

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155607	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2012
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NAME OF PROVIDER OR SUPPLIER  BETHEL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 6015 KRATZVILLE RD EVANSVILLE, IN 47710
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 23, 24, 25, 26, 2012</p> <p>Facility number-000436 Provider number-155607 AIM number-100275120</p> <p>Survey team: Diane Hancock, RN, TC Vickie Ellis, RN Amy Wininger, RN Barbara Fowler, RN</p> <p>Census bed type: SNF/NF: 59 Total: 59</p> <p>Census payor type: Medicare: 2 Medicaid: 40 Other: 17 Total: 59</p> <p>Sample: 15 Supplemental sample: 1</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective February 25, 2012 to the annual licensure survey conducted on January 23, 2012 through January 26, 2012.</p>	
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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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	Quality review 1/27/12 by Suzanne Williams, RN			

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F0241 SS=D	<p>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.</p> <p>Based on observation, record review and interview, the facility failed to ensure 1 of 6 sampled residents who required total care with bathing and dressing, in the total sample of 15, was cared for in a manner to maintain her dignity, in that CNAs left the resident in her bed with her pants pulled down around her ankles after her morning bath. (Resident #9)</p> <p>Finding includes:</p> <p>On 01/24/12 at 9:00 A.M., CNA #1 and CNA #2 were observed to get Resident #9 up from the bed. CNA #1 was observed to pull back the cover and Resident #9 was observed to be lying in bed with sweatpants down around her ankles.</p> <p>During an interview at that time, CNA #1 indicated, "Third shift washes her in the bed...gets her dressed and leaves her pants down so we can change her before we get her up..."</p> <p>On 01/25/12 at 9:00 A.M., Resident #9 was observed lying in bed with her pants down around her ankles.</p> <p>During an interview with the DoN</p>	F0241	<p><b>F241</b></p> <p><b>It is the practice of Bethel Manor to assure that every resident receives services in a manner that enhances dignity.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>Resident #9 receives services in a manner that enhances their dignity. When resident is prepared for getting up, the resident is dressed appropriately at that time.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b></p> <p>All residents have been reviewed to assure that each service they receive are completed in a manner that enhances dignity.</p> <p><b><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></b></p> <p>All nursing staff has been in-serviced related to assuring dignity when services are provided. The in-service</p>	02/25/2012			

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	<p>[Director of Nurses] on 01/24/12 at 3:00 P.M., the above was reviewed and the DoN indicated, "...not our policy to leave someone's pants down around ankles while in bed."</p> <p>The Ivy Unit Shower List, provided by the MDS [Minimum Data Set Assessment] Coordinator on 01/26/12 at 8:00 A.M., indicated, "3rd shift get ups:...[name of Resident #9]..."</p> <p>3.1-3(t)</p>		<p>includes assuring that residents are fully dressed immediately prior to getting residents up. Nurses will be responsible for assuring that residents receive services in a manner that enhances dignity on their designated shifts via rounds. Please see below for means of monitoring through the QA system.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents to assure that residents always receive services in a dignified manner. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed.</p> <p><b>The date the systemic changes will be completed:</b></p> <p>2-25-12</p>		

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F0280 SS=D	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure the care plan was revised for 1 of 3 residents with a urinary catheter, in the total sample of 15, in that the resident's urologist indicated the need to remove tension from the catheter tubing using a leg strap, and the care plan was not revised to indicate the change. (Resident #11)</p> <p>Finding includes:</p> <p>On 1/24/12 at 10:30 a.m., CNA #3 and CNA #4 were observed while caring for Resident #11. The resident was observed in his recliner chair at the bedside, dressed in a hospital type gown. His catheter tubing was hanging freely, with</p>	F0280	<p><b>F280</b></p> <p><b>It is the practice of Bethel Manor to assure that care plans are revised appropriately when there are changes related to resident care.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>Resident #11 plan of care has been updated to reflect the catheter strap as ordered by the urologist.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b></p> <p>All residents care plans have been reviewed to assure that they</p>	02/25/2012			

