

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155790	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/12/2014
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER	STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033
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F000000	<p>This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00154507 and IN00154059.</p> <p>Complaint IN00154059 Substantiated- No deficiencies cited.</p> <p>Complaint IN00154507 Substantiated- Federal deficiencies related to the allegations are cited at F 246.</p> <p>Survey dates : September 8, 9,10, 11 and 12, 2014.</p> <p>Facility number : 012548 Provider number : 155790 AIM number : 201023760</p> <p>Survey team : Michelle Hosteter, RN-TC Janet Stanton, RN Sandie Nolder, RN Gloria Bond, RN Geoff Harris, RN Tracina Moody, RN</p> <p>Census bed type: SNF : 33 SNF/NF : 33 Total : 66</p> <p>Census Payor type: Medicare : 25</p>	F000000	<p>This Plan of Correction is the centers's credible allegation of compliance. 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully requests a desk review for this plan of correction.</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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F000156 SS=E	<p>Medicaid : 19 Other : 22 Total : 66</p> <p>Sample : 6</p> <p>These deficiencies reflect State findings cited in accordance with accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on September 19, 2014.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for</p>				

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	<p>Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State</p>			

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	<p>survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on interview and record review, the facility failed to inform residents their skilled nursing services had ended in a timely manner for 6 or 6 residents reviewed for Notice of Medicare Non-Coverage. (Residents #326, #280, #66, #298, #63 and #28)</p> <p>Findings include:</p> <p>The following residents were given Notice of Medicare Non-Coverage notices that indicated, "The Effective Date Coverage of Your Current Skilled Nursing Services Will End: [date]...</p>	F000156	<p>1. Residents # 326, 280, 66, 298, 63 and 28 have been discharged from the facility.</p> <p>2. All residents eligible for the Notice of Medicare Non-Coverage letter have the potential to be affected.</p> <p>3. The Case Manager has been educated on the Procedure for issuing the Notice of Medicare Non-Coverage letters.</p> <p>4. The ED/Designee will audit Medicare Non-Coverage Letters weekly for compliance with date issued prior to end of service for three months. All findings will be reviewed in the Monthly PI meeting. The PI Committee will determine when 100% compliance is achieved</p>	10/07/2014

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	<p>Please sign below to indicate you received and understood this notice. I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO [Quality Improvement Organization]."</p> <p>Resident #326's record was reviewed on 9/12/14 at 11:16 A.M. He was discharged on 8/29/14 10:30 A.M. His Notice of Medicare Non-Coverage letter indicated his effective date of services ended on 8/28/14. The letter indicated the resident signed the Notice of Medicare Non-Coverage letter on 8/27/14.</p> <p>Resident #280's record was reviewed on 9/12/14 at 11:31 A.M. He was discharged at 10:41 A.M. His Notice of Medicare Non-Coverage letter indicated his effective date of services ended on 8/28/14. The letter indicated the resident signed the Notice of Medicare Non-Coverage letter on 8/27/14.</p> <p>Resident #66's record was reviewed on 9/12/14 at 12:24 P.M. He was discharged on 6/14/14 at 4:26 P.M. His Notice of Medicare Non-Coverage letter indicated his effective date of services ended on 6/12/14. The letter indicated</p>		or if continued monitoring is needed.				

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	<p>the resident signed the Notice of Medicare Non-Coverage letter on 6/13/14.</p> <p>Resident #298's record was reviewed on 9/12/14 at 12:29 P.M. He was discharged on 8/29/14 at 11:00 A.M. His Notice of Medicare Non-Coverage letter indicated his effective date of services ended on 8/28/14. The letter indicated the resident signed the Notice of Medicare Non-Coverage letter on 8/27/14.</p> <p>Resident #63's record was reviewed on 9/12/14 at 12:53 P.M. She was discharged on 7/18/14 at 1:55 P.M. Her Notice of Medicare Non-Coverage letter indicated her effective date services ended on was 7/17/14. The letter indicated the resident signed the Notice of Medicare Non-Coverage letter on 7/17/14.</p> <p>Resident #28's record was reviewed on 9/12/14 at 1:12 P.M. He was discharged from the facility on 8/21/14 at 12:51 P.M. His Notice of Medicare Non-Coverage letter indicated his effective date services ended on was 08/20/14. The letter indicated the resident signed the Notice of Medicare Non-Coverage letter on 8/19/14.</p>			

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	<p>During an interview on 9/11/14 at 5:16 P.M., the Case Manager indicated she was in charge of completing the Notice of Medicare Non-Coverage letters and obtaining the resident's signatures for the residents whose Medicare services were ending. She indicated Residents #280, #298 and #326's skilled nursing services ended on 8/28/14 and they had all been given their Notice of Medicare Non-Coverage letters on 8/27/14. She indicated she had 48 hours prior to the resident being discharged off of the services they were receiving or 48 hours prior to the resident being discharged from the facility to give the Notice of Medicare Non-coverage letter to the resident or the resident's legal representative to sign.</p> <p>The Case Manager indicated the facility did not charge for the day of discharge. She indicated all the residents had a 48 hour notice before skilled services were discontinued because she had them sign the Notice of Medicare Non-Coverage the day before their services ended and they were discharged the next day. She indicated the residents did not receive any therapy after the service end date written on the Non-Coverage letters. The Case Manager indicated she explained to the residents when she had them sign the Non-Coverage letters, that their services</p>			

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	<p>end on the day the letter states the services would end, but they will not be charged for the day of discharge, so the residents did have 48 hours to appeal if they wished to appeal the decision. She indicated this was the way she had always done the Non-Coverage letters.</p> <p>During an interview on 9/12/14 at 9:56 A.M., the Case Manager indicated she was trained by (name of company) in orientation six years ago when she oriented for this job position and was educated in the process of completing the Notice of Medicare Non-Coverage letters.</p> <p>During an interview on 9/12/14 at 10:30 A.M., the Case Manager indicated that Resident #66's date of coverage for current skilled services ended on 6/12/14 and he signed the non-coverage letter on 6/13/14, Resident #63's date of coverage for current skilled services ended on 7/17/14 and she signed the non-coverage letter on 7/17/14 and Resident #28's date of coverage for current skilled services ended on 8/20/14 and she signed the non-coverage letter on 8/19/14.</p> <p>3.1-4(f)(3)</p>			

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F000202 SS=D	<p>483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. Based on record review and interview, the facility failed to ensure discharge information and a physician's order for discharge was included within the resident's closed record for 1 of 30 sampled residents (# 51).</p> <p>Findings include:</p> <p>On 9/9/14 at 1:34 P.M., Resident #51's record was reviewed.</p> <p>The last progress note, dated 6/18/14,</p>	F000202	<p>1. Resident #51 was transferred from an MD appointment to the hospital for direct admission. 2. All residents discharging from the facility have the potential to be affected. An audit of all residents discharged from the facility in the past 30 days has been completed to validate documentation of discharge information is included. 3. Nursing staff have been educated on the policy for Transfer and Discharge. 4. The DNS/Designee will review all discharges for documentation in the clinical record for discharge</p>	10/07/2014			

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	<p>indicated Resident #51 had been refusing her medication on 6/16/14 and 6/17/14 until seen by the cardiologist. The progress note indicated Resident #51's blood pressure was improved, but heart rate was often high. The progress note indicated Resident #51 had a follow up with the cardiologist scheduled for 6/19/14.</p> <p>The last "Health Status Note", dated 6/24/2014, indicated on 6/19/14 at 2:26 P.M., Resident #51 was picked up and transferred by wheelchair van to an appointment with Doctor (name specified). Resident #51's daughter accompanied the Resident.</p> <p>No further nursing, physician orders, progress notes, or therapy notes were found in the resident's chart dated after 6/24/14.</p> <p>On 9/9/14 at 1:52 P.M., information regarding discharge was requested from the Director of Nursing Services (DNS).</p> <p>On 9/12/14 at 9:30 A.M., information regarding Resident #51's discharge was requested from the Executive Director (ED).</p> <p>On 9/12/14 at 4:00 P.M., during the exit conference with ED and District Director</p>		<p>information daily five times a week for three months. All findings will be reviewed in monthly PI meeting and the PI committee will determine when 100% compliance is achieved or if continued monitoring is required.</p>		

