

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155207	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/15/2015
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NAME OF PROVIDER OR SUPPLIER  NEW HAVEN CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 DALY DR NEW HAVEN, IN 46774
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 8, 9, 10, 11, 14 and 15, 2015</p> <p>Facility number: 000114 Provider number: 155207 AIM number: 100266640</p> <p>Census bed type: SNF/NF: 91 Total: 91</p> <p>Census payor type: Medicare: 4 Medicaid: 68 Other: 19 Total: 91</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on September 16, 2015 by 17934.</p>	F 0000	<p>"This Plan of Correction is prepared and submitted as required bylaw. By submitting this Plan of Correction, <b>Genesis New Haven Center</b> does not admit that the deficiencies listed on this form exist, nor doesthe Center admit to any statements, findings, facts, or conclusions that formthe basis for the alleged deficiencies listed on pages 1-16 of the 2567. The Center reserves the right to challenge in legal and/or regulatory oradministrative proceedings the deficiencies, statements, facts, and conclusionsthat form the basis for the deficiencies."</p>	
F 0323 SS=E Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p>			

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

TITLE

(X6) DATE

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

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	<p>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 observation, interview and record review, the facility failed to ensure a narcotic medication was stored in a safe, secure manner during 1 of 2 medication cart observations. This deficient practice had the potential to affect 9 mobile and confused residents and 13 mobile and oriented residents on the South nursing unit.</p> <p>Findings include:</p> <p>1. An interview with RN #7 on 9-14-2015 at 1:20 p.m., indicated RN #7 asked the surveyor what should be done with a narcotic medication that was requested by a resident and was unable to be given due to an ultrasound procedure being done. RN #7 indicated the ultrasound technician would not allow the nurse to enter the resident's room during the procedure. The response given to the RN #7 by the surveyor was to follow the facility's policy. RN #7 indicated the facility's policy was to keep the medication with her.</p> <p>2. On 9/14/15 at 1:50 p.m., the south nursing unit was observed. The 100 hall and 200 hall intersected at the nurses</p>	F 0323	<p>F323 SS=E 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> 1.Residents residing at the New Haven Facility have the potential to be affected by the deficient practice. The residing residents did not have any adverse outcomes from the incident. RN#7 was re-educated by facility NPE on 09/14/2015 on securing medications per the policy. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> 2.Residents residing at the New Haven Facility have the potential to be affected by the deficient practice. The residing residents did not have any adverse outcomes from the incident. The licensed nurses were re-educated on medication administration and securing medications by 9/16/15 ongoing by the Director of Nursing and Unit Managers and NPE <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient</b></p>	09/30/2015			

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	<p>station. The therapy department was also located at the intersection of these halls. The 200 unit medication cart was observed positioned in the 200 hall, away from the nurses station. The medication cart was observed to be accessible by residents, visitors and staff passing by the medication cart in the hall. The medication cart was observed to have a clear, plastic medication (med) cup on top of the cart, with a white pill inside the med cup. No nursing staff were observed to be monitoring the pill on the top of the medication cart. RN #5, the Unit Manager, and another staff member were observed to be sitting at the desk at the nurses station. RN #5 was sitting with her back to the medication cart and it was not visible to her. At 1:52 p.m., the medication cart was observed with RN #5. At this time, there were no staff observed to be monitoring the pill in the med cup on top of the cart. The clear medication cup remained on top of the medication cart, unsupervised. No name or identifying information was observed to be on the medication cup. RN #5 indicated she was unaware what the medication was in the medication cup and which resident it belonged.</p> <p>On 9/14/15 at 1:52 p.m., RN #7 approached the medication cart. She had not been observed to be at the nurses'</p>		<p><b>practice does not recur; 3, The Nurse Managers will complete an audit that will be conducted on Medication Administration for nursing staff, (5x) a week times (2) weeks, (4) times a week times (2) weeks, (3) times a week times (2) weeks and weekly thereafter times (4) months to ensure compliance and proper handling and distribution of controlled substances and routine medications. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 4 The Director of nursing/ NPE or designee will provide results of the audits at the monthly Performance Improvement Meeting for any additional recommendations for three months to ensure we are meeting regulatory guidelines for the safe delivery of Medications to our residents.</b></p>		

