

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155556	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2011
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 300 FAIRGROUNDS RD TIPTON, IN46072
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: July 6, 7, 8, 10, 11 & 12, 2011</p> <p>Facility number: 000505 Provider number: 155556 AIM number: 100266350</p> <p>Survey team: Toni Maley, BSW Tammy Alley, RN (7/6, 7, 8, 10 & 11/2011) Donna M Smith, RN</p> <p>Census bed type: SNF: 13 SNF/NF: 118 Total: 131</p> <p>Census payor type: Medicare: 15 Medicaid: 91 Other: 25 Total: 131</p> <p>Sample: 24 Supplemental sample: 5</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC</p>	F0000		

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.

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

PRINTED: 08/04/2011

FORM APPROVED

OMB NO. 0938-0391

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	16.2. Quality review completed 7/13/11 Cathy Emswiller RN				

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F0225 SS=D	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an allegation of mistreatment was immediately reported to the Administrator and promptly investigated for 1 of 1</p>	F0225	Please accept the following credible allegation of compliance to the deficient practice cited under tag F225, of which ALL residents had the potential to be affected by. Upon first hearing of	08/11/2011	

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	<p>allegation in a sample of 24. (Resident #102)</p> <p>Findings include:</p> <p>1. On 7/06/11 at 9:35 a.m., medication pass was observed. As LPN #2 was administering Resident #102's medications, the resident indicated last night someone was "snotty with me," and she had felt like a prisoner. She also indicated several different times during this same medication administration observation, she had been scolded last night. She became tearful and crying when she indicated when they had gotten her up to a chair, she was afraid they were going to let her fall out of the chair initially, but they did not. When LPN #2 asked when this had happened, Resident #102 indicated the time was late last night to early in the morning. LPN #2 then asked if the resident would like to go to activities. When the resident inquired if she meant the downstairs' activities, LPN #2 said no, and the resident declined activities. LPN #2 then repositioned the resident in her wheelchair to look out of her room door, left the room, and continued with her medication pass.</p> <p>2. On 7/06/11 at 10:35 a.m. during an interview when questioned concerning Resident #102's allegations of being</p>				<p>this allegation, the Administrator and Director of Nursing immediately went and met with this resident and began investigating the claim. A determination was soon made and the facility is doing what it can to address this resident's concerns. The nurse who did not immediately report the allegation was also formally counselled on reminded of the facility's reporting policy and procedures. It is the policy of Miller's Health Systems that all allegations of suspected abuse are reportedly immediately to a supervisor who will then contact the Administrator and Director of Nursing. In an effort to avoid any future delays or confusion with abuse/neglect reporting, all such allegations are now to be called in directly to the Administrator by the person making the claim.</p> <p>Their supervisor will also still immediately be made aware. This will ensure that all reports of allegation are receiving immediate attention and any potential interference of a "middle man" not getting the report turned over to the Administrator timely will be negated. All staff were in-serviced on this new procedure on 6/22/11. On 7/22/11, all staff were again in-serviced on our reporting procedures of abuse and neglect. To prevent a recurrence of this deficient practice, abuse/neglect in-services will continue on-going</p>		

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	<p>mistreated were reported, LPN #2 indicated she had not and would check with her unit manager concerning Resident #102's earlier remarks during medication pass.</p> <p>On 7/06/11 at 10:40 a.m. during an interview, Unit Manager #1 indicated she would check with the nurse who had worked Resident #102's hall last night.</p> <p>On 7/06/11 at 10:55 a.m. during an interview, Unit Manager #1 indicated the Administrator would be right up concerning Resident #102's allegations from last night.</p> <p>On 7/11/11 at 7:25 a.m. during an interview, the Administrator indicated any allegation, whether the resident was confused or not, should be investigated.</p> <p>3. Resident #102's record was reviewed on 7/07/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, presenile dementia, anxiety state, and depressive disorder. The admission minimum data set assessment, dated 6/20/11, indicated the resident had difficulty making decisions requiring supervision.</p> <p>The Administrator's conclusion, dated 7/06/11 (no time), concerning the</p>		<p>as needed and no less than semi-annually, which will address our reporting procedures. Furthermore, the social service staff will speak with a total of 6 residents and/or family members weekly for four weeks and then monthly thereafter using the Abuse and Neglect Review Quality Assurance Tool (Attachment #1A) to help ensure that no episodes of abuse/neglect have occurred and gone unreported. Results of these interviews will be discussed at monthly QA committee meetings and any identified trends or new concerns will be addressed by the committee appropriately. Any concerns identified during an abuse/neglect review will be reported to the Administrator and addressed immediately, as per facility policy.</p>		

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	<p>resident's allegations indicated the resident was anxious about living upstairs and also was confused. He had indicated the staff from the previous evening were questioned concerning the resident's allegation of being scolded with no one indicating they had witnessed any event. The Administrator spoke also with the son, who indicated his mother was upset over being in the facility and not at home. No residents were indicated as being interviewed at this time. Social Services also was instructed to move the resident downstairs when a room was available. Also, Activities was to attempt to bring the resident downstairs for activities to see if she would be more comfortable and less anxious in the downstairs environment where she had been prior to the present move.</p> <p>4. The "Subject: Abuse Prohibition, Reporting, and Investigation" policy was provided by the Administrator on 7/06/11 at 10:30 a.m. This current policy indicated the following:</p> <p>"1. POLICY</p> <p>...* Miller's Health Systems has policies and procedures in place that all alleged violation are thoroughly investigated,...</p> <p>...3. EMPLOYMENT PROCEDURES: ...C. It is the responsibility of every</p>				

