

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

PRINTED: 08/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345328	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
NAME OF PROVIDER OR SUPPLIER GIVENS HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 800 BARRETT LANE ASHEVILLE, NC 28803	
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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews the facility failed to ensure Physician's Orders for bowel protocol were implemented for one (1) of eight (8) sampled residents. (Resident # 3) The facility also failed to ensure oxygen was administered as ordered for two (2) of three (3) sampled residents with orders for oxygen. (Residents # 8 and # 12).</p> <p>The findings are:</p> <p>1. A facility document titled "Standing Orders" dated 03/16/10 stated in part as follows: "For Daily Bowel Regimen: a. Fiber Supplement of choice one (1) tablespoon by mouth daily or Power Pudding 30 cc (cubic centimeter) by mouth twice daily, b. Glycolax seventeen (17) Gm (gram) by mouth daily - hold for loose BM (bowel movement), c. If no BM for two (2) days, give Senna two (2) tablets by mouth at bedtime, d. If no BM for three (3) days, give Senna two (2) tablets twice a day and do rectal check; disimpact as needed, e. If no BM for four (4) days, continue Senna two</p>	F 309	<p>Disclaimer:</p> <p>The component elements of the following plan of correction are those specifically required by Section 7304 of the CMS State Operations Manual. This filing does not constitute an admission that the deficiencies alleged did in fact exist. This POC is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality resident care. This POC constitutes written allegation of substantial compliance with written Medicare and Medicaid requirements.</p> <p>1) During the survey staff reminders and informal re-education began on the facility bowel protocol. The day after the survey the Director of Nursing reviewed all resident records and documentation to ensure that all residents potentially effected either had a bowel movement or received the proper treatment per the bowel protocol.</p> <p>The Director of Nursing has reeducated the licensed nurses to ensure that the bowel protocol is fully understood by them and followed for every resident. Further, she has reminded and re-educated the CNA's of their responsibilities to ensure that the documentation is timely and accurate. This ensures that the Licensed Staff receive accurate and timely information on which to act. Furthermore CNA's were reminded that they can and should document bowel movements when residents self report.</p>	8/25/2011

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

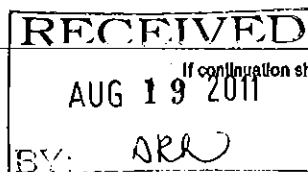
TITLE

(X6) DATE

Robin J. Suelcher

HEALTH CARE ADMINISTRATOR 8/19/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 60 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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F 309	<p>Continued From page 1</p> <p>(2) tablets twice a day and administer Fleets type enema. Call physician if no BM for five (5) days, or if resident has two (2) episodes of constipation requiring Fleets type enema."</p> <p>Resident # 3 was admitted to the facility on 09/27/07 with diagnoses including dementia, constipation, embolic strokes and generalized muscle weakness. The most recent Minimum Data Set (MDS), a quarterly assessment completed 07/12/11, indicated Resident # 3 had short and long term memory problems and severely impaired cognitive skills for daily decision making. The MDS also indicated Resident # 3 required extensive assistance with transfer/toileting, was always incontinent of bowel and frequently incontinent of bladder.</p> <p>A plan of care last updated on 02/02/11 indicated Resident # 3 had altered bowel elimination. The goal stated Resident # 3 would have a bowel movement at least every three days with interventions which included:</p> <ol style="list-style-type: none"> 1. Facility will assess/document bowel activity daily 2. Hospice will evaluate/implement the hospice bowel protocol as needed 3. Facility will evaluate for constipation/impaction as needed and report to Hospice Registered Nurse. <p>Review of Resident # 3's "Resident Bowel and Bladder by Shift Chart" data from 06/01/11 through 07/28/11 revealed no bowel movements documented for:</p> <p>06/07/11 - 06/10/11 (4 days), 06/12/11 - 06/15/11 (4 days), 06/17/11 - 06/20/11 (4 days),</p>	F 309	<p>The bowel records for every resident will be monitored on a daily basis by the RN Resident Care Coordinators to ensure that all residents are receiving the appropriate bowel protocol at the appropriate time. This daily monitoring will be ongoing until the Director of Nursing feels that ongoing compliance is achieved. Additionally, this will be spot monitored by the Director of Nursing and the Assistant Director of Nursing Services.</p> <p>The Director of Nursing will report progress in this area monthly to the QI Committee. The QI Committee will monitor this issue until the QI Committee has determined that this correction has been consistently achieved.</p>	

