

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155183	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/06/2013
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NAME OF PROVIDER OR SUPPLIER WATERS OF MARTINSVILLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2055 HERITAGE DR MARTINSVILLE, IN 46151
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 29, 30, and May 1, 2, 3, and 6, 2013</p> <p>Facility number: 000096 Provider number: 155183 AIM number: 100290890</p> <p>Survey team: Susan Worsham, RN-TC Cheryl Mabry, RN Diana McDonald, RN</p> <p>Census bed type: SNF/NF: 92 Total: 92</p> <p>Census payor type: Medicare: 23 Medicaid: 51 Other: 18 Total: 92</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on May 15, 2013; by Kimberly Perigo, RN.</p>	F000000	<p>RECERTIFICATION AND STATE LICENSURE SURVEY 5-6-2013</p> <p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>The facility respectfully requests paper compliance for this citation.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000329 SS=E	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</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 record review and interview, the facility failed to ensure adequate monitoring, gradual dose reductions, and adequate indications for its use for 4 of 10 residents reviewed for unnecessary medications. (Resident #19, #37, #43, #63)</p> <p>Findings Include:</p> <p>A. Resident #63's clinical records</p>	F000329	<p>F 329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS <u>It is the intent of this facility to ensure that each resident's drug regimen is free from unnecessary drugs and that those residents who use antipsychotic drugs receive gradual dose reductions. . 1.</u></p> <p>Actions Taken: a. In regard to resident #63, medications were reviewed and an evaluation for dosage reduction was completed. In-serviced nursing staff on importance of monitoring for adverse reactions to</p>	06/05/2013			

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	<p>were reviewed on May 6, 2013 at 11:40 a.m..</p> <p>Resident #63's diagnosis included but were not limited to anxiety and chronic obstructive pulmonary disease.</p> <p>The April 2013 recapulation physician orders indicated Resident #63 was prescribed Paxil 20mg tablet by mouth every evening, Ativan 1mg tablet 1 tablet by mouth three times a day, Norco 10/325mg tablet, 1 tablet by mouth 3 times a day, and Remeron Soltab 30mg 1 tablet by mouth every evening at bedtime.</p> <p>Documented common adverse reactions indicated: Ativan - disorientation, dizziness, and drowsiness. Paxil - dizziness and drowsiness Norco - confusion, drowsiness, and sedation Remeron - drowsiness, dizziness, and confusion</p> <p>Interview on April 30, 2013 at 2:30 p.m.; indicated he had fallen while walking to the bathroom in his room. The fall is documented, in his clinical record, as having occurred on April 19, 2013, in the evening.</p>		<p>medications. b. In regard to resident #37, received clarification orders and completed labs as ordered. Labs indicated that hyperkalemia was resolved. In-serviced nursing staff regarding, definition, signs and symptoms, & labs related to the diagnosis of hyperkalemia. c. In regard to resident #19, received clarification orders and completed labs as ordered, provided standing order for monitoring laboratory levels. d. In regard to resident #43 medications were reviewed and a gradual dose reduction has been attempted where appropriate. 2. Others Identified: a. Audit of current resident charts who receive psychotropic medications was conducted to ensure GDR's are attempted when appropriate. 3. Measures Taken: a. Audit of pharmacy recommendations completed to ensure appropriate follow-up. This will be on-going monthly. b. Psych services, Social Services, and Director of nursing to meet at least monthly to review gradual dose reduction recommendations, and supporting documentation (ie: moods, behaviors, labs, & adverse reactions) c. Social Services to maintain GDR monitoring tool for psychotropic medications. d. Director of Nursing/designee to review new admissions and readmission charts to ensure that labs are completed as ordered. 4. How</p>				