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F0248 SS=D	<p>employee of Miller's Health Systems to not only report abuse situations, but also suspicion of abuse and unusual observations and circumstances, to their immediate supervisor....."</p> <p>3.1-28(c)</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observations, interview, and record review, the facility failed to ensure a cognitively impaired, physical dependent resident was out of bed and available to attend group activities for 1 of 1 dependent resident reviewed for out of room activities in a sample of 24. (Resident #131)</p> <p>Findings include:</p> <p>1. On 7/06/11 at 9:00 a.m. during initial tour, Resident #131 was observed in her room in bed. During an interview at that time, Unit Manager #1 indicated the resident would wave at you at times and had said "love you" and "shirt pretty."</p>	F0248	Please accept the following credible allegation of compliance to the deficient practice cited under tag F248, of which all cognitively imparied, physcially dependent residents in the facility had the potential to be affected by. To correct this deficient practice, the Activities Director, through completion of activities assessments of each resident, has identified all residents in the facility who are unable to take themselves to group activities due to cognitive impairment and/or phycial dependence, including resident #131. Each of these residents, in addition to receiving one-on-one activities visits, will be assisted to group activities that	08/11/2011	

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	<p>She also indicated she would get up in a chair.</p> <p>On 7/06/11 at 11:40 a.m. during an interview, CNA #4 indicated Resident #131 would get up in a chair at times.</p> <p>On 7/06/11 at 11:55 a.m. after personal care had been completed on Resident #131, CNA #4 was observed to open the window blinds. Resident #131 was observed to turn her head and look out the window. At this same time during an interview, CNA #4 indicated the resident did like to look out the window.</p> <p>Resident #131 was observed in her room in bed as follows:</p> <p>On 7/06/11 at 12:25 p.m. and was heard yelling out.</p> <p>On 7/07/11 at 7:40 a.m. and was presently quiet.</p> <p>On 7/08/11 at 1:45 p.m. and was initially heard yelling out. At this same time during an interview, the Director of Nursing indicated Unit Manager #1 had gotten the resident up in a chair recently and had taken her outside, which she had enjoyed. At this same time during an interview, RN #6 exited the resident's room and indicated the resident must had been cold as she had been covered up and was presently quiet.</p>		<p>are being offered outside of their rooms as often as tolerated by the residents and/or taking into consideration the appropriateness of their involvement in specific activities. At a minimum, all dependent residents will be offered/assisted to attend group activities daily as they are offered which include but are not limited to: outside entertainers/performers, book reading, church services / devotions, soda shoppe/refreshments hour, movie night, outdoor walks/rides, etc.All Activities staff will continue to maintain records of group activities, whereby all resident participation in group activities is tracked. To prevent recurrence of this deficient practice, the Activities Director or her designee will review the group activity tracker daily for participation of all residents, paying special attention to participation of cognitively impaired, physically dependent residents. Any concerns with lack of participation will be identified, investigated and addressed appropriately. To monitor for recurrence, the Activity Director or her designee will complete the QA tool entitled Activity Participation Review (Attachment 2A) twice weekly for 4 weeks and then monthly thereafter. Results of the Activity Participation Review will be discussed at monthly QA committee meetings and any</p>		

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	<p>2. Resident #131's record was reviewed on 7/07/11 at 1:20 p.m. The resident's diagnoses included, but were not limited to, hypertension, diabetic mellitus Type II, cardiovascular disease, and spinal stenosis. The quarterly minimum data set assessment, dated 6/14/11, indicated the resident rarely made decisions. The resident required extensive to total assistance of 1 to 2 people for activities of daily living.</p> <p>The activity assessment, dated 6/21/11, indicated nursing would attempt to start getting resident out of bed, and group activities will be attempted at that time.</p> <p>The activity attendance calendar from 6/21/11 to 7/07/11 was provided by the Activity Director on 7/08/11 at 1:05 p.m. This activity calendar indicated the resident had attended the 7/01/11 "Daily News" activity at 11:00 a.m. only. At this same time during an interview, the Activity Director indicated the resident had not been up and/or available.</p> <p>3. The CNA's assignment sheet indicated Resident #131's mobility was a wheelchair requiring 2 for her transfer needs.</p> <p>The July activity calendar indicated the</p>		<p>identified trends or new concerns will be addressed by the committee appropriately.</p>		

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F0309 SS=D	<p>following:</p> <p>On 7/06 - 10 a.m. - Book Club; 11 a.m. - daily news; 1:30 p.m. - Soda Shoppe; 2 p.m. - Men's Happy Hour; 3 p.m. - Golf cart rides; 7 p.m. - movie night;</p> <p>On 7/07 - 10 a.m. - (name) visitor entertainment; 10:30 a.m. - Resident Council; 2:30 p.m. - Bingo with (name); 3:30 p.m. - refreshments; 7:00 p.m. - (name) "Elvis;"</p> <p>On 7/08 - 9:30 a.m. (name) spiritual; 10:30 a.m. - Bible study with (name); 11:30 a.m. - daily news; 1:30 p.m. - Soda shoppe; 2:00 p.m. - Craft Corner.</p> <p>3.1-33(a)</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a resident, who was constipated, was continually assessed and evaluated for further effective</p>	F0309	Please accept the following credible allegation of compliance to the deficient practice cited under tag F309, of which all residents had the potential to be	08/11/2011	

