STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155426	A. BUILDING 00 B. WING	08/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER	3500 MAPLE AVE TERRE HAUTE, IN47804

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F0000	This visit was for a Recertification and State Licensure survey. Survey Dates: August 22, 23, 24, 25, 26, 29 & 30, 2011 Facility Number: 000513 Provider Number: 155426 AIM Number: 100275360 Survey Team: Mary Weyls RN TC Laura Brashear RN Teresa Buske RN Census Bed Type: SNF/NF: 190 Total: 190 Census Payor Type: Medicare: 34 Medicaid: 126 Other: 30 Total: 190 Sample: 29 Supplemental Sample: 1 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2	F0000	September 13, 2011We are requesting a desk review for our follow-up to our plan of correction. We have monitoring tools in place to ensure ongoing compliance.We will be reporting to the Performance Improvement Committee monthly with quantitative data to ensure continued compliance.Thank You,Susan J. Baker, RN, DNS	

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

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	Quality review completed on September 1, 2011 by Bev Faulkner, RN			
F0167 SS=C	A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation, interview, and record review, the facility failed to make available the most recent survey report and plan of correction in a place readily accessible to residents. This had the potential to affect all 190 residents of the facility. Finding includes: After the environmental tour with the Maintenance Supervisor on 8/29/11 at 1:40 p.m., a sign was observed indicating the survey results were available in the Executive Director's office. The Executive Director was interviewed at that time and presented a binder containing the most recent survey reports and plans of correction. The Director indicated the reports were maintained in her office, and that she was available	F0167	I. The most recent survey results conducted by Federal or State surveyors and the plan(s) of correction are readily available for residents examination. A notice has been posted of the survey results availability. Readily accessible means available without asking anyone to see them.II. All residents residing in the facility were affected by the deficient practice. The administrative team has reviewed F 167. There is a clear understanding that a notice of survey results being available must remain posted and the most recent survey results and plan(s) of correction must remain readily available for residents access.Readily accessible means available without asking anyone to see them.III. The Executive Director will validate at least weekly that the most recent survey results and plan(s) of correction remain readily	09/26/2011

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	"24/7" [twenty-fours a day, seven days a week]. A facility policy, titled "Examination of Survey Results," dated 4/28/11, included: "Policy, The patient may examine the results of the most recent survey of the center and any plan of correction in effect with respect to the center. Compliance Guidelines: 1. The survey results include the Statement of Deficiencies (CMS-2567) and the Statement of Isolated Deficiencies generated by the most recent standard survey and any subsequent extended surveys, and any deficiencies resulting from any subsequent complaint investigation. 2. The survey results and approved plan of correction, if applicable, are available in a form easily readable by the patient and remain unaltered (unless authorized by the state agency). 3. The survey results are readily accessible in a place frequented by most patients and at wheel chair height where the patient does not have to ask to see them." 3.1-3(b)(1)		accessible to the residents.IV. The Executive Director will submit a report to the Performance Improvement Committee each month. The report will ensure the most current survey results and plan(s) of correction are readily accessible to residents at all times.	
F0221 SS=D	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview, and record review, the facility failed to ensure	F0221	I. Resident #61 is released from restraint during meals.I. Resident	09/26/2011