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F 309	<p>Continued From page 2</p> <p>06/23/11 - 06/26/11 (4 days), 07/02/11 - 07/07/11 (6 days), 07/09/11 - 07/15/11 (7 days), 07/17/11 - 07/21/11 (5 days) and 07/23/11 through 07/28/11 (6 days).</p> <p>Review of Medication Administration Records (MARs) for 06/01/11 through 07/28/11 revealed Resident # 3 had current Physician's orders for and received Power Pudding (a high fiber food supplement) 30 cc twice daily for constipation, Miralax 17 grams (laxative) in 8 ounces fluid twice daily for constipation and Senokot (laxative) 8.6mg (milligrams) one tablet by mouth daily at 6:00 p.m. for constipation. Review of the June MARs revealed Resident # 3 received Senokot 8.6mg two tablets by mouth as a PRN (as needed) dosage for constipation on 06/30/11. Review of the July MARs revealed Resident # 3 received Senokot 8.6mg two tablets by mouth as a PRN dosage for constipation on 07/12/11, 07/13/11, 07/15/11, 07/25/11 and 07/28/11. Resident # 3 also received Dulcolax 10mg suppository on 07/15/11 as a PRN for constipation.</p> <p>Review of Resident # 3's Nurse's Notes for 06/01/11 through 07/28/11 revealed a note dated 07/15/11 at 6:40 p.m. which stated: "PRN Dulcolax suppository administered per rectum. No hard stool noted in rectum." An additional note dated 07/16/11 at 6:38 p.m. read: "Bowel sounds active and no fecal impaction noted." There was no other documented assessment of bowel sounds, rectal checks or implementation of Physician's standing orders (Fleets type enema). There was also no documentation of Physician notification that Resident # 3 had not had a bowel</p>	F 309		

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F 309	<p>Continued From page 3</p> <p>movement from 07/02/11 -07/07/11, 07/09/11 - 07/15/11, 07/17/11 - 07/21/11 and 07/23/11 - 07/28/11.</p> <p>During an interview on 07/28/11 at 4:15 p.m. the Director of Nursing (DON) stated nursing assistants (NAs) were responsible for documenting residents's bowel movements in the "Caretracker" system every shift. The Resident Care Coordinators run a report every morning before the morning medication pass of residents who have not had a bowel movement (BM) in more than two (2) days. The medication nurse is then expected to use the list to implement the bowel protocol for those residents on the list. She stated her expectation was that Resident # 3 should have been checked for an Impaction after three (3) days without a BM and it should have been documented in the Nurse's Notes. She stated her expectation is that the medication nurses implement the bowel protocol for residents who have not had a bowel movement in two (2) days or more.</p> <p>An interview on 07/28/11 at 4:35 p.m. with Licensed Nurse # 4 revealed she is given a list every morning of residents who have not had a BM in two (2) days or longer. For residents who have not had a BM in two (2) days the night (11-7) nurse implements the bowel protocol. For residents who have not had a BM in three days the day (7-3) nurse implements the bowel protocol and reports to the night nurse if the resident does not have a BM.</p> <p>An interview on 07/28/11 at 4:38 p.m. with Licensed Nurse # 1, a Resident Care Coordinator, revealed she looks at the BM record</p>	F 309			

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F 309	Continued From page 4 every morning on the Caretracker system and gives the medication nurses a list of residents who have not had a BM in two days or longer. The medication nurse is expected to implement the bowel protocol for those residents. 2. Resident # 8 was admitted on 12/17/04 with diagnoses including Parkinson's disease, anemia and depression. A review of the quarterly Minimum Data Set (MDS) dated 05/10/11 revealed the resident had no short or long-term memory problems and had no impairment with daily decision making. A review of a care plan dated 05/13/11 for assistance with activities of daily living indicated interventions for oxygen at all times. A review of a physicians order dated 06/07/11 stated oxygen at three (3) liters per minute continuously per nasal cannula. A review of the oxygen saturation percentage recorded on 07/27/11 at the beginning of the 7:00 a.m. to 3:00 p.m. shift revealed Resident # 8's oxygen saturation was 95 percent. On 07/27/11 at 9:10 a.m. Resident # 8 was observed sitting in her room in a wheelchair with an oxygen concentrator next to her bed, a nasal cannula in her nose and oxygen turned on at 1.5 liters per minute. On 07/27/11 at 10:27 a.m. Resident # 8 was observed in her room during Incontinence care	F 309	2) Immediately following the survey all residents' Oxygen orders were reviewed to ensure that all residents were receiving the MD ordered amount of Oxygen. The Director of Nursing has worked with the RN Resident Care Coordinators to develop protocols to ensure that residents receive the amount of oxygen that the MD has ordered. These are as follows: a. The licensed Nurses will now begin to document, on the Treatment Record, the number of liters that the resident was receiving when they check O2 saturation level per the MD order. This protocol forces the licensed staff to more closely monitor not only the saturation level but also the amount of O2 that the resident is receiving as they will be required to document the specific amount.	8/25/2011

