

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155473	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/09/2016
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NAME OF PROVIDER OR SUPPLIER  CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY ST BERNE, IN 46711
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 2, 3, 4, 5, 8 and 9, 2016</p> <p>Facility number: 000546 Provider number: 155473 AIM number: 100267370</p> <p>Census bed type: SNF/NF: 32 Total: 32</p> <p>Census payor type: Medicare: 3 Medicaid: 27 Other: 2 Total: 32</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on August 11, 2016 by 17934.</p>	F 0000	Submission of this plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance.	
F 0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE			

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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Bldg. 00	<p><b>PLANS</b></p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to implement a plan of care to include interventions recommended by the Registered Dietitian (RD) for 1 of 4 residents who met the criteria for significant weight loss. (Resident #1)</p> <p>Findings include:</p> <p>On 8/5/16 at 10:10 a.m., the clinical record of Resident #1 was reviewed. Diagnoses included, but were not limited to, the following: anemia, anxiety, chronic obstructive pulmonary disease, rheumatoid arthritis, depression,</p>	F 0279	<ol style="list-style-type: none"> <li>Resident #1 care plan was updated immediately to reflect the Registered Dietitian recommendations</li> <li>All resident care plans were audited to assure that they all reflected current care interventions including all of the Registered Dietitians dietary recommendations for the past 3 months. Director of Nursing was re-educated on care plans and how they need to show all recommendations given by the Registered Dietitian.</li> <li>The facility's policy for care plan development has been reviewed and no changes are recommended at this time. The Director of Nursing was re-educated on care plans and</li> </ol>	09/08/2016

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	<p>congestive heart failure and dementia. The MDS (Minimum Data Set) Assessment, dated 7/1/16, included, but was not limited to, the following: independent cognition and limited assist with eating (resident highly involved in activity, staff provide guided maneuvering of limbs).</p> <p>A Nutritional Progress Note, dated 5/6/16, indicated the following: "RD review of weight changes...No sig (significant) wt (weight) changes...wt (arrow up and arrow down). Rec (recommend) place on SWAT (Skin, Weight, Assessment Team)...."</p> <p>On 8/8/16 at 4:25 p.m., the DON (Director of Nursing) provided a copy of the resident's plan of care, dated 7/21/16, which addressed "Alteration in Nutritional...status...." Approaches included, but were not limited to, the following: "Monitor Weight...Notify Nursing of significant or progressive weight change...SWAT prn (as needed)...comfort measures..." Documentation was lacking of frequency of weight monitoring.</p> <p>On 8/8/16 at 11:00 a.m., the RD was interviewed. She indicated she had a form which documented the resident's weights. At 11:24 a.m., the RD provided</p>		<p>how they need to show all recommendations given by theRegistered Dietitian. An audit tool hasbeen developed.</p> <p>4. The DON and/or designee will audit all Dietaryrecommendations given by the Registered Dietitian and place them in the resident's care plan 1x bi-weekly for 3 months and then monthly thereafter todetermine ongoing compliance with monitoring dietary recommendations. Should concerns be noted during theaforementioned audits, immediate corrective actions shall be taken. The DON and/or designee will report findingsof these audits and any corrective actions to the QA committee monthly on anongoing basis for a minimum of 6 months and the plan will be adjustedaccordingly.</p>				

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	<p>the form "(Name of Facility) Weights 2016", which included the following weights for Resident #1:</p> <p>January: 128 lbs February: 126.7 lbs March: 125.4 lbs April: 121.6 lbs May: 118.8 lbs June: 116.1 lbs July: 102.1 lbs.</p> <p>On 8/8/16 at 11:24 a.m., the RD was interviewed. She indicated the resident began losing weight in June 2016, when her weight was 116 lbs. The RD referred to the Weights 2016 form, which indicated the resident's percent of weight loss for 2016. She indicated the resident had a 12.1% weight loss from July to June; a 16% weight loss from July to April; and a 20.2% weight loss from July to January. The RD indicated these weights corresponded with the MDS. She indicated she noticed the resident started to lose weight significantly in July. The RD indicated the resident was put on weekly weights in July.</p> <p>On 8/8/16 at 11:24 a.m., the RD provided a copy of the resident's "Individual Swat (Skin, Weight, Assessment Team) Record. The form had an initial meeting date of 7/7/16. The form had one date documented from June, which was a</p>			