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	<p>station at 1:50 p.m. When RN #7 approached the medication cart, RN #5 indicated "(name of RN #7) you left this on the cart." RN #5 indicated to RN #7, "no one was watching this", as she pointed to the unmarked pill in the medication cup sitting on the med cart.</p> <p>On 9/14/15 at 2:10 p.m., RN #7 was interviewed. She indicated the pill left on top of the medication cart unsupervised, was a Percocet (Schedule II controlled substance, opiod analgesic), dose of 10-325 milligrams. She indicated she had taken the pill out of the medication cart narcotic drawer and put it in the medication cup to take to the resident's room. She indicated just as she was going to the room, the ultrasound technician had come to do an ultrasound on the resident. RN #7 indicated she had asked an ISDH (Indiana State Department of Health) Surveyor what to do with the medication. She indicated the ISDH surveyor had instructed her to follow the facility policy and procedure. RN #7 indicated she was not to take the medication out of the medication bubble pack until the medication was ready to be given to the resident. RN #7 indicated she "was in a dilemma" because she had already removed the pill from the medication bubble pack and was unable to give it to the resident. RN #7</p>			

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	<p>indicated she placed the pill down on the medication cart and was getting ready to put the narcotic pill in the cart when RN #5 approached the medication cart.</p> <p>On 9/15/15 at 10:40 a.m., the Corporate Nurse Manager provided a current copy of the facility policy and procedure dated 7/1/15, "Medication: Administration: General." The policy included, but was not limited to, the following: "...Purpose: to provide a safe, effective medication administration process...Remain with patient until administration is complete. Do not leave medications at the patient's bedside...If medication is refused by patient, discard medication and attempt to administer again at a later time...."</p> <p>On 9/15/15 at 11:46 a.m. the Corporate Nurse Manager provided a current copy of the facility policy and procedure for "Management of Controlled Drugs", dated 5/5/14. This policy and procedure, included but was not limited to, the following: "...All staff who administer medications will safeguard controlled drugs...Controlled drugs will not be accessible to other than licensed nursing staff...All controlled drugs are stored under double lock...Access to keys for controlled drugs double locked box/cabinet for each medication cart is limited to the licensed nursing staff...."</p>			

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F 0371 SS=F Bldg. 00	<p>On 9/15/15 at 11:55 a.m. the ADON (Assistant Director of Nursing) provided a roster of the resident's on the 100 and 200 halls. This form indicated of the 24 residents on the 100 hall, 13 residents were mobile and of the 13 mobile resident's, 7 were considered confused. Of the 17 resident's on the 200 hall, 9 residents were mobile and of those, 2 were considered to be confused.</p> <p>3.1-45(a)(2)</p> <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 staff failed to wash their hands for the recommended amount of time and perform hand hygiene after touching soiled items and before assisting residents with their meals</p>	F 0371	3.1-45(a)(2)F 371 SS=F 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY <b>Whatcorrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> 1) No	09/30/2015

