STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	01/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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. This visit included the Investigation of Complaint IN00249564. Complaint IN00249564 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 2, 3, 4, 5, 8 and 9, 2018 Facility number: 000321 Provider number: 155614 AIM number: 100286130 Census bed type: SNF: 11 SNF/NF: 110 Total: 121 Census payor type: Medicare: 9 Total Medicaid: 85 Other: 27 Total: 121 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on January 16,	F 0000		

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

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	2018.			
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure accurate documentation of the administration of discontinued medication for 1 of 26 residents reviewed for medication administration. (Resident 59) Findings include: On 01/04/18 at 08:49 a.m., QMA (Qualified Medication Aide) 1 was observed administering medications to Resident 59, and upon looking for the spiriva 2.5 mcg (micrograms) 2 puffs inhaled daily, she indicated it was out of stock. "It was typically pulled 3-4 days ahead of time and sent to the pharmacy, but we don't have it yet." She checked for an EDK (Emergency Drug Kit), which was now an automated medication dispensing system and she did not know how to use it. Upon	F 0658	The plan of correction is to serve as Lincoln Hills Healthcare Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Lincoln Hills Healthcare Center or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. 1. The medication was transcribed as discontinued on resident #59's medication administration record. Medication administration is being documented accurately for resident #59. 2. Other resident orders, re-writes and MAR/TARs were	02/08/2018

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	talking to an unknown staff member, she was notified the medication was discontinued on 11/05/17, and showed her the order, which was located in the resident's chart under Physician's Orders. An observation of the order at this time indicated on 11/05/17 "...D/C [discontinue] Spiriva inhale R/T [related to] refuses to use." The January, 2018 MAR (Medication Administration Record) indicated the medication was administered on 01/01/18, 01/02/18, and 01/03/18 by staff initials. During an interview at that time QMA 1 indicated that was her initials yesterday, on 01/03/18, and "Obviously, I didn't give it." During an interview, on 01/04/18 at 10:15 a.m., with the DON (Director of Nursing), she indicated the November and December MAR showed the medication had been discontinued on 11/05/17. LPN Licensed Practical Nurse) 2 and QMA 1 had initialed the medication as administered, but the QMA told her she did not administer the medication yesterday (01/03/18), when she did initialed it in the MAR. She provided copies of the November and December, 2017 MAR. At the time when the medication orders come in they are faxed to the pharmacy. She did not know why the		reviewed for accuracy. Any inaccurate documentation was addressed immediately. 3. QMA #1, LPN #2, and other RNs, LPNs and QMAs are being educated on Medication Administration, emergency drug kit use, Re-write procedures and accurate documentation of medication administration. The Unit Managers will review all discontinued orders daily to ensure proper procedures are followed and discontinued orders have been forwarded to the Pharmacy. The Monthly Re-writes will be reviewed by the nurse managers, or designee, for accuracy each month prior to use. 4. The DON, or designee, will audit all newly discontinued medications for accurate documentation daily, 5 days per week, for 4 weeks, then 3 newly discontinued medications per week for 8 weeks, then 5 discontinued medications monthly for 9 months for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. 5. Date of Compliance: February 8th, 2018	

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	order to discontinue the medications was not transcribed onto the MAR for January, 2018. On 01/04/18 at 12:35 p.m., the DON provided a copy of the "LICENSED NURSE PROCEDURE MONTHLY RECAP OF PHYSICIAN ORDERS" which indicated, but was not limited to, the following: "...assure the accuracy and completeness of monthly computerized physician orders...The licensed nurse will review computerized physician orders monthly to ensure that the orders reflect current regiment for the resident...The licensed nurse will review orders for those residents assigned. She will compare new printout with physician's orders on the chart, MAR...Review any discontinued orders and draw a line though the order and write D/C'd and date to the right of the discontinued order...The nurse will also ensure that any stop dates and alternating or intermittent administration times are added..." During the review of the "LICENSED NURSE AND QMA PROCEDURE ADMINISTRATION OF MEDICATIONS" indicated, but was not limited to, the following: "...To safely administer medications as		The Administrator will be responsible for ensuring the facility is in compliance by the date of compliance listed.	