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	<p>weight of 116.1 lb., dated 6/5/16.</p> <p>On 8/9/16 at 9:10 a.m., the DON provided a copy of the policy and procedure "Skin and Weight Assessment Team (SWAT) Protocol, " dated 10/2013. The protocol included, but was not limited to, the following: "...The Registered Dietician will be responsible to address any SWAT issues listed on the RD referral form at the time of routine facility visits...All residents identified for SWAT due to weight concerns will be weighed weekly. NOTE: In the case of resident's on hospice, obtaining of weights will be at the discretion of the resident/legal representative, respectful of resident condition and potential discomfort associated with the obtaining of weights..."</p> <p>On 8/9/16 at 9:50 a.m., the DON was interviewed. She indicated the above form "Individual SWAT Record" included all the SWAT notes. She indicated the resident was started on the SWAT program on 7/7/16. The DON indicated she does not read the Dietary notes. She indicated the RD gives her a form, which has recommendations for residents to be added to the SWAT program. At this time, the DON provided a copy of the "...Registered Dietician Recommendations to Facility",</p>			

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	<p>dated 5/6/16. Documentation was lacking of the resident having any recommendation on 5/6/16. The DON indicated at this time, there were no additional weights for the resident in May 2016 (other than the weight on 5/1/16), and for June 2016, (other than the weight documented on 6/5/16.)</p> <p>On 8/9/16 at 11:20 a.m., the DON provided a current copy of the policy and procedure, dated 10/2014, for "Care Plan Development and Review." The policy included, but was not limited to, the following: "...Care plans shall be revised with changes in the resident's condition. Changes in the resident's care as a result of condition change shall be promptly addressed on the care plan..."</p> <p>On 8/9/16 at 12:20 p.m., the FSM (Food Service Manager) was interviewed. She indicated she was unaware of the May 2016 recommendation from the RD of the resident to be on SWAT.</p> <p>On 8/9/16 at 1:00 p.m., the DON was interviewed. She indicated per policy, the weight monitoring frequency should be indicated on the resident's care plan. She indicated the resident had been on "Comfort Measures only" for at least a year.</p>			

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F 0323 SS=E Bldg. 00	<p>3.1-35(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the maintenance and mechanical rooms were secured which stored chemicals and cleaning supplies and failed to ensure personal care items and cleaning supplies were secured inside residents' rooms. This deficiency had the potential to affect 4 confused and independently mobile residents as identified by the facility, of the 32 residents who resided in the facility.</p> <p>Findings include:</p> <p>During the initial tour of the facility on 8-2-2016 at 10:00 a.m., the following were observed:</p> <p>The mechanical room door in the North hall was observed to be unlocked. Inside the room, were multiple maintenance supplies and a cabinet with "Flammable"</p>	F 0323	<p>1. and 2. No residents were negatively affected but all residents have the potential to be affected. The maintenance room and mechanical room doors were both shut and locked to secure chemicals that could be harmful to residents. All resident's rooms were cleaned. Any personal items and cleaning items were secured inside residents' rooms that can be hazardous to other residents.</p> <p>3. The Director of Maintenance was re-educated immediately on keeping the mechanical and maintenance room closed and locked to secure all chemicals supplies and any items that can be hazardous to residents. The Housekeeping Supervisor and housekeeping staff were re-educated on cleaning resident's rooms and to make sure all items that can be hazardous are secured. All nursing staff were re-educated on securing all items that can be hazardous to residents. All respiratory staff were re-educated on securing their</p>	09/08/2016