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F000246 SS=D	<p>of Clinical Operations (DDCO) no additional information was provided.</p> <p>3.1-12(a)(5)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview and record review, the facility failed to ensure call lights were positioned in a manner to allow residents an opportunity to call for help for 2 of 35 residents observed for call light positioning. (Resident D).</p> <p>Findings include:</p> <p>1. On 9/8/14 at 1:04 P.M., during an observation of Resident D a pressure/touch call light was observed on his lap. When prompted to press the call light, the resident was unable to do so. Upon entering the room CNA #21 prompted the resident to press his call light. CNA #21 was observed to have to place the call light into the resident's hand before the resident was able to press the light.</p>	F000246	<p>1. Resident D continues to use the pressure/touch call light and it is care planned to be placed on his shirt on his chest area when in his bed. The evening and dayshift will attach the call light to his lower chest while in his wheelchair.</p> <p>2. All residents have the potential to be affected. An audit of all residents for positioning of the call light was completed.</p> <p>3. Staff have been educated on Call Lights and positioning of call lights.</p> <p>4. The IDT will complete daily audits to validate call lights are positioned within the resident's reach for three months. All findings will be reviewed in monthly PI and the PI committee will determine when 100% compliance is achieved and if further monitoring is required. An IDR is being requested to</p>	10/07/2014

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	<p>On 9/9/14 at 8:58 A.M., Resident 's pressure call light was observed fastened to the resident's shirt. The resident was prompted to squeeze and activate light, the resident was able to activate the light. At the same time during an interview CNA #20 indicated she would place the call light on his shirt and in his hand everyday and re-orient the resident to feel for the rough side of the light to turn the call light on.</p> <p>During an interview with Resident D on 9/11/14 at 1:55 P.M., the resident shifted in his wheelchair causing his call light to dislodge from his shirt and fall to floor. The resident was unable to locate his call light until the staff entered and secured it to his shirt.</p> <p>On 9/12/14 at 9:22 A.M., during an interview with the Executive Director (ED) and Regional Director of Clinical Operations (RDCO), the RDCO indicated an assessment was completed on 9/11/14 regarding Resident D's call light. The RDCO indicated staff were questioned and the resident wished to have the call light attached to his shirt on his chest area and within his reach. She indicated the night staff attached the call light to his upper chest when he was in bed. The evening and dayshift staff attached the</p>		review the positioning of the patients call light.				

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F000278 SS=D	<p>call light to his lower chest while in his wheelchair. She indicated training of any new staff coming to the floor would be the nursing and CNA responsibility to communicate about the positioning of the call light. The RDCO indicated the resident's care plan and the CNA assignment sheet had been updated to indicate the call light needed to be clipped to resident's shirt.</p> <p>Resident D's record was reviewed on 9/10/14 at 10:54 A.M. The resident's diagnoses include, but was not limited to, debility, Parkinsonism, mild cognitive impairment, glaucoma, and legal blindness. The quarterly Minimum Data Assessment (MDS) dated 8/18/14, indicated Brief Interview for Mental Status (BIMS) of 13 indicating the resident is without cognitive impairment.</p> <p>This Federal tag relates to complaint IN00154507.</p> <p>3.1-3(v)(1)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the</p>				

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	<p>resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to accurately assess the skin and pressure ulcers upon admission and readmission for 1 of 2 sampled residents (#163).</p> <p>Findings include:</p> <p>On 9/11/14 at 10 A.M., Resident #163's record was reviewed. The admission Minimum Data Set (MDS) assessment,</p>	F000278	<p>1. Resident #163 has had a modified MDS submitted to include the accurate pressure ulcers and staging.</p> <p>2. An audit has been completed of all residents with a pressure ulcer for validation of accuracy with pressure ulcers present and staging with the MDS.</p> <p>3. Education has been provided to the MDS nursing staff regarding accuracy with the MDS and pressure ulcers.</p> <p>4. The DNS/Designee will validate</p>	10/07/2014			

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	<p>dated 7/18/14, indicated the resident on admission had one stage 4 pressure ulcer and one unstageable pressure ulcer due to suspected deep tissue injury in evolution. The readmission MDS, dated 8/20/14, indicated the resident had one stage 1 pressure ulcer.</p> <p>The "Weekly Pressure Ulcer Report," for the right buttocks indicated: 7/11/14, stage 4 7/17/14, stage 4 7/25/14, stage 3 8/1/14, stage 4 8/8/14, stage 4 8/13/14, stage 4 8/20/14, stage 3</p> <p>The "Weekly Pressure Ulcer Report," for the coccyx indicated: 7/14/14, stage 2 7/25/14, stage 2 8/1/14, unstageable 8/8/14, unstageable 8/13/14, unstageable 8/20/14, stage 1 8/27/14, stage 3</p> <p>The "wound assessment" from St Vincent outpatient wound clinic, dated 8/20/14, indicated the Resident had a stage 1 wound on the coccyx and a stage 3</p>		<p>the accuracy of the MDS for any resident with a pressure ulcer before submission times 3 months. All findings will be reported to the PI committee monthly and the PI committee will determine when 100% compliance is achieved.</p>		

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F000314 SS=D	<p>wound on her right gluteal fold.</p> <p>During an interview with RN#12 on 9/12/14 at 1:29 P.M., she indicated she had completed the MDS utilizing information from staff assessments, progress notes, Medication Administration Records and Treatment Administration Record. She indicated she did have documentation of the resident's stage 4 pressure ulcer for MDS assessments. She indicated both pressure ulcers should have been on the MDS dated 8/20/14.</p> <p>3.1-31(h) 3.1-31(j)</p> <p>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 nursing staff utilized correct infection</p>	F000314	<p>1.Residents' #92 and #163 pressure ulcers are without infection.</p> <p>2.All residents with a MD order for</p>	10/07/2014	

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	<p>control techniques, related to handwashing, disposable glove use, and sanitation of scissors, to prevent possible cross contamination of a pressure ulcer wound during a dressing change for 2 of 2 residents reviewed for pressure ulcers. (Residents #92 and #163)</p> <p>Findings include:</p> <p>1. During an interview on 9/8/14 at 1:11 P.M., R.N. #4 indicated Resident #92 had a deep tissue injury of the right heel, and a Stage 3 pressure ulcer on the coccyx, both of which developed after the resident was admitted to the facility. She indicated the resident was being seen by the Wound clinic, and the Nurse Practitioner would be in to evaluate and measure the areas. R.N. #4 indicated the coccyx area was improving.</p> <p>The clinical record for Resident #92 was reviewed on 9/10/14 at 9:44 A.M. Diagnoses included, but were not limited to, personal history of fall with a fall at home resulting in a comminuted right intratrochanteric fracture and subsequent surgical repair, osteoporosis, malignant lymphoma lymph nodes multiple sites, history of malignant neoplasm of breast and brain with extensive radiation treatment, history of Lupus, history of fibromyalgia long term use of steroids,</p>		<p>a dressing change have the potential to be affected. A skills validation for Clean Dressing Change and Hand washing has been completed with RN #3, 4, 12 and LPN #10 and #16.</p> <p>3.All Licensed nurses have completed education on Clean Dressing Change, Hand Hygiene and Infection Control Practices to include Skills validation competency.</p> <p>4.The DNS/Designee will observe dressing changes three times a week for 60 days then weekly for 30 days. All findings will be reviewed in monthly PI and the PI committee will determine when 100% compliance has been achieved or if continued monitoring is required.</p>	