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	<p>treatments/services related to her abdominal discomfort/pain for 1 of 1 resident reviewed with symptoms of constipation in a sample of 24. (Resident #102)</p> <p>Findings include:</p> <p>1. Resident #102's record was reviewed on 7/07/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, presenile dementia, anxiety state, and depressive disorder. The admission minimum data set assessment, dated 6/20/11, indicated the resident made poor decisions requiring supervision. The resident was continent of bowel and bladder but required extensive assistance of 1 person for toileting.</p> <p>The physician's order, originally dated 6/09/11, was Milk of Magnesia (MOM) by mouth give 30 milliliters daily as needed for constipation.</p> <p>The progress notes indicated the following:</p> <p>On 6/10/11 at 9:38 p.m., a physician order was indicated as had been received to check for impaction and evacuate, use soap suds enema as needed for impaction. This was a one time order.</p>		<p>affected by. It is policy of this facility to provide a complete and accurate assessment of a resident, consistently implement a care plan based on the information collected from the assessment, and finally, evaluate and revise interventions as necessary to attain or maintain the highest practical physical well being in accordance with the comprehensive plan of care. Facility failed to provide an ongoing evaluation or revision of interventions that were put in place for resident #102, who was experiencing signs and symptoms of constipation. Upon notification of this deficiency the management team reviewed the bowel movement records of all current residents to ensure that no other residents had been negatively affected by this practice. To prevent recurrence of this deficient practice an all nursing staff in-service was held on 7/22/11 which covered the facilities policies and procedures on abdominal assessment, enemas, and bowel elimination. Continued compliance will be monitored through daily review of nursing progress notes, shift to shift reports, and bowel movement records by the Director of Nursing or designee. Continued compliance will be monitored through the use of the QA tool titled "24 Hour Condition Reports Review" (Attachment 8A). The Director of Nursing or</p>		

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	<p>On 6/11/11 at 1:18 p.m., the resident was having liquid stool when in bed with brief on and continued to put her fingers up her rectum. The resident had a small bowel movement (BM) this a.m. while in the shower, but she indicated she continued to feel BM. The resident had been placed on the toilet 2 times this shift with no relief.</p> <p>On 6/12/11 at 12:50 p.m., the resident continued to have constipation with hard stool present and was expelled with much difficulty this a.m. She continued to complain of pain when toileted due to seat was too hard, but yelled out to the nurse wanting the BM removed. She had been toileted 4 times with a small amount each time, which was indicated to equal a medium BM.</p> <p>On 6/12/11 at 2:01 p.m., the resident had an extra large BM with the complaint of pain when expelled the BM but "feels better now."</p> <p>The June 2011 medication record indicated no Milk of Magnesium had been given throughout the month of June.</p> <p>The care plan, initially dated 6/09/11, indicated the focus was potential for constipation related to anxiety with the goal to be comfortable with a regular bowel movement every 1 to 3 days. The</p>		designee will be responsible for completing this tool daily for 4 weeks, weekly for 4 weeks and monthly thereafter. Any trends will be documented on the QA log and reviewed & discussed with the QA team during the monthly QA meeting.		

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	<p>interventions included monitor bowel sounds prn (as needed); monitor of signs and symptoms constipation; and record BM size.</p> <p>The "Gastrointestinal System Assessment" indicated the following:</p> <p>On 6/09/11, the abdomen was soft and non distended;</p> <p>On 6/10/11, the resident was constipated with little to no BM in last 3 days;</p> <p>On 6/11/11 at 2:42 a.m., the abdomen was soft and non distended with constipation with little to no BM in last 3 days;</p> <p>On 6/11/11 at 8:24 a.m., the abdomen was soft and non distended with constipation with little to no BM in last 3 days and regular BM every 1 to 3 days;</p> <p>On 6/12/11 at 9:40 a.m., the abdomen was soft and non distended with constipation with little to no BM in last 3 days; A comment indicated the resident required laxatives frequently due to constipation upon admission.</p> <p>No further information was indicated in the resident's record related to any further interventions for the relief of the resident's constipation.</p> <p>2. On 7/12/11 at 10:45 a.m. during an interview, the Director of Nursing indicated the nurse had given a</p>				