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	<p>Interview on May 06, 2013 at 10:30 a.m., with the Director of Nursing indicated Resident #63 had fallen on April 19, 2013.</p> <p>Documentation was not provided which indicated an evaluation of Resident #63's medications after his fall nor an evaluation for dosage reduction.</p> <p>B. Resident #37's clinical records were reviewed on May 06, 2013 at 2:25 p.m.</p> <p>Resident #37's diagnosis included, but were not limited to Hyperkalemia, a condition in which the concentration of electrolyte potassium (K+) in the blood is elevated. Extreme hyperkalemia is a medical emergency, due to the risk of potentially fatal abnormal heart rhythms.</p> <p>Review of the April 2013, physician recapulation orders indicated Resident #37 was prescribed Potassium Chloride 10% (20meq/15ml) once a day by mouth. Review of current medication administration records indicated Resident #37 had received Potassium Chloride daily as prescribed.</p>		<p>Monitored: a. The Director of Nursing/designee will audit/review all new physician orders and 24 hour reports daily in clinical meeting for accuracy of completion. This will be ongoing.</p> <p>b. The Social Services Director will audit psychotropic GDR monitoring tool at least on a quarterly basis. This will be ongoing. c. The CEO/designee will review all audits in quarterly QA meeting with IDT and Medical Director. This will be ongoing.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 06-05-13.</p>		

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	<p>On May 06, 2013 at 2:00 p.m., the Director of Nursing was interviewed. During the interview, the DON was asked about Resident #37 receiving Potassium Chloride daily with a diagnoses of hyperkalemia. The Director of Nursing indicated a lack of knowledge that hyperkalemia was high potassium. The DON further indicated an in-service in regard to hyperkalemia is in the process for all nursing staff.</p> <p>C. Resident #19's clinical records were reviewed on May 03, 2013 at 2:24 p.m.</p> <p>Resident #19's diagnosis included, but were not limited to major depression, anxiety, and coronary artery disease.</p> <p>The current Minimum Data Set Assessment dated March 25, 2013; indicated a BIMS (brief interview for mental status) score of 6, with a score of 8 being interviewable.</p> <p>The May 2013 physician recapulation orders indicated Resident #19 was prescribed medications which included, but were not limited to Warfarin (blood thinner), Synthroid 100 mcg (thyroid medication), Potassium 20 meq (supplement),</p>				

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	<p>Lasix 20 mg (water pill), Zocor 20 mg (cholesterol) and Celexa 20 mg (depression).</p> <p>Resident #19's laboratory data results lacked documentation which indicated laboratory levels had been monitored for Synthoid and Zocor medications.</p> <p>During an interview with LPN #13 on 5/3/13 at 3: 00 p.m., indicated no labs in the chart for TSH nor lipids panel. LPN #13 indicated, "not sure if completed will call lab to see if they had results for these test." There were no results presented, which indicated Resident #19 had a TSH and thyroid panel for monitoring of Synthroid and Zocor medications.</p> <p>On 5/6/13 at 9:45 a.m. (date of exit from survey), received results for TSH (thyroid lab) and Lipids panel (cholesterol) from the DON (director of nursing).</p> <p>D. On May 03, 2013 at 2:30 p.m., Resident #43's clinical records were reviewed.</p> <p>Resident #43's diagnosis included, but were not limited to chronic obstructive pulmonary disease, diabetes mellitus, dementia, gastric esophageal reflux disease, anxiety</p>			

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	<p>disorder, major depression, psychosis, and irritable bowel syndrome.</p> <p>A note to the physician from the pharmacist dated 3/5/13 indicated, "Resident #43 has been on sertraline (Seroquel) 15 mg every night and Remeron 30 mg every night since 12/11. Please evaluate and see if GDR [gradual dose reduction] is appropriate at this time."</p> <p>The clinical record(s) lacked documentation which indicated a reduction of sertraline and Remeron had been implemented as indicated by the pharmacist's review dated March 05, 2013.</p> <p>During an interview 5/6/13 at 9:45 a.m., with the DON indicated Resident #43 was, "taking Remeron for appetite suppressant." She also indicated Resident #43 was stable on the medications and there has not been a GDR attempt.</p> <p>A note dated May 06, 2013. from Resident #43's primary physician indicated, "mood pleasant, continues to have periods of anxiety-GDR of Zoloft, Remeron, or Ativan risk</p>			