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	1 of 2 residents reviewed utilizing seat belt restraints were provided the least amount of time in a restraint in that a plan of care to provide the least amount of time in a restraint was not consistently implemented for Resident #61, and 1 of 1 resident reviewed utilizing a reclining geri-chair was not assessed, or care planned for need for the device to treat a medical symptom [Resident #183] in a sample of 29. Findings include: 1. During initial tour on 8/22/11 which began at 11:00 a.m., with RN #2, Resident #183 was identified as utilizing a low bed with floor mats, had a urinary tract infection required assistance of 1 to 2, and utilized a geri-chair when out of bed. On 8/22/11 at 2:00 p.m., the resident was observed reclined in a geri-chair across from the nurses' station and attempting to sit up. On 8/23/11 at 9:30 a.m., Resident #183 was observed reclined back in a geri-chair in the lounge/dining room of the unit and working with a Speech Therapist. On 8/23/11 at 12:10 p.m., the resident was observed sitting up 90 degrees at the table in the dining room, having lunch with her		# 183 has been reassessed by the IDT to ensure any and all restraint devices being utilized have a current assessment and care plan in place for need for the device to treat a medical symptom. The resident is no longer utilizing a reclining geri-chair.II. All residents utilizing a restraint device have the potential to be affected by the same deficient practice. An inservice will be provided to nursing employees clearly detailing devices that are considered a restraint, the expectation that restraints are to be released during meals, restraints being utilized to treat a medical symptom require a restraint assessment and care plan.Residents are to be visited @ least every hour while in restraint and released @ least every 2 hours for repositioning which may include toileting or incontinence care. If the resident is in a restorative program restraints will be released during programming also.III. Restraint education/inservice will be provided to nursing employees during orientation and annually thereafter. IDT will review new physician orders for restraint use and therapy recommendations for reclining geri-chair use during the daily IDT meeting to ensure assessments and care plans are in place at the onset of implementation. The Unit Managers will observe release of	

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	family member. On 8/24/11 at 10:00 a.m., the resident was observed reclined in a geri-chair across from the nurses' station. At 1:30 p.m., the resident was observed reclined in a geri-chair across from the nurses' station, attempting to sit up. On 8/25/11 at 9:25 a.m., Resident #183 was observed reclined in a geri-chair across from the nurses' station repeatedly raising up her head and neck. On 8/25/11 at 10:55 a.m., the resident's family member was observed, pulling the resident backwards, reclined in the geri-chair to the hallway across from the nurses' station. The resident indicated her neck hurt, as she was trying to raise up. The family member replied to the resident it is probably because you keep raising it up. The resident indicated she needed to use the restroom. At 11:10 a.m., CNAs #17 and #18 were observed to transfer the resident in the reclined geri-chair to the shower room for toileting. The resident made a comment about the ceiling in the shower room that she was looking at. The staff applied a gait belt to the resident and provided minimal assistant for the resident to stand. The resident was observed standing independently holding onto the safety bar next to the stool, and		restraints during meal times @ least 3 times each week. A monitoring tool will be put into place to document compliance. The monitoring tool will be submitted weekly to the DNS. Restraint education includes residents are to be visited @ least every hour while in restraint and released @ least every 2 hours for repositioning which may include toileting or incontinence care. If the resident is in a restorative program restraints will be released during programming also.IV. The Director Nursing Services will submit a report to the Performance Improvement Committee each month. The report will identify the number of restraint devices in use along with validation that each device is to treat a medical symptom, has a current assessment, current care plan and is being released during meals and staff supervised activities.	

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	to follow directions and pivot self back and onto the toilet. After completion of toileting, the resident stood independently while dressing was completed. At 12:00 p.m., the resident was observed seated in an upright position in the geri-chair at the dining table having lunch without difficulty. On 8/25/11 at 1:45 p.m., the resident was observed reclined in the geri-chair in the hallway across from the nurses' station asleep. On 8/25/11 at 4:45 p.m., the resident was observed reclined in a geri-chair in the hallway across from the nurses' station repeatedly trying to sit up. The Assistant Director of Nursing was observed next to the resident. On 8/25/11 at 5:10 p.m., the resident was observed seated upright at a 90 degree angle in the dining room at the table, without difficulty. Resident #183's clinical record was reviewed on 8/24/11 at 11:05 a.m. An admission date was noted of 7/6/11. Diagnoses included, but were not limited to: Hallucination, manic attacks with Schizophrenic component. An initial Minimum Data Set [MDS]			