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	prescribed...Always adhere to the five rights of medication administration...plus right documentation..." 3.1-35(g)(1)			
F 0659 SS=D Bldg. 00	483.21(b)(3)(ii) Qualified Persons §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure labs were drawn as per physician order for 1 of 5 residents reviewed for unnecessary medications. (Resident 78) Findings include: Review of the clinical record for Resident 78, on 1/8/18 at 9:00 a.m., indicated the resident had diagnoses which included, but were not limited to, Alzheimer dementia, depression, anxiety, and delirium. The clinical record lacked any laboratory Valporic acid level results.	F 0659	1. Resident #78 had no adverse effects related to the missed lab. After MD review the lab order was discontinued related to the Depakote was being administered for behavior management and routine lab monitoring was not warranted. 2. Other Residents lab orders were reviewed for completion and no other Residents were found to be affected. 3. Licensed Nurses are being educated on. The ADON will print off the daily lab orders and follow up for completion and address any concerns immediately. 4. The DON, or designee, will audit all lab orders for completion daily, 5 days per week, for 4 weeks, then 3 lab orders for completion weekly per week for 8 weeks, then 5	02/08/2018

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	The Monthly Physician Orders for January 2018 included an order dated 6/21/16 for Depakote (mood/bipolar disorder) 125 milligrams - 1 capsule TID (3 times a day) and Valporic Acid level (to determine how much Depakote was in the blood system) to be drawn Monthly (no specific order date listed). A 10/16/17 care plan listed the following: "Psychotropic drug use, potential for drug related complications...Will have no side effects from psychotropic meds...Monitor lab data if ordered..." On 01/09/18 at 10:52 a.m., the Director of Nursing indicated " We are going to clarify the order with the physician as normally we do not do Valporic acid levels monthly. Psychiatric services may ask for it as a one time order usually. The levels have not drawn monthly per the order." 3.1-35(g)(2)		lab orders for completion monthly for 9 months for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. 5. Date of Compliance: February 8th, 2018 The Administrator will be responsible for ensuring the facility is in compliance by the date of compliance listed.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity			

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	§483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure physician's orders were followed to promote healing or prevention of pressure ulcers for 1 of 2 residents reviewed for pressure ulcers. (Resident 69) Findings include: On 01/04/18 at 09:38 a.m. Resident 69 was observed laying on the right side of the bed which was in a low lying position. The resident's heels were lying directly on the mattress with no heel protector boots in place. During an observation, on 01/08/18 at 03:31 p.m., the resident was sitting up in bed watching television. He indicated the	F 0686	1. The heel protector boots were discontinued by the physician per resident preference. 2. Other Residents with physician orders for heel protector boots were reviewed for placement per physician order. 3. Nursing staff are being educated on pressure relief and the prevention of pressure areas including the application and importance of heel protector boots. A list of all Residents receiving special pressure relieving devices, including heel protector boots, was developed to be utilized during daily rounds to ensure proper application has taken place, any areas of concern will be addressed immediately. The list will be reviewed and updated as needed by the Nurse Unit Managers. The CNA sheets were reviewed for accuracy related to the pressure relieving devices. 4. The DON and/or Designee will review 3 random residents from	02/08/2018

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	heel protector boots were not ever on his feet. The resident's feet were not elevated and he was not wearing protector boots. The Physician's Orders, dated 09/20/17, indicated an order for "...[heel protector]...boots @ [at] all x's [times] while abed. Skin prep to heels bid [twice a day] R/t redness/soft. Low air loss mattress. Elevate bil [bilateral] feet/legs with pillows while abed." On 01/08/18 at 03:37 p.m. the review of the MAR (Medication Administration Record) for January, 2018 indicated, but was not limited to, "...[brand name of protector boots] BOOTS AT ALL TIMES WHILE IN BED. LOW AIR LOSS MATTRESS. ELEVATE BIL FEET/LEGS WITH PILLOWS WHILE IN BED (09/20/17)..." The September, 2017 MAR indicated initials by the nursing staff of the (protector) boots on the resident. The October, November, and December, 2017 and the January, 2018 MAR did not have documentation, by initials, of the (heel protector) boots being on the resident. The clinical record was reviewed, on 01/08/18 at 04:16 p.m. The Nurses Notes indicated the resident refused the pressure reduction mattress. No notes were found of		the list daily to ensure compliance x4 weeks, then 5 residents weekly for 8 weeks, then 5 residents monthly for 9 months for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. 5. Date of Compliance: February 8th, 2018 The Administrator will be responsible for ensuring the facility is in compliance by the date of compliance listed.	

