STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 27, 28, 31, September 1, 2, 3, & 4, 2015 Facility number: 000217 Provider number: 155324 AIM number: 100289590 Census bed type: SNF/NF: 57 Total: 57 Census payor type: Medicare: 9 Medicaid: 39 Other: 9 Total: 57 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 14466 on September 10, 2015.	F 0000	This plan of correction is prepared and executed because of the provisions of State and federal law require it and not because Mitchell Manor agrees with the allegations and citations listed. Mitchell Manor maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character so as to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance, that the alleged deficiencies cited have been or will be corrected by the date(s) indicated. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following Plan of Correction. *Request paper compliance please	
F 0224	483.13(c)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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SS=D Bldg. 00	PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure each resident was free from mistreatment for 1 of 1 resident reviewed for abuse. (Resident #13) Findings include: Resident #13's clinical record was reviewed on 9/1/15 at 3:30 p.m. Diagnoses included, but was not limited to: dementia. The current quarterly Minimum Data Set (MDS) assessment dated 6/9/15, indicated Resident #13 was severely cognitively impaired and not interviewable. Resident #13 needed extensive assistance of 1 staff person for eating. On 8/27/15 at 12:35 p.m., Resident #13 was observed sitting at the table in the main dining room eating lunch with her fingers. Resident #13 was observed to stick her fingers into the mashed potatoes on her plate. Certified Nursing Assistant	F 0224	F224 1. Resident affected by alleged deficient practice: ·Resident #13 will remain free from mistreatment. 2. Residents at risk to be affected by alleged deficient practice: ·Other residents have the potential to be affected by the alleged deficient practice. ·Investigation initiated immediately as indicated on 8/27/15. ·Plan of care for resident #13 reviewed by nursing admin and updated as indicated on 8/27/15. 3. Systems to ensure alleged deficient practice does not recur: ·Staff in-service completed on 8/28/15 for Mistreatment, Resident Rights, Abuse, & Behaviors. ·Ongoing education with staff will be provided as indicated for mistreatment by nursing admin. ·Nursing admin will continue to immediately investigate all allegations of mistreatment and education an or progressive discipline will be initiated as needed 4. Monitoring to ensure alleged deficient practice does not recur: ·Plan to be updated as	09/28/2015

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	#2 (CNA) was then observed to forcefully grab Resident #13's hand out of the mashed potatoes and pushed Resident #13's hand to the side. Resident #13 being severely cognitively impaired did not respond to her hand being grabbed, but continued to eat with her fingers. CNA #2 was observed to hand Resident #13 some silverware and walked away with providing assistance. On 8/27/15 at 3:30 p.m., the Administrator and the Director of Nursing were informed of the observation of mistreatment. On 8/31/15 at 1:50 p.m., the Director of Nursing provided the policy "Abuse, Mistreatment, & Neglect" undated, and indicated the policy was the one currently used by the facility. The policy indicated, "...Any form of resident...mistreatment, ...will not be tolerated. ...c. Mistreatment- the use of ...physical ...restraints ... 7. Mistreatment:... The use of ...unreasonable and unprofessional restrictions on the resident ...Dementia residents are at greater risk ... staff should be educated about risk, how to cope with stress, and safe approach and redirection techniques." On 9/1/15 at 2:05 p.m., the Director of Nursing provided the policy "Residents'		indicated ·Nursing admin will continue to immediately investigate all allegations of mistreatment. ·Nursing Administration will review and or observe 3 residents weekly for mistreatment X 6 months. Observations will be reported to the Performance Improvement Committee and PI committee will evaluate need for ongoing audits. Dateof compliance: 9/28/15	

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	Right" undated, and indicated the policy was the one currently used by the facility. The policy indicated, " ... 9. A resident is treated with consideration, respect and full recognition of her ... dignity and individuality, including ... care for ... her personal needs. ..." 3.1-28(a)			
F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. Based on observation, interview, and record review, the facility failed to ensure dignity was maintained for a resident who regurgitated and threw food on the main dining room floor for 1 of 1 randomly observed resident during dining observation. (Resident #3) Findings included: On 8/27/15 at 12:40 p.m., Resident #3 was observed eating her food with fingers, regurgitating, and throwing the food on the floor underneath and by the	F 0241	F241 1.Resident affected by alleged deficient practice: ·Resident #3 will receive care with dignity. 2. Residents at risk to be affected by alleged deficient practice: ·Residents eating in the dining room have the potential to be affected by the alleged deficientpractice. ·Plan of care for resident #3 reviewed by nursing admin and updated as indicated on 8/27/15. ·Plan of care for residents #29, #32, and #72 reviewed by nursing	09/28/2015