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	<p>written on the outside. Inside the unlocked cabinet labeled "Flammable," were various paints, sprays and cleaners. In the same room, was another unlocked cabinet with various cans of paint and polyurethane.</p> <p>In room 301, an observation of the room door indicated it was opened and a large container of powder and peri wash was out on the overbed table.</p> <p>At the nurses station, a pump bottle of "brand name" pain relief spray, two small bottles of hand sanitizer and a tube of lotion were observed at the accessible nurse station counter.</p> <p>In room 209, a container of antibacterial wipes was on the bedside table.</p> <p>In room 105, a container of bleach wipes was observed on the bedside table.</p> <p>In room 103, a container of bleach wipes and a container of lotion was observed on the bedside table.</p> <p>Observations of several of the residents' rooms indicated many personal care products were accessible and not secured within the rooms. Observations indicated the following:</p> <p>On 8-2-2016 at 1:46 p.m., room 207 had personal care products of shaving cream and assorted lotions out on the counter by the sink. A package of "brand" cough drops with "keep out of reach of</p>		<p>door to keep all hazardous items secured. An audit tools have been developed.</p> <p>4. The Director of Maintenance and/or designee will monitor themaintenance, mechanical, and respiratory room to be sure they are secured daily on scheduled work days for a month and then weekly thereafter. The housekeeping supervisor and/or designee will monitor all residents rooms to ensure that hazardous items are secured daily on scheduled work days for a month, then weekly for a month, then bi-weekly for a month, and then monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p>		

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	<p>children" on the package and a container of "brand" cough suppressant, topical analgesic ointment was on the overbed table with "keep out of reach of children...if swallowed, get medical help or contact a Poison Control Center right away...." on the label. In the bathroom, on the back of the toilet was a can of shaving cream and a "brand" air freshener, both with "keep out of reach of children" on the labels.</p> <p>On 8-2-2016 at 2:07 p.m., room 101 had all sorts of lotions, body wash and a container of hand sanitizer in the room.</p> <p>On 8-2-2016 at 2:20 p.m., room 205 had a can of "brand" shaving cream, lotion and a "brand" air freshener on the back of the toilet. On the counter by the sink in the room, there were 2 mouthwash bottles, a box of denture cleanser, a can of shaving cream and a container of deodorant all with "keep out of reach of children" on the labels. In addition, there were 2 pump bottles of lotion, shampoo and body wash and perineal wash. On the overbed table, there was a 3 ounce container of "brand" cough suppressant, topical analgesic ointment with "keep out of reach of children" on the label.</p> <p>On 8-2-2016 at 2:29 p.m., room 103 had a container of bleach wipes on the</p>			

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	<p>counter which was at waist height. "Keep out of reach of children" was printed on the label.</p> <p>On 8-2-2016 at 2:39 p.m., room 206 had an overbed table with a 4 ounce container of mouthwash, a 4 ounce bottle of baby lotion and a small container of "brand" deodorant, all with "keep out of reach of children" on the labels. On the counter by the sink, were 2 bottles of "brand" shampoo and body wash and a 4 ounce bottle of body lotion, both with "keep out of reach of children" on the labels.</p> <p>On 8-2-2016 at 2:44 p.m., room 414 had three 8 ounce bottles of peri wash, a bottle of hydrogen peroxide, a 20 ounce bottle of skin lotion and a 4 ounce tube of skin protectant both with "for external use only" on the labels. In addition, an 11 ounce container of cocoa butter lotion with "for external use only, keep out of reach of children" on the label, a 30 ounce bottle of "brand" laundry spray and an 8 ounce spray aerosol of "brand" air freshener, both with "keep out of reach of children" on the labels were also found in the room.</p> <p>On 8-2-2016 at 2:45 p.m., room 208 had a table next to the chair with a 10 ounce bottle of nail polish remover and a 7.5 ounce container of petroleum jelly with</p>			