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	assessment, completed on 7/15/11, coded the resident with severe cognitive impairment, required extensive assistance of two for bed mobility and transfers, non-ambulatory, total assistance of 1 for hygiene. The assessment indicated the resident had falls prior to admission, and did not utilize any restraints. A form titled "Bed Safety Evaluation," completed on 7/14/11 indicated the resident had hallucinations and utilized a low bed with soft mats, tab and pressure alarms. A weekly-Occupational Therapy [OT] progress note for time period of 7/29-8/4/11 included, but not limited to, "Pt [patient] agitated this date. ...had unwitnessed fall from geri-lounge chair in which pt. attempted to climb from chair. Recommend pt. be supervised when up in wheelchair/geri-chair to decrease risk of falls. An OT note for period of 8/5/11-8/11/11 included, but not limited to, "During periods of increased agitation pt is at risk of falls from geri-lounge chair. Pt was switched to tilt-in-space w/c [wheelchair] on 8/5/11. Chair sits higher off ground increasing risk of injury with fall. Unit manager...decided to switch back to geri-lounge chair on 8/11/11. ...Collaborated with staff on safest seating option; standard wheelchair, geri-lounge chair, or tilt in space. Pt. requires 24/7 [twenty-four hours a day, seven days a			

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	week] supervision. OT notes of period from 8/12-18/11 included, but was not limited to, "Pt. is currently positioned in geri lounge chair. Pt. is very compulsive with trying to get out of chair throughout day. ...Pt. is unaware of safety risk involved with trying to get out of wheelchair independently..." Documentation was noted in a nursing note, dated 8/4/11, of resident attempting to get up unassisted, rolling sideways with legs over edge of chair/recliner and scooting out the end of the recliner constantly. Unable to stand or ambulate at this time. ...at nurses' station for constant supervision. Physical Therapy [PT] progress notes for the period of 8/11-17/11 included, but was not limited to, continues to demonstrate hallucinations...continues to try to get out of chair constantly. A PT note for the period of 8/4-10/11 included, but was not limited to "Pt continues to be seen five times a week increased agitation noted this week as pt has been trying to get out of chair yelling also hitting and scratching staff. ...Pt gait training with rolling walker 50 feet with moderate assist and wheel chair to follow			

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	when not agitated. ...Requires assistance to maneuver.... Requires cues to stay on task." A plan of care, dated 7/15/11 addressed the problem of impaired physical mobility related to general weakness and debility secondary to recent hospital stay for manic disorder with Schizophrenia, diabetes mellitus, lethargy and hypertension. Interventions included but were not limited to: transfer with total assistance of two and gait belt. Up daily in wheelchair, therapy to evaluate and treat as indicated. Dycem to Geri-chair lounger seat, geri lounger. The Director of Nursing (DON) was interviewed on 8/30/11 at 9:30 a.m. The DON indicated the geri-chair was not considered a restraint for the resident and was not assessed or care planned as such. 2. On 8/25/11 at 12:15 p.m., Resident #61 was observed to be in recliner chair with soft Velcro restraint applied. CNA #30 was observed to be sitting next to the resident and feeding him. The soft Velcro restraint was secured around the resident. On 8/26/11 at 12:25 p.m., Resident #61 was observed to be in recliner chair with the soft Velcro restraint applied. CNA #31 was observed to be sitting next to the resident and feeding him. The soft Velcro restraint was secured around the resident.			

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	Review of the clinical record of Resident #61 on 8/30/11 at 10:19 a.m., indicated the physician order, dated 1/3/2008, of "May use seat belt restraint every shift when up in wheelchair due to unawareness of safety impaired balance, seizure disorder, congenital brain injury and cerebral palsy. Check placement of restraint at least every hour. Release restraint at least every two hours toilet and provide incontinence care when released from restraint. Release restraint during meals and activities when staff is present." The resident's current plan of care identified the use of seat belt restraint and wrap around belt to rocker [recliner], dated 5/25/10 and updated 6/20/11. The approaches included but were not limited to release from restraint during meals and when participating in activity program when associate in close observation. 3.1-26(o)			
F0323 SS=D	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, record review and interview, the facility failed to ensure 2 of 3 residents (#19 and #16) were transferred	F0323	I. Resident #19 and resident #16 are being transferred by mechanical lift according to	09/26/2011