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	<p>and feeding residents their meals. The facility also failed to protect clean clothing protectors from potential contamination, silverware from potential contamination and failed to ensure staff did not handle food from a resident's meal tray with bare fingers before giving it to the resident to eat. This occurred during 7 observations in 2 of 2 dining rooms and the passing of hall trays potentially affecting 49 of 49 residents who ate their meals in the main dining room, 9 of 9 residents who ate their meals in the assist dining room, and 30 of 30 residents who received room trays.</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal in the main dining room on 9/8/15, the following was observed:</p> <p>At 11:17 a.m., a male resident was observed self-propelling himself in his wheelchair with the assistance of his left hand on the wheel of the wheelchair. A stack of clean clothing protectors were observed on his lap. The bottom clothing protector was resting directly on his slacks and the edges of all the clothing protectors were resting up against his shirt. He was observed to place 10 clean clothing protectors at place settings on dining room tables with his left hand.</p>		<p>specific resident was identified in sample. Residents residing at the facility have the potential to be affected by the alleged deficient practice. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> 2) Residents residing at Genesis New Haven Center have the potential to be affected by the alleged deficient practices related to infection control. Audits will be implemented to manage and monitor infection control practices. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> 3) Staff to receive re-education and training on proper technique of infection control processes related to handwashing, proper handling of linens, transporting of residents to the dining areas, and handling of food items related to infection control. Training from 09/16/2015 and ongoing to ensure we are meeting infection control guidelines. Residents will no longer be able to participate in the distribution of linens to other residents. They were educated on infection control practices within the facility and verbalized understanding of why they will no longer distribute clothing protectors. <b>How the corrective action(s)</b></p>		

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	<p>At 11:33 a.m., Activity Staff #1 was observed to push a resident seated in a wheelchair into the dining room and up to a dining room table. She was then observed to place a clean clothing protector on the resident. She was not observed to wash her hands or perform hand hygiene prior to handling the clean clothing protector.</p> <p>At 11:38 a.m., Certified Nursing Assistant (CNA) #2 was observed to push a resident seated in a wheelchair into the dining room and up to a dining room table. She was then observed to place a clean clothing protector on the resident and obtain 2 glasses of ice for the resident. She was not observed to wash her hands or perform hand hygiene prior to handling the clean clothing protector and obtaining the glasses of ice.</p> <p>At 11:41 a.m., Activity Staff #1 was observed to push a resident seated in a wheelchair into the dining room and up to a dining room table. In order to push the resident's wheelchair to her table setting, Activity Staff #1 had to push another resident seated in a wheelchair already at the dining room table away from the table. She then pushed the wheelchair of the first resident to her table setting and moved the second</p>		<p><b>will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>4) Facility Department Heads and Managers will monitor meal services to ensure that the deficient practice does not occur. Audit tools will be put in place to monitor the areas identified in the 2567 for compliance with Infection control processes. Audits will be conducted on Infection Control Processes by Facility Managers, (5x) a week times (2) weeks, (4) times a week times (2) weeks, (3) times a week times 2() weeks and weekly thereafter times (4) months to ensure compliance. The Director of Nursing/NPE or Designee to provide results of the reviews to monthly Quality Assurance Committee meeting for review and approval by the facility Administrator for any additional recommendations for three months.</p>		

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	<p>resident back to her table setting. She then was observed to place clean clothing protectors on both of the residents. She was not observed to wash her hands or perform hand hygiene prior to handling the clean clothing protectors.</p> <p>At 11:54 a.m., CNA #3 was observed to serve the lunch meal to a resident. She asked the resident if he wanted her to cut his Sloppy Joe sandwich in half. When he replied "yes", she was observed to pick up his knife with her right hand and hold the bun with her bare left hand while she cut his sandwich in half.</p> <p>At 12:00 p.m., CNA #4 was observed to enter the dining room. He was observed to lather his hands with soap for 10 seconds prior to rinsing. He then was observed to assist with meal service.</p> <p>At 12:05 p.m., CNA #3 was observed to cut a Sloppy Joe sandwich in half for a resident by holding her knife in her right hand and holding the bun with her bare left hand. She then was observed to pick up the sandwich with both bare hands to separate the two halves.</p> <p>At 12:11 p.m., CNA #4 was observed to lather his hands with soap for 10 seconds prior to rinsing.</p>			