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	exacerbation and worsening of depressive, anxious moods." 3.1-48(a)(3) 3.1-48(a)(4)				

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F000364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview, and record review, the facility failed to ensure food was palatable, attractive, and served at the proper temperature for 8 out of 15 residents interviewed. (Resident #10, #13, #25, #63, #66, #75, #82, #88)</p> <p>Findings Include:</p> <p>Interview on April 30, 2013 at 2:57 p.m., with Resident # 63 indicated the resident does not like the taste of the food and the food is always cold.</p> <p>There were 8 out of 15 residents that indicate the food was served cold, did not look attractive or palatable. Resident #10, #13, #25, #63, #66, #75, #82, and #88.</p> <p>On 4/30/2013 at 12:00 p.m., a sample lunch tray was requested. The hot food was cold and the milk was warm. The fish patty was overcooked and dry. The diced potatoes were hard and cold. The other plate of pasta</p>	F000364	<p>F 364 NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP It is the intent of this facility to provide each resident with food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at proper temperature. 1. Actions Taken: a. Dietary Manager or designee updated all resident preferences and updated meal cards. b. Dietary Manager/designee to check meal temps prior to being served. c. Staff have been in-serviced on passing trays to resident at time of tray carts arriving on the hallway. d. Milk will be kept refrigerated until tray is to be served. 2. Others Identified: a. Residents will be frequently asked about meal satisfaction and ongoing adjustments will be made to accommodate all residents. 3. Measures Taken: a. Dietary Manager/designee will monitor the appearance, temperature, and sample meals prior to serving for 2 meals/5x weekly for four consecutive weeks with no negative findings.</p>	06/05/2013

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	<p>removed the chicken from the service line and put it back in the oven. The dietary staff continued to monitor the temperature of the chicken. The second temperature was at 138, and a third temperature at 118. During interview with Cook #4, indicated the temperature should be 165 degrees. The Dietary Manager told Aide #7 to remove and not serve. The temperature of the milk was 43 degrees.</p> <p>During a second meal observation on 4/30/13 at 12:38 p.m., indicated the lunch meal being served in the dining room with final tray being served 1:10 p.m. Lunch is scheduled to be served beginning at 11:30 a.m. for hall trays and 12:00 p..m. for main dining room.</p> <p>During a third meal observation on 5/1/13 at 12:10 p.m., hall trays were being prepared. The meal cart arrived on Comfort Cove's hall at 12:32 p.m., and CNA #20 started to delivering room trays at 12:40 p.m.. During delivery of the 1st room tray, CNA #20 went into room 18 D to assist CNA #6 with resident care. Room 24 did not receive their tray until 12:55 p.m. At that time the food temperatures were checked. The fish measured 116 degrees, potatoes 106 degrees, milk 50 degrees, and</p>			