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	<p>and depressive disorder,</p> <p>On 9/10/14 at 10:12 A.M., R.N. #3 with the assistance of R.N. #4, were observed while performing a dressing change to the resident's right heel and coccyx areas.</p> <p>R.N. #3 carried the dressing supplies into the resident's room, and after moving some of the resident's belongings off of the top of the overbed table, placed the items in a space she had cleared. While she was washing her hands, R.N. #4 got several paper towels, wet them with water, picked up dressing supplies on table, and wiped about one half to two thirds of top of overbed table. She put supplies back down on the cleaned area.</p> <p>After washing her hands, R.N. #3 put on disposable gloves. She used her gloved hands to raise the bed using the hand control, move the pillows and bedspread, open packages containing 4 X 4 (4 inch by 4 inch) gauze pads and Kerlix wrap gauze. She took a pair of scissors from her uniform pocket, and placed them on the table near the edge that had been wiped with the wet towels. With the same gloves, she picked up a bottle of Betadine, took the cap off, and set the bottle on the table. The nurse removed the dressing covering the resident's right heel. She picked up a 4 X 4 gauze pad,</p>			

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	<p>poured some Betadine on it, and used the pad to wipe the resident's right heel. Without changing gloves, the nurse repeated the process for the resident's left heel. At that point, the nurse took her gloves off and used hand sanitizer.</p> <p>After putting on new gloves, R.N. #3 obtained a thick gauze pad, placed it over the resident's right heel, and wrapped it with the Kerlix gauze wrap. After wrapping some of the Kerlix around the heel to hold the pad in place, she took the scissors from the table and cut the Kerlix, then placed the scissors back onto the table. She reached into her uniform pocket and got a pen to write the date on the heel dressing. She took the gloves off and used hand sanitizer.</p> <p>R.N. #3 and R.N. #4 repositioned the resident and prepared her to have the coccyx area treatment and dressing done.</p> <p>After putting on new gloves, R.N. #3 got a tube of Santyl (a debriding pressure ulcer ointment treatment) out of a plastic bag containing all of the medications to be used for this resident's pressure ulcer treatment. She removed the top from the tube, opened a package of cotton-tipped applicators and took one out, and squeezed a small amount of the ointment onto applicator tip. She laid the</p>			

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	<p>applicator down across the applicator package, with cotton tip and ointment up off of the table, replaced the cap on the Santyl tube and put it back into the plastic bag. The nurse opened a package of 4 X 4 gauze, opened a bottle of Normal Saline and poured some onto the 4 X 4s, picked the wet gauze up and wiped the coccyx area to clean it. The nurse picked up the applicator and applied the Santyl. Next, she took a tube of Calmoseptine (a barrier cream) out of plastic bag and removed the cap. She opened a second package of cotton-tipped applicators, removed one, squeezed a small amount of ointment onto the end of the applicator, and applied around coccyx open area. The nurse returned the tube of Calmoseptine to the bag. Next, the nurse took the tube of Hydrogel (a hydrating dressing) from the bag, opened a dressing package, applied a small amount of gel onto the gauze pad, placed the pad with the Hydrogel over the open area, and covered it with an adhesive bandage.</p> <p>Following the dressing change, R.N. #3 collected and appropriately disposed of the remainder of the paper and gauze items. She picked up the bottles of Normal Saline and Betadine, and put the scissors into uniform pocket.</p> <p>R.N. #3 was followed to the treatment</p>			

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	<p>room. She placed the remaining supplies and medications into the treatment cart. In an interview at that time, she indicated the scissors were still in her pocket. The nurse went back out to the Nurses Station, opened a box containing item to check blood sugars, removed an alcohol wipe package, opened it, took the scissors from her pocket, wiped them, and then put them back into her pocket.</p> <p>In an interview at 10:45 A.M., R.N. #3 and #4, both R.N.'s indicated they did not know of anything they would have changed in the dressing change procedure they had just completed. R.N. #4 indicated a barrier for the table was not used because she had wiped the table with a wet paper towel. R.N. #3 indicated she had other items in her uniform pocket (pens) as well as the scissors.</p> <p>2. On 9/11/14 at 10 A.M., Resident #163's record was reviewed. The minimum data set (MDS) assessment, dated 8/20/14, indicated the resident had the following diagnoses: wound infection, multiple sclerosis, and traumatic brain injury. The physician orders, dated 9/8/14, indicated the resident needed to be placed in isolation for clostridium difficile colitis.</p>						

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	<p>Resident #163's personal care was observed on 9/10/14 from 9:44 A.M., to 11:00 A.M. After CNA #17 and CNA #13 had completed the partial bed bath, the resident was rolled over onto her left side. The resident had been incontinent of bowel movement. A wound vacuum was observed on the resident's right gluteal. A red area was observed on the inner right gluteal next to wound vacuum and up to the labia. A gauze dressing with borders and tape was observed on the coccyx. The tape below the gauze dressing with borders was observed soiled from the bowel movement. RN #12 entered the resident's room to check the wound dressing. RN #12 removed her gloves left the room. No hand washing or hand gel use was observed by RN #12.</p> <p>Next, LPN #10 and LPN #16 entered the resident's room wearing isolation gowns and gloves in order to change the resident's soiled pressure ulcer dressing. LPN #10 first removed the soiled dressing, utilizing a pair of scissors. She then laid the scissors on the resident's bed. An open red area the size of a pencil tip was observed under this dressing. LPN #10 was observed to remove her gloves and wash her hands for 10 seconds before donning pair of</p>			
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	<p>new gloves. In preparation for the dressing change, LPN #10 moved the scissors from the resident's bed to the dresser. LPN #10 was observed to clean the wound with normal saline, removed her gloves and hand washed for less than 10 seconds. After LPN #10 completed the dressing change, she was observed to pick up the used scissors with her bare hands and place them in her uniform pocket. Then, LPN #10 was observed to leave the resident's room with no hand washing and/or hand gel use observed.</p> <p>On 9/10/14 at 12:45 P.M., during an interview, LPN #10 indicated she would wash her hands when entering and exiting a resident's room, including a resident who was in isolation. She indicated she would wear a gown and gloves if the resident was in isolation. She also indicated she would wash her hands by singing happy birthday twice and turning off the water with her arm. For shared equipment, she indicated scissors should be cleaned with bleach or sanitizer after use.</p> <p>On 9/10/14 at 11:00 A.M., R.N. #4 provided a Policy/Procedure titled "Clean Dressing Change," and dated 4/28/10. The "Procedure" section included, but was not limited to, the following:</p>						

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F000315 SS=D	<p>"... 6. Create clean field with paper towels or drape. 7. Put on first pair of gloves. ... 9. Remove soiled dressing. 10. Remove gloves and dispose in plastic bag. 11. Perform hand hygiene and put on second pair of gloves. ... 13. Remove gloves and perform hand hygiene. 14. Open dressing pack. 15. Put on third pair of gloves...."</p> <p>3.1-40(a)(2)</p> <p>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 and record review, the facility failed to ensure a Foley catheter drainage bag was positioned in a manner to prevent the possibility of infection during a Hoyer transfer for 1 of 1 residents observed for Foley catheter</p>	F000315	<p>1. Resident # 163 was treated with Cipro PO for a UTI. 2. All residents with an indwelling catheter have the potential to be affected. C.N.A. #13 has completed education and skills competency validation for indwelling urinary</p>	10/07/2014			