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	<p>2. During an observation of the lunch meal in the main dining room on 9/10/15, the following was observed:</p> <p>At 11:16 a.m., the same male resident previously observed on 9/8/15, was observed to obtain a stack of 9 clean clothing protectors from a cabinet in the dining room and place them on his lap. The bottom clothing protector was resting on his slacks and and edges of all the clothing protectors were resting up against his shirt. He was observed to self-propel himself throughout the dining room with the assistance of his left hand on the wheel of the wheelchair and placed the clean clothing protectors at place settings on the dining room tables with his left hand.</p> <p>At 11:18 a.m., the male resident repeated the process of passing a stack of 14 clean clothing protectors to place settings. He self-propelled himself throughout the dining room with the assistance of his left hand on the wheel of the wheelchair. He was also observed to wipe his nose with his left hand. He was observed to keep the stack of clean clothing protectors steady on his lap with his arm, and used his left hand to place the clothing protectors at the place settings on the dining room tables.</p>			

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	<p>At 11:22 a.m., a female resident was observed to enter the dining room and remove a stack of 8 clean clothing protectors from the cabinet. She was observed to hold the clothing protectors up against her top as she passed them out at place settings on the dining room tables.</p> <p>At 11:23 a.m., the same female resident was observed to repeat the process of passing a stack of 7 clean clothing protectors to place settings on the dining room tables by holding them up against her top.</p> <p>At 11:27 a.m., RN #5 was observed to push a resident who was seated in a wheelchair into the dining room and up to a dining room table. She was observed to place a clean clothing protector on the resident. She was not observed to wash her hands or perform hand hygiene prior to handling the clean clothing protector.</p> <p>At 11:30 a.m., a female resident who was seated in her wheelchair at a dining room table was observed to unroll her silverware from the linen napkin at her place setting and place the napkin and the silverware into the pocket of her sweater.</p> <p>At 11:31 a.m., RN #6 was observed to push a resident seated in a wheelchair</p>			

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	<p>into the dining room and up to a dining room table. She was observed to place a clean clothing protector on the resident. She was not observed to wash her hands or perform hand hygiene prior to handling the clean clothing protectors.</p> <p>At 11:34 a.m., CNA #2 was observed to push a resident who was seated in a wheelchair into the dining room and up to a dining room table. She was observed to place a clean clothing protector on the resident. She was not observed to wash her hands or perform hand hygiene prior to handling the clean clothing protectors.</p> <p>At 11:39 a.m., the female resident who placed her silverware into the pocket of her sweater, was taken to the bathroom by CNA #4. She was observed to still be wearing her clothing protector and her napkin and silverware were still in the pocket of her sweater.</p> <p>At 11:42 a.m., RN #7 was observed to serve the lunch meal to a resident. She was observed to reposition the resident's hot dog on the plate by picking up the bun with her bare hands.</p> <p>At 11:47 a.m., CNA #8 was observed to push a resident seated in a wheelchair into the dining room and up to a dining room table. She was observed to place a</p>			

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	<p>clean clothing protector on the resident. She was not observed to wash her hands or perform hand hygiene prior to handling the clean clothing protector. She was then observed to carry a covered bowl of soup with packaged crackers down the hallway for a resident. She was not observed to wash her hands or perform hand hygiene before obtaining the bowl of soup and crackers for a resident.</p> <p>At 11:50 a.m., CNA #4 was observed to bring the female resident back to the dining room he had taken to the bathroom. He pushed her up to her setting at the dining room table. She was observed to still be wearing her clothing protector. At 11:53 a.m., CNA #9 was observed to serve her lunch meal. CNA #9 noticed she did not have any silverware at her place setting. CNA #4 informed CNA #9 the resident's silverware was in the pocket of her sweater. The resident was asked to remove the silverware from her pocket. She immediately began eating with the silverware. Neither CNA #9 nor CNA #4 provided her with clean silverware.</p> <p>3. During an observation of the lunch meal in the assist dining room on 9/10/15, the following was observed:</p>			