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	<p>"phosphate" enema, which the nurse indicated was a "soap suds" enema. At this same time she also provided the "24 hour condition report" dated 6/10/11, 6/11/11, and 6/12/11. This report indicated the following:</p> <p>On 6/10/11 for the 6 a.m. to 2 p.m. shift, Milk of Magnesium (MOM) was given to the resident due to constipated.</p> <p>On 6/10/11 for the 2 p.m. to 10 p.m. shift, the resident was indicated as still constipated with a physician order for an enema, which was given with little success.</p> <p>On 6/11/11 for the 10 p.m. to 6 a.m. shift, no BM this shift.</p> <p>On 6/11/11 for the 6 a.m. to 2 p.m. shift, small BM with assist and liquid around hard stool.</p> <p>On 6/11/11 for the 2 p.m. to 10 p.m. shift, very small BM with MOM given at supper and "dug self out."</p> <p>On 6/12/11 for the 10 p.m. to 6 a.m. shift, "digging self out."</p> <p>On 6/12/11 for the 6 a.m. to 2 p.m. shift, "still put hands in BM x (times) 2 yells out every 5 minutes. (minutes)..."</p> <p>On 6/12/11 for the 2 p.m. to 10 p.m. shift, "much more relaxed..."</p> <p>3. The DON provided the "Drug Information" for "Saline Laxative" with the drug name Sodium Phosphates on</p>						

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	<p>7/12/11 at 11:10 a.m. This information indicated the common use was a saline laxative combination used to treat constipation.</p> <p>The "Subject: Fecal Impaction Removal" policy was provided by the DON on 7/12/11 at 12:50 p.m. This current policy indicated the following:</p> <p>"Fecal Impaction Removal: A. PURPOSE 1. To manually extract feces from the rectum when the resident is unable to evacuate normally. (To be done by licensed professional) * . The definition of a fecal impaction is: The presence of hard stool upon digital rectal exam.... ...C. PROCEDURE ...8. Follow with an enema, if ordered....."</p> <p>3.1-37(a)</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, record review, and interview, the facility failed to ensure incontinent care/peri-care was provided for 1 of 3 residents observed during incontinent care in the prevention of skin irritation and/or urinary infections in a sample of 24. (Resident #128)</p> <p>Findings include:</p> <p>On 7/06/11 from 11:07 a.m. to 11:35 a.m., Resident #128's personal care was observed. After the resident's brief was removed, BNA (student/ basic nurse's aide) #3 indicated the resident had been incontinent of urine. During an interview at that time, BNA #3 then was observed to put on a new brief with no peri-care/incontinent care observed as the resident was dressed for lunch.</p> <p>Record #128's record was reviewed on 7/07/11 at 3:10 p.m. The resident's diagnoses included, but were not limited</p>			F0315	<p>Please accept the following credible allegation of compliance to the deficient practice cited under tag F315, of which ALL residents had the potential to be affected by. It is the policy of this facility that peri-care will be performed for each resident who has an incontinent episode. Although peri-care was not performed for resident #128 at the time of the cited occurrence, she did not exhibit any negative symptoms nor did any infections present thereafter. Her skin integrity was also assessed by the nurse and no new areas of concern were noted. An all nursing staff in-service was held on 7/22/11 which covered the facility's policy and procedure for peri-care. Additionally, each nursing employee was then checked off for proper demonstration of peri-care procedures. BNA #3 is no longer an employee of this facility. To prevent recurrence of this deficient practice, the Inservice Director or designee will be performing random</p>		08/11/2011

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	<p>to, dementia and chronic ischemic heart disease. The significant change minimum data set assessment, dated 4/30/11, indicated the resident was a high skin risk with no present open areas.</p> <p>The urine culture, dated completed on 6/06/11, indicated the growth of Escherichia Coli (bacteria). The physician's order at this same time was Septra DS (Double Strength) (an antibiotic) 1 by mouth 2 times a day for 7 days.</p> <p>The care plan, dated 1/30/08 and revised 5/11/2011, indicated the "focus" was self care deficit related to dementia. The interventions included, but were not limited to, assist with toileting and pericare as directed.</p> <p>On 7/08/11 at 8:25 a.m. during an interview, LPN #5, who instructed the BNA's, indicated the student nursing aides were taught to complete incontinent care when a resident was incontinent of urine.</p> <p>On 7/11/11 at 11:00 a.m. during an interview, Unit Manager #1 indicated she had reeducated BNA #3 concerning pericare was to be completed on residents after each incontinent episode.</p> <p>The "Subject: Peri Care" policy was</p>		<p>skills checks of nursing staff as they are performing peri-care using the Quality Improvement Performance Evaluation entitled "Perineal Care Procedure" (Attachment 7A). These random skills checks will be conducted to evaluate 2 nursing staff from each shift weekly for 4 weeks, monthly for 3 months and quarterly thereafter. Additionally, peri-care is a skill that all nursing staff must successfully demonstrate during annual Skills Validation Evaluations. Continued compliance will be monitored through use of the same Performance Evaluation Tool, during the annual Skills Validation and through random, quarterly observations. Compliance will be monitored by the Director of Nursing, Inservice Director and/or designee. Results of all skills validations checks, including random peri-care observations, will be discussed at monthly QA committee meetings and any identified trends or new concerns will be addressed by the committee appropriately. Any concerns identified during peri-care skills observations will also be addressed individually at the time of the occurrence.</p>		