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	table. There was no supervision observed for Resident #3. There were several staff members in the main dining room at that time. The Housekeeping supervisor was made aware by the surveyor at that time. The Housekeeping supervisor was observed to inform LPN #1 (Licensed Practical Nurse) who was sitting at a table diagonal of Resident #3's table. LPN #1 was observed to walk over to Resident #3 and ask Resident #3 why was she doing that (regurgitating and throwing food on the floor). "Is your stomach upset." Resident #3 indicated, "Yes, take me to my room." On 8/27/15 at 12:45 p.m., LPN #1 was observed to have CNA #1 remove Resident #3 from the main dining room and took Resident #3 to her room. CNA #1 indicated "It is typical for them to throw food on the floor. [indicating Resident #3]. It happens everyday." On 8/27/2015 at 12:55 p.m., interview with Resident #29 indicated Resident #3 makes a mess everyday for lunch and dinner. "Not sure why she does it. Makes me feel terrible." She (Resident #3) has done that for as long as I remember. On 8/27/2015 at 3:24 p.m., interview with Resident #73 indicated, Resident #3 always throws her food. "She does it		admin and updated as indicatedon 9/14/15. ·Speech Therapy completed screen for resident #3. ·Social Service reviewed plan of care and initiated behavior plan for resident #3 on 8/27/15. 3. Systems to ensure alleged deficient practice does not recur: ·Ongoing education will be provided as indicated for dignity by nursing admin to staff. ·Staff will have in-servicing completed by 9/28/15 on dignity and respect by Nursing admin/Social Services. 4. Monitoring to ensure alleged deficient practice does not recur: ·Plan to be updated as indicated. ·Admin will audit 5 residents/wk on alternating shifts for dignity 7 days a week x 6 months. ·Ensure 100% PI compliance monthly x 6 months. Date of compliance: 9/28/15	

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	everyday. Staff just ignores it [throwing food on the floor]. They let her stay there and make a mess." On 8/28/2015 at 10:16 a.m., an interview with Resident #29 indicated "Resident #3 chews her food up and spits it out under the table. It makes me sick to my stomach." Resident #3 does that everyday at noon and supper time. Resident #3 also sits at that table and eats everything with her hands. She (Resident #3) even eats ice cream with her hands. "That is sickening and it makes me lose my appetite. I have to sit with my back towards her it's disgusting!" On 8/31/15 at 9:35 a.m., Resident #32 indicated Resident #3 had been throwing her food on the floor under the table every since she had been a resident. "This is everyday lunch and dinner. Staff just ignores her." Resident #32 indicated staff was aware of Resident #3's behavior. "I have suggested to staff to sit with her [Resident #3] so she wont throw food on the floor." On 8/31/2015 at 12:33 p.m., Resident #3 was observed in the hallway asking for someone to lay her down. Food was observed on the floor below where Resident #3 sits.			

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	On 9/1/15 at 12:48 p.m., Resident #3 was observed seated at the table in the main dining room with Resident #13. Both residents were unsupervised and had a puddle of food on the floor underneath the table. Resident #3 was observed to remove what appeared to be slimy food from her mouth and throw on the floor under the table. There were several Certified Nursing Assistants (CNAs) in the main dining room assisting with meals. Resident #3's clinical record was reviewed on 9/1/15 at 10:55 a.m. Diagnoses include, but were not limited to: nausea with vomiting, dementia, and psychotic disorder. The current annual Minimum Data Set (MDS) dated 1/22/15, indicated, a Brief Interview of Mental Status (BIMS) score of 6, which indicated severely impaired and not interviewable. Resident #3 needed supervision of one staff person for eating. The current quarterly MDS dated 7/30/15, indicated Resident #3 needed limited assistance of one staff person for eating. Care plan "Inappropriate disposal of unwanted food" dated 8/27/15 through 11/27/15, indicated, "... has socially inappropriate behavior r/t [related to]			