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	the resident's refusal of the heel protector boots or feet being elevated on pillows. Diagnoses included, but were not limited to, chronic venous insufficiency, severe major depressive disorder, type 2 diabetes mellitus, muscle weakness, and chronic kidney disease-stage 4. The Care Plan for "At risk for further impairment in skin integrity AEB [as exhibited by]: CKD [chronic kidney disease]. Decreased mobility. Dx [diagnosis] PVD [peripheral vascular disease]. Hx [history] of pressure ulcer left heel and Hx of bilateral stasis ulcers. Excoriation abdominal folds." Interventions indicated "...9/20/17 Upgraded to a low air mattress...if resident immobile elevate heels." During an interview, on 01/08/18 at 04:51 p.m., the resident indicated it didn't do any good to prop his feet up on a pillow, because he moved them. He had never had any heel protector boots on and the staff would put them on his deceased roommate. On 01/08/18 at 05:12 p.m. during an interview with LPN (Licensed Practical Nurse) 5, she indicated the resident usually had them on. "He is a man of his own mind, and sometimes he has them on and sometimes he doesn't. "I document on the			

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	MAR his refusal of care." The FYI (for your information) means it was just routine and if he refused, we should document on the back of the MAR. She could not locate documentation of the resident's refusal to ware the heel protector boots. 01/08/18 at 5:24 p.m., during an observation and interview with QMA (Qualified Medication Aide) 1, indicated she had to find new heel protector boots, because the resident didn't have any in his room. Observation of the resident's heels indicated the left heel had a quarter sized callous, which was white in color. During an interview on 01/08/18 at 05:28 p.m., with the DON (Director of Nursing), she indicated they don't have to sign it off on the MAR because it is an FYI. He does pull the pillows off from under his feet. They will send the heel protector boots to laundry and do not throw them away. They should get replacement heel protector boots while those are in the laundry. The nurses should document refusal of the boots or the pillow in their notes. "It is the CNAs job to document the existence of the boots." The Care Plan Implementation CNA Assignments policy provided by the DON on 01/08/18 at 6:02 p.m., indicated, but			

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	was not limited to, the following: "...The shift charge nurse is responsible for providing each CNA with a written assignment..." 3.1-40(a)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of			

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	records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the pharmacy and facility failed to ensure the accuracy of the Medication Administration Records (MAR) for 1 of ___ residents reviewed for medications. (Resident 59). Findings include: On 01/04/18 at 08:49 a.m., QMA (Qualified Medication Aide) 1 was observed administering medications to Resident 59, and upon looking for the spiriva 2.5 mcg (micrograms) 2 puffs inhaled daily, she indicated it was out of stock. "It is typically pulled 3-4 days ahead of time and sent to the pharmacy, but we don't have it yet." She checked for an EDK (Emergency Drug Kit), which she indicated was now an automated medication dispensing system and she did not know how to use it. Upon talking to an unknown staff member, she was notified the medication was discontinued on 11/05/17, and showed her the order, which was located in the	F 0755	1. The medication was transcribed as discontinued on resident #59's medication administration record. 2. Other resident orders, re-writes and MAR/TARs were reviewed for accuracy. Any inaccurate documentation was addressed immediately. 3. Pharmacy personnel in charge of processing physician orders and licensed nurses are being educated on Re-write procedures. The Unit Managers will review all discontinued orders daily to ensure proper procedures are followed and discontinued orders have been forwarded to the Pharmacy. 4. The DON, or designee, will audit re-writes for accuracy once monthly for 12 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. 5. Date of Compliance: February 8th, 2018	02/08/2018

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	resident's chart under Physician's Orders. An observation of the order at this time indicated on 11/05/17 "...D/C [discontinue] Spiriva inhale R/T [related to] refuses to use." The January, 2018 MAR (Medication Administration Record) indicated the medication was administered on 01/01/18, 01/02/18, and 01/03/18 by staff initials. During an interview at that time QMA 1 indicated that was her initials yesterday 01/03/18 and "Obviously, I didn't give it." During an interview on 01/04/18 at 10:15 a.m. with the DON (Director of Nursing), she indicated the November and December MAR showed the medication had been discontinued on 11/05/17. LPN Licensed Practical Nurse) 2 and QMA 1 had initialed the medication as administered, but the QMA told her she did not administer the medication yesterday (01/03/18). She provided copies of the November and December, 2017 MAR. When orders come in they are at that time faxed to the pharmacy. When the December MAR was printed, that would be signed by the doctor. She could not answer as to why the new order was not transcribed onto the MAR for January, 2018.			