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F0322 SS=D	<p>provided by the Administrator on 7/11/11 at 7:45 a.m. This current policy indicated the following:</p> <p>"PURPOSE * To cleanse the perineum for prevention of infection, irritation and to contribute to the residents positive self-image....."</p> <p>3.1-41(a)(2)</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observations, interviews, and record review, the facility failed to ensure the correct positioning of a resident with a gastrostomy tube (G-tube) during personal care and to check for residual prior to a medication administration for 1 of 1 resident observed with a G-tube in the prevention of aspiration, vomiting, and/or other possible complications in a sample of 24. (Resident #131)</p>	F0322	Please accept the following credible allegation of compliance to the deficient practice cited under tag F322, of which all residents with naso-gastric or gastrostomy tube feedings had the potential to be affected by. This facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives appropriate treatment and services. Resident #131 demonstrated no negative outcome or symptoms for as a	08/11/2011	

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	<p>Findings include:</p> <p>1. On 7/06/11 from 11:45 a.m. to 11:55 a.m., Resident #131's personal care was observed. The resident was observed with a continuous G-tube feeding at 55 cc (cubic centimeters) per hour. In preparation, BNA (student nurse's aide) #3 lowered the resident's head of bed in the flat position. As CNA #4 returned to the bedside and during an interview at this same time, CNA #4 indicated the resident's head of bed should be at least 40 degrees due to the resident's continuous tube feeding and to prevent aspiration. BNA #3 proceeded to raise the head of the bed at 40 to 45 degrees. Resident #131's personal care was then completed.</p> <p>On 7/06/11 at 11:55 a.m. during an interview, BNA #3 indicated she was not sure about the positioning of a resident with a gastrostomy tube as she had received so much information in the past 3 weeks. She indicated she was being tested on Friday.</p> <p>On 7/08/11 at 8:25 a.m. during an interview, LPN #5, who instructed the BNA's, indicated the student nursing aides were taught to not pull on a gastrostomy tube, call the nurse if any problems, and to</p>		<p>result of staff deficient practices related to her G-Tube. This resident, and all residents receiving naso-gastric or gastrostomy tube feedings, have had their MAR's/TAR's updated to reflect the detailed step by step procedure regarding administration of a tube feeding including checking for residual. An all nursing staff inservice was held on 7/22/11 which included the review of the facility Tube Feeding Procedure, including Enteral-Care of the Resident and proper head elevation procedures, as well as Enteral Medication Administration Procedure, which includes checking for residual. The Inservice Director or designee will be responsible for completing the QA Tool entitled "Enteral Medication Administration Procedure" (Attachment 6A) with all licensed nursing staff by 8/11/11. Continued compliance will be monitored through use of the same QA Tool during the facility annual Skills Validation and through random, quarterly observations, conducted by the In-service Director, Director of Nursing or Assistant Director of Nursing. These on-going, quarterly observations will be conducted to evaluate no less than 6 nursing staff each quarter, selecting at least 2 to observe from each shift per month. Results of all skills validations checks, including</p>		

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	<p>keep the head of the bed elevated at a 45 degree angle.</p> <p>2. On 7/06/11 from 12:10 p.m. to 12:50 p.m., Gastrostomy tube (G-tube) medication pass was observed for Resident #131. With the prepared G-tube medication, Unit Manager #1 was observed to check the G-tube placement by auscultation and then, proceeded to flush the G-tube with 60 cc (cubic centimeters) of water followed by the diluted medication and a total of 180 cc of water flush. No check for gastric residual was observed during this same observation.</p> <p>On 7/11/11 at 11:00 a.m. during an interview, Unit Manager #1 indicated Resident #131 frequently had a lot of bile and should always check for residual.</p> <p>3. Resident #131's record was reviewed on 7/07/11 at 1:20 p.m. The resident's diagnoses included, but were not limited to, cardiovascular disease, hypertension, and diabetes mellitus Type II. The quarterly minimum data set assessment, dated 6/14/11, indicated the resident had a G-tube.</p> <p>The July, 2011 physician's rewrite orders, signed and undated, indicated the resident was NPO (nothing by mouth); received the tube feeding, Jevity 1.2, at 55 cc per</p>		<p>enteral care and G-tube medication administration observations, will be discussed at monthly QA committee meetings and any identified trends or new concerns will be addressed by the committee appropriately. Any concerns identified during these observations will also be addressed individually at the time of the occurrence.</p>		

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F0332 SS=E	<p>hour; head of bed elevated at 45 degrees every shift; check residual prior to medications and flushes. If residual was greater than 100 cc to hold feedings for 2 hours and then resume.</p> <p>4. The "Subject: Enteral - Medication Administration" policy was provided by the Administrator on 7/08/11 at 8:45 a.m. This current policy indicated the following:</p> <p>"Administering Medications via a Gastric Tube</p> <p>Goal: The resident receives the medication via the tube and experiences the intended effect of the medication. ...22. Insert tip of 60-ml (milliliter) syringe into tube. Release gastric tube. Pull plunger back using constant, gentle pressure to check for residual feeding and to check tube placement....."</p> <p>3.1-44(a)(2)</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater. Based on observations, record reviews, and interview, the facility failed to ensure</p>	F0332	Please accept the following credible allegation of compliance to the deficient practice cited	08/11/2011	