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	food and dining, AEB [as evident by] chewing her food, spitting chewed food in hand. Some times Resident #3 will throw the chewed food to the floor or put chewed food on table. ...has food item she does not want, ... will throw the food item in the floor or just throw it. ...Goals ... will not throw unwanted or chewed food items in floor, ... will use her napkin and/or clothing protector to dispose of unwanted or chewed food items, ...Approaches: Speech therapy will screen PRN [as needed], observe Resident #3 for throwing food. Gently remind Resident #3 this is not an appropriate way to dispose of food. Offer ...napkin or clothing protector to remove food ...chewed or food ... does not want." On 8/27/15 at 1:10 p.m., interview with the Assistant Director of Nursing (ADON) indicated she was not aware of Resident #3's behavior for regurgitating and throwing food on the floor. The ADON indicated there was no careplan nor behavior monitoring for this behavior. On 8/27/15 at 1:15 p.m., interview with the Director of Nursing (DON) indicated she had not heard of Resident #3's behavior of regurgitating and throwing food on the floor. "I will have social service and therapy to evaluate her			

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	[Resident #3]." On 9/1/15 at 12:00 p.m., interview with the Social Service Worker indicated she was not made aware of Resident #3's behavior until 8/27/15, at that time a care plan was initiated. On 9/2/15 at 4:00 p.m., interview with the Social Worker, the Director of Nursing, and Minimum Data Set Coordinator, indicated, the only behaviors being monitored for Resident #3 was hoarding food and smearing feces. On 9/2/15 at 10:39 a.m., interview with the DON indicated when a resident displays a behavior staff should report the behavior to the nurse and the nurse will report to social service. Resident #'3 behavior had not been reported to social service by the nursing staff. On 9/3/15 at 4:15 p.m., the Director of Nursing provided policy "Dignity" dated 6/17/2008, and indicated the policy was the one currently used by the facility. The policy indicated, "... All residents are treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full			

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	recognition of ... her individuality. ...Promoting residents' independence and dignity in dining. ..." 3.1-3(t)			
F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for			

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	each assessment. Clinical disagreement does not constitute a material and false statement. Based on observation, interview, and record review, the facility failed to ensure a resident was accurately assessed on the admission and comprehensive Minimum Data Set (MDS) assessments for 1 of 3 residents reviewed for dental status and services. (Resident #72) Findings include: On 9/2/15 at 3:26 p.m., Resident #72 was observed to have no natural teeth or dentures in place. The resident indicated he has not had any natural teeth for several years and he believed he had a pair of dentures at home. He was observed to open his mouth and reveal an edentulous (without teeth) mouth. On 9/3/15 at 9:48 a.m. with LPN #1 present, Resident #72 was observed to be edentulous. On 9/3/15 at 10:45 a.m., CNA #5 indicated Resident #72 has never had teeth. On 9/3/15 at 10:52 a.m., the MDS coordinator indicated Resident #72 had some teeth, but she was unsure which teeth he had.	F 0278	F278 1. Resident affected by alleged deficient practice: ·Resident #72 had an accurate oral assessment completed on 9/4/15 by nursing admin. A MDS was completed on 9/16/15 by MDS Coordinator to reflect the accurate oral assessment as well. 2. Residents at risk to be affected by alleged deficient practice: ·Other residents have the potential to be affected by the alleged deficient practice. ·Plan of care,assessments, and MDS reviewed for resident #72 by nursing admin on 9/16/15 to assure accuracy. ·100% oral assessment review to be completed on all residents by and compared to admission MDS by MDS Coordinator to assure accuracy by 9/28/15. 3. Systems to ensure alleged deficient practice does not recur: ·Corporate MDS nurse to re-educate MDS Coordinator on assessment/MDS completion process by9/28/15. ·In-Serving to becompleted by Nursing admin on completing oral assessments accurately for licensed nursing staff by 9/28/15. 4. Monitoring to ensure alleged deficient practice does not recur:	09/28/2015

