.m. through 11/14/12 at 3:35 a.m.; 11/15/12 at 2:52 a.m. through 11/20/12 at 10:32 a.m., and 11/21/12 at 9:23 p.m. through 12/03/12 at 8:56</p>		<p>Development Coordinator or designee will also address the administration of PPIs on an empty stomach. The nurse involved in the administration of the Prevacid without holding the enteral feeding was retrained on the need to administer PPIs on an empty stomach by the Staff Development Coordinator by 12/18/12. 4. The DON or designee has designed an audit tool for all residents with AV access fistulas and all residents with orders for PPIs to ensure that staff follows policy for assessment for thrill and bruit and that staff administers PPIs on an empty stomach. The DON or designee will audit this information with any new admissions and identified residents weekly for 6 months. The DON presents a report of her findings at the monthly QA/QI meeting. Any negative trends will be addressed with an action plan. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN 12/28/12</p>				

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	<p>a.m.</p> <p>There was a lack of documentation on the Medication and Treatment Administration Records, dated 10/12 and 11/12, to indicate the thrill and bruit had been assessed daily and/or every shift.</p> <p>A Nurses' Note, dated 11/19/12 at 9:24 a.m., indicated, "...Dialysis nurse called to inform that dialysis not successful r/t (related to) nonworking shunt...hospital to be performing shunt repair..."</p> <p>During an interview on 12/03/12 at 10:43 a.m., LPN #1 indicated the assessment of the thrill and bruit should be on the resident's Treatment Administration Records (TAR). LPN #1 indicated the assessments were not on the TARs dated 10/12 and 11/12. She indicated the assessments should be completed every shift and when he returns from dialysis.</p> <p>An undated facility policy, received from the Administrator on 12/03/12 at 11:39 a.m., titled, "Dialysis", indicated, "...The shunt site shall be checked on a daily basis with physician notification for any known or suspected problem...monitor shunt</p>						

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	<p>site on a routine basis..."</p> <p>2. During an observation of a gastro-tube medication administration technique on 11/29/12 at 6:37 a.m., Resident #1 was lying in bed, the resident's tube feeding was infusing at 70 cc (cubic centimeters) per hour.</p> <p>RN #3 turned off the tube feeding, then placed a powdered substance in a glass containing water and then administered the powdered substance and water through the gastro-tube (g-tube), then flushed the g-tube with water. RN #3 indicated the powdered substance administered was Prevacid (stomach medications). RN #3 then administered two more medications, and then restarted the liquid feeding at 70 cc/hour.</p> <p>Resident #1's record was reviewed on 11/29/12 at 8 a.m. The resident's diagnoses included, but were not limited to, cerebral palsy and stroke.</p> <p>The Physician's Recapitulation Orders, dated 11/12, included an order for Prevacid 30 mg (milligrams), give one tablet (dissolve) through g-tube two times a day.</p> <p>A Professional Resource, titled,</p>						

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	<p>"Nursing Spectrum Drug Handbook 2010", indicated, "....Prevacid...take before meals..."</p> <p>An undated facility policy, received from the RN Corporate Consultant on 11/30/12 at 10:39 a.m., titled, "Feeding Tube-Instilling Medication", indicated, "...Residents on continuous or intermittent tube feedings have tube clamped (one hour before and one hour after giving medication) if medication is incompatible with feedings..."</p> <p>3.1-37(a)</p>			

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F0322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview and record review, the facility failed to provide the appropriate treatment and services to a resident with a gastrostomy tube(G-tube) (feeding tube) related to administration of medications 1 of 2 residents with a g-tube observed for medication administration. (Resident #1)</p> <p>Findings include:</p> <p>During an observation on 11/29/12 at 4:42 a.m., RN #3 prepared Resident #1's medication, which included, Atenolol (blood pressure medicine) 25 mg (milligrams), Cogentin (anticholinergic) 0.5 mg, Flexeril (muscle relaxer) 10 mg, Prozac (antidepressant) 20 mg, Lasix (diuretic) 20 mg, and diazepam (antianxiety) 2 mg.</p>	F0322	<p>F 322</p> <p>SS = D 1. On 12/9/12, resident #1 was assessed by licensed nursing staff to ensure that the gastric tube was patent and she did not exhibit any signs or symptoms of complications related to her enteral feeding such as aspiration, gastrointestinal upset, infection or malfunction. There were no negative findings. 2. A listing of all residents with enteral feeding orders was generated from the Sofcare clinical record database on 12/09/12. On 12/09/12, the DON and designees reviewed documentation and assessed these residents to ensure the gastric tube was patent and there were no symptoms of aspiration, gastrointestinal upset, infection or malfunction. There were no negative findings. 3. The Staff Development Coordinator retrained RN#3 on the policy for administering medications via a gastric feeding tube and performed a competency</p>	12/28/2012	