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	by mechanical lifts according to manufacturer's instructions and failed to ensure a dependent resident was turned and positioned in bed in a safe manner (#146) for 3 of 3 residents observed for safe transfer and bed positioning. Findings include: 1. On 8/24/11 at 2:55 p.m., CNA #'s 3 and 4 were observed providing care for Resident #146. The CNAs were observed to roll the resident toward the left side of the bed in order to place a mechanical lift sling The resident was laying on the edge of the bed with her body resting up against CNA #4. CNA #3 indicated "she gets scared, doesn't like to see the edge of the bed, afraid she'll fall." During review of Resident #146's clinical record, on 8/25/11 at 3:40 p.m., a diagnosis of Encephalomyelitis resulting in quadriplegia was noted. During review of the facility policy titled "Positioning the Resident", dated 4/28/09, received on 8/30/11 at 2 p.m., from the DON (Director of Nursing), the policy indicated when turning a dependant resident, move the resident to the opposite side of the bed that the resident will be		manufacturer's instructions. Resident #146 is being turned and repositioned in bed in a safe manner.II. All residents transferred by mechanical lift and all dependent residents requiring staff assistance to turn and reposition in bed have the potential to be affected by the same deficient practice. An inservice will be provided to nursing employees clearly detailing: 1) The Mechanical Lift procedure with special emphasis on making certain wheels of lift are not locked and are able to move freely before elevating the resident. 2) The Positioning the Resident procedure with special emphasis on when turning a dependant resident, move the resident to the opposite side of the bed that the resident will be turning towards, prior to turning the resident on to their side.III. Mehcanical Lift and Positioning the Resident education/inservice will be provided to nursing employees during orientation and annually thereafter. The Unit Managers will observe staff performance of both utilizing the mechanical lift and repositioning a resident in bed to ensure reeducation/inservicing was effective and for eontinued compliance. The observations will occur rendomly on their units for each task at least three times each week. A monitoring tool will be put into place to document compliance. The monitoring tool	

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	turning towards, prior to turning the resident on to their side. 2. On 8/29/11 at 10 a.m., Resident #19 was observed to be transferred from the bed to the wheelchair utilizing the mechanical "Hoyer" lift by CNAs #19 and #20. The CNAs were observed to lock the back wheels of the lift prior to attaching the sling to the lift. The wheels remained locked when the resident was lifted from the bed. The CNAs were observed to unlock the wheels and then move to resident from the bed to the wheelchair. 3. On 8/29/11 at 10:20 a.m., Resident #16 was observed to be transferred from the wheelchair to the bed utilizing the mechanical "Hoyer" lift by CNAs #21 and #22. The CNAs were observed to lock the back wheels of the lift prior to attaching the sling to the lift. The wheels remained locked when the resident was lifted from the wheelchair. The CNAs were observed to unlock the wheels and then move the resident from the wheelchair to the bed. Review of the "Hoyer" manufacturer's		will be submitted weekly to the DNS.IV. The Director Nursing Services will submit a report to the Performance Improvement Committee each month. The report will identify the number of observation, performance outcomes and any corrective actions taken if applicable.	

