

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/10/2013
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NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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F0000	<p>This visit was for the Investigation of Complaint IN0012224.</p> <p>Complaint IN0012224 - Substantiated. Federal/state deficiencies related to the allegations are cited at F 241, F 309, F 311, F 315, F 323 and F 441.</p> <p>Survey dates: January 9, 10, 2013</p> <p>Facility number: 000336 Provider number: 155376 AIM number: 100290170</p> <p>Survey team: Tammy Alley, R.N.</p> <p>Census bed type: SNF/NF: 64 Total: 64</p> <p>Census payor type: Medicare: 7 Medicaid: 49 Other: 8 Total: 64</p> <p>Sample: 6</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law.	

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

TITLE

(X6) DATE

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

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	Quality Review completed on January 20, 2013, by Brenda Meredith, R.N.			

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F0241 SS=A	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on interview and observation, the facility to ensure resident's personal dignity by calling them by their given name for 1 of 6 residents observed for dignity (Resident B) in a sample of 6 and for one randomly observed resident. (Resident I)</p> <p>Findings include: During a care observation on 1/9/13 at 11:21 a.m., CNA # 2 stood Resident B up and called her baby, then stated "come on sweetheart ." She then transferred the resident into the bathroom and again stated "come on sweetheart. " During the observation Resident B was talking to CNA #2 and CNA #2 stated to Resident B, "do what sweetheart." During a random observation on 1/9/13 at 1:45 p.m., Resident I was in her room yelling out. CNA # 8 entered the room and stated "hey sweetie." On 1/10/13 at 2:06 p.m., LPN # 9 was</p>	F0241	<p>1. CNA #2 was immediately re educated regarding use "terms of endearment" with residents. 2. Any resident could be affected. During rounds and survey observations are being made for those staff members who are using "terms of endearment" when addressing staff. Re education is occurring on the spot.3. An inservice was held on 1/30 and 2/4/13 discussing the proper way to address residents. If a resident wishes to be called anything other than their given name it must be care planned by social service and put on the care tracker profile.4. Daily rounding by licensed nurses and mock survey observation by the IDT will remind staff our policy to maintain dignity for our residents. Morning meeting infractions will be discussed and appropriate disciplinary action taken. IDT team and licensed staff responsible. Excutive Director to monitor and report toQAQI for further recommendations monthlyDate of completin 2/9/13</p>	02/09/2013

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	<p>observed to enter Resident B's room when the alarm was sounding. She stated to Resident B, "...not supposed to do that darlin (SIC). "</p> <p>On 1/10/13 at 4:45 p.m., during interview, the Administrator indicated using terms of endearment became a habit for the staff and it was a hard habit to break.</p> <p>3.1-3(t)</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</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, observation and interview, the facility failed to ensure a resident complainant of discomfort was reported and assessed timely for 1 of 1 resident observed for discomfort in a sample of 6. (Resident E)</p> <p>Finding include:</p> <p>The record for Resident E was reviewed on 1/9/13 at 2:41 p.m.</p> <p>The current diagnoses included, but were not limited to, chronic kidney disease, fatigue, senile dementia, difficulty walking and lack of coordination.</p> <p>A physician order, dated 1/2/13, indicated an order for a urinalysis (UA) and culture and sensitivity (C&S) for complaints of burning and itching.</p> <p>A physician order, dated 12/19/12, indicated an order for a UA and C&S due to foul urine and to apply</p>	F0309	<p>1. LPN #9 notified the physician on 1/11/13 and new order was obtained for Diflucan on 1/11/13. CNA #10 terminated employment on 1/10/13.2. All residents were asked an/or observed for signs or symptoms of discomfort on 1/30/13. Any resident with complaints of or observed signs and symptoms of discomfort had a pain assessment tool completed. The physicaian was notified of assessment results. the leegal respresentative or family member was notified or assessment and any new orders obtained in regards to pain assessment.3. CNAs were inserviced on 1/30/31 and 2/05/13 on recognizing the signs and symptoms of pain and discomfort and on reporting all changes in condition, including discomort, to the nurse via the STOP AND WATCH form. The nurses were inserviced on discomfort/pain control and on the pain assessment tool on 1/30/13 and 2/5/13. The DON or designee will review all STOP AND WATCH forms and ensure that appropriate assessment and</p>	02/09/2013			