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	<p>RN #3 crushed the tablets separately and left the medication in the plastic bags they were crushed in. RN #3 then entered the room to administer the medications to the resident through the g-tube.</p> <p>RN #3 then administered 50 cc (cubic centimeters) of water through the g-tube. RN #3 did not check for the placement of the g-tube or residual from the feeding tube. RN #3 then purged the water through the g-tube.</p> <p>RN #3 then place a powdered substance directly into the asepto syringe then placed, "10cc" of water into the asepto and purged the medicine and water through the g-tube. RN #3 then flushed the g-tube</p> <p>RN #3 then placed a powdered substance in the asepto, which he identified as Lasix (diuretic), then placed 10cc of water in the asepto. RN #3 then flushed the g-tube.</p> <p>During an interview at the time of the observation, RN #3 indicated he usually puts the powdered medicines in water and mixes them, but he had been showed both ways of medication administration (powder into the asepto).</p>		<p>assessment by 12/18/12. The Staff Development Coordinator also developed an inservice that addresses the policy for administration of medication via a gastric feeding tube and competency assessments for licensed nursing staff and QMAs. The inservice and competencies will be provided/completed by 12/28/12. 4. The DON or designee has developed an audit tool for random surveillance of licensed nursing staff and QMAs that evaluates compliance with practice guidelines and addresses follow-up for any identified training needs. The DON or designees will randomly audit staff compliance with management of enteral feedings on all shifts 5x per week for 6 months. The DON presents a report of her findings at the monthly QA/QI meeting. Any negative trends will be addressed with an action plan. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN 12/28/12</p>				

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	<p>RN #3 then proceeded to give the resident the rest of the powdered medications, separately after mixing the medications in water prior to administering the medications.</p> <p>During an interview after the medications were administered, RN #3 indicated he had checked tube placement earlier when he gave the resident her midnight medications. He indicated he only checks placement of the g-tube one time a shift. He indicated the g-tube could dislodge in between times he checks the placement.</p> <p>An undated facility policy, received from the RN Corporate Consultant on 11/30/12 at 10:39 a.m., titled, "Feeding Tube-Instilling Medication", indicated, "...Attach syringe to end of the tube and insert 20 cc of air. a. check placement and patency by auscultation...Insert medication by syringe slowly into tube..."</p> <p>An undated facility policy, received from the RN Corporate Consultant on 11/30/12 at 10:39 a.m., titled, "Procedure for Administering PO (by mouth) Medications through an Enteral Feeding Tube", indicated, "...If a tablet must be crushed, be sure it is</p>						

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	well pulverized and dispersed in warm or room-temperature water..." 3.1-44(a)(2)			

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F0332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, record review and interview the facility failed to ensure that it was free of medication error rate of 5% or greater related to, 3 medication errors out of 55 opportunities for error, resulting in an 5.45% error rate. This affected 3 out of 15 residents observed for medication pass. (Resident #3, #49 and #129)</p> <p>Findings include:</p> <p>1. On 11/27/12 at 9:14 a.m., RN #1 was observed giving Resident #129 Lantus (insulin) 20 Units.</p> <p>Resident #129's clinical record was reviewed on 11/27/12 at 9:55 a.m. The physician recapitulation orders, dated November, 2012, indicated the resident was to receive 20 Units of Lantus at 7:30 a.m., and 15 Units of Lantus at 5:30 p.m.</p> <p>Interview with RN #1 during this time indicated insulin can be given up to 1 hour before or up to 1 hour after scheduled time.</p>	F0332	<p>F332</p> <p>SS = D 1. Residents #3, #49 and #129 were assessed by the DON on 12/9/12 to ensure no adverse effects were identified related to the timing of the administration of medication on 11/27/12. There were no negative findings. 2. All facility residents have the potential to be affected by the inappropriate timing of medication administration. 3. The Staff Development Coordinator has developed an inservice that addresses the importance of following the Life Care Centers of America policy for medication administration in respect to the timing of the administration of medications. Inservicing has been developed to present to RN#1 and LPN#2 by 12/18/12 and all licensed nurses and QMAs will be inserviced on this policy by 12/28/12. 4. The DON and designees have developed an audit tool to ensure that licensed nursing staff and QMAs adhere to the guidelines for medication administration and specifically to administration of medications within the timeframe of one hour before/after the time that medication is ordered. This audit tool will be used to audit the</p>	12/28/2012