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	<p>it was free of a medication error rate of 5% or greater for 4 of 41 opportunities during 2 of 6 nursing staff observed and for 4 of 14 residents observed during medication pass. The medication error rate was 9.75 %.</p> <p>(LPN #8 and Unit Manager #9) (Resident #'s 108, 110, 111, 10)</p> <p>Findings include:</p> <p>1. On 7/07/11 from 9:10 a.m. to 9:45 a.m. during medication pass, the following was observed.</p> <p>a.) LPN #8 was observed to prepare and to administer Resident #108's oral medications. These 4 oral medications included, but were not limited to, Lipitor 20 milligram (mg) (for elevated cholesterol). The medication package indicated the time for the Lipitor was at 10:00 a.m.</p> <p>On 7/08/11 at 9:55 a.m. during an interview, RN #6 indicated Resident #108's Lipitor medication package was marked for 10:00 a.m., but she had changed the time to 8:00 p.m. when the medication was due to be given.</p> <p>Resident #108's record was reviewed on 7/08/11 at 1:45 p.m. The resident's diagnoses included, but were not limited</p>		<p>under tag F332, of which ALL residents had the potential to be affected by. Resident #108 experienced no negative symptoms or outcome from Lipitor being administered at 10:00 am. Resident #110 experienced no negative symptoms or outcomes from Omeprazole being administered at 10:00 am, nor receiving just one Divalproex instead of the prescribed dose of 2 capsules. Resident #111 experienced no negative symptoms or outcome from Omeprazole being administered at 10:00 am. The facility must ensure that it is free of medication error rates of 5 percent or greater. Miller's Health Systems has a policy and procedure on medication administration which all nurses receive training on upon hire. Additionally, upon completion of orientation, all nurses must demonstrate and be checked off that they can safely and successfully administer medications as per our company policy and procedure. On 7/22/11, all facility nurses were re-inserviced on our medication administration policy and procedure. Using the Quality Improvement Performance Evaluation entitled: "Medication Pass Procedure" (Attachment 3A), the Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse and/or In-service Director will observe</p>		

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	<p>to, hypertension and high cholesterol. The physician order, originally dated 5/06/11 and clarified on 5/26/11, was Lipitor 20 mg take 1 every day at 8:00 p.m.</p> <p>b.) LPN #8 was observed to prepare and to administer Resident #110's medications. These 6 oral medications included, but were not limited to, Omeprazole (Prilosec) (to suppress gastric acid) 20 milligrams.</p> <p>Resident #110's record was reviewed on 7/10/11 at 10:00 a.m. The resident's diagnoses included, but were not limited to, mental retardation. The physician order, originally dated 2/08/11, was Prilosec 20 milligram 1 capsule by mouth scheduled at 10:00 a.m.</p> <p>c.) Next, LPN #8 was observed to prepare and administer Resident #111's oral medication of Divalproex Na (Sodium) (Depakote) (mood stabilizer) 125 milligram sprinkles 1 capsule.</p> <p>At 7/07/11 at 10:50 a.m. during an interview, after checking the medication administration record, LPN #8 indicated the resident should had been given 2 capsules of Divalproex Na not 1 capsule, which was then administered.</p>		<p>and check off all facility nurses during live med passes as to validate each nurses' understanding of this policy and procedure. This skills checks will be completed by 8/5/11. To prevent recurrence of this deficient practice, the In-Service Director or designee will be responsible to complete the Quality Improvement Performance Evaluation entitled: "Medication Pass Procedure" monthly (random) for 3 months, observing no fewer than 6 nurses per month, 2 from each shift. Quarterly observations will be completed thereafter, checking off no fewer than 3 nurses each quarter from all shifts, to ensure ongoing competency of medication administration. Results of all skills validations checks, including random medication administration observations, will be discussed at monthly QA committee meetings and any identified trends or new concerns will be addressed by the committee appropriately. Any concerns identified during medication administration skills observations will also be addressed individually at the time of the occurrence.</p>		

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	<p>Resident #111's record was reviewed on 7/06/11 at 3:05 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and senile dementia.</p> <p>The physician order, dated 2/10/11, was Depakote 250 milligrams by mouth 2 times a day. May use 2 of the 125 mg Depakote sprinkles.</p> <p>d.) Unit Manager #9 was observed to prepare and administer Resident #10's six oral medications. These oral medications included, but were not limited to, Omeprazole (to suppress gastric acid) 20 milligrams. The Omeprazole package indicated the time to be given as 5:00 a.m. At this same during an interview, Unit Manager #9 indicated the medication was scheduled to be given at 10:00 a.m., and the pharmacy had the wrong time on the package.</p> <p>Resident #10's record was reviewed on 7/08/11 at 1:30 p.m. The resident's diagnoses included, but were not limited to, esophageal reflux/GERD (gastroesophageal reflux disease). The physician's order, dated 6/27/11, was Omeprazole 20 milligrams 1 tablet by mouth daily and was scheduled for 10:00 a.m.</p> <p>2. On 7/07/11 at 3:45 p.m. during</p>				