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	<p>antifungal cream to perineal area every shift for one week.</p> <p>A nursing note, dated 12/19/12, indicated the resident had foul urine and red raw perineal area. The physician ordered a UA C&S.</p> <p>During a care observation on 1/9/13 at 2:17 p.m., CNA # 10 took Resident E to the bathroom. Resident E urinated and had a bowel movement. Resident E indicated she burned when she was urinating. She asked CNA # 10 to tell the nurse. CNA #10 applied cream to the resident's perineal area and bottom. She then pulled up the resident's pants. Resident E stated, " burning clear up inside of me. " She indicated the cream did help some.</p> <p>During an interview on 1/10/13 at 11:56 a.m., LPN #9 indicated she was informed this morning by the day shift CNA that the resident was complaining for burning in her perineal area. She indicated she was given no information regarding this during her a.m. report.</p> <p>During interview on 1/10/13 at 12:27 p.m., LPN #11 indicated she worked evening shift on 1/9/13, and CNA #</p>		<p>necessary care was provided.4. The DON or designee will log all completed STOP AND WATCH forms on the QA log to ensure that assessment was completed, physician was notified f assessment results, necessary care & serviceswere provided in accordance to the comprehensive care plan. The results of the QA log will be addressed at monthly QAPI meeting.Date of completion 2/9/13</p>				

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	10 did not report any concerns related to Resident E. 3.1-37(a)			

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F0311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on record review and interview, the facility failed to ensure the Restorative Nursing Program (RNP) was completed daily for 3 of 3 residents reviewed for RNP services in a sample of 6. (Resident B, E and G)</p> <p>Findings include:</p> <p>1. The record for Resident B was reviewed on 1/10/13 at 10:24 a.m. The current diagnoses included, but were not limited to, difficulty walking. A physician order, dated 12/24/12, indicated to continue RNP for cognition and ambulation. A physical therapy discharge note, dated 10/7/12, indicated the resident was recommended to have RNP services. The note indicated RNP had been established and all care givers had been trained and demonstrated 100 % carryover. A RNP plan of care, dated 10/10/12, indicated the resident was to walk</p>	F0311	<p>1. Effective 1/11/13 restorative CNA's are not to be pulled to the floor to work as a floor CNA. The resident Restorative Records were reviewed on 1/31/13 to insure that residents B, E and G had received restorative nursing care as ordered since 1/10/13.2. The Resident Restorative Records for all residents with restorative orders were reviewed on 1/31/13 to ensure they received resorative nursing care as ordered since 1/10/13.3. An inservice was held on 1/30/13 and 2/5/13 with the restorative CNA's and restorative nurse on restorative nursing program and documentation. The restorative nurse or designee will print off the Resident Restorative Record for each resident with restorative nursing care weekly. The record will be checked to insure that each resident received restorative nursing care as odered and that it was documented appropriately.4. The ADON or designee will complete the Restorative Nurse's Aide ProgramPI tool monthly x 4 then every other month. The results of the PI tool will be addressed at the monthly QAPI meeting to ensure threshold is</p>	02/09/2013	

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	<p>with a wheeled walker 150 feet with staff assist daily through the next review.</p> <p>The RNP documentation indicated, between 12/1/12 and 1/2/13, the resident received RNP ambulation for 7 days. No documentation of refusals were noted or other attempts were noted.</p> <p>2. The record for Resident E was reviewed on 1/9/13 at 2:41 p.m. The current diagnoses included, but were not limited to, chronic kidney disease, fatigue, senile dementia, difficulty walking and lack of coordination.</p> <p>A RNP plan of care, dated 11/8/12, indicated the resident was to ambulate with a rolling walker with assist of staff 30-100 feet daily as tolerated.</p> <p>The RNP documentation, from 12/9/12-1/9/13, indicated the resident received 8 days of ambulation with 3 days of refusals documented.</p> <p>3. The record for Resident G was reviewed on 1/10/13 at 1:51 p.m. The current diagnoses included, but were not limited to, senile delusion, dementia with behavior, difficulty</p>		met.Completion date February 9, 2013				