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	<p>2. On 11/27/12 at 11:37 a.m., LPN #2 was observed giving Resident #49 two tablets of Mag 64 (magnesium replacement).</p> <p>Resident #49's clinical record was reviewed on 11/27/12 at 12:30 p.m. The physician recapitulation orders, dated November, 2012, indicated the resident was to receive two Mag 64 tablets at 9:00 a.m., 1:00 p.m., and 5:00 p.m.</p> <p>Interview with LPN #2 during this time indicated the Mag 64 was to be given at 1:00 p.m.</p> <p>3. On 11/27/12 at 11:42 a.m., LPN #2 was observed giving Resident #3 Baclofen 20 mg (milligram) tablet (assist with muscle spasms).</p> <p>Resident #3's clinical record was reviewed on 11/27/12 at 12:40 p.m. The physician recapitulation orders, dated November, 2012, indicated the resident was to receive 20 mg of Baclofen at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.</p> <p>Interview with LPN #2 during this time indicated the Baclofen was to be given at 1:00 p.m.</p> <p>A Professional Resource, titled,</p>		<p>medication administration randomly on all shifts 5x per week for 6 months. The DON presents a report of her findings at the monthly QA/QI meeting. Any negative trends will be addressed with an action plan. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN 12/28/12</p>		

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	<p>"Geriatric Medication Handbook", reviewed on 12/04/12 at 9 a.m., indicated, "...Accurate medication administration...right time..."</p> <p>3.1-25 (b)(9) 3.1-48 (c)(1)</p>			

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F0441 SS=E	<p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, interview and record review, the facility failed to</p>	F0441	F441	12/28/2012			

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	<p>ensure gloves were changed and hands were washed between soiled and clean tasks, for 1 of 1 residents observed for wound care and 2 of 2 meal services observed. (Residents #14, #15, #24, #40, #64, #129, and #148, RN #1, CNA #4, and CNA #5)</p> <p>B. Based on observation, interview and record review, the facility failed to ensure equipment used for a gastrostomy feeding tube was clean, related to dropping an asepto syringe on the floor during 1 of 2 observations of gastrotomy tube medication administrations. (Resident #1 and RN #3)</p> <p>Findings include:</p> <p>A.1. On 12/3/12 at 9:50 a.m., RN #1 was observed changing a dressing to Resident #129 left foot. RN #1 washed her hands and applied gloves. RN # 1 placed dressing supplies on the bed, lowered the resident's bed, removed the resident's shoe, moved the resident's w/c (wheel chair) back and elevated the resident's foot on to the bed, and placed the foot on top of a pad. RN #1 then cut and removed the soiled dressing, and removed her gloves. RN #1 reapplied gloves, opened a 4 x 4 gauze package and sprayed saline</p>		<p>SS = E 1. Residents #1, #14, #15, #24, #40, #64, #129 and #148 are not symptomatic for any signs of infection related to staff hand washing practices. 2. Infection control data analysis on 12/05/12 does not demonstrate any negative outcomes related to staff hand washing practices. 3. The Staff Development Coordinator has developed an inservice that addresses the facility policy for hand washing guidelines. This inservice will be provided to all facility staff by 12/28/12 and will be accompanied by competency evaluations on hand washing for all facility staff. 4. Using the WHO guide to hand hygiene improvement strategies (www.cdc.org), the DON has designed an audit tool for facility audits each shift randomly 5x per week for 6 months. The DON presents a report of her findings at the monthly QA/QI meeting. Any negative trends will be addressed with an action plan. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN 12/28/12</p>		

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	<p>on the gauze over the trash can and proceeded to clean the resident's heel wound. RN #1 opened a new package of 4 x 4 gauze and patted the heel dry. RN #1 removed her gloves, opened a package of Tegaderm with foam dressing and proceeded to reapply new gloves. RN #1 opened a package of cotton tip applicators and dipped them into an ointment container and proceeded to apply the ointment with the cotton tip applicators to the resident's heel. RN #1 applied the Tegaderm with foam dressing to the resident's heel and proceeded to put the unused portion of the Kerlix back into the package, and washed her hands at this time. RN #1 left the room and returned with tape to secure the Kerlix. After securing the Kerlix with tape, RN #1 put the tape in the drawer, applied gloves and removed the resident's foot from the bed. Hand sanitizer was used prior to leaving the room.</p> <p>Interview with RN #1, during this time, indicated she should have washed her hands between changing gloves.</p> <p>Interview with the Infection Control Nurse on 12/3/12 at 12:25 p.m., indicated the last wound care inservice was done in July and it is done yearly. Administration does</p>			