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	During an interview on 01/08/18 at 01:25 p.m., the Pharmacist indicated they do no do updates from the MAR, they do the updates from the MD (medical doctor) orders. "The telephone order would be sent to us, but the 2nd chance would be when the rewrites were done by the nurse. Ideally the nurse would see it on the rewrites and send it to us to print. The earliest would have been on the December rewrites, so there was a breakdown in communication." On 11/05/17 a telephone order was sent to the pharmacy and was missed by the order processing person for the December, 2017 rewrites. The January, 2018 MAR was missed by nursing at the facility those are supposed to be checked by the nurse before signing off on them. On 01/08/18 at 1:55 p.m., the review of the Pharmacy Procedure indicated, but was not limited to, the following: "...HOW TO DISCONTINUE AN ORDER...Find the medication that is being request to discontinue...Associate the order to the document (hit document, associated, then...Stop Order (DC)...Click discontinue at the top of the screen, save then profile. The medication should be discontinued...Send that document to...Review."			

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	155614	A. BUILDING 00 B. WING	01/09/2018

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	3.1-25(e)(1) 3.1-25(e)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement			

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	based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.			

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	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to follow infection control guidelines per facility policy for handwashing procedures during 2 of 5 residents observed for care. (Resident 113 and 7) Findings include: 1. During an observation on 01/03/2018 at 10:22 a.m. CNA (Certified Nursing Assistant) 2 walked out of Resident 69's room (a contact isolation room). The CNA touched the resident's bedding and her dancing toy by the window. The CNA walked out of the room and down the hallway without washing her hands or using hand sanitizer. The nurse standing in the hallway advised CNA 2 that Resident 113 "needed changed". CNA 2 walked into Resident 113's room, talked to the resident, touched his bed, and advised him she would be right back. She	F 0880	1. Staff are following infection control guidelines per facility policy for handwashing procedures for resident #113 and #7. 2. Staff are following infection control guidelines per facility policy for handwashing procedures for other residents residing at the facility. 3. CNA 1, CNA 2, CNA 3, and other Nursing Staff are being educated on handwashing procedures and other infection control precautions including procedure for items dropped on the floor. Nursing staff have completed a return demonstration for handwashing. 4. The SDC, or designee, will audit staff members providing peri-care for proper infection control and handwashing procedures 3 times weekly for 4 weeks, then 3 times monthly for 8 weeks then, 1 time monthly for 9 months for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of	02/08/2018

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	walked out into the hallway, went to the clean linen closet, and collected towels and washcloths. As she was returning to the resident's room, the CNA held the linens close to her body with one arm and used her hands to fix Resident 77's collar on his shirt. The CNA walked back to the resident's room and touched the bed, chair, and new mattress, brought into the room by maintenance. CNA 2 set the linens down on the resident's bed and walked back out of the room to collect a lift sheet. The CNA walked back into the room, donned gloves, turned on the water with her gloves, and filled the wash basin with warm water. CNA 3 walked into the resident's room to help CNA 2 provide perineal care (washing the genitals and anal area) for Resident 113. CNA 2 turned off the water with her gloved hand and walked out of the bathroom. After sitting the basin on the resident's bedside stand, she rolled the resident to his right side. The resident had a bowel movement and was cleaned front to back with one wash cloth folded over three times and a second wash cloth folded over twice. CNA 2 removed her gloves and walked out of the resident's room and into the hallway. She gathered a clean gown off of the linen cart and walked back into the resident's room. CNA 3 removed her gloves and walked out with bagged soiled linens,		reviews will be increased as needed, if compliance is below 100%. 5. Date of Compliance: February 8th, 2018. The Administrator will be responsible for ensuring the facility is in compliance by the date of compliance listed.	