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	<p>walking and Alzheimer's Disease.</p> <p>A physical therapy note, dated 12/4/12, indicated the resident was discharged from physical therapy and RNP was recommended.</p> <p>A restorative plan of care, dated 12/24/12, indicated the resident was to walk 50 feet daily.</p> <p>The RNP documentation indicated the resident received 3 days of restorative ambulation between 12/4/12 and 1/9/13. No restorative ambulation between 12/4/12-12/27/12.</p> <p>During an interview on 1/10/13 at 1:45 p.m., with LPN # 6, who indicated she was over restorative nursing, was queried regarding the lack of restorative care. She indicated she thought it could be a computer issue or the CNA's may not be documenting if they do not get the 15 minutes. She indicated she had no answer for the lack of restorative nursing.</p> <p>On 1/10/13 at 2:20 p.m., during interview, Physical Therapy Assistant (PTA) # 5 indicated when a resident discharges from therapy a form is given to Restorative Nursing with</p>						

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	<p>what restorative nursing program a resident needs.</p> <p>During an interview on 1/10/13 at 3:40 p.m., CNA # 4, indicated she was a restorative CNA. She indicated she was often utilized as a floor CNA instead of as a Restorative CNA very often. She indicated when this occurred she was unable to complete the RNP for the residents.</p> <p>During interview on 1/10/13 at 4:25 p.m., LPN # 7 indicated she did the nursing schedule and when restorative worked the floor, the aids are to pitch in a do the restorative.</p> <p>The daily staffing was reviewed and indicated between 12/1/12-1/9/13, there were no restorative CNA's scheduled 11 days.</p> <p>A policy titled "Restorative Nursing Program" was provided by LPN # 7 on 1/10/13 at 3:30 p.m., and deemed as current. The policy indicated: "Policy: The Restorative Nursing Program is a process in which a resident is aided in achieving optimum physical, emotional, psychological and social potential...Purpose...to provide quality restorative care to its residents by</p>			

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	meeting the individual needs of each resident and assisting each resident in reaching his/her highest practical level of physical, mental and psychosocial functioning...." 3.1-38(2)(B)			

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <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 record review and observation, the facility failed to ensure perineal care was provided in a manner to prevent the possibility of infection for 1 of 3 resident's observed for perineal care in a sample of 6. (Resident B)</p> <p>Findings include:</p> <p>The record for Resident B was reviewed on 1/10/13 at 10:24 a.m.</p> <p>The current diagnoses included, but were not limited to, hypertonicity of the bladder.</p> <p>Physician orders dated 12/2/12, 9/20/12 and 9/2/12, indicated orders for a Urinalysis (UA) with Culture and Sensitivity (C&S).</p> <p>A physician order, dated 9/7/12, indicated the resident was treated</p>	F0315	<p>1. Resident B was asked and assessed for signs and symptoms of a urinary tract infection on 1/30/13.2. All residents were asked &/or assessed for signs and symptoms of a urinary tract infection on 1/30/13.3. CNA #2 was given a coaching plan, including education on proper perineal care and infection prevention on 1/21/13. All CNA's were inserviced on perineal care and infection prevention on 1/30/13 & 2/5/13. The DON or designee will complete 5 care observations per month to ensure perineal care was provided in a manner to prevent the possibility of infection.4. The DON or disignee will tract urinary tract infections by CNA assignment on the infection control surveillance report to identify any trends. The results of care observations and infection conrol surveillance will be addressed at monthly QAPI meeting to ensure threshold</p>	02/09/2013			

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	<p>with Bactrim (antibiotic) for a urinary tract infection.</p> <p>During a care observation 1/9/13 at 11:21 a.m., with CNA #2, the Resident B was taken to the bathroom. After the resident had finished urinating and having a bowel movement, CNA #2 donned gloves, wet and applied soap to a wash cloth. She washed the resident by multiple swipes front to back and back to front of the perineal area. She used one wash cloth to wash the resident and did not change or fold the wash cloth for a clean area after each swipe. A policy titled "Perineal Care" was provided by LPN # 7 on 1/10/13 at 10:30 a.m., and deemed as current. The policy indicated: Policy Perineal care will be provided as needed in order to keep the resident clean and free of infection...Female:...3. Wash wiping from front to back...."</p> <p>3.1-41(a)(2)</p>		met.Completion date 2/9/13		