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	<p>spot checks and staff may receive 1:1 inservice if it was found they were not following policy well.</p> <p>A Wound Care Treatment/Dressing skills checklist stapled to the Pressure Ulcer Care policy, dated 10/7/10, was provided by the Infection Control Nurse on 12/3/12 at 12:45 p.m. The check list indicated the following: "...Clean off bedside table work area. Wipe with disinfectant wipes and place table liner...Clean scissors for 60 seconds with alcohol wipes, before taking supplies into the room. Set up the supplies on the clean table liner at bedside...wash hands...cut the tape you will need with your already clean scissors, apply clean gloves, remove soiled dressing and place in small plastic trash bag, place the soiled scissors on one corner of your setup, remove gloves and discard into bag, clean the scissors 60 seconds with alcohol wipes and place on a clean corner of setup area, wash hands again or use alcohol based hand rub, apply gloves, clean wound as ordered from center outward. Place soiled gauze used for cleaning in plastic trash bag. Remove gloves and discard into bag. Apply clean gloves. Apply clean dressing with medication as ordered. Remove gloves and discard into bag..."</p>			

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	<p>A. 2. During an observation of the lunch serving in the Dining Room on the 100 Hall on 11/26/12 at 11:27 a.m., CNA #4 was passing food trays to the residents in the dining room.</p> <p>CNA #4 delivered a lunch tray to Resident #14. CNA #4 moved the resident's wheelchair closer to the table, and touched the resident's shoulder, then prepared the resident's food tray.</p> <p>CNA #4 then went back to the tray cart and obtained lunch tray, delivered the tray to Resident #148 and prepared the lunch meal for the resident. CNA #4 touched the resident and the resident's handles on the silverware, and carried the resident's drinks by the upper rim of the glass.</p> <p>CNA #4 then returned to the tray cart and obtained another tray and delivered it to Resident #15, and opened the food items for the resident.</p> <p>CNA #4, then used the sanitizing wipes on her hands. CNA #4 had not washed her hands or used the sanitizing wipes prior to this.</p> <p>A. 3. During an observation on 11/27/12 at 8:16 a.m. CNA #5 set up Resident #64's breakfast tray in the resident's room. CNA #5 then asked another CNA to help</p>						

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	<p>her lift the resident up in the bed for better positioning. The CNA's used a draw sheet and moved the resident up on the mattress.</p> <p>CNA #5, then left the resident's room, without washing her hands, went to the food cart in the hallway, and delivered a breakfast tray to Resident #24's room.</p> <p>CNA #5 then went into Resident #40's room, put gloves on and stripped the resident's bed, took the dirty laundry to the soiled utility room and washed her hands.</p> <p>An undated facility policy, received from the Director of Nursing on 11/30/12 at 10 a.m., titled, "My 5 Moments for hand Hygiene", indicated, "...This approach recommends health-care workers to clean their hands before touching a patient, before clean/aseptic procedures, after body fluid exposure/risk, after touching a patient, and after touching patient surroundings."</p> <p>An undated facility policy, received from the Administrator on 11/30/12 at 10 a.m., titled, "Personal Protective Equipment", indicated, "...wear appropriate gloves when it can be reasonable anticipated that there may be hand contact with blood or other potentially infectious materials, and</p>			

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	<p>when handling or touching contaminated items or surfaces..."</p> <p>B.1. During an observation on 11/29/12 at 6:37 a.m., RN #3 entered Resident #1's room to administer medications through the resident's feeding tube (g-tube). RN #3 turned the feeding off, disconnected the feeding line from the g-tube, picked up the asepto syringe and then dropped the syringe on the floor. RN #3 did not apply gloves to his hands.</p> <p>RN #3, then reconnected the feeding line, picked up the asepto syringe, and took the syringe to the bathroom and ran warm water over the syringe.</p> <p>RN #3 then returned to the resident's bedside, disconnected the feeding line and started to attach the asepto syringe to the g-tube. RN #3 was then stopped from continuing the procedure.</p> <p>During an interview at the time of the observation, RN #3 indicated the bulb was not sanitized correctly after dropping it on the floor. RN #3 then left the room to obtain a new asepto syringe.</p> <p>RN #3 returned to the room, and without gloves or washing his hands, he disconnected the feeding line from the g-tube, checked for placement of the tube</p>			

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	<p>using the asepto syringe, then administered the resident's morning medications and flushes, and then reconnected the feeding line.</p> <p>RN #3 then rinsed out the asepto syringe and washed his hands.</p> <p>3.1-18(l)</p>			

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