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	<p>"keep out of reach of children" on the labels. At the sink, was an open container with 4 disposable razors inside the container with the blade of the razor up, a 4 ounce bottle of caring body lotion and an 8 ounce bottle of "brand" shampoo and body wash with "keep out of reach of children" on both of the labels.</p> <p>On 8-2-2016 at 2:47 p.m., room 212 had a container of "brand" cough suppressant, topical analgesic ointment and a 33 ml (milliliter) bottle of eyeglass cleaner on the bedside table, both with "keep out of reach of children" on the labels. At the sink, there were two 8 ounce containers of "brand" shampoo and body wash with "keep out of reach of children" on the labels. A 30 gram bottle of a prescription anti-fungal topical powder was observed on top of the microwave.</p> <p>On 8-2-2016 at 2:51 p.m., room 209 had a bedside table with a 40 count container of antibacterial wipes, an 8 ounce container of lens cleaner, two 8 ounce containers of "brand" air freshener, a 1.4 ounce container of deodorant, all with "keep out of children" on the labels. On the counter by the sink, there was an 8 ounce bottle of "brand" shampoo and bodywash with "keep out of reach children" on the label.</p>			

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	<p>On 8-2-2016 at 2:53 p.m., room 105 had a counter under the window with containers of body wash and deodorant. There was a bottle of aftershave with "keep out of reach of children" on the label, a tube of toothpaste, bodywash with "for external use only" on the label, shaving lotion, shaving cream and a 3 in 1 shampoo on a shelf in the bathroom. All of the products were within reach and unsecured in the resident's bathroom.</p> <p>An observation of the unattended nurse's station on 8-2-2016 at 4:25 p.m., indicated a container of a "brand name" pain relief spray with "keep out of reach of children" on the label and 3 small containers of hand sanitizing gel were out on the accessible counter.</p> <p>An observation of the nurse's station on 8-3-2016 at 8:55 a.m., indicated a container of hand sanitizer and a container of "brand name" germicidal wipes were both on the counter and accessible inside the nurse's station. A door was observed at the nurse's station that had the capability to lock and secure the area inside the nurse's station, but the door was not closed or locked. At this time, the door at the nurse's station was observed to be wide open.</p>			

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	<p>An observation of the unattended nurse's station on 8-3-2016 at 9:33 a.m., indicated a container of germicidal wipes and a 2 ounce container of hand sanitizing gel were out on the accessible counter inside the nurse's station.</p> <p>An observation of the unattended maintenance room door on 8-3-2016 at 3:45 p.m., indicated the door was open. Inside the maintenance room were cans of paint, a spray cleaner and spackling within view of the hallway.</p> <p>An observation of the maintenance room on 8-4-2016 at 2:10 p.m., indicated the door was not secured tightly and the room was unattended. Inside the room, were paint cans and cleaning solution.</p> <p>An observation of the maintenance room on 8-4-2016 at 2:35 p.m., indicated the Maintenance Man was observed to leave the room with the door not secured. The door was able to be opened. A lock was observed on the door handle and was not engaged.</p> <p>An observation of the mechanical room door on 8-4-2016 at 3:40 p.m., indicated the mechanical room door was still unlocked with the same supplies and equipment inside.</p>			

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NAME OF PROVIDER OR SUPPLIER  CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY ST BERNE, IN 46711
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	<p>An observation of the mechanical room door on 8-5-16 at 8:30 a.m., indicated the door was unlocked at this time, with the contents remaining the same.</p> <p>An observation of the mechanical room on 8-5-16 at 9:30 a.m., indicated the mechanical room door was observed to be unlocked with the contents remaining the same with the exception of the following, two spray cans of "solvent based stripping paint" with "Danger, extremely flammable" written on the cans. Both cans were observed to be laying on a cart, within 12 inches of the floor.</p> <p>An observation of the respiratory room door by the North dining room on 8-5-2016 at 10:45 a.m., indicated the door was wide open and the room was unattended. A container of disinfectant wipes were observed from the doorway on a counter with "keep out of reach of children" on the label.</p> <p>An observation of the mechanical room on 8-8-2016 at 9:05 a.m., indicated the door was unlocked and the room was unattended. An observation of the mechanical room door handle indicated there was a lock on the handle and it was in the unlocked position. An observation at this time inside the room was a large,</p>			