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	guidelines on 8/30/11 at 12:45 p.m., indicated the following: "...Do not lock the brakes or block the wheels when lifting patient. The wheels must be FREE to roll to allow the lifter to center itself beneath patient..." 3.1-45(a)(2)			
F0371 SS=F	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			
	Based on observation, record review and interview, the facility failed to ensure food was stored, prepared and served food under sanitary conditions for 2 of 2 kitchen observations in that; 1). 3 compartment sink utilized for sanitation of dishes lacked sanitizer; 2). ice machine lid was observed with dark substance ; 3). a walk in freezer had ice build up; 4). food temperatures were not maintained at appropriate temperatures during meal service. This had the potential to affect 187 of 190 residents receiving meals from the facility kitchen. Findings include: 1. During the initial kitchen observation on 8/22/11 at 11:05 a.m., the following	F0371	I. The 3 compartment sink utilized for sanitation of dishes has sanitizer at all times. The ice machine lid is clean and free of dark substance. The walk in freezer is free of ice build up. Food temperatures are maintained at appropriate temperatures during meal service.II. All residents residing in the facility are affected by the deficient practice. An inservice has been provided to dietary & maintenance employees clearly detailing: 1) Prior to sanitizing you must test the sanitizing solution concentration. Add more sanitizer or water to achieve appropriate concentration as needed prior to sanitizing. 2) The Ice Machine is to be cleaned monthly by maintenance with dish detergent, sanitizer, de-limer and stainless steel cleaner following	09/26/2011

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	was observed: a. The 3 compartment sink was observed to be utilized for sanitation of dishes. The Dietary Manager attempted to check the sanitizer level of the 3 compartment sink and the sanitizer level did not register. The "Quat" sanitizer bottle was observed to be almost empty. Dishes were observed to be drying in racks near the 3 compartment sink. The Dietary Manager was observed to add an undetermined amount of "Quat" sanitizer. The Dietary Manager then tested the level of the sanitizer which measured 200 parts per million. Interview of the Dietary Manager on 8/22/11 at 11:10 a.m., indicated the 3 compartment sink was currently being utilized for sanitation of dishes. The Dietary Manager indicated the dishes would have to be re-sanitized. The Dietary Manager also indicated the sanitizer level should be at least 200 parts per million. Review of the "Dishwashing: Pot and Pan Sink," dated 7/9/10, on 8/24/11 at 10:05 a.m., indicated the following: "...6. Fill the last compartment 3/4 full with water and chemical sanitizer. The temperature of the water and amount of sanitizer is at the appropriate levels to effectively		the ice machine cleaning instructins. Maintenance will document the monthly cleaning on the Preventative Maintenance Task Sheet. 3) The walk in freezer is to be inspected daily for ice build up including the ceiling and water pipes at the back of the freezer. 4) Minimum holding temperatures on the tray line is 140 degrees for hot foods. The food temperatures must be taken immediately before every meal service. The food temperature is to be recorded on the Food Temperature Record prior to serving.III. Education/inservicing will be provided to dietary and maintenance employees during orientation to include the aforementioned expectations/practices. The Dietary Department will be inspected for continued compliance by the Nurtition Services Supervisor daily, the Executive Director weekly and a District Team member during facility visits. The inspection will be documented on the Nurtition Services Quick Rounds Form.IV. The Executive Director will submit a report to the Performance Improvement Committee each month. The report will summarize weekly results of Quick Rounds and any corrective actions taken if applicable.	

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	155426	A. BUILDING 00 B. WING	08/30/2011

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	sanitize...." b. The ice machine was observed to have dark substance on the inside lid of the machine. Interview of the Dietary Manager on 8/22/11 at 11:10 a.m., indicated the ice machine was maintained by Maintenance. Review of the Preventive Maintenance Task Sheet on 8/24/11 at 10:05 a.m., indicated the ice machine had last been cleaned on 7/13/11. c. The walk-in freezer was observed with a large amount of ice build up on the ceiling the freezer, and on the water pipes at the back of the freezer. Large pieces of ice was noted to have dripped and fallen onto boxes stored in the freezer. 2. During observation of meal service on 8/24/11 at 8:05 a.m., with the Dietary Manager the following food temperatures were observed: a. A pan of soft fried eggs were observed sitting on top of the steam table. The pan was not in one of the water wells. The temperature of the eggs measured 90 degrees Fahrenheit.			