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	without washing her hands. CNA 2 walked into the bathroom and dumped the water out of the wash basin into the sink. She removed her gloves and turned off the water with her bare hand. The wash basin was dried with paper towels and placed in the resident's closet. CNA 2 walked out of the room into the hallway gathered a sheet, dropped a box of gloves on the floor from the top of the linen cart, picked the box of gloves up off the floor, walked back into the resident's room, placed the box of gloves on the resident's bedside table, placed the sheet over the resident, handed him his call light, picked up the box of gloves off of the resident's bedside stand, and walked out of the room. The box of gloves was carried to the nurse's station and placed on the desk. The resident's bedside table was not wiped off prior and after the procedure. No handwashing was observed throughout the procedure by CNA 2 or CNA 3. 2. On 01/04/18 at 8:50 a.m. during an observation of perineal care (peri care) and a sponge bath, for Resident 7, CNA 1 was in the resident's room and CNA 2 entered the resident's room. CNA 1 filled the basins with warm water. She sat the basins on the resident's bedside table without a barrier between table and basins. CNA 1 pulled the privacy curtains and explained the			

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	procedure to resident 7. CNA 2 donned gloves and assisted the resident with removing her linens and gown. She draped the resident with her gown for privacy while CNA 1 performed a sponge bath. CNA 1 used one wash cloth and wiped one time before putting the washcloth in a plastic bag at the foot of the bed. When CNA 1 ran out of washcloths CNA 2 was removed her gloves, and left the room for more wash clothes. When CNA 2 returned to the resident's room she donning gloves, and assisted the resident with the removal of her soiled brief. CNA 1 applied soap to a washcloth, separated the labia, wiped from front to back using one washcloth at a time, and disposed of the washcloth in a plastic bag at the foot of the resident's bed. CNA 1 proceeded to use a downward stroke and washed outward to the thighs using one wipe at a time with one washcloth at a time before running out of washcloths. CNA 2 removed her gloves and left the resident's room for a second time to retrieve more washcloths. CNA 2 returned to the resident's room with the washcloths. CNA 2 donned gloves and continued to provide assistance with peri care. CNA 1 used a clean wash cloth, rinsed, and dried the resident in the same manner. CNA 2 assisted the resident to her left side. CNA 1 used a clean washcloth, washed the left and			

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	right buttock in a downward stroke. The resident was rinsed and patted dry with a towel. CNA 1 and 2 assisted resident 7 with putting on a clean brief, pants, and a shirt before repositioning the resident. CNA 2 placed the soiled linens in a plastic bag, removed her gloves, tied the bags, and sat the soiled linen bags on the floor. CNA 2 took the water basins to the bathroom, emptied the water in the sink, turned on the facet with her bare hands, rinsed out the basins, and turn off the facet with her bare hands. She dried the basins and put the basins in the resident's closet. CNA 2 picked up the soiled linen bags and left the room. CNA 1 removed her gloves and washed her hands per protocol and turned off the facet with a paper towel. The resident's bedside table was not wiped off prior or after the procedure. No handwashing was observed throughout the procedure or when entering and exiting the room by CNA 2. During a record review, on 01/09/18 at 2:00 p.m., the Assignment Completion Report indicated the CNA's had completed an in-service and training assignment pertaining to infection control and handwashing on the following dates: CNA 2 on 05/07/17, CNA 1 on 09/16/17, and CNA 3 on 08/30/17.			

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	During an interview on 01/04/18 at 10:15 a.m., RN (Registered Nurse) 1 indicated, "We wash our hands...when entering the resident's room and before leaving the room. If we have to remove our gloves we wash out hands." On 01/05/18 at 1:20 p.m. during an interview with the DON (Director of Nursing), she indicated "Anytime the gloves come off during resident care the hands have to be washed." During an interview, on 01/08/18 at 4:38 p.m., CNA 4 indicated "Our policy is to wash our hands for 20 seconds. If we have to leave the room for something when we remove our gloves we are to wash our hands after entering or leaving the room." A review of the Policy and Procedures, on 01/09/18 at 2:00 p.m., for handwashing procedures indicated, but was not limited to: "Wash your hands before and after resident care contact, after glove removal, when hands are visibly soiled, before leaving isolation room,...Turn off water using a dry paper towel..." 3.1-18(1)			

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