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	On 9/3/15 at 2:14 p.m., a phone interview was conducted with Resident #72's wife. She indicated her husband has not had any natural teeth or his own dentures for many years and he did not have any teeth when he was admitted to the facility. On 9/2/15 at 11:06 a.m., Resident #72's clinical record was reviewed. The resident was admitted on 9/13/14. Resident #72's admission Oral Assessment Form, dated 9/13/14, indicated, "Teeth: Yes ... Missing Teeth: Upper ... several gone... Lower ... several gone ..." The form did not indicate which teeth were present on admission nor which teeth were missing at admission. Resident #72's Oral Assessment Form, dated 4/1/15, indicated, "Teeth: Yes. Dentures: No. Missing teeth: Yes ..." The form did not indicate which teeth were present nor which teeth were missing. Resident #72's admission Minimum Data Set (MDS) assessment, dated 9/19/14, Oral/Dental Status indicated, " .... Z. None of the above were present." Resident #72's comprehensive Minimum Data Set assessment, dated 7/2/15, Oral/Dental Status indicated, " .... Z.		·Plan to be updated as indicated. ·MDS Coordinator will audit 5 residents/wk x 6 months for accurate oral assessments and accurate MDS completion. ·Ensure 100% PI compliance monthly x 6 months. Date of compliance: 9/28/15	

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	None of the above were present." On 9/3/15 at 11:20 a.m., the MDS coordinator indicated she could not find any additional dental assessments for Resident #72 which would identify missing teeth. On 9/3/15 at 3:45 p.m., the Director of Nursing (DON) provided a Family and Resident Questionnaire form, dated 9/15/15, for Resident #72 and she indicated it was completed by the resident's daughter. The questionnaire indicated, " ... No teeth. No dentures. Has never worn dentures." On 9/3/15 at 3:45 p.m., the DON provided the facility policy, "Oral Assessment," undated, and indicated it was the policy currently being used. The policy indicated, "Oral Assessments ... A licensed nurse will establish the condition of the oral cavity and will complete oral assessment on all admission ... Inspect overall condition of the mouth by using a flashlight ... note the following: 1. Condition of teeth: any loose or broken teeth and location. 2. Presence of dentures ... 10. Condition of the gums ..." 3.1-31(i)			

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F 0323 SS=D Bldg. 00	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 implementation of a gait belt for a resident who was unable to transfer independently from their wheelchair to their bed to prevent an accident for 1 of 1 randomly observed resident during stage 1. (Resident #28) Findings include: On 8/28/15 at 11:12 a.m., CNA #4 (Certified Nursing Assistant) was observed to enter Resident #28's room to assist Resident #28 from her wheelchair to the bed, without use of a gait belt. CNA #4 was observed to place their hands underneath Resident #28's arm, lift Resident #28 to a slight standing position and slid Resident #28 over to the side of the bed. Resident #28 was seated on the side of the bed and assisted to lay down in the bed. Resident #28's clinical record was reviewed on 9/4/15 at 9:14 a.m. Diagnoses include, but were not limited	F 0323	F323 1. Resident affected by alleged deficient practice: ·Resident #28 will remain free from injury and utilize gait belt with staff assist during transfers. · CNA # 3 was educated on 9/16/15 by Nursing admin on appropriate use of gait belt. 2. Residents at risk to be affected by alleged deficient practice: ·Residents that require assistance with transfers/ambulation have the potential to be affected by the alleged deficient practice. ·Plan of care for resident #28 reviewed by nursing admin as indicated on 9/14/15. 3. Systems to ensure alleged deficient practice does not recur: ·Ongoing education will be provided as indicated for gait belt use by nursing admin/therapy. ·In servicing will be completed by Nursing admin to include appropriate use of gait belts to licensed and certified nursing staff by 9/28/15. 4. Monitoring to ensure alleged deficient practice does not recur: ·Plan to be updated as indicated.	09/28/2015

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	155324	A. BUILDING 00 B. WING	09/04/2015