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	b. A pan of bacon on the steam table measured 100 degrees Fahrenheit. The bacon was observed to be served. The bacon temperature was measured again at 8:20 a.m. and measured 100 degrees Fahrenheit. c. A pan of hard boiled eggs on the steam table measured 130 degrees Fahrenheit. The hard boiled eggs were observed to be served. d. The pureed meat on the steam table measured 120 degrees Fahrenheit. e. A second pan of Fried eggs sitting on top of the steam table measured 98 degrees Fahrenheit. f. The ground sausage measured 136 degrees Fahrenheit. g. A pan of sausage patties measured 100 degrees Fahrenheit. All items on the steam table were observed to be uncovered. At this time, the surveyor requested the food not be served at the current temperatures. Interview of Cook #23 on 8/24/11 at 8:15 a.m., indicated the steam table was started at 5:30 a.m. with hot water in the wells. The cook indicated the food was placed			

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	on the steam table at 6:30 a.m., and that the temps were taken prior to placing the items on the steam table. The cook indicated the temperatures of the food should be taken prior to service. Interview of Cook #24 on 8/24/11 at 8:20 a.m., indicated the temperatures of the food on the steam table had not been taken prior to meal service. Interview of the Dietary Manager on 8/24/11 at 8:10 a.m., indicated the temperatures of the food should be maintained at 140 degrees Fahrenheit. The manager verified the eggs were pasteurized. During the Group meeting on 8/23/11 at 10:05 a.m., residents indicated food was served "cold" in the main dining room. Review of the facility's policy and procedure titled "Internal Food Temperatures Matrix," dated 10/31/10, on 8/24/11 at 10:40 a.m., indicated the following: "... Holding - Minimum holding temperatures on the tray line for potentially hazardous food is 41 degrees Fahrenheit or less for cold foods and 140 degrees or greater for hot foods. If a food falls below 140 degrees , reheat to 165 degrees Fahrenheit for 15 seconds within 2 hours..."			

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	3.1-21(i)(2) 3.1-21(i)(3)			
F0441 SS=E	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. (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.			

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	Based on observation, record review and interview, the facility failed to ensure infection control procedures were practiced by facility staff related to glove use, hand washing and handling of glucose meters. This affected 5 of 5 residents observed for infection control practices (Resident #'s 49, 146, 157, 178 and 185) and involved the following staff: (CNA #'s 5, 7, 8), (RN#2 and 11), and (LPN #6). Findings include: 1. On 8/24/11 at 12 p.m., CNA #5 and LPN #6 were observed to provide care to resident #146. CNA #5 was observed, while wearing gloves, to wash feces from the resident's buttocks. While wearing the same gloves, the CNA touched the resident's clean blanket and the privacy curtain. 2. On 8/26/11 at 11:05 a.m., CNA #'s 7 and CNA # 8 were observed to provide care to Resident #157. The CNAs transferred Resident #157 from a wheelchair to the bed. During the transfer, CNA #8, while wearing gloves, hung the resident's urinary drainage bag from her uniform. After handling the urinary tubing and drainage bag, and	F0441	I. The facility will ensure infection control procedures are practiced by facility staff for residents #49, #146, #157, #178 & #185.II. All residents requiring staff assistanc with: incontinence care, transfer with indwelling urinary catheter & catheter drainage bag, repositioning/handling gastrostomy tube and/or accucheck blood glucose testing have the potential to be affected by the same deficient practice. An inservice will be provided to nursing employees clearly detailing: 1) Infection control work practices regarding removal of gloves followed by hand washing after providing incontinence care before touching other surfaces to prevent cross contamination. 2) Infection control work practices regarding handling urinary drainage bag and tubing in that urinary drainage bags are no to come into contact with the employee's uniform; specifically the drainage bag must never be hung from the uniform pocket for any rason or any length of time. The staff member must immediately remove gloves after touching/ transferring urinary drainage bag and/or tubing followed by washing hands before touching other surfaces including the resident and/or resident's clothing or linens to prevent cross contamination. 3) Infection control work practices regarding handling gastrostomy tube in that	09/26/2011