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NAME OF PROVIDER OR SUPPLIER  NEW HAVEN CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 DALY DR NEW HAVEN, IN 46774
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	<p>At 12:36 p.m., CNA #10 was observed to move a chair over next to a resident and then move the resident's wheelchair closer to the table. She was then observed to begin feeding the resident lunch and also moved a bowl of soup and a bowl of peaches closer to a resident seated at the same table. She was not observed to wash her hands prior to feeding the resident or assisting the other resident.</p> <p>At 12:38 p.m., RN #11 was observed to wash her hands for the recommended amount of time. She was observed to sit down next to a resident seated at a dining room table to assist him to eat. She then was observed to get up from the table, reposition his wheelchair, and immediately sit down next to the resident to continue assisting him with his meal. She was observed to get up from the table and pour him a glass of water. She was not observed to wash her hands or perform hand hygiene after touching soiled surfaces.</p> <p>4. During an observation of the lunch meal in the main dining room on 9/14/15, the following was observed:</p> <p>At 11:19 a.m., Activity Staff #1 was observed to push a resident seated in a wheelchair into the dining room and up</p>			

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	<p>to a dining room table. She was observed to place a clean clothing protector on the resident. She was not observed to wash her hands or perform hand hygiene prior to handling the clean clothing protector.</p> <p>At 11:21 a.m., CNA #12 was observed to push a resident seated in a wheelchair into the dining room and up to a dining room table. She was observed to place a clean clothing protector on the resident. She was not observed to wash her hands or perform hand hygiene prior to handling the clean clothing protector.</p> <p>At 11:27 a.m., CNA #3 was observed to push a resident seated in a wheelchair into the dining room and up to a dining room table. She was observed to place a clean clothing protector on the resident. She was not observed to wash her hands or perform hand hygiene prior handling the clean clothing protector.</p> <p>At 11:28 a.m., CNA #13 was observed to push a resident seated in a wheelchair into the dining room and up to a dining room table. She was observed to place a clean clothing protector on the resident. She was then observed to push a second resident seated in a wheelchair up to a dining room table. She was observed to place a clean clothing protector on the resident. She was not observed to wash</p>			

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	<p>her hands or perform hand hygiene prior to handling the clean clothing protectors.</p> <p>At 11:32 a.m., CNA #13 was observed to push a resident seated in a wheelchair into the dining room and up to a dining room table. She was observed to place a clean clothing protector on the resident. She was not observed to wash her hands or perform hand hygiene prior to handling the clean clothing protector.</p> <p>At 11:33 a.m., CNA #3 was observed to push a resident seated in a wheelchair into the dining room and up to a dining room table. She was observed to place a clean clothing protector on the resident. She was not observed to wash her hands or perform hand hygiene prior to handling the clean clothing protector.</p> <p>At 11:35 a.m., CNA #12 was observed to push a resident seated in a wheelchair into the dining room and up to a dining room table. She was observed to place a clean clothing protector on the resident. She was not observed to wash her hands or perform hand hygiene prior to handling the clean clothing protector.</p> <p>At 11:37 a.m., CNA #4 was observed to push a resident seated in a wheelchair into the dining room and up to a dining room table. He started to place a clothing</p>			

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	<p>protector on the resident, but was advised by a resident already seated at the dining room table she had taken it off of herself because she had spilled apple juice on it. He was then observed to obtain a clean clothing protector from the cabinet in the dining room and placed it on the resident. He was not observed to wash his hands or perform hand hygiene after handling the soiled clothing protector and prior to handling the clean clothing protector.</p> <p>At 11:41 a.m., CNA #3 was observed to serve lunch to a resident. She was observed to pick up the lettuce leaf from the plate, remove the top slice of bread from the sandwich, place the lettuce leaf on the sandwich and return the top slice of bread from the sandwich with her bare hands. She was then observed to cut the sandwich in half by holding the knife in her right hand and holding the bun with her bare left hand.</p> <p>At 11:56 a.m., CNA #3 was observed to carry a room tray from the dining room through common hallways to a resident's room. Before leaving the dining room, she was observed to place the silverware on top of a linen napkin on the tray. The silverware was not covered to protect it from contamination.</p> <p>At 12:08 p.m., LPN #14 was observed to</p>			