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	<p>some tension on the tubing as it exited the penis. The CNAs assisted the resident to transfer to a shower chair, using a mechanical sit-to-stand lift. During the transfer, CNA #3 initially held the catheter bag above the level of the bladder before clipping it to the lift at a position below the bladder. Tension was observed on the catheter tubing, pulling on the penis.</p> <p>The resident was then assisted to the shower room. Throughout the shower, tension was observed on the catheter tubing. After the shower, the urine in the tubing was observed to be blood tinged.</p> <p>Resident #11's clinical record was reviewed on 1/24/12 at 10:25 a.m. Nurses' notes included, but were not limited to, the following: 1/10/12 05:22 [5:22 a.m.] "Noted shaft of penis splitting from urinary meatus down side from catheter erosion. Res. [resident] having increased c/o [complaint of] pain in the area. Call placed to triage, [name of RN] requested fax be sent and they will inform Dr. [name]." 1/10/12 08:21 [8:21 a.m.] "Dr. [name] faxed per triage request re: urology consult r/t [related to] shaft of penis eroding from catheter and increased c/o pain in the area..." 1/10/12 12:55 p.m. "Appointment made</p>		<p>accurately reflect the residents' current condition.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>It is the nurses' responsibility to update and revise the plan of care as changes occur. In addition, the interdisciplinary team will be reviewing all new physician orders each business morning to assure the plan of care has been updated as necessary to reflect the current services received by the resident. The nurses have been in-serviced related to updating the plan of care as services change related to the residents.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to the plan of care and reflection of the resident's current condition and updates with pertinent revisions. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with</p>				

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	<p>with [Urologist name]..."</p> <p>A progress note from the urologist, dated 1/13/12, indicated the following: "Foley [urinary catheter] since May, urethral erosion...Pt. needs to have tension taken off foley catheter where it exits penis...Obtain leg strap..."</p> <p>The record review on 1/24/12 at 10:25 a.m., included a review of the resident's care plan. The care plan had not been updated to include the leg strap and preventing tension on the catheter. Review of the Nurse Aide Assignment Sheets, provided by the Minimum Data Set assessment coordinator on 1/25/12 at 11:20 a.m., indicated the use of the leg strap and preventing tension on the penis had not been added.</p> <p>This information was reviewed with the Administrator and Director of Nurses on 1/25/12 at 2:05 p.m. Both indicated they were aware of the resident's problem with tension on the catheter and the care plan and assignment sheets should have been revised.</p> <p>3.1-35(d)(2)(B)</p>		<p>recommendations as needed.</p> <p><i>The date the systemic changes will be completed:</i></p> <p>2-25-12</p>				

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F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff provided care in accordance with the plan of care for 2 of 13 current residents, in the sample of 15, in that a resident's restraint was not released at mealtime, two persons were not used to turn a resident and the same resident was placed on the right side when she was care planned to stay off of that side. (Residents #9, #26)</p> <p>Findings include:</p> <p>1. During the initial tour on 01/23/12 at 10:20 A.M., RN #1 indicated Resident #9 required total care, was not interviewable, and utilized a seatbelt restraint. At that time Resident #9 was observed to be in the activity room with activity staff nearby, seated in a wheelchair, with a seatbelt restraint intact across her lap. The clinical record of Resident #9 was reviewed on 01/24/12 at 8:30 A.M. The clinical record indicated the diagnoses included, but were not limited to, Alzheimer's and urinary frequency.</p> <p>On 01/23/12 at 12:00 P.M., Resident #9 was observed to be eating lunch with her spouse and the seatbelt restraint was</p>	F0282	<p><b>F282</b></p> <p>It is the practice of Bethel Manor to assure that all services that are provided are completed in a manner that is in accordance with the plan of care.</p> <p><b>The correction action taken for those residents found to be affected by the deficient practice include:</b></p> <p>Resident #9 seatbelt is being release during meal times.</p> <p>Resident #26 is now being repositioned in accordance with the plan of care.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b></p> <p>All residents have been reviewed to assure that they are receiving services in accordance with the plan of care.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>An in-service has been conducted for all nursing staff related to the</p>	02/25/2012			