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	<p>positioning in a sample of 1. (Resident #163)</p> <p>Findings include:</p> <p>Resident #163's personal care was observed on 9/10/14 from 9:44 A.M. to 11:00 A.M. After personal care was completed, CNA #13 positioned the Hoyer sling under the resident. As the transfer from the bed to the wheelchair with the Hoyer lift was to begin, CNA #13 was observed to place the Foley bag above the resident's bladder under the lift strap. Yellow urine was observed in the catheter tubing. The Foley bag was lowered and placed in a privacy bag once the resident was seated in her wheelchair.</p> <p>Resident #163's record was reviewed on 9/10/14 at 1:36 P.M. The physician's orders summary, dated 9/1/14, indicated the resident had the following diagnoses: neurogenic bladder, retention of urine, and renal and urethral disorder. The "history and physical," dated 8/12/14, from St. Vincent hospital indicated the resident had a diagnosis of neurogenic bladder. The minimum data set (MDS) assessment, dated 8/20/14, indicated the resident had an indwelling catheter. The Nursing Aide assignment sheet, dated</p>		<p>catheters.</p> <p>3.All nursing staff have completed education on Indwelling Catheter Care.</p> <p>4.The DNS/Designee will complete audits daily of residents with an indwelling urinary catheter to validate positioning of the drainage bag below the bladder for 30 days, then three times weekly for 30 days, then weekly for 30 days. The DNS will report all findings in the monthly PI meeting and the PI committee will determine when 100% compliance is achieved.</p> <p>An IDR is being requested because the patients catheter was equipped with an anti-reflux valve to provide one-way passage of fluids while providing stoppage of reflux flow of any discharge liquids.</p>				

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	<p>8/25/14, indicated the resident had a Foley catheter.</p> <p>Resident #163's "care plan," revised 8/13/14, indicated the resident had an indwelling catheter related to urinary retention and was at risk for urinary tract infections and sepsis. The "care plan" goal was for the resident to not show signs or symptoms of a urinary tract infection. The "care plan" indicated the staff was to change the Foley catheter drainage bag per policy and change the catheter per policy or physician order. The "care plan" indicated the staff should keep the drainage bag below the level of the resident's bladder.</p> <p>The physician order, dated 9/5/14, ordered the staff to change the Foley catheter and then obtain a urine sample for a urinalysis (UA) and culture and stain (C/S).</p> <p>The progress note dated, 8/15/14, indicated the resident had a urinary tract infection and was started on Ciprofloxacin (antibiotic) for 7 days.</p> <p>The policy and procedure for "indwelling</p>						

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F000323 SS=D	<p>catheters," dated 8/31/12, indicated, "If an indwelling catheter is medically justified and inserted, interventions should be in place to reduce the likelihood of an infection." The "indwelling catheters" policy indicated guidelines to prevent catheter associated infections included, but were not limited to the following: indwelling catheters are used only when medically necessary, good hygiene was maintained at the catheter-urethral interface, and staff performed hand hygiene before and after any contact with or manipulation of the catheter, catheter tubing or apparatus.</p> <p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure the safety of a resident during personal care in the prevention of a fall for 1 of 3 residents reviewed in a sample of 8. (Resident #163).</p> <p>Findings include:</p>	F000323	<p>1.Resident #163 sustained a small hematoma to the left temporal area when she slid off the air mattress during care. Resident #163's plan of care was revised to include assist of 2 staff with care and transfers.</p> <p>2.The C.N.A. is no longer employed at the facility. All residents requiring assist with transfers and care have the</p>	10/07/2014			

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	<p>Resident #163's record was reviewed on 9/10/14 at 1:36 P.M. The minimum data set (MDS) assessment, dated 7/18/14, indicated the resident had the following diagnoses: multiple sclerosis, traumatic brain injury, and history of falls.</p> <p>The MDS, dated 7/18/14, indicated the resident had total dependence with bed mobility, transfer, toileting, personal hygiene, and bathing. The MDS indicated the status of total dependence required the resident to have two or more people to physically assist the resident. The MDS also indicated the resident had functional limitations with range of motion in both the upper and lower extremities on both sides.</p> <p>During an interview on 9/12/14 at 1:29 P.M., the executive director (ED) indicated the staff used the MDS assessments to help determine the amount of the assistance necessary to provide care for a resident.</p> <p>During an interview on 9/9/14 at 11:10 A.M., LPN #10 indicated the resident had a fall within the last 30 days and sustained injuries.</p> <p>During an interview on 9/11/14 at 4:38 P.M., Resident #163 indicated she had a fall while at the facility. Resident #163</p>		<p>potential to be affected. All residents were reviewed to ensure plan of care reflected appropriate assist for care and transfers.</p> <p>3.All nursing staff have been educated on Positioning a resident and Accidents and Supervision to prevent accidents.</p> <p>4.The DNS/Designee will complete daily rounds, 5 times a week, on each unit to validate safety interventions are in place to prevent accidents for 30 days, then three times a week for 30 days then weekly for 30 days. The DNS will report all findings to the PI committee and the PI committee will determine when 100% is achieved or if continued monitoring is required.</p>				

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	<p>indicated, " It wasn't the aide's fault, he didn't have help." The resident indicated she had an air mattress and rolled out of bed during care while being assisted by one certified nursing assistant (CNA). The resident indicated she received a bump and cut on her head. The resident indicated, "Before my fall I would have two people to assist me for the Hoyer lift transfer but otherwise only one to help assist me." The resident indicated after her fall two staff members have assisted with her transfer and personal care.</p> <p>The "CNA incident interview " report, dated 8/12/14 at 7:47 P.M., indicated the physician and CNA had been in the resident's room and the resident had been rolled on her left side. Then the physician requested the CNA leave the room to get the nurse. The CNA returned to the resident's room with supplies to perform patient care. The resident was on her back and the physician was not in the room. The CNA rolled the resident onto her right side and started to perform personal care. The incident report indicated, "The CNA rolled the patient forward a little more resulting in the patient rolling out of the bed." The incident report indicated the resident fell on the floor and hit her head.</p> <p>The progress note, dated 8/15/14,</p>						

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	<p>indicated, "Pt (patient) was in bed being cleaned up by a CNA when she rolled out onto the floor and hit her head on a chair." The progress note indicated the fall was witnessed and the resident was sent to the emergency room by the physician. The progress note, dated 8/22/14, indicated, the resident was recently sent to the hospital after she fell out of bed and had a small hematoma to the left temporal area.</p> <p>A "Rapid In-service", dated 8/12/14, was provided by the staff development coordinator (SDC). The "Rapid In-service" summary indicated CNAs were required to review the updated daily CNA sheet and to be familiar with the number of staff assistance required for a resident. The "Rapid In-service" indicated, "If two people are indicated, than two CNAs need to be in the room."</p> <p>The policy and procedure entitled, "Accidents and Supervision to Prevent Accidents," dated 04/28/11, indicated, "the facility staff must identify hazards and risks; evaluate and analyze circumstances and situations that may be a hazard or risk for accidents; monitor and modify to ensure that interventions are implemented correctly and consistently, evaluate the effectiveness of interventions, and modify or replace</p>						

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F000329 SS=D	<p>interventions as necessary."</p> <p>The policy and procedure entitled, "Positioning the Resident," dated 4/28/14, indicated the following must occur when positioning a resident: "determine the resident's ability to reposition herself, develop or update care plan as needed to address residents that are immobile and/or has limited activity levels, communicate to care givers initiation of interventions including nursing report, morning stand-up meeting, nurse's aide assignment sheet, care plan". The policy indicated when positioning a resident the staff should "obtain help when needed". The policy indicated when a resident was turned and cannot assist the nursing assistant should do the following: " Put the side rail up on the far side of bed, raise the bed to a comfortable working height, lower the backrest and footrest, adjust arms, adjust legs, roll gently-placing one hand on resident's hip, the other on the shoulder, flex the resident's upper knee to keep resident from rolling on their abdomen, and support with pillows."</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM</p>				