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	to: non Alzheimer dementia and fall risk. The current Change of Therapy (COT) Minimum Data Set (MDS) assessment date 9/2/15, indicated Resident #28 needed limited assistance of one staff person for transfer. The current 60 days MDS dated 8/5/15, indicated Resident #28 needed limited assistance of 1 staff person for transfers. Physician's order dated 8/21/15, indicated, "D/C [discontinue] prior mobility order. Patient to be up with assist x1 in room. ..." Review of the "FALL RISK EVALUATION" dated 8/21/15, indicated a score of 16, when a score of 10 or more interventions should promptly be put in place. Rehabilitation services multidisciplinary screening tool dated 8/21/15, indicated "Reason for Screen: fall ...fall in room, ...Transfers: educated staff on improved safety ... up c [with] A [assist] x 1 ..." Care plan "FALL RISK" dated 8/21/15 through 9/22/15, indicated "... RISK FOR FALLS R/T [related to] DECREASED MOBILITY R/T DX OF DEMENTIA. Goals: WILL BE FREE OF FALLS WITH INJURY ... Approaches:		·Nursing admin will observe 5 resident transfers per week on alternating shifts for gait belt use 7 days a week x 6 months. ·Ensure 100% PI compliance monthly x 6 months. Performance Improvement committee will determine the need for further audits. Date of compliance: 9/28/15	

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	... FALLING STAR PROGRAM [program put in place for all residence at risk for falling] ..." Care plan "ADL IMPAIRMENT" dated 6/22/15 through 9/22/15, indicated "NEED OF ASSIST X1 [STAFF] WITH ADL'S R/T DX OF DEMENTIA, Goals: ... WILL MAINTAIN CURRENT LEVEL OF FUNCTIONAL ABILITY, ... Approach: THERAPY REFERRAL AS INDICATED, PROVIDE AMOUNT OF ASSIST REQUIRED TO MEET ...DAILY CARE NEEDS." On 9/4/15 at 9:32 a.m., an interview with the Assistant Director of Nursing (ADON) indicated, the Falling Star Program will alert all staff, resident was a fall risk. "The CNA's are encouraged to use gait belts. Any resident on the Falling Star Program should be transferred with a gaitbelt. The CNA's should be wearing the gait around their waist." On 9/4/15 at 10:00 a.m., an interview with the Director of Rehab indicated staff should use gait belts for all transfers. "We teach new employees the use of gaitbelt with all residents upon hire. This is the safest practice." On 9/4/15 at 9:06 a.m., the ADON			

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	provided policy "Gait Belts for Transfer" undated, and indicated the policy was the one currently used by the facility. The policy indicated, "...Gaits belts are provided to assist staff to safely transfer or ambulate the resident. ... 2. Apply belt around resident waist.... 3. Stand as close to resident as possible, marinating a broad base of support. 4. To transfer: a. Assist resident to a standing position by grasping belt at the waist from underneath. b. Pivot resident into chair of [sic] bed. ... 7. Note use of gait belt in resident care plan." On 9/4/15 at 10:56 a.m., the Staff Development Coordinator provided policy "Gait Belts for Transfer" undated, and indicated the policy was the one currently used by the facility. The policy indicated "Policy: Gait belts are provided to assist staff to safely transfer ...the resident. ...Gait Belts should be accessible [sic] at all times and are considered part of the uniform for CNA's, ..." On 9/4/15 at 12:46 p.m., the Assistant Director of Nursing (ADON) provided policy "Falls Management" undated, and indicated the policy was the one currently used by the facility. The policy indicated, " ... b. If a resident receives a score of 10 or greater on the Fall Risk Assessment ...			

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	the resident is assessed for fall prevention measures. ... d. An interdisciplinary care plan is developed as necessary to reflect each resident's current safety status, needs and interventions. 3.1-45(a)(2)			
F 0441 SS=D Bldg. 00	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. (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. (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.			