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	without changing gloves, the CNA assisted the resident to ambulate to the bed, and assisted the resident into the bed. During review of the facility's policy titled "Infection Control Work Practices", dated 4/28/10, received from the DON (Director of Nursing) on 8/30/11 at 2 p.m., documentation indicated "Hands and body areas having been in contact with blood or other potentially infectious materials are washed with soap and water immediately or as soon as feasible."		prior to handling the gastrostomy tube the employee must wash hands with soap and water and put on gloves. The employee must immediately remove gloves after touching/repostioning the gastrostomy tube followed by washing hands before touching other surfaces to prevent cross contaminatin. 4) Infection control work practices regarding Accucheck blood glucose testing in that the following procedure is followed:a) wash handsb) cleanse exterior of glucometer with 10% bleach wipec) dry with damp non-sterile cloth (gauze)d) place cleaned machine on barrier on table/carte) take 1 test strip into the room and place on barrier on table/cartf) put on glovesg) clean the puncture site with an alcohol wipeh) dry site thoroughly with a gauze padi) wipe away the first drop of blood with a gauze pad, and avoid squeezing the puncture sitej) apply the drop of blood to the appropriate area on the test stripk) insert the test strip into the glucometerl) apply gauze pad to puncture site briefly apply pressurem) discard the lancet in a sharps containern) dispose other supplies in trash can o) remove both glovesp) wash hands with soap and waterq) put on glovesr) obtain a 10% bleach solution moistened wipes) pick up the glucometer and remove the glucometer from the residents roomt) without setting the glucometer down, begin	

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			cleaning the glucometer using the 10% bleach solution moistened wipeu) place the glucometer on a barrier on a table or cart outside of the resident's room for at least 1-minute before drying the glucometerv) remove your glovesw) wash hands with soap and waterx) after allowing a 1-minute contact time, wipe away any residual bleach solution from the meter with a damp non-sterile gauze.III. Infection control procedures related to glove use, hand washing and handling of glucose meters education/inservice will be provided to nursing employees during orientation and annually thereafter. The Infection Control Nurse (1), Staff Development Coordinators (2) and Unit Managers (5) will observe staff performance of the above listed infection control practices to ensure reeducation/inservicing was effective and for continued compliance. The observations will occur randomly for each area of deficiency @ least 3 times each week by each of the 8 aforementioned managers. A monitoring tool will be put into place to document compliance. The monitoring tool will be submitted weekly to the DNS.IV. The Director Nursing Services will submit a report to the Performance Improvement Committee each month. The report will identify the number of	

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	3. On 8/23/11 at 2:30 p.m., Resident # 49 was observed to be transferred from the bed to the wheelchair. During the transfer, RN # 11, without gloves on, was observed to handle the resident's gastrostomy tube and reposition the tube under the resident's shirt. Without washing hands, RN # 11 was observed to touch the alarm box and the resident's wheelchair. The RN was observed to wash her hands before exiting the resident's room. Review of the facility's current policy and procedure titled "Enteral Feeding: Pump Method (Open or Closed system)," dated 4/28/10, on 5/30/11 at 2:30 p.m. indicated the following: "...3. Assembly equipment. 4. Identify the resident, provide privacy, and explain the procedure. 5 . Wash hands and put on disposable gloves...7. Remove gloves and perform hand hygiene..." 4. On 8/23/11 at 11:55 a.m., RN #2 was observed to perform an Accucheck blood glucose test on Resident #178. The nurse wiped the meter prior to entering the resident's room with a Dispatch Sani-cloth and let the meter air dry. The nurse took the glucometer, bottle of test strips, and lancet into the resident's room. The items were placed on a paper towel on the resident's over bed table. While wearing		observations, performance outcomes and any corrective actions taken if applicable.	