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F0323 SS=D	<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 record review, observation and interview, the facility failed to ensure chair alarms were turned on when in use for 2 of 5 residents observed with alarms (Resident B and H) and failed to ensure a transfer was completed with a gait belt for 1 of 3 transfers observed (Resident C) in a sample of 6.</p> <p>Findings include:</p> <p>1. The record for Resident B was reviewed on 1/10/13 at 10:24 a.m. The current diagnoses included, but were not limited to, personal history of falls, difficulty walking, and hypertonicity of her bladder. Current physician orders for January 2013, indicated an order to have a bed and chair alarm and to check presence and function every shift. A fall risk assessment, dated 12/20/12, indicated a score of 16, high risk for falls. A fall investigation tool, dated</p>	F0323	<p>1. The facility replaced the alarms for Resident B and H on 1/11/13 to a type of alarm that can not be turned off. The plan of care, resident profile and kardex were reviewed for Resident C to ensure the need for a gait belt and was communicated to the CNA.2. The facility replaced all alarms for residents to a type of alarm that could not be turned off. The plan of care, resident profile and kardex were reviewed for all residents requiring the need for a gait belt to ensure it is communicated to the CNA's.3. CNA#2 & CNA#8 were given coaching plan, including education on fall prevention. CNA#3 was given a coaching plan, including education on fall prevention and gait belt use. CNA's were inserviced on fall prevention and gait belt use on 1/30/13 & 2/4/13. The Restorative CNA's will check alarms daily to ensure they are in place as ordered. The Restorative Nurse or designee will complete 5 care observations per month to ensure that the residents require the use of a gait belt during transfers.4. The results of the alarm checks anc</p>	02/09/2013

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	<p>10/25/12, indicated the resident had an unwitnessed fall. The CNA fall investigation tool indicated the resident had an alarm but the alarm was not turned on or working. A nursing note, dated 10/25/12, indicated Resident B fell in her room at 4 a.m.</p> <p>A fall investigation tool dated 12/1/12, indicated Resident B fell getting out of her wheelchair in the dining room.</p> <p>A fall investigation tool dated 12/4/12, indicated Resident B was found on the floor in her room.</p> <p>A nursing note, dated 12/4/12, indicated the alarm was sounding in the resident's room and the resident was found on the floor in front of the toilet. No injury.</p> <p>On 1/9/13 at 12:43 p.m., Resident B wheeled herself to hallway entrance out of the dining room. CNA # 1 gave the resident her walker, applied a gait belt and stood the resident up. The chair alarm did not sound. The resident and CNA # 1 began walking down the hallway. At that time, CNA #2 arrived to push the wheelchair behind the resident. At that time during interview, CNA # 1 indicated</p>		are observations will be addressed at monthly QAPI meeting to ensuer hreshold is met. February 9, 2013				

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	<p>she had not turned the alarm off and CNA # 2 checked the chair alarm and it was turned off.</p> <p>2. The record for Resident C was reviewed on 1/10/13 at 9:33 a.m. The current diagnoses included, but were not limited to, falls, memory loss, and Benign Prostatic Hypertrophy with urinary obstruction. A fall risk assessment, dated 8/6/12, had a score of 18, high risk for falls. The Care Plan for Fall Risk indicated, approaches that included, but were not limited, alarms in bed and chair, low bed, and memory matic brakes to wheelchair. A nursing note, dated 12/13/12, indicated the resident was found on the floor in the dining room. He indicated he had slid out of his wheelchair. No injury was noted. A nursing note, dated 12/30/12, indicated the resident was found self toileting and witnessed standing up from the toilet and sat on the floor. A fall investigation tool, dated 12/31/12, indicated the resident was found in the bathroom self toileting, when staff gave him his wheel chair, he was transferred a fell to the floor.</p>			

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	<p>No gait belt was applied and he fell. The investigation indicated a gait belt was to be used to aid in preventing falls.</p> <p>During an observation on 1/9/13 at 1:23 p.m., Resident C was in bed, and requested to go to the bathroom. CNA # 3 assisted the resident to stand and transferred him to his wheelchair. He was then taken to the bathroom and assisted to transfer to the toilet and when finished he was assisted to transfer to his wheelchair. No gait belt was utilized during this observation.</p> <p>3. The record for Resident H was reviewed on 1/10/13 at 12:50 p.m. The current diagnoses included, but were not limited to, abnormal gait and vascular dementia.</p> <p>The current physician orders for January 2013, indicated an order for a chair alarm while in her wheelchair and to check for function and presence every shift.</p> <p>A fall risk assessment, dated 10/11/12, indicated a score of 15, high risk for falls.</p> <p>A fall risk plan of care, dated 12/20/12, indicated Resident H was to</p>						