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	<p>metal, unlocked cabinet with "flammable" labeled on the outside. Inside the unlocked cabinet, were 4 shelves of various products including but not limited to, paint, polyurethane, cleaning chemicals, bleach, lubricants, and paint thinner with "Keep out of Reach of Children" on the labels. A gallon container of "outdoor coil cleaner" located on the bottom shelf of the cabinet was labeled with "fatal if swallowed" and "keep out of reach of children."</p> <p>An observation on 8-8-2016 at 9:07 a.m., indicated the Maintenance Man was observed to leave the maintenance room and left the door unsecured.</p> <p>A list of confused and independently mobile residents was provided by the Corporate Nurse on 8-8-2016 at 9:35 a.m. The list indicated there were 4 confused and independently mobile residents in the facility.</p> <p>On 8-8-2016 at 1:40 p.m., one of the facility identified, confused and independently mobile residents was observed to walk down the North hall and past the maintenance room door and the mechanical room door and into the North Dining Room. The resident indicated he was looking for a nurse.</p>			

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	<p>An interview and observation with the Administrator and the DON (Director of Nursing) on 8-8-2016 at 2:53 p.m., indicated the mechanical room and the maintenance room doors should not be unlocked. An observation of each of the doors, indicated the Administrator was able to lock each door. At this time, the Maintenance Man was observed to be standing outside the mechanical and maintenance room door. The Maintenance Man was interviewed and he indicated he was not aware that either of the doors (mechanical room and maintenance room) were supposed to be locked. Further interview with the Administrator and DON, indicated several residents were observed to have personal care products and cleaning products out in their rooms or bathrooms which had "Keep out of Reach of Children" on the labels.</p> <p>An observation of room 402 on 8-8-2016 at 3:02 p.m., indicated multiple over the counter products were out in the room and a 32 ounce bottle of "All Purpose Cleaner" was observed on the counter by the sink. The label indicated "may irritate eyes...may irritate skin...dangerous fumes formed when mixed with other products...keep out of reach of children...."</p>			

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	<p>A current policy, "Storage and Security of Items Potentially Hazardous to Residents" dated 1/2016 was provided by the Administrator on 8-8-2016 at 3:08 p.m. The policy indicated, "...this facility shall provide each resident an environment that is as free as possible from hazards over which the facility has control, to include but not be limited to safe storage of toxic chemicals and medications...resident vulnerability is based on risk factors including the individual resident's functional status, medical condition, cognitive abilities...examples of hazards...disabled locks...access to toxic chemicals...certain sharp items may be appropriate for many residents but hazardous for others with cognitive impairments...."</p> <p>"...Procedure:</p> <p>2. Chemicals must be secured when not in use unless in the possession/visual range of the employee using the chemical, in which case, the chemical would be securely stored after use.</p> <p>3. Individual abilities of the resident and potential safety concerns must be considered by the Interdisciplinary Team in determining items which may be appropriate for a resident's personal use, yet hazardous for another resident who could gain access...."</p> <p>3.1-45(a)(1)</p>			

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F 0371 SS=F Bldg. 00	<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 ensure staff washed their hands after coughing, touching residents, and touching soiled items, and before assisting residents with their meals and feeding residents their meals. The facility also failed to ensure beverages on room trays were covered when transported through common hallways and clean clothing protectors were protected from potential contamination. This deficient practice had the potential to affect 31 of 32 residents who received food and beverages prepared and served by the facility.</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal in the dining room on 8/2/16, the</p>	F 0371	<p>1. and 2. No residents were negatively affected but all residents have the potential to be affected. All staff, including C.N.A.'s # 1, 2, 3, 5, 6, 8, Dietary Aide #4, and LPN #7, were re-educated on proper distribution and meal service undersanitary conditions including but not limited to: Proper hand washing technique with return demonstration; when to wash hands- including but not limited to, after moving a stool, coughing, rubbing residents' back, moving a resident's chair, removing a soiled clothing protector, picking up crumbs of food, after using keys to open door, placing hands on hips, pushing hair behind ear, before passing beverages, meal trays, picking up utensils etc. Staff should not touch the rims of any cup or dish served to residents. Staff should not carry uncovered drinks down the hall.</p> <p>3. All staff, including C.N.A.'s #</p>	09/08/2016