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	<p>enter the dining room and wash her hands for the recommended amount of time. She then crossed her arms in front of her with the palms of her hands and fingers touching her upper arm and the sleeves of her uniform top. She then was observed to serve a resident the lunch meal.</p> <p>5. During an observation of the lunch meal on 9/8/15 in the assist dining room, nine residents were assisted with their meal and the following was observed:</p> <p>At 12:22 p.m., CNA #2 was observed to wash her hands with soap and water, lathering her hands for 20 seconds before she rinsed her hands with water. She dried her hands with clean, dry paper toweling. CNA #2 then touched a resident's wheelchair handles to position the resident closer to the table. The CNA then touched her uniform when she sat down next to a resident and assisted the resident with their meal without performing hand hygiene after she contaminated her hands.</p> <p>At 12:25 p.m., LPN #15 was observed to wash her hands with soap and water, lathering her hands for 21 seconds before rinsing her hands with water. She dried her hands with clean, dry paper toweling. LPN #15 then touched her uniform pants to pull them up before she sat down</p>			

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	<p>between 2 residents. She then assisted both residents to eat their meals without performing hand hygiene after she contaminated her hands.</p> <p>At 12:28 p.m., LPN #16 was observed to wash her hands with soap and water. She lathered her hands for 10 seconds before she rinsed her hands with water and dried her hands with clean, dry paper toweling. LPN #16 then sat down next to a resident and assisted them to eat their meal.</p> <p>6. An observation of the meal tray delivery in the South hall on 9-8-2015 at 11:35 a.m., indicated CNA #4 delivered a meal tray to room 103, washed his hands at the resident's bathroom sink for 10 seconds and continued to pass meal trays to the residents in the South hall.</p> <p>7. An observation of the meal tray delivery in the South hall on 9-9-2015 at 11:30 a.m., indicated CNA #4 rubbed his nose and without washing his hands or performing hand hygiene, and continued to pass meal trays to the residents in the 200 hall.</p> <p>The Director of Nursing (DON) and the Clinical Operations Manager were interviewed on 9/15/15 at 10:43 a.m. During the interview, they indicated staff were to lather their hands for 20 seconds</p>			

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	<p>prior to rinsing, before starting to pass meal trays, and after touching a soiled object. They also indicated everything on a hall tray should be covered including the silverware, the silverware the resident had placed in the pocket of her sweater should have been replaced, and clothing protectors should be protected from possible contamination. They further indicated staff were not to touch a resident's food with their bare hands.</p> <p>A current facility policy "Food Handling", with a revision date of 3/16/15 and provided by the DON on 9/15/15 at 11:35 a.m., indicated "...Foods are...served in a safe and sanitary manner...To prevent bacterial contamination and the possible spread of infection...No bare hand contact with ready to eat food is allowed...Appropriate utensils are used to serve food...During transportation of food from the kitchen to the dining rooms, patient/resident rooms, or other dining locations, care is taken... and protected from contamination...."</p> <p>A current facility policy " Linen Handling", dated 9/1/04 and on the table in the conference room on 9/13/15 at 12:34 p.m., indicated "...All linen will be handled...to contain and minimize exposure to waste products...Cleanse hands before handling clean linen; do not</p>			

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	<p>allow linen to touch uniform...Cleanse hands after handling soiled linen and before handling clean linen...."</p> <p>A current facility policy "Hand Washing", with a revision date and on the table in the conference room on 9/13/15 at 12:34 p.m., indicated "Hand washing is performed frequently and using correct hand washing technique...To minimize the spread of disease...Hand washing is performed after:...Before touching any clean utensils, plates, cups...When moving from one task to another...Hand washing technique includes the following...Wash hand for a minimum of 15-20 seconds...."</p> <p>3.1-21(i)(2)</p>						