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	<p>have a chair alarm on.</p> <p>On 1/9/13 at 11:30 a.m., Resident H was in her wheelchair in the main dining room. Her chair alarm light was not flashing to indicated it was on and working.</p> <p>On 1/9/13 at 1:08 p.m., Resident H was wheeled to her room CNA # 4. The CNA then exited the room. After she exited the room she was queried to check the alarm. During observation at this time with CNA # 4, she indicated the alarm was turned off.</p> <p>3.1-45(a)(2)</p>			

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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record review, observation and interview, the facility failed to</p>	F0441	1. LPN #7 removed items from bathrooms 112 and 218 durig	02/09/2013			

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	<p>ensure resident care equipment was stored and bathroom floors were cleaned in a manner to prevent the possibility of contamination (Rooms 112, 117, 209, 215, and 218) and failed to ensure hand washing was completed for the adequate time for 1 of 3 care observations. (Resident C) in a sample of 6.</p> <p>Findings include:</p> <p>1. During the initial tour with LPN # 7 on 1/9/13 between 10 a.m. and 10:30 a.m., the following was observed in resident bathrooms:</p> <p>Room 112: There was a bed pan and a bed side commode bucket on the floor under the sink. At that time during interview, LPN #7 indicated these items should not be stored on the floor.</p> <p>Room 117: There were brown splatters around the base of the toilet.</p> <p>Room 209: There was brown splatters on the wall and floor on the right side of the toilet.</p> <p>Room 215: There were scattered papers and splatters on the floor.</p> <p>Room 218: There was a urine collection container on the floor.</p>		<p>initial tour. LPN #7 contacted housekeeping to clean bathrooms 117, 209, and 215 during same tour. The floor in bathroom 117 was stripped and waxed on 1/20/13. The floor in bathroom 209 was replaced with tile. The floor in bathroom 215 was deep cleaned and the base of the toilet was recaulked on 1/30/13. CNA#3 was immediately educated on hand washing with a return demonstration required, upon notification by the surveyor. 2. LPN #7 checked all bathrooms after initial tour to ensure resident care equipment was stored and bathroom floors were cleaned in a manner to prevent the possibility of contamination. 3. Each resident bathroom is checked daily during mock survey process. Any resident care equipment not stored in a way to prevent possible contamination. If bathroom floors are not clean, the action is logged on the Homework Sheet and Housekeeping staff notified. Housekeeping staff was inserviced on cleaning of bathroom floors and infection prevention on 1/30/13 and 1/31/13. The CNA's were inserviced on storage of equipment and infection prevention 1/20/13 and 3/4/13. The DON or designee will complete 5 hand washing observations during perineal care observations per month to ensure hand washing is completed for an</p>		

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	<p>2. On 1/9/13 at 1:23 p.m., CNA # 3 took Resident C to the bathroom. She assisted the resident to take down his pants and sit on the toilet. She then donned gloves and applied lotion to the resident's back due to the resident had complained of itching. She then removed her gloves, washed her hands for less than 10 seconds. . She donned clean gloves, stood the resident up, wiped his bottom and pulled up his pants. The CNA then washed her hands less than 10 seconds and assisted the the resident back to bed.</p> <p>A policy titled "Care and Use of Equipment" was provided by LPN # 6 on 1/10/13 at 4:30 p.m., and deemed current. The policy indicated: "...Bedpans,...urine graduates 1. Rinse with water after each use. Return to nightstand or bathroom cabinet in the resident's room. Bed pans are kept in plastic bags...."</p> <p>A policy titled "Hand Washing Technique" was provided by LPN # 7 on 1/10/13 at 10:30 a.m., and deemed as current. The policy indicated: "...6. Rub hands together vigorously for 10-15 seconds...."</p>		<p>adequate time.4. The Executive Director will monitor the mock survey forms and homework sheets on a daily basis during Morning meeting. Any trends will be adressed at the monthly QAPI meeting. The hand washing observations will be addressed at the monthly QAPI meeting to ensure threshold is met.Nursing staff responsible, Executive Director to monitor and report to QAPIcommittee.Date of Completion: 2/9/13</p>		

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	3.1-18(l)			