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	(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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed related to handwashing and changing gloves during patient care as indicated by the facility policy and Center for Disease Control for 3 of 3 randomly observed residents for infection control. (Resident #28, Resident #60, Resident #55) Findings include: 1). On 8/28/15 at 9:39 a.m., CNA #6 and CNA #7 were observed to provide ADL (Activity of Daily Living) care for Resident #60. CNA #7 was observed to roll Resident #60 onto her right side with assistance from CNA #6 to wipe Resident #60's buttock wearing clean gloves. CNA #7, with the dirty gloves on, was observed to remove a sling from the geri chair in Resent #60's room and place on the bed underneath Resident #60.	F 0441	F441 1. Resident affected by alleged deficient practice: ·Residents #28,#55, and # 60 have had no adverse effect from alleged deficient practice. · CNA # 3, 4, 6, 7, and RN # 1 have been educated on hand washing/glove use by Nursing admin on 9/17/15. 2. Residents at risk to be affected by alleged deficient practice: ·Residents receiving staff support for care have the potential to be affected by the alleged deficient practice. ·Plan of care reviewed for residents #28, #55, and #60 were reviewed by nursing admin and updated as indicated on 9/14/15. 3. Systems to ensure alleged deficient practice does not recur: ·Ongoing education with nursing will be provided as indicated for non-compliance regarding hand washing/glove change during resident care.	09/28/2015

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	CNA #7, with assist from CNA #6, was observed to roll Resident #60 on her right side to place the sling under the resident. The CNA's both still had on the dirty gloves. CNA #7 was observed to remove the dirty gloves and handwash. CNA #7 was observed to leave the room with the dirty trash. CNA #6 was observed to position the covers on Resident #60 with the dirty gloves still on. CNA #6 was observed with the dirty gloves on to lift Resident #60's legs to assist in transfer of the mechanical lift. CNA #6 was observed to remove the dirty gloves and handwash. 2). On 8/28/15 at 10:38 a.m., observed CNA #3 to enter Resident #55's room to answer the call light and reposition Resident #55 in the bed. No handwashing was observed. CNA #3 was observed to removed the pillow from behind Resident #55's back and place in a recliner chair than exit the room. No handwashing was observed. 3). On 8/28/15 at 10:56 a.m., RN #1 and CNA #3 were observed to enter Resident #55's room to assist Resident #55 up in the bed. No handwashing was observed. RN #1 was observed to move Resident #55's gown out of the way to observed an area on Resident #55's chest. No handwashing was observed. RN #1 was		·Nursing admin will in service and educate licensed and certified nursing staff by 09-28-15 on handwashing/glove use during resident care. 4. Monitoring to ensure alleged deficient practice does not recur: ·Plan to be updated as indicated. ·Nursing admin will audit 5 residents/wk on alternating shifts receiving staff support for care regarding hand washing/glove change during resident care x 6 months. ·Ensure 100% PI compliance monthly x 6 months. Dateof compliance: 9/28/15	

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	observed to use hand sanitizer upon exiting the room. On 8/28/15 at 11:03 a.m. interview with RN #1 indicated she should "handwash when entering and exiting patients room." RN #1 indicated she thought she had used hand sanitizer upon entering the room. 4). On 8/28/15 at 11:12 a.m., CNA #4 (Certified Nursing Assistant) was observed to enter Resident #28's room to assist Resident #28 from her wheelchair to the bed. Resident #28 was seated on the side of the bed and assisted to lay in the bed. CNA #4 indicated he should handwash between each resident, after ADL (Activity of Daily Living) care. He should have handwashed upon entering the resident's room and providing care. On 8/28/15 at 12:31 p.m., CNA #6 indicated she should handwash when changing from something dirty to something clean. On 9/1/15 at 2:05 p.m., the Director of Nursing provided the policy "Hand Hygiene" dated 5/1/12, and indicated the policy was the policy currently used by the facility. The policy indicated,, " ...Handwashing ... is generally considered the most important single procedure for			

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	preventing monsoonal [hospital acquired] infections. On 9/1/15 at 2:05 p.m., the Director of Nursing provided the policy "Standard Precautions" dated 7/18/11, and indicated the policy was the policy currently used by the facility. The policy indicated, "... Follow hand hygiene recommendations immediately ...after removal of gloves, ...Remove PPE [personal protective equipment] after it becomes contaminated and before leaving the work area. ..." On 9/8/15, review of the Centers for Disease Control and Prevention dated December 16, 2013, "Handwashing: Clean Hands Save Lives ... When ...to Wash Your Hands ... Before and after caring for someone who is sick, ..." 3.1-18(l)			