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	<p>following was observed:</p> <p>At 11:53 a.m., Certified Nursing Assistant (CNA) #1 was observed to wash her hands appropriately for the recommended amount of time. She was observed to move a dining room chair with her clean hands closer to a resident seated in her Geri-chair at a dining room table. She was then observed to move the resident's Geri-chair into a more upright position. She immediately started to feed the resident her lunch meal without re-washing her hands or performing hand hygiene.</p> <p>At 12:00 p.m., CNA #2 was observed to pick up a dining room chair with her hands and move it next to a resident seated in her Broda chair at a dining room table. She was then observed to pick up the resident's silverware and began to feed her the lunch meal. She was not observed to re-wash her hands or perform hand hygiene after touching a soiled item.</p> <p>At 12:04 p.m., Both CNA #1 and CNA #2 were observed to get up from the dining rooms chairs where they were seated and use hand sanitizer on their hands. When they returned to the dining room table they switched residents they were feeding.</p>		<p>1, 2, 3, 5, 6, 8, Dietary Aide #4, and LPN #7, werere-educated on proper distribution andmeal service under sanitary conditions including but not limited to: Proper hand washing techniquewith return demonstration; when to wash hands- including but not limited to, after moving a stool,coughing, rubbing residents' back, moving a resident's chair, removing a soiled clothingprotector, picking up crumbs of food, after using keys to open door, placing hands on hips, pushing hairbehind ear, before passing beverages, meal trays, picking up utensils etc. Staff should nottouch the rims of any cup or dish served to residents. Staff should not carry uncovered drinks downthe hall. An audit tool has beeninitiated.</p> <p>4. Inan effort to ensure ongoing compliance with distributing and serving food undersanitary conditions, theAdministrative staff will monitor meals at varied times on scheduled work days as follows: 5 days per week for 4 weeks then weekly for 4weeks then monthly thereafter, to assure proper distribution and meal serviceunder sanitary conditions. Should concerns be observed,immediate corrective action shall be taken. Results of these reviews and any correctiveactions will be discussed during the facility's monthly QA meetings on anongoing basis for a minimum of</p>	

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	<p>At 12:06 p.m., CNA #2 was observed to get up from the dining room chair where she was seated and knock on the kitchen door to retrieve items a resident seated at another dining room table had requested. At 12:08 p.m., she was observed to sit back down on the dining room chair and continue feeding the resident the lunch meal. She was not observed to re-wash her hands or perform hand hygiene after touching a soiled item.</p> <p>2. During an observation of the lunch meal room tray service on the East Hall, the following was observed:</p> <p>At 11:45 a.m., CNA #3 took a room tray into the room of a resident who was fed by staff. The resident was observed to be asleep. CNA #3 was observed to use her hands to gently rub the left shoulder of the resident and also used her hands to stroke the left cheek of the resident to try to get her awake to eat her lunch. She was then observed to pick up the resident's spoon and feed her 2 small bites of pudding. She was not observed to wash her hands or perform hand hygiene after touching the resident's clothing and her face.</p> <p>At 11:48 a.m., CNA #3 was observed to place her hands on the resident's bed and</p>		sixmonths and the plan will be adjusted if indicated.	

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	<p>siderail while talking to her. She was then observed to pick up the resident's glass of orange drink and place a drinking straw into the glass of orange drink and place the straw into the resident's mouth while she took several sips of the liquid. She was not observed to wash her hands or perform hand hygiene after touching a soiled object.</p> <p>3. During an observation of the lunch meal in the facility kitchen on 8/4/16, the following was observed:</p> <p>At 11:21 a.m., Dietary Aide #4 was observed on the tray line, adding beverages and assorted food items to the meal trays of residents. She was observed to cough into her arm several times. She continued to place beverages and food items on the meal trays without washing her hands.</p> <p>4. During an observation of the lunch meal tray service on the West Hall on 8/4/16, the following was observed:</p> <p>At 11:43 a.m., CNA #3 was observed to pour a cup of coffee into a mug and place the mug on a room tray for a resident. She was then observed to carry the meal tray from the food cart through the 200 Hall to a resident's room. The mug of coffee was not covered.</p>			