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	<p><b>UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to monitor for use of non-pharmacological interventions in the prevention of resident calling out and yelling for 1 of 5 residents reviewed for unnecessary medications. (Resident #58).</p> <p>Relevant Findings:</p> <p>Resident #58's record was reviewed on 9/10/14 at 10:54 A.M. The resident's diagnoses include, but was not limited to, Parkinsonism, mild cognitive impairment, glaucoma, and legal</p>	F000329	<p>1. Resident #58 Non-pharmacological interventions related to behavior management are being monitored and documented according to policy and procedure</p> <p>2. Other residents that have non-pharmacological interventions related to behavior have the potential to be affected by this practice. The Behavior Monitoring flowsheets have been reviewed for these potentially affected residents. Education on the documentation requirements for non-pharmacological interventions has been provided to the nursing staff</p> <p>3. The Licensed nursing staff have been educated by the</p>	10/07/2014

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	<p>blindness. The quarterly Minimum Data Assessment (MDS) dated 8/18/14, indicated a Brief Interview for Mental Status (BIMS) of 13, indicating the resident was without cognitive impairment.</p> <p>The physician's orders were as follows: The physician order, dated 5/23/14, was Seroquel 25 milligrams (mg) by mouth at bedtime for delusional disorder; The physician order, dated 7/8/14, was Vericare for psychiatric evaluation and treatment. The physician order, dated 7/8/14, was increase Seroquel to 37.5 mg by mouth at bedtime.</p> <p>Resident #58's nursing care plan indicated the following: A) Resident exhibiting some delusions (i.e., thinks he is on a cliff, etc), history of delusions related to diagnosis of Parkinson's. Goals: Resident will be easily calmed/redirectioned if experiencing delusions. Interventions: 1) Attempt to redirect with snacks, activities of choice, call to wife. 2) Attempt to reorient resident PRN (as needed) but do not argue with resident that delusions, etc., are false as this will increase agitation. 3) Observe for signs and symptoms of delusions and report any to nursing, family, SSD, MD as appropriate. 4)</p>		<p>SDC/Designee on documenting non-pharmacological interventions related to behavior management.</p> <p>4. Social Services/designee will audit the Behavior Monitoring Flowsheets weekly 3 times/week for 30 days, then weekly for 30 days and then monthly for 30 days. Social Services will report all findings to the monthly Performance Improvement committee and the Performance Improvement committee will determine when 100% is achieved or if continued monitoring is required.</p> <p>An IDR is being requested because the facility was monitoring the usage and effectiveness of the non-pharmacological interventions for this patient.</p>				

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	<p>Psychiatric services as ordered.</p> <p>B) Resident has episodes of yelling out at night asking for the time or wanting to talk, calling out his past roommates name. Resident is legally blind and is unable to identify objects, noting difficulty with sleep at nighttime. Goal: Resident will be easily calmed/redirected when calling out in the middle of the night. Interventions: 1) Anticipate and meets resident's needs, such as hunger, thirst, toileting, or pain. 2) Assist and encourage resident up to wheelchair when awake at night calling out repeatedly to sit by nurses station. 3) Caregivers to provide opportunity for positive interaction, attention. Address his needs when calling out at night. 4) Encourage the resident to stay awake during the day more. 5) Inform the resident with time of night with each contact when awake and calling out. 6) Notify MD/family of challenges with sleep patterns. 7) Provide resident calm environment and comfort at night. 8) Provide reassurance at night and check on him frequently. 9) Support family visit and visitors during the day.</p> <p>The Physician's Progress Note, dated 5/23/14, indicated anxiety/delusional disorder.</p> <p>Vericare progress note dated 7/8/14, the</p>						

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	<p>chief complaint indicated resident had been yelling out at night and was hard to redirect. Seroquel was started on 5/23/14 which has been minimally helpful. Patient was noted to have very fine hand tremors.</p> <p>The NP's notes, dated 7/9/14, indicated Resident #58's Seroquel increase was to assist with nighttime delusions.</p> <p>The progress note were as follows:</p> <p>6/1/14 at 5:00 A.M., indicated resident having occasional episodes of calling out for his past roommate. When reminded by staff of roommate not being there anymore, resident indicated "I don't know why I say the things I do, I'm trying not to, but can't help it." Staff provided resident with headphones and CNN on his television at his request.</p> <p>6/27/14 at 3:54 A.M., indicated resident restless and calling for help. When asked what he wanted, he was unable to indicate what he needed. Resident reoriented to time and provided his headphones and TV turned to CNN at his request.</p> <p>7/6/14 at 4:59 A.M., indicated resident restless and having difficulty getting to sleep at the beginning of the shift. Staff</p>			

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	<p>reoriented resident to time and circumstance. Once clarified, resident quieted and staff indicated he appeared to be sleeping.</p> <p>8/8/14 at 2:47 A.M., indicated resident yelling "help" at start of shift. Staff addressed residents needs. Resident indicated, "I'm trying to stop yelling, I don't know why I do that." Resident indicated he did not need anything. Staff indicated he then was able to fall asleep.</p> <p>8/16/14 at 3:22 A.M., indicated resident yelling out instead of using call light. Resident had episode of incontinence. Staff indicated when resident was cleaned up and repositioned he went to sleep.</p> <p>8/22/14 at 6:21 A.M., indicated resident awake in the night yelling for help, but indicated he did not need anything. Resident indicated he wants to stop yelling, but he has no control. Staff indicated resident continued to yell out even while staff was hands on providing care.</p> <p>9/2/14 at 2:03 A.M., indicated resident yelling out at the beginning of the night shift. Staff assisted resident with wants and needs.</p>			

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	<p>Review of the resident's "BEHAVIOR MONITORING FLOWSHEET" for June, July, August, and September indicated the monitoring of the behavior of sleeplessness, yelling out at night and delusions. The "Suggested Interventions" were: 1. Anticipate and meet needs such as thirst, hunger, toileting, pain. 2. Encourage resident up in wheelchair when awake at night at nurses station. 3. Encourage resident to stay awake during day more. 4. Provide calm environment and comfort at night. 5. Provide reassurance and check on resident frequently.</p> <p>For June 2014 behavior monitoring flowsheet, no information was indicated on 6/1/14. No behavior was indicated on 6/12/14 and 6/27/14. On 6/17/14 during the evening shift the resident demonstrated two times the above behaviors with intervention number 5 was successful times two. On 6/26/14 during the dayshift the intervention number 5 successful times two.</p> <p>For July 2014 behavior monitoring flowsheet, no information was indicated on the dayshift of 7/4/14, 7/9/14 and 7/22/14; on evening shift of 7/3/14 and 7/15/14; on night shift on 7/4/14. On nightshift on 7/6/14 instructions indicated to see the nurses notes.</p>			

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	<p>For August 2014 behavior monitoring flowsheet, on the evening shift of 8/21/14, four times the behavior was demonstrated with interventions of 1 to 5 successful; on night shift on 8/3/14 instructions were to see nurses notes. On 8/7/14 for two behavioral times, 8/9/14 for two behavioral times, 8/14/14 for two behavioral times, 8/17/14, 8/19/14, 8/21/14, and 8/28/14 for four behavioral times each date, and 8/30/14 for three behavioral times, interventions number 1 and number 5 were successful. "Additional Behavior Details" indicated on 8/21/14 at 4:00 P.M., the resident was yelling out "hello, hello". Successful interventions were resident toileted, snack and fluids provided "pain med PRN (as needed)."</p> <p>For September 2014 behavior monitoring flowsheet, no information was indicated for 9/1/14 evening shift. On 9/2/14 for four behavioral times, on 9/3/14 for six behavioral times, on 9/9/14 for three behavioral times, interventions number 1 and number 5 were successful. On 9/5/14 three behavioral times were indicated with unclear intervention results.</p> <p>On 9/12/14 at 12:33 P.M., during an interview with the Social Service Director (SSD), the Executive Director</p>			