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	<p>spinach 133 degrees.</p> <p>During an interview 4/29/13 at 12:00 p.m., with Resident #69's husband indicated, "It always takes a long time to receive trays."</p> <p>During an interview with Resident #88 on 4/30/13 at 11:10 a.m., indicated food was not appetizing and usually cold. Several other residents indicated the food was cold and not good. There were unidentifiable residents who indicated, "I dine in my room and food was nasty and cold upon arrival."</p> <p>3.1-21(a)(2)</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 facility failed to prepare, distribute, and serve food under sanitary conditions and equipment used to prepare food was maintained in a sanitary condition during 2 of 2 kitchen observations. This had the potential to affect 93 of 93 residents who received meals from the kitchen.</p> <p>Findings included:</p> <p>During the kitchen walk through on 4/29/13 at 10:55 a.m., with the DM (Dietary Manager) the following were observed:</p> <p>1. The walk-in freezer had ice build-up on the floor, fan, and on several boxes of food. The Dietary Manager (DM) indicated that she has a work order in, because the freezer has been broke, "They have been working on it daily."</p>	F000371	<p>F 371 FOOD PROCURE, STORE/PERPARE/SERVE -SANITARY It is the intent of this facility to store, prepare, distribute, and serve food under sanitary conditions. 1. Actions Taken: a. Freezer repaired b. Opened food boxes without dates were disposed of. c. Dysfunctional trashcan was disposed of and replaced. d. Installed light covers over food prep area. e. Ceiling return duct cleaned. f. All kitchen appliances cleaned. g. Disposed of outdated or unattractive produce. h. In-serviced dietary staff on hand washing and glove use. i. Dietary consultant in-serviced dietary staff on sanitary conditions. _ 2.</p> <p>Others Identified: a. The above mentioned actions and preventative measures should prevent all residents within the facility from unsanitary conditions. _ 3. Measures Taken: a. Dietary Manager or Designee to conduct audits 3x weekly in regard to food product dates, kitchen appliance sanitation, and proper food storage. Negative findings will be addressed immediately. This</p>	06/05/2013			

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	<p>2. Baking powder biscuit mix and gelatin boxes were open, with no open date documented on it. The Dietary Manager threw them away.</p> <p>3. Cook #4 was observed to measure food temperatures, She was wearing gloves. She dropped the thermometer on the floor, picked up thermometer, and removed one glove, and did not wash her hands. She was observed replacing the glove and then use alcohol prep to wipe the thermometer and continued to check temperatures.</p> <p>4. The DM checking temperatures at 11:25 a.m., was observed to check food temperatures without having first washed her hands.</p> <p>5. The pop-up trash can by the handwashing sink, pop-up lid not working properly.</p> <p>6. The Dietary aide #2 was observed at 10:50 am, to wash her hands for 5 seconds, to cut off the faucet with bare hands, and then proceeded to help with meal trays.</p> <p>7. During observation on 5/1/13 at 10:30 a.m., there were no light coverings on lighting over food prep area. Dust build up was observed on</p>		<p>monitoring will be conducted for four consecutive weeks of no findings and as needed thereafter. b. Maintenance Manager to conduct weekly rounds to ensure kitchen appliances and equipment are functioning properly. Negative findings will be addressed immediately. c. On-going audits and education to be provided by dietary consultant. 4. How Monitored: a. CEO/Designee will review audits in daily QA meeting and quarterly in QA meeting with the IDT and Medical Director. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 06-05-13.</p>				

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	<p>the ceiling return duct. The mixer and meat cutter had dried old food on them.</p> <p>8. During an observation on 5/1/13 at 11:15, the temperature on outside of freezer door was 20 degrees and the door wouldn't stay shut. The DM indicated, "maintenance indicated 'lock needs to be used until freezer adjust lock has to be on until it can,' oh I don't know something." Drinks inside the reach-in refrigerator had expired dates of April 24-27. Dietary Aide #7 indicated, "only good for 2 days." The DM indicated 3 days expiration.</p> <p>9. During a third kitchen observation the DM was checking food temperatures on spinach without wearing gloves and dropped the thermometer, 3 times in the food and took out with bare hands. When asked what she did DM indicated, "dropped thermometer in spinach." When asked her what else she did she indicated, "picked up with hands. Oh I need to start over."</p> <p>10. During observed 4/29/13 at 11:00 a.m., a green leafy vegetable was on a tray in the refrigerator with brownish/gray leaves and another leafy vegetable was in a baggies with</p>			

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	<p>wilted leaves. There were cups of desserts on a tray without lids nor date. The DM indicated that it was for today's meal.</p> <p>The DM indicated that she goes through the produce on Mondays to remove rotten ones and "haven't done it yet."</p> <p>11. During a second refrigerator observation 4/30/13 at 11:00 a.m., the leafy vegetable remained on the shelf along with other wilted vegetable still in the baggie and the dessert cups had not been served.</p> <p>12. During a third observation on 5/1/13 at 11:15 a.m., indicated that the lettuce was still on the shelf. The DM indicated, "I guess I lied, I do pull on Mondays and haven't had a chance." The dessert cup remain on the shelf, and now had a loose lid over the top of containers. The DM indicated that they were serving the desserts today. This dessert was not served today instead they served, "dump cake."</p> <p>3-1-21(i)(3)</p>				