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F 309	<p>Continued From page 5</p> <p>with oxygen on at 1.6 liters per minute. An oxygen concentrator was sitting next to Resident # 8's bed and NA # 2, LN # 1 and LN # 2 were present in the room providing care to her.</p> <p>On 07/27/11 at 12:35 p.m. Resident # 8 was observed sitting in her wheelchair in her room with a nasal cannula in place and oxygen on at 1.5 liters per minute.</p> <p>On 07/27/11 at 1:15 p.m. Resident # 8 was observed sitting in her room in her wheelchair trying to drink liquids from a cup with a nasal cannula in place and oxygen on at 1.5 liters per minute.</p> <p>On 07/27/11 at 1:42 p.m. during an interview NA # 2 stated nurse aides could turn oxygen on and off and they should check the oxygen and the liters per minute when they entered a resident's room to make sure the setting was correct. He further explained he had a daily assignment sheet that gave the oxygen flow rates for each resident who had oxygen and he checked the liter per flow setting when he went into the resident's room.</p> <p>On 07/27/11 at 2:01 p.m. during an interview the Assistant Director of Nurses verified Resident # 8's oxygen concentrator was set on 1.6 liters per minute. She also verified Resident # 8 had a physicians order for continuous oxygen at three (3) liters per minute. She stated NA # 2 and licensed nurses should have checked the liter per minute flow rate on Resident # 8's oxygen concentrator to make sure it was on the correct setting. She stated it was her expectation oxygen should be administered according to the physicians order.</p>	F 309	<p>b. The Resident Care Coordinators will work with the Nursing Administrative Assistant to ensure that the Resident Daily Care Plan has the correct oxygen orders. They will ensure this information is updated as new orders are received or orders are changed.</p> <p>c. The correct number of liters of O2 that is on the MD order will be posted on the back of the resident's concentrator in addition to the Daily Care Plan so that it is more easily available for all nursing staff to access and monitor.</p> <p>Nursing Staff have been reeducated on the facility policy and the facility expectations on Resident Oxygen usage specific to regular monitoring and transportation from the resident's room to dining rooms or other common areas.</p> <p>This will be monitored by the RN Resident Care Coordinators and the Assistant Director of Nursing. For ninety days, the RN Resident Care Coordinators and will check daily to ensure that residents are receiving the correct amount of oxygen per the MD order. This will occur daily for ninety days and then randomly thereafter.</p>	

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F 309	<p>Continued From page 6</p> <p>On 07/27/11 at 2:09 p.m.during an interview the Director of Nurses (DON) stated It was her expectation oxygen should have been delivered at three (3) liters per minute continuously according to the physclans order for Resident # 8. She further stated nursing assistants should check the liler flow of oxygen when they went into a residents room and inform the nurse when it was not on the correct lilers per minute setting.</p> <p>On 07/27/11 at 2:24 p.m.during an interview with Resident # 8's physclan she stated hospice had requested oxygen for the resident and she had approved the order for the resident to receive three (3) liters of oxygen continuously.</p> <p>3. Resident # 12 was admitted on 09/25/07 with diagnoses including dementia and depression. A review of the quarterly Minimum Data Set (MDS) dated 06/20/11 revealed the resident had short-term memory problems, no long-term memory problems and was severely impaired in dally decision making.</p> <p>A review of a physicians order dated 05/05/11 stated oxygen at two (2) liters per minute per nasal cannula due to hypoxia.</p> <p>A review of the monthly physician's orders dated 07/01/11 until 07/31/11 indicated continuous oxygen at two (2) lilers per minute.</p> <p>A review of a document that was undated and titled "Daily care plan" stated oxygen on at all times for Resident # 12.</p> <p>On 07/26/11 during continuous observation from</p>	F 309	<p>Additionally, the ADON will randomly perform weekly checks to ensure that all of these tasks are followed and that residents are on the MD ordered amount of oxygen. The DON will monitor overall compliance by receiving regular Oxygen Reports of the above.</p> <p>The Director of Nursing will report progress in this area, monthly, to the QI Committee. The QI Committee will monitor this issue until the QI Committee has determined that this correction has been consistently achieved.</p>	

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F 309	<p>Continued From page 7</p> <p>4:15 p.m. until 5:02 p.m. Resident # 12 was observed sitting in her wheelchair in the restorative dining room with a nasal cannula in her nose but the oxygen tubing was not connected to a oxygen concentrator or oxygen tank.</p> <p>On 07/26/11 at 4:15 p.m. Resident # 12 was transported into the restorative dining room in her wheelchair by a LN # 3. Resident # 12 had