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	<p>(ED), and the Regional Director of Clinical Operation (RDCO) present, the SSD indicated identified behaviors were documented either on the behavior monitoring flowsheet or in the progress notes, which RDCO confirmed. The SSD indicated the Nurse Practitioner (NP) reviewed the behavior monitoring flowsheet and the progress notes during her assessment to make recommendations for resident's care. The SSD indicated the increase of the Seroquel on 7/8/14 was made by the NP after the psychiatric evaluation on 7/8/14. RDCO indicated the behaviors were decreasing following the initiation of the low dose Seroquel in May, and the NP felt a slight increase would further benefit the resident's symptoms.</p> <p>On 9/12/14 at 1:45 P.M., during an interview LPN #19 indicated if one would witness a behavior by Resident #58, she would attempt to re-orient the resident and provide alternate activities. She indicated if the behavior continued she would give a PRN medication if a PRN medication was ordered for the resident's behavior. She indicated she would document the behavior and the intervention in the resident's progress notes.</p> <p>3.1-48(a)(3)</p>				

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F000371 SS=F	<p>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</p> <p>Based on observation, interview and record review, the dietary staff at the facility failed to hand wash for the required amount of time and failed to use gloves according to the guidelines to assure infection control was observed for 4 of the 4 dining areas observed serving meals. In addition a dietary assistant was observed not sanitizing a food temperature thermometer after using it and another failed to follow infection</p>	F000371	<p>1. Residents #132, 163, 165, 172, 176,200,217,311,315 &amp; 325 were not affected by the noted infection control practices.</p> <p>2. All other residents have the potential to be affected by these practices. The following employees have been re-educated on proper handwashing &amp;/or gloving procedures according to policy and procedure: DA #1, DA#2,DA#6, DA#18, DA #23, ST #22, RN#25, LPN #24 &amp; CNA#17. DA #1 has</p>	10/07/2014

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	<p>control guidelines during a table setting observation. These deficient practices had the potential to affect 65 of 66 residents currently reciting in the facility and being served meals by the dietary staff.</p> <p>Findings include:</p> <p>1. On 9/8/2014 at 8:12 A.M., a breakfast service observation was conducted on the 2000 hall dining area. At this time Dietary Assistant (DA) #2 was observed with the same gloves on; cracking open eggs to cook and cooking them, touching a tray, touching a bread item and putting it in the toaster and then turning around and serving a few trays. DA #2 did not sanitize her hands or change gloves during this time.</p> <p>On 9/10/2014 at 12:30 P.M., a lunch service observation was conducted on the 2000 hall dining area. At this time, DA #1 was observed rinsing his hands for 3 seconds, drying his hands on a couple paper towels and then putting gloves on. At this time, the interim Dietary Manager was observed reminding DA #1 to use soap when washing his hands. DA #1 was observed going back and using soap to wash his hands, taking 7 seconds to wash his hands, drying them and putting gloves on. After DA #1 served some</p>		<p>been re-educated on proper procedure for table setting. DA#8 has been re-educated on proper cleaning of thermometers after taking food temperatures and documentation requirements of the temperatures.</p> <p>3. Facility staff to include contract employees, have been re-educated on proper handwashing and gloving procedure by the SDC/Designee. The Dietary staff have been re-educated on proper table setting procedure, cleaning of thermometers and documentation of food temperatures by the Dietary Manager.</p> <p>4. The SDC/Designee will conduct rounds 5 times a week to audit for proper handwashing and gloving procedures for 30 days, then 3 times weekly for 30 days and then weekly for 30 days. Any observation of non-compliance will result in immediate corrective action. The results of these audits will be presented to the Performance Improvement Committee monthly until 100% has been achieved or if continued monitoring is required. The Dietary Manager/Designee will audit daily the food temperature logs for completeness and proper cleaning of thermometers after obtaining a food temperature for 30 days, then 3 times weekly for 30 days then weekly for 30 days. The results of these audits will be presented to the monthly Performance Improvement Committee until 100% is achieved or if continued monitoring is required.</p>		

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	<p>residents and touched the cabinets, the interim Dietary Manager instructed him to wash his hands. This time DA #1 washed his hands for 10 seconds, dried his hands and put gloves on. Then he continued preparing plates of food to serve.</p> <p>2. During a food temperature check observation on 9/11/14 at 1:15 P.M., DA #8 was observed taking the temperature of chicken, then wiping the thermometer with a paper towel and putting the thermometer back into the thermometer sleeve.</p> <p>At this time, DA #8 was observed continuing to collect the food without documenting the temperature.</p> <p>The "Food Temperature Measurement," policy and procedure, dated 2/28/14 was reviewed on 9/12/14 at 3:30 P.M. The procedure indicated the following, "...Immerse the thermometer stem into clean sanitizing solution at the proper concentration and contact time recommended by the sanitizer manufacturer. Air dry before using. Use a 'foodservice compliant' alcohol prep pad/wipe... Record the temperature reading of each food measured...."</p> <p>3. On 9/10/14 at 1:40 P.M., Dietary Aide</p>			

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	<p>#1 was observed placing glassware and center pieces on the seats chairs in dining room. Next he was observed to position tablecloths over the tables by fanning the tablecloth on the table. He returned the glassware to the clean tablecloth. A second tablecloth was positioned on a another table in the same manner.</p> <p>During an interview on 9/11/14 at 7:00 P.M., the Regional Dietary Manager indicated he was unable to locate a policy and procedure on table setting. He indicated what Dietary Assistant #1 was observed doing was not common practice and the dietary staff was surprised to hear such practice was carried out. The tablecloths are placed on the tables and table wear is not put on the chairs.</p> <p>4. On 9/8/14 from 7:47 A.M. to 8:20 A.M. in the dining room, breakfast was observed. The Dietary Assistant #18 was observed to wash his hands and donned a pair of gloves. After he grabbed bread from a package and placed this bread in the toaster, he was observed to serve up cooked cereal and brown sugar with the serving spoons, followed bacon with tongs for the same resident. Then, Dietary Assistant #18 removed the toast out of toaster with the same gloved hands and placed it on plate with bacon. Next,</p>			

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	<p>Dietary Assistant #18 continued to serve food for the residents ( #176, #165, and #217) in the dining room without changing gloves.</p> <p>On 9/8/14 at 8:13 A.M., CNA #17 was observed to wash her hands with soap and water for 13 seconds then delivered a room tray to Resident #328.</p> <p>At 8:15 A.M. Dietary Assistant #18 was observed to pull bread out of the bread package with gloved hands and put the bread in the toaster, and continues to serve the eggs with the serving spoon. When the toast was ready, Dietary Assistant #18 used the same gloved hands to remove the toast out of toaster and placed the toast on the plate and cut the toast in half. Then, Dietary Assistant #18 prepared room meal trays for residents (#200, #325, #311, #315, #132, #172, and #163) without changing gloves during this observation.</p> <p>On 9/10/14 at 12:28 P.M., during an interview CNA #17 indicated she washed her hands after every third plate of food or meal tray she delivered during meals.</p> <p>5. On 9/8/14 at 8:23 A.M., during dining observation, Dietary Aide #2 was observed serving food on the 2000 hall.</p>						

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	<p>She was observed handwashing for 12 seconds and return to serving food to the residents. She was observed a second time washing her hands for 5 seconds without using soap and returning to serving food to the residents.</p> <p>On 9/11/14 at 1:50 P.M., during an interview Dietary Aide #50 indicated the procedure for handling the food was to wear gloves during serving. He indicated he is to change gloves and wash hands for every 5 plates. He indicated the handwashing procedure was to wash with soap for 20 seconds and turn the water off using a paper towel.</p> <p>6. On 9/8/14 at 7:39 A.M., the breakfast meal was observed being served in the 4000 unit dining room. The following was observed:</p> <p>At 7:40 A.M., Speech Therapist (ST) #22 washed her hands under running water for five seconds then poured orange juice from a multi use container for a resident.</p> <p>At 7:53 A.M., ST #22 washed her hands under running water for 10 seconds then went into a resident's room.</p> <p>At 8:03 A.M., ST #22 washed her hands under running water for 15 seconds then</p>						

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	<p>she sat down next to a resident at the dining room table.</p> <p>On 9/11/14 at 12:34 P.M., the lunch meal was observed being served in the 4000 unit dining room. The following was observed:</p> <p>At 12:43 P.M., the Dietary Aide (DA) #23 washed her hands for 10 seconds then donned clean gloves and began serving food.</p> <p>At 12:38 P.M., LPN #24 washed her hands for 10 seconds.</p> <p>At 12:41 P.M., RN #25 washed her hands for 10 seconds then served trays.</p> <p>At 1:00 P.M., the DA #23 removed her gloves, reached into a cabinet to get salt and pepper squeeze bottles out of the cabinet, washed her hands for 10 seconds, donned clean gloves and began serving food again.</p> <p>At 1:06 P.M., the DA #23 removed her gloves, reached into the cabinet, removed a bowl, washed her hands for 9 seconds, donned clean gloves and finished serving lunch.</p> <p>During an interview on 9/12/14 at 10:04 A.M., District Director of Clinical Operations indicated she expected all</p>						

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	<p>facility staff to wash their hands for 20 seconds.</p> <p>7. A. On 9/8/14 at 7:08 A.M., the 5000 Hall "Temperature Log and Checklist" in the "5000 Documentation and Information Book" was reviewed. There were no Breakfast or Dinner food holding temperatures recorded for 9/2 and 9/3; no Breakfast or Lunch food holding temperatures recorded for 9/4; and no Dinner food holding temperatures recorded for 9/6 and 9/7.</p> <p>The breakfast meal food on 9/8/14 had not yet been delivered to the unit kitchenette, and no holding temperatures were yet recorded.</p> <p>At 7:34 A.M., the interim Dietary Manager came into unit kitchenette, got the log book, and began to write in it. After he left, the log book was checked. The holding temperatures for three hot food items were written down on the log, however none of the breakfast foods had been delivered to the kitchenette at that time.</p> <p>At 7:36 A.M., the cart with hot food for</p>				

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	<p>the steam tables was brought to kitchenette.</p> <p>On 9/10/14 at 11:00 A.M., the interim Dietary Manager was observed writing in the log for the 5000 Hall. He indicated he had written in the name of the hot entrees and vegetables. At that time, copies of the food temperature log from 9/2/14 were requested. The Administrator then entered the kitchenette area, and asked about concerns. He was informed about the multiple meal food holding temperatures from 9/2/14 that were not documented in log. In an interview at that time, the interim Dietary Manager indicated he had just been in facility a week, and had just instituted the food temperature logs on each unit. The Administrator indicated he thought the previous Dietary Manager had kept a food temperature log in the main kitchen, but was not sure it included the unit kitchenette food holding temperatures.</p> <p>On 9/10/14 at 3:00 P.M., copies of food holding temperature logs for 9/2 through 9/8 were provided by the interim Dietary Manager. Additional food holding temperatures had been added for the dates and meals previously missing.</p> <p>During an interview on 9/10/14 at 3:25</p>						

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	<p>P.M., the Administrator indicated that the Dietary Department and its staff were from a contracted company. He indicated he was aware the copies of the food holding temperature log were to be provided as they were originally written.</p> <p>8. On 9/8/14 from 7:08 A.M., in the 5000 Hall kitchenette, the following was observed: At 7:36 A.M.--the cart with hot food for the steam tables was brought to kitchenette. At 7:38 A.M.--Dietary Assistant #6 opened the doors to the "hot" cart containing the hot food items for the breakfast meal. At 7:39 A.M.--he placed the food bins from the cart onto the steam table, then washed his hands, and put on gloves. After touching multiple surfaces and kitchen items, he took the gloves off, and put another pair without washing his hands. 7:41 A.M.--Dietary Assistant #6 was observed to touch pans, drawer and cabinet handles, and the electric griddle. He opened wrapped utensils and took out a brush for the melted butter, and a ladle for the pancake batter. He took his gloves off and started to leave the kitchenette, then turned and unplugged the griddle. 7:44 A.M.--Dietary Assistant #6 returned</p>						

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	<p>to the unit, and washed his hands. He started to put on gloves, but before he did, he plugged in griddle. He completed putting on the gloves, shuffled through multiple paper menus that had been laying on the counter, picked one out, and took it over to a resident to get her selection for breakfast. He came back to the kitchenette and plugged in the toaster and another electrical piece of equipment. He used the brush, covered with liquid butter, to coat the griddle, then ladled pancake batter onto griddle. Continuing to use the same gloves, he opened upper and lower cabinet doors, got out bowls, and a knife (which he rummaged around under table cloths in lower cabinet for). He placed a slice of bread into the toaster. He took the pancakes off griddle with a spatula, and placed them on plate, which he put it into the hot cart. He took the toast out of toaster (continued using same gloves), and put it on the cutting board surface at the steam table, cut it in half, put on plate and took over to resident.</p> <p>7:56 A.M.--Dietary Assistant #6 unplugged, then plugged in the griddle using same gloves. He drizzled butter on griddle, and cracked three eggs onto griddle. He took the plastic wrap off of the pans on the steam table. He reached into the freezer and got package of frozen french toast, took two pieces out</p>			

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	<p>(continuing to use the same gloves) and put them into the toaster.</p> <p>8:30 A.M.--the Dietary Assistant started serving several residents in the dining room with food from the steam table. The holding temperatures were not taken for the food that had been on the steam table since delivery from the main kitchen at 7:36 A.M.</p> <p>On 9/11/14 at 12:22 P.M., the "hot" cart containing the lunch meal food was observed sitting next to steam table in 5000 Hall kitchenette. There were no dietary staff in area.</p> <p>At 12:29 P.M., Dietary Assistant #6 arrived in the kitchenette, and opened the doors to the hot cart. He washed his hands, and put on gloves. With his gloved hands, he put his hands on his knees as he looked into the bottom of the hot cart. He took the lids off of the wells for steam table; and took the pans out of the hot cart and placed them on the steam table. He took a stack of small bowls out of an upper cabinet, lifting the stack so that his thumb was touching the inside rim of the top bowl. He repeated this process several times with 4-5 stacks of bowls. He opened a bottom cabinet and rummaged around through some of the objects in cabinet. He put a food thermometer into a pan of food on the steam line to check the temperatures,</p>			

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	<p>then reached into the pocket of his apron to get alcohol wipe packets, which he opened and used to clean the thermometer probe before placing it into the next pan of food. After taking a food temperature, he picked up a pen next to the temperature log book, and wrote down the results for each food.</p> <p>The "Sanitation and Infection Control... Hand Hygiene," dated 1/14 policies and procedures, was reviewed on 9/11/14 at 10:30 A.M. The policies indicated the following:"Before each shift, before handling food or clean utensils /dishes/ equipment, before putting on gloves,... after any other activity that may contaminate the hands." The procedures indicated the following, "...wet hands with warm water and apply a disinfectant soap, lathering up to mid-arm. Work lather into hands for 20 seconds, including areas under fingernails, between fingers, on the inside and outside of hands... Dry hands with a single use, disposable towel. Do not use common towels for drying or wiping hands...."</p> <p>The policy entitled, "Disposable glove use, " dated 1/14, indicated disposable gloves should be worn at the following times: "when handling ready-to-eat foods, over cut gloves when handling</p>			