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications in 2 of 2 medication storage rooms had a</p>	F000431	F 431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS It is the intent of this facility to use drugs and biologicals which are labeled in	06/05/2013			

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	<p>documented open date on the bottle, 4 of 4 medication carts had a documented open date on 11 out of 12 insulin bottles and on 2 of 9 flexpens, and 1 of 1 refrigerated medications was stored at the appropriate temperature.</p> <p>Findings include:</p> <p>On 4/30/13, at 10:00 a.m., on the Misty Falls unit Medication Storage room with the DON indicated that Residents#78's box of Avonex (30 mg 0.5 ml) box had frozen particles on box (was under freezer). Medication directions on box indicated that the medication was not to be frozen and kept between 36 - 46 degrees. The DON checked the medication and indicated the medication was not frozen. Re-observation on 5/6/13 at 10:45 a.m., indicated the medication was now stored away from freezer area.</p> <p>Observation on 4/30/13 at 9:40 a.m., of the Medication Storage rooms and medication carts with the Director of Nursing (DON) indicated no documented opened dates on the bottles for 11 of 12 opened bottles of insulin and 2 of 9 opened flexpens.</p> <p>3.1-25 (j)</p>		<p>accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. It is also the intent of this facility to store drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to keys. 1. Actions Taken: a. In regard to resident #78 box of Avonex, Director of Nursing ensured that medication was not frozen and relocated to an area within the refrigerator away from freezer area. b. Ensured that undated bottle of insulin was in original box (which was dated) and dated bottle accordingly. c. Disposed of and replaced undated Flexpens. d. In-serviced nursing staff regarding expiration date labeling in accordance with accepted professional principles and proper storage and temperature controls. 2.</p> <p>Others Identified: a. No other residents were affected. 3.</p> <p>Measures Taken: a. Director of Nursing/Designee will conduct audits of all med carts and med storage areas on a weekly basis for four weeks of no negative findings and as needed thereafter. b. Refrigerators placed on a monthly or as needed defrost schedule. 4. How</p>				

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	3.1-25(m)		Monitored: <u>a</u> . CEO/Designee will review audits weekly in the daily stand-up meeting and quarterly in QA meeting with IDT and Medical Director. <u>5</u> . This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 05-20.13.		

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to ensure staff</p>	F000441	F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS It	06/05/2013			

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	<p>washed their hands after resident care for 1 of 1 random observations. (CNA #11 and #12)</p> <p>Findings include:</p> <p>Observation on 5/2/13 at 9:45 a.m., CNA #11 and #12 were observed to change Resident #84's incontinence brief. The C.N.A.'s did not wash their hands before putting on gloves and beginning the care. After having completed the care, C.N.A. #11 and #12 did not remove their gloves and wash their hands before adjusting Resident #84's pillow.</p> <p>Interview on 5/02/13 at 9:55 a.m., both C.N.A.'s indicated they should have washed there hands before putting on gloves.</p> <p>3.1-18(l)</p>		<p>is the intent of this facility to maintain an infection control program that provides safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1. Actions Taken: a. In-serviced nursing staff on universal precautions as well as proper hand washing. In-service includes skills validation form. 2. Others Identified: a. No other residents were affected. 3. Measures Taken: a. In-serviced all nursing staff on universal precautions and hand washing. In-service includes a skills validation form. This will be an ongoing process. 4. How Monitored: a. Director of nursing/designee will watch resident care of at least one CNA on each shift per week for 4 weeks. Any negative findings will be cause for additional in-servicing. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 06-05-13.</p>		