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	<p>intact across her lap. On 01/24/12 at 12:10 P.M., Resident #9 was observed to be eating lunch with the seatbelt restraint intact across her lap. On 01/25/12 at 12:00 P.M., Resident #9 was observed to be eating lunch with her spouse and the seatbelt restraint was intact across her lap.</p> <p>During an interview with the DoN [Director of Nursing] on 01/25/12 at 3:00 P.M., she indicated, "The restraint should be released at mealtimes."</p> <p>A Care plan, dated 05/13/11, identified a problem of "Use of self-release belt to w/c [wheelchair]..." with interventions that included, but were not limited to, "...release belt...for ...meals..."</p> <p>2. The clinical record of Resident #26 was reviewed on 01/23/12 at 12:00 P.M. The clinical record indicated the diagnoses included, but were not limited to, Alzheimer's and rheumatoid arthritis.</p> <p>The MDS [Minimum Data Set Assessment] dated 11/15/11 indicated, Resident #26 was totally dependent on two staff for bed mobility.</p> <p>On 01/25/12 at 9:30 A.M., LPN #1 was observed to reposition Resident #26 while in bed by pulling on the sheet underneath the resident and rolling the resident onto</p>		<p>importance of following the plan of care when providing services to the residents. The in-service included positioning and release of restraints during supervised meal service. The CNA assignments sheets have been reviewed to assure that they accurately reflect the services to be provided to the residents in correlation with the plan of care. Nurses will be responsible for assuring that all services provided are completed in accordance with the care plans on their designated shifts via observation. Please see below for monitoring as part of the QA process.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to providing services in accordance with the plans of care. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed.</p> <p><b>The date the systemic changes will</b></p>				

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	<p>her right side.</p> <p>During an interview on 01/25/12 at 10:00 A.M., LPN #1 indicated, "When she first fractured, we used two people to turn her, but now we use one."</p> <p>A Care Plan dated 11/09/11 identified a problem of "Resident has a bone fracture of the right humerus..." with interventions which included, but were not limited to, "...when in bed, position on back and left side only, ..."</p> <p>During an interview with the DoN [Director of Nursing] on 01/25/12 at 3:00 P.M., she indicated, "She [Resident #26] should have two people to turn her, she should not have been put on her right side."</p> <p>3.1-35(g)(2)</p>		<p><i>be completed:</i></p> <p>2-25-12</p>	
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F0315 SS=D	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents with a urinary catheter, in the sample of 15, was provided care to prevent complications, in that the resident was observed with tension on the foley catheter after being treated for problems related to the tension. (Resident #11)</p> <p>Finding includes:</p> <p>On 1/24/12 at 10:30 a.m., CNA #3 and CNA #4 were observed while caring for Resident #11. The resident was observed in his recliner chair at the bedside, dressed in a hospital type gown. His catheter tubing was hanging freely, with some tension on the tubing as it exited the penis. The CNAs assisted the resident to transfer to a shower chair, using a mechanical sit-to-stand lift. During the transfer, CNA #3 initially held the catheter bag above the level of the bladder before clipping it to the lift at a position below the bladder. Tension was observed</p>	F0315	<p><b>F315</b></p> <p><b>It is the practice of Bethel Manor to assure that residents receive appropriate services related to urinary catheters.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>Resident #11 is receiving appropriate services related to the urinary catheter. A leg strap is now in place to reduce tension.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b></p> <p>All residents that have urinary catheters have been reviewed to assure that appropriate services are in place.</p> <p><b><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></b></p>	02/25/2012	

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	<p>on the catheter tubing, pulling on the penis.</p> <p>The resident was then assisted to the shower room. Throughout the shower, tension was observed on the catheter tubing. After the shower, the urine in the tubing was observed to be blood tinged.</p> <p>Resident #11's clinical record was reviewed on 1/24/12 at 10:25 a.m. Nurses' notes included, but were not limited to, the following: 1/10/12 05:22 [5:22 a.m.] "Noted shaft of penis splitting from urinary meatus down side from catheter erosion. Res. [resident] having increased c/o [complaint of] pain in the area. Call placed to triage, [name of RN] requested fax be sent and they will inform Dr. [name]." 1/10/12 08:21 [8:21 a.m.] "Dr. [name] faxed per triage request re: urology consult r/t [related to] shaft of penis eroding from catheter and increased c/o pain in the area..." 1/10/12 12:55 p.m. "Appointment made with [Urologist name]..."</p> <p>A progress note from the urologist, dated 1/13/12, indicated the following: "Foley [urinary catheter] since May, urethral erosion...Pt. needs to have tension taken off foley catheter where it exits penis...Obtain leg strap..."</p>		<p>The nursing staff has been in-serviced related to proper care related to catheters. The in-service includes assuring that physician orders are followed appropriately as well as maintaining the urinary drainage bag below the level of the bladder during transfers. The nurses are responsible for assuring that urinary catheter care is completed appropriately on their designated shifts. Please see below for monitoring through the QA process.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that random reviews 5 residents (if applicable) related to urinary catheters. The tool observes transfers and observes services provided to assure they are in accordance with the physicians' orders and the plan of care. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed.</p>				