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	<p>At 11:43 a.m., CNA #5 was observed to pour a cup of coffee into a mug and place the mug on a room tray for a resident. She was then observed to carry the meal tray from the food cart through the 200 Hall to a resident's room. The mug of coffee was not covered.</p> <p>5. During an observation of the lunch meal in the dining room on 8/4/16, the following was observed:</p> <p>At 11:44 a.m., CNA #1 was observed to push a resident seated in a Geri chair into the dining room. 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 before placing the clean clothing protector on the resident.</p> <p>At 11:45 a.m., CNA #6 was observed to push a resident into the dining room seated in a Broda chair. She was observed to cough into her arm and immediately place a clean clothing protector on the resident. She was not observed to wash her hands or perform hand hygiene after coughing and placing the clean clothing protector on the resident.</p> <p>At 11:59 a.m., Corporate LPN #7 was</p>			

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	<p>observed to pull a dining room chair with her hands over next to a resident seated at a dining room table. She was then observed to un-wrap the resident's silverware and place drinking straws into her beverage glasses. She was not observed to wash her hands or perform hand hygiene after touching a soiled item.</p> <p>At 12:01 p.m., CNA #6 was observed to move a dining room chair up next to a resident seated at a dining room table. She washed her hands appropriately for the recommended amount of time. She was then observed to scoot the dining room chair up closer to the table with her clean hands and began feeding the resident her lunch meal. She was not observed to re-wash her hands or perform hand hygiene after touching a soiled object.</p> <p>At 12:07 p.m., CNA #6 was observed to cough into her arm while still feeding the resident her lunch meal. She was observed to continue feeding the resident her lunch meal without washing her hands or performing hand hygiene.</p> <p>At 12:08 p.m., CNA #6 was observed to cough into her arm twice while still feeding the resident her lunch meal. She was observed to continue feeding the resident her lunch meal without washing</p>			

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	<p>her hands or performing hand hygiene.</p> <p>6. An observation on 8-2-2016 at 11:50 a.m., indicated CNA #8 was assisting a resident in room 104 with her noon meal. CNA #8 was observed to deliver the meal tray to the resident's room and placed it on overbed table. CNA #8 washed her hands appropriately. CNA #8 was observed to move a large chair by picking the chair up with both her hands and then CNA #8 picked up the resident's spoon and began to feed the resident. CNA #8 was observed to get up, walk to the other side of the bed and adjusted the height of the bed by using her hand on the bed control. CNA #8 was then observed to use her hands to adjust the height of the overbed table. CNA #8 was observed to return to the chair and moved the chair with both her hands. CNA #8 sat down and began to feed the resident without re-washing her hands or performing hand hygiene.</p> <p>The Administrator was interviewed on 8/9/16 at 9:55 a.m. During the interview, she indicated staff should wash their hands after coughing, after touching a resident, and after touching a soiled item. She also indicated staff should wash their hands before placing a clean clothing protector on a resident. She further indicated all foods and beverages on meal</p>			

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	<p>trays should be covered when they are transported through a hallway.</p> <p>A current facility policy "Handwashing/Hand Hygiene", dated 10/2014 and provided by the Administrator on 8/9/16 at 10:40 a.m., indicated "...Hand hygiene is the single most important measure for preventing the spread of infection...This facility shall require facility personnel use accepted hand hygiene after each direct resident contact for which hand hygiene is indicated...Situations that require hand hygiene include, but are not limed (sic) to:... Before and after direct resident contact...Before and after assisting a resident with meals...After coming in contact with a resident's intact skin...after handling soiled equipment or utensils..."</p> <p>The policy indicated staff were to wash their hands after blowing or wiping their nose, but did not indicate staff were to wash their hands after coughing.</p> <p>A current facility policy "Linen, Handling", dated 12/2015 and provided by the Administrator on 8/9/16 at 10:40 a.m., indicated "...The facility shall handle linen in a manner to prevent the spread of infection...."</p> <p>3.1-21(i)(2) 31.-21(i)(3)</p>			

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

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