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	gloves, the nurse inserted a test strip into the meter, swabbed the resident's finger with an alcohol pad, performed the finger stick, and squeezed a drop of blood onto the strip inserted in the meter. The nurse wiped the finger prick site using the left hand, and obtained the glucose reading. The nurse removed the right glove, picked up the meter, exited the room, and placed the meter and vial of test strips on top of the medication cart. The meter and vial of test strips were not placed on a barrier on the medication cart. The nurse removed the left glove and utilized hand gel. The nurse administered insulin to the resident and an oral medication. The nurse took the medication cart to Resident #185's doorway, utilized a Dispatch sani-cloth to cleanse the glucometer. The nurse took the meter, vial of test strips, and lancet into the resident's room. The items were placed on a tissue on the resident's table. A test strip was inserted into the meter, donned gloves, swabbed the resident's finger with an alcohol pad, performed the finger stick and placed a drop of blood on the test strip. The nurse utilized both hands to squeeze the blood from the resident's finger, and was observed to touch the exterior of the meter. The test was observed to not read due to not enough blood was placed on the test strip. The			

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	nurse changed gloves, repeated the finger stick, and placed a drop of blood on the test strip in the meter. The nurse picked up the meter and vial of test strips in the room, removed the right glove exited the room, and placed the meter and vial of test strips on top of the medication cart without placing on a barrier surface. The nurse was observed to continue down the hallway to continue medication administration. A facility policy titled "Blood Glucose Monitoring," dated 4/28/11, provided by the DON 8/30/11 at 10:00 a.m., included, but was not limited to, "9. Prior to initial blood glucose monitoring, cleanse exterior of glucometer with 10 per cent bleach wipe and dry with damp non-sterile cloth (gauze). Place cleaned machine on barrier on table/cart. 10. Put on gloves. ...Clean the puncture site with ...alcohol. wipe,...16. Apply the drop of blood to the appropriate area on the test strip. ...21. Remove gloves, and wash hands. 23. Dispose of test strip. 24. Clean the glucometer using a 10 percent bleach solution moistened wipe between each patient." 3.1-18(l)			

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	155426	A. BUILDING 00 B. WING	08/30/2011

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F0465 SS=D	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure sanitary environment for 1 of 1 kitchen areas in that the floors of storage and freezer areas were observed with dirt and debris throughout. Findings include: 1. During the initial kitchen tour on 8/22/11 at 11:05 a.m., the following was observed: a. The food storage area was observed to have debris on the floor that included hair net, drinking straws, food crumbs, sweetener packets, and plastic cutlery throughout on the floor and under the storage shelves. b. The floor of the walk in freezer was observed to have debris throughout and under the shelves. Interview of the Dietary Manager on 8/22/11 at 11:05 a.m., indicated the floors of the freezer and storage room were to be swept/cleaned daily. Review of the cleaning schedule log on 8/22/11 at 12:45 p.m., indicated the	F0465	I. Floors of storage and freezer areas were cleaned and remain free of dirt and debris throughout.II. All residents residing in the facility are affected by the deficient practice. An inservice has been provided to dietary employees clearly detailing the procedures/expectations to maintain sanitary conditions in the kitchen including floors of storage and freezer areas. The expectation is that storage areas and the walk in freezer floors are to be swept and cleaned daily including under equipment/shelves.III. Education/inservicing will be provided to dietary employees during orientation to include the aforementioned practices. The Dietary Department will be inspected for continued compliance by the Nutrition Services Supervisor daily, the Executive Director weekly and a District Team Member during facility visits. The inspection will be documented on the Nutrition Services Quick Rounds Form.IV. The Executive Director will submit a report to the Performance Improvement Committee each month. The report will summarize weekly results of Quick Rounds and any corrective actions taken if applicable.	09/26/2011

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	storage room and freezer had not been cleaned on 8/20/11 or 8/21/11. Review of the policy and procedure titled "Kitchen Cleaning Reference," dated 10/31/10, indicated the storage area and freezer area should have been cleaned daily. 3.1-19(f)			