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	<p>Nurses' notes further included, but were not limited to, the following:            1/13/12 13:25 [1:25 p.m.] "Returned via [name of ambulance company] with wife from [urologist]. NNO [no new orders] rec'd [received]. Progress note rec'd."            1/15/12 21:48 [9:48 p.m.] "Resident catheter observed with bright red colored, with small red clots. Resident stated that he had pulled on it. Stated that it did hurt, but doesn't now. Will cont. [continue] to monitor. CNA stated that when she laid resident down urine in catheter bag was yellow. When she went to empty catheter later that there was red color urine in catheter bag."            1/19/12 03:02 [3:02 a.m.] "Foley cath patent and draining maroon colored urine. Resident has small amount of blood visible in cath. Two small blood clots in draining tubing found..."            1/20/12 18:35 [6:35 p.m.] "Received new orders from Nursing Home Triage regarding resident's gout and swollen scrotum. 1) Cipro 500 mg [milligrams] 1 PO [by mouth] BID [twice a day] X 7 days for epididymitis [infection involving scrotal and penile area]. 2) Bacid 2 tabs po BID X 21 days. [probiotic supplement to prevent antibiotic related diarrhea]..."            1/23/12 01:58 [1:58 a.m.] "Res. yelling 'help help help' CNA reported that res having pain in catheter. Stating 'someone</p>		<p><i>The date the systemic changes will be completed:</i></p> <p>2-25-12</p>				

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	<p>turned my catheter off, I need to see a Dr.' This nurse approached res with some pain medication, asking res to point to pain. Pointed to right groin and said 'it feels like a flame...'"</p> <p>The record review on 1/24/12 at 10:25 a.m., included a review of the resident's care plan. The care plan had not been updated to include the leg strap and preventing tension on the catheter. Review of the Nurse Aide Assignment Sheets, provided by the Minimum Data Set assessment coordinator on 1/25/12 at 11:20 a.m., indicated the use of the leg strap and preventing tension on the penis had not been added.</p> <p>This information was reviewed with the Administrator and Director of Nurses on 1/25/12 at 2:05 p.m. Both indicated they were aware of the resident's problem with tension on the catheter and the care plan and assignment sheets should have been revised.</p> <p>3.1-41(a)(2)</p>			
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F0441 SS=E	<p>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>Based on observation, record review and interview, the facility failed to ensure procedures were followed to prevent potential infection transmission during</p>	F0441	<p><b>F441</b></p> <p><b>It is the practice of Bethel Manor to assure that all personal care and</b></p>	02/25/2012	

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	<p>resident care, for 5 of 7 residents observed during care, in the sample of 15, in that gloves were not changed and hands washed between clean and soiled tasks, gloves were not worn during procedures where blood was involved, and catheters were not handled in a manner to prevent complications. (Residents #11, #55, #9, #26, #2)</p> <p>Findings include:</p> <p>1. On 1/24/12 at 10:30 a.m., CNA #3 and CNA #4 were observed while caring for Resident #11. The resident was observed in his recliner chair at the bedside, dressed in a hospital type gown. His catheter tubing was hanging freely, with some tension on the tubing as it exited the penis. The CNAs assisted the resident to transfer to a shower chair, using a mechanical sit-to-stand lift. During the transfer, CNA #3 initially held the catheter bag above the level of the bladder before clipping it to the lift at a position below the bladder. Tension was observed on the catheter tubing, pulling on the penis.</p> <p>The resident was then assisted to the shower room. CNA #3 put on gloves and washed the resident's arms, legs, front periaerea and catheter tubing, and buttocks and anal area. She then obtained a clean</p>		<p><b>procedures are conducted in a manner that is in accordance with infection control guidelines.</b></p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Resident #11 personal care including bathing and catheter care is being completed within acceptable parameters of infection control</p> <p>Resident #55 blood sugar checks and insulin administration are being provided in a manner within acceptable parameters of infection control.</p> <p>Resident #9 is receiving personal care in accordance with infection control guidelines.</p> <p>Resident #26 is receiving personal care in accordance with infection control guidelines.</p> <p>Resident #2 is receiving services after proper hand washing has occurred</p> <p><b>Other residents that have the potential to be affected have been identified by:</b></p> <p>All residents are now receiving services in a manner that follows acceptable parameters of infection control.</p>				