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	<p>medication pass observation, LPN #10 indicated with the new method for passing medication, one had to be careful to check the time on the package with the medication administration record. She indicated they had been different then the scheduled administration time.</p> <p>On 7/08/11 at 7:30 a.m. during an interview, the Director of Nursing and LPN #2 indicated their source for medication information was from their "2010 Nursing Drug Handbook." In this same source the information for Omeprazole (Prilosec) indicated the following: Use: to suppress gastric acid; GERD (gastroesophageal reflux disease); Administration: give drug 30 minutes before meals; Patient teaching: instruct to take 30 minutes before meals.</p> <p>On 7/12/11 at 12:45 p.m. during an interview, the Director of Nursing indicated the present medication administration was a 1 week cycle packet method.</p> <p>3. The "MEAL TIMES" were provided by the Administrator on 7/06/11 at 10:30 a.m. The second floor meal times were at 7:45 a.m. at breakfast and at 12:15 p.m. for lunch.</p> <p>3.1-48(c)(1)</p>				

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F0356 SS=C	<p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure staffing was posted daily and in a timely manner for 3 of 5 days of the survey. This deficiency</p>	F0356	Please accept the following credible allegation of compliance to the deficient practice cited under tag F356 of which ALL residents had the potential to be	08/11/2011	

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	<p>had the potential to impact 131 of 131 residents and visitors. (July 6, 7 and 8, 2011)</p> <p>Findings include:</p> <p>During observation on 7/6/11 at 9 a.m. and 10:20 a.m., the staffing posted was for 7/5/11.</p> <p>During observation on 7/7/11 at 10:50 a.m., 12:30 p.m., and 2:35 p.m., the staffing posted was for 7/6/11.</p> <p>During observation on 7/8/11 at 8:15 a.m., the staffing posted was for 7/6/11. At this same time during an interview, the Administrator indicated the staffing should be posted daily and the staff were usually very good about keeping it up to date.</p> <p>3.1-13(a)</p>		<p>affected by. This facility maintains daily nurse staffing data that is posted in the front lobby and available to be reviewed by other staff, residents and visitors. Upon being made aware that this staffing sheet was not current, an updated copy of the day's current nurse staffing data was taken to the lobby and posted. The Director of Nursing or designee will be responsible to post each day's nurse staffing in the front lobby in a timely manner. This will include posting the staffing data each morning and making changes to it as changes occur in staffing for that day. Furthermore, these data sheets will be posted on Fridays with the upcoming weekend staffing levels included. To prevent recurrence of this deficient practice, the Director of Nursing will bring a copy of this nurse staffing data sheet to stand up meetings daily. This daily staffing data will be reviewed and it will be checked off as being posted in the front lobby for public viewing. Furthermore, the Administrator will be conducting monthly random checks for compliance by using the QA Tool entitled "General Observations Of The Facility Review" (Attachment 4A) whereas results of the audit and any negative findings/trends will be discussed monthly at the QA meeting.</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. Based on observations, interview, and record review, the facility failed to ensure infection control practices were followed in a manner to prevent the potential for the spread of infections and diseases</p>	F0441	Please accept the following credible allegation of compliance to the deficient practice cited under tag F441, of which ALL residents had the potential to be affected by. It is the policy of	08/11/2011	

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	<p>concerning handwashing and glove use for 3 of 6 nursing staff (BNA #3, CNA #4, and Unit Manager #1) observed for 2 of 4 residents (Resident #128 and #131) observed during personal care, and concerning medication pass for 5 of 6 nursing staff (LPN #'s 2, 7, and 8; Unit Manager #'s 1 and 9) for 7 of 14 residents (Resident #'s 10, 68, 95, 108, 109, 111, and 131) observed during medication pass.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 7/06/11 from 9:35 a.m. to 10:00 a.m., medication pass was observed. LPN #2 with gloved hands was observed to administer Resident #95 her eye drops into each eye. After removing her gloves, she was observed to return to the medication cart and obtained the resident's oral pain medication. No handgel use or handwashing was observed. On 7/06/11 from 11:07 a.m. to 11:35 a.m., Resident #128's personal care was observed. BNA (student nurse's aide) #3 was observed to handwash, turn the water off with her wet hand, and then dried her hands. She then checked the resident's brief with gloves hands and indicated her brief needed to be changed. After handwashing and donning a new pair of gloves, BNA #3 then proceeded to change 		<p>Miller's Merry Manor - Tipton to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection. None of the residents involved in the identified deficient procedures or med passes experienced any negative side effects or outcome. Any identified staff members will be thoroughly inserviced/re-educated on hand-washing with regards to peri-care, glove use and medication administration. An all nursing staff inservice was held on 8/22/11 which included the review of Medication Administration Procedure, Handwashing Policy and Procedure and the Use of Medical Gloves Policy and Procedure. Each staff member was observed and checked off to validate their understanding of the application of these policies. To ensure ongoing compliance with the corrections, the Infection Control Nurse, Director of Nursing or other designee will be responsible for completing the the QA Tool entitled "Infection Control Review" (Attachment 5A) weekly for 4 weeks then monthly for 2 months and quarterly thereafter, whereas no fewer than 10 facility employees, including employees</p>		