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F000441 SS=D	<p>ready-to-eat foods, when handling clean utensils/dishes/equipment, when serving food or assembling patient meals, when rolling silverware, when handling soiled dishware, when handling garbage, and over a bandaged cut or lesion. " The policy indicated employees should wash hands before putting on and after removing disposable gloves. The policy also indicated disposable gloves should be changed and hands washed when gloves are dirty, ripped, and when moving from one task to another.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <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;</p>			
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	<p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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 infection control practices were followed during personal and wound care for 1 of 2 dressing and personal care observations (Resident #163) and failed to ensure table ware was set in a manner to prevent the possibility of cross contamination for 1 of 1 observation of dining room preparation.</p> <p>Findings include:</p> <p>1. Resident #163's record was reviewed on 9/10/14 at 1:36 P.M. The physician</p>	F000441	<p>1. Resident #163 was not affected by the noted practice. The resident has remained free of infection. 2. Other residents noted in isolation precautions or receiving dressing changes have the potential to be affected by these practices. LPN #10 has had a Skills validation for Clean Dressing Change. LPN #10, CNA#17 and CNA#13 have had a Skills Validation for Hand washing. 3. All Licensed nurses have completed education on Clean Dressing Change, Hand Hygiene and Infection Control Practices to include Skills</p>	10/07/2014			

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	<p>orders, dated 9/4/14, ordered a stool sample to check for clostridium difficile colitis (C-diff) due to loose stools. The physician orders, dated 9/8/14, indicated the resident needed to be placed in isolation for clostridium difficile colitis (C-diff).</p> <p>The progress note, dated 8/14/14, indicated the resident was positive for C-diff.</p> <p>On 9/10/14 from 9:44 A.M. to 11:00 A.M., Resident #163's personal care was observed. The certified nursing assistant (CNA) #17 and CNA #13 indicated the resident was in contact isolation as both CNAs donned gloves and gowns before entering the resident's room. In preparation, CNA #17 and CNA #13 were observed to undress the resident and begin to wash the resident's upper body. CNA #17 was observed to empty the urine from the Foley catheter bag without changing gloves. Then CNA #17 removed her gloves and donned a new pair of gloves. CNA #17 and CNA #13 rolled the resident onto her left side. Resident #163 had been incontinent of a bowel movement. CNA #13 and CNA #17 were observed completing the resident's peri care. Next, CNA #17 was observed with the same gloves to open and rummage through the resident's</p>		<p>validation competency. All nursing staff have completed education on isolation precautions and handwashing procedures. 4. The DNS/Designee will observe dressing changes three times a week for 60 days then weekly for 30 days. The SDC/Designee will conduct rounds daily to audit for proper handwashing procedres for 30 days, then 3 times weekly for 30 days and then weekly for 30 days. Any observation of non-compliance will result in immediate corrective action. The results of these audits will be presented to the Performance Improvement Committee monthly until 100% has been achieved or if continued monitoring is required. All findings will be reviewed in monthly PI and the PI committee will determine when 100% compliance has been achieved or if continued monitoring is required.</p>				

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	<p>supply drawers and touch multiple packages. No handwashing or change of gloves was observed as CNA #17 then removed her gloves and gown and left the room. With the same gloves CNA #13 put on the resident's deodorant and socks. Registered nurse (RN) #12 came into the resident's room and checked the resident's soiled wound dressing by touching it, removed her gloves and left the room. No handwashing was observed.</p> <p>Then, Licensed Practical Nurse (LPN) #10 and LPN #16 entered the resident's room with supplies to change the wound dressing. After LPN #10 removed the soiled dressing with scissors. LPN #10 placed the dirty scissors in the resident's bed. An open red area the size of a pencil tip was observed under the dressing. LPN #10 was observed to wash her hands for 10 seconds then donned a new pair of gloves. CNA #13 with the same gloves cleaned the area around the wound with soap and water. CNA #13 changed gloves without washing her hands. LPN #10 moved the scissors from the resident's bed to the dresser and completed the wound treatment. LPN #10 was observed to hand wash and then pick up the soiled scissors with her bare hand and place the scissors in her pocket. No handwashing was observed as LPN #10 left the resident's room. With the</p>			

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	<p>same gloved hands, CNA #13 was observed to place the resident's toothbrush under the running water and to place toothpaste on the toothbrush. CNA #13 touched the inside door handle to the resident's room with her gloved hand and was then observed to go through the supplies on the outside of the door to get a bag for the dirty linens. CNA #13 was observed to wash her hands with soap and water for 13 seconds.</p> <p>During an interview with LPN #10 on 9/10/14 at 12:45 P.M., she indicated she washed her hands when entering and exiting rooms, after touching residents, during medication pass, and in between residents. LPN #10 indicated she washed her hands, "anytime I touch something contaminated." LPN #10 indicated the proper technique to washing hands was to scrub her hands front and back while she sang "happy birthday two times." LPN #10 indicated she then rinsed her hands and turned the water off with her arm. She indicated with isolation residents she wore a gown and gloves, and washed her hands before entering. LPN #10 indicated when she left an isolation room she took off her gloves and gown, and washed her hands. She indicated that shared equipment such as scissors should be cleaned with bleach or sanitizer in</p>			

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	<p>between each use.</p> <p>During an interview with CNA #17 on 9/10/14 at 12:28 P.M., she indicated she washed her hands at the following times: before and after entering resident rooms, after care with the residents, before she left resident rooms, and after providing peri care. CNA #17 indicated she took the following precautions for isolation residents: donned gown and gloves before entering the room, washed hands before and after donning gloves, washed hands before leaving the resident's room, washed hands after taking the trash out. CNA #17 indicated the proper washing technique was to start the warm water, get soap, scrub hands for 20 seconds (including between fingers, under nails, the thumbs, and up the arm), then rinse one hand at a time.</p> <p>During an interview on 9/10/14 at 12:37 P.M., CNA #13 indicated she washed her hands at the following times: before and after resident care, during resident care "if I handled something yucky including a BM (bowel movement)." CNA #13 indicated with isolation residents she would change gloves and wash hands with water and soap for 2-3 minutes before and after care. CNA #13 indicated she placed dirty linens from isolation rooms in the appropriate bins in the</p>						

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	<p>soiled utility room. Then, she indicated she washed her hands again across the hall from the utility room</p> <p>During an interview on 9/11/14 at 9:22 A.M., staff development coordinator (SDC) #11 indicated the facility did not have special rooms for isolation residents because all of the resident rooms were private except for the 2000 hall. SDC #11 indicated if a resident being admitted needed isolation, the staff made sure to follow the policy and procedures and to have all the necessary supplies. SDC #11 indicated the facility had differences in the infection control management for contact and enteric isolation. With enteric isolation or C-diff, the facility had special reminders to wash hands with soap and water. SDC #11 indicated the staff should be washing their hands with soap and water when exiting the all isolation rooms.</p> <p>SDC #11 indicated Resident #163 should be on contact isolation because the resident was positive for C-diff. She indicated it was the facility's policy or routine to place a sign on the resident's door. The sign educated the staff and family on how to wear protective equipment and wash hands.</p> <p>The policy entitled, "Transmission-Based</p>			

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	<p>Precautions," dated 8/31/13, was provided by the DDCO on 9/10/14 at 12:35 P.M. The policy indicated hand hygiene was, "the most important method to prevent transmission." The policy indicated staff should be educated on appropriate handwashing technique and when to wash hands.</p> <p>The policy and procedure entitled "Clostridium Difficile Infection (CDI) -Associated Diarrhea," dated 9/19/12, indicated gloves should be donned when entering a resident's room. The gloves should be removed when leaving the room and hands should be washed. The "CDI" policy indicates the staff should wash hands using soap and water. Staff should wash their hands after the following: incontinence care, after toileting a resident, after handling potentially contaminated items, after leaving the resident's room, and after removal of personal protective clothing. The "CDI" policy indicated non-disposable equipment should be disinfected. The "CDI" policy indicated staff should clean rooms with an Environmental Protection Agency (EPA) registered hypochlorite-based disinfectant based on the label's instructions. A generic source of hypochlorite such as household chlorine bleach was allowed if appropriately diluted. The "CDI" policy</p>			

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	indicates the cleaning solution and mop head should be changed after use in the transmission based room. Disposable cloths should be used to clean contaminated room and discarded after use.				