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	<p>wash cloth, wet it, wrung it out, and washed the resident's face. She did not remove the soiled gloves, do hand hygiene, and put on clean gloves before washing the resident's face.</p> <p>When the bath was completed and the CNA was drying the resident, she stated, "I know I forgot to change my gloves before the peri-care." She was queried about changing gloves between the peri-care and washing the face and indicated she did not.</p> <p>Throughout the shower, tension was observed on the catheter tubing. After the shower, the urine in the tubing was observed to be blood tinged.</p> <p>Resident #11's clinical record was reviewed on 1/24/12 at 10:25 a.m. The record indicated the resident was being treated for epididymitis, an infection involving the scrotal and penis area.</p> <p>2. During the medication pass observed on 1/24/12 at 4:25 p.m., RN #1 was observed to check Resident #55's blood glucose level using a blood glucose monitor. RN #1 used a lancet to prick the resident's finger and obtain a drop of blood. After placing the drop of blood on the test strip, the RN wiped the remaining blood off of the finger using an alcohol</p>		<p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>An in-service has been conducted for all nursing staff related to proper infection control practices. This in-service addresses proper hand washing, proper changing of gloves, and assuring that catheter tubing remains below the level of the bladder. The nurses have been in-serviced related to the proper infection control protocol for blood sugar testing and insulin administration. Nursing Administration will be randomly reviewing staff that is providing services to assure that proper infection control protocol is followed in accordance with facility policies.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 nursing staff members related to following of proper infection control procedures during the provision of services. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance</p>		

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	<p>wipe. The RN wore no gloves during the procedure. She then returned to the medication cart and drew up insulin to administer to the resident. She administered the insulin into the abdomen of the resident. She did not wear gloves during the administration. She used alcohol gel for hand hygiene after the administration.</p> <p>3. During observation of care of 01/24/12 at 9:00 A.M., CNA #1 and CNA #2 were observed to provide perineal care to Resident #9. CNA #1 was observed to doff [take off] gloves and don [put on] new gloves without performing hand hygiene. CNA #1 was then observed to apply a new incontinence product and doff the gloves without performing hand hygiene. CNA #1 was then observed to smooth Resident #9's hair and clothing with bare hands without performing hand hygiene.</p> <p>CNA #1 was then observed to enter the room of Resident #2 at 9:30 A.M., don gloves and give a bath without performing hand hygiene.</p> <p>4. During observation of care on 01/24/12 at 10:15 A.M., CNA #2 was observed to provide incontinence care to Resident #26. CNA #2 was then observed to doff gloves and don clean gloves</p>		<p>Committee will review the tools at the scheduled meetings with recommendations as needed.</p> <p><b>The date the systemic changes will be completed:</b></p> <p>2-25-12</p>				

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	<p>without performing hand hygiene. CNA #2 was then observed to touch the contaminated incontinence pad with her gloved hand and then grasp the controller for the mechanical lift.</p> <p>The policy and procedure for glove use, dated 2/4/10, was provided by the Administrator on 1/26/12 at 8:40 a.m. The policy included, but was not limited to, the following: "Single-use disposable gloves are worn to provide a protective barrier to prevent contamination of the hands when directly touching blood, body fluids, secretions, excretions, mucous membranes and non-intact skin, items contaminated with blood or body fluids, or the cleaning or handling of items contaminated with such..." "Gloves should be removed and hands washed when activity is complete, when the integrity of the glove is in doubt, and between residents." "Gloves are to be changed during a procedure on one resident when moving from one site to another, e.g. from one eye to the other, from wound to wound, after completing peri-care and before adjusting clothing..."</p> <p>3.1-18(b)(1) 3.1-18(l)</p>				

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