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	<p>the resident's brief and with these same gloves dressed the resident. As Resident #128's shoes were put on, CNA #4 entered the room to assist with the resident's transfer. CNA #4 was observed to handwash for 10 seconds as he began to assist the resident to transfer from her bed to her wheelchair. Due to the resident's difficulty with pivoting for the transfer, BNA #3 removed her gloves and left the room to inform the nurse. No handwashing/handgel use was observed. After the transfer was completed by Unit Manager #1 and CNA #4, both were observed to handwash for less than 20 seconds.</p> <p>3. On 7/06/11 from 11:45 a.m. to 11:55 a.m., Resident #131's personal care was observed. The resident had been incontinent of a small amount of bowel movement (BM). With gloved hands BNA #3 cleansed the rectal area. As the resident's bed linens were changed by turning the resident from side to side, CNA #4 with gloves hands cleansed the resident again due to a small amount of incontinent BM. With the same gloved hands, CNA #4 and BNA #3 proceeded to reposition the resident in her bed, pull the covers up to her neck, and CNA #4 opened the window blinds. CNA #4 and BNA #3 then removed their gloves and handwashed.</p>		<p>from all shifts, will be selected to observe and check off for infection control practices. Results of all skills validations checks, including random infection control observations, will be discussed at monthly QA committee meetings and any identified trends or new concerns will be addressed by the committee appropriately. Any concerns identified during infection control skills observations will also be addressed individually at the time of the occurrence.</p>		

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	<p>On 7/06/11 at 11:55 a.m. during an interview, BNA #3 indicated one should handwash before and after resident's care only.</p> <p>4. On 7/06/11 at 12:10 p.m., medication pass was observed for Resident #131. After Unit Manager #1 had prepared the gastrostomy tube (G-tube) medication, she entered the resident's room and obtained the water for flushing from the bathroom sink. She then was observed to handwash for less than 10 seconds. She then completed the administration of the prepared G-tube medication.</p> <p>5. On 7/07/11 at 7:25 a.m., medication pass was observed. LPN #7 was observed to prepare and administer Resident #68's insulin injection into her upper right outer arm. LPN #7 was then observed to handwash for less than 15 seconds, turned the water off with her wet hand, and then, dried her hands. At this same time during an interview, LPN #7 indicated one should handwash for 20 seconds, rinse one's hands, dried one's hands, and then, turn the water off with a paper towel.</p> <p>6. On 7/07/11 from 9:10 a.m. to 9:45 a.m., medication pass was observed. After LPN #8 administered Resident #108's oral medications to her, no handgel</p>				

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	<p>use and/or handwashing was observed. LPN #8 then was observed to prepare and to administer Resident #109's oral medications and inhaler. She was observed to handwash for 15 seconds. After preparing Resident #111's oral medication by opening the capsule and mixing it with applesauce, LPN #8 was observed to handwash for less than 10 seconds.</p> <p>7. On 7/07/11 from 9:48 a.m. to 10:03 a.m., medication pass was observed. After preparing Resident #10's oral medications, Unit Manager #9 administered the medications to the resident. At this same time, Resident #10 complained of pain. Unit Manager #9 returned to her medication cart and obtained the oral pain medication and administered it to the resident. No handgel use/handwashing was observed as Unit Manager #9 was observed to prepare the next resident's medications.</p> <p>8. The "Subject: Use of Medical Gloves (application and removal)" policy was provided by the Administrator on 7/11/11 at 7:45 a.m. This current policy indicated the following:</p> <p>"1. POLICY: * Medical glove use by HCW's (Health Care Workers) is recommended for tow</p>				

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	<p>main reasons: 1) to reduce the risk of contaminating the HCW's hands with blood and other body fluids, 2) to reduce the risk of the germ dissemination to the environment and the transmission from the HCW's to the patient and vice versa, as well as from one patient to another. Gloves are worn to provide a protective barrier and prevent gross contamination of the hands when touching blood, body fluids, specimen collection, secretions, excretions, mucus membranes and non-intact skin.</p> <p>...3. GUIDELINES ...D. Gloves should be removed and hands washed with soap and water immediately after glove removal. (Hand washing with soap and water is highly recommended when gloves are removed because of a tear or puncture and HCW has had contact with blood or another body fluid, hand rub with alcohol gel may be used only if soap and water is not available upon removal of gloves.) E. Gloves should be removed and hands washed between care activities with patients. ...H. Gloves may need to be changed during the care of a single patient....."</p> <p>The "Subject: Hand Washing and Hand Asepsis" policy was provided by the Administrator on 7/11/11 at 7:45 a.m. This current policy indicated the</p>				

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	<p>following:</p> <p>"1. POLICY: * To provide protection for resident and staff when performing direct care procedure. To ensure that hands remain clean so as to assist in maintenance of a clean environment and assist in the prevention of and the transmission of disease and infection.</p> <p>2. PROCEDURE: ...D. Angle arms down holding hands lower than elbows. Wet hands and wrists. Rub vigorously for at least 20 seconds.... ...F. Rinse hands thoroughly, keeping them downward, allow the water to run from the wrist to the fingers. G. Pat hands dry with paper towel. H. Turn off faucets with paper towel and discard towel immediately in waste receptacle.</p> <p>...3. Key Procedural Points: A. SPECIFIC TIMES HANDS MUST BE WASHED: ...II. Before and after direct resident contact...."</p> <p>The "Subject: Eye Drops and Eye Ointment Procedure" policy was provided by the Director of Nursing on 7/12/11 at 12:05 p.m. The current policy indicated the following:</p> <p>"...Goal: The medication is instilled</p>				

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	successfully into the eye. ...26. Remove gloves and perform hand hygiene....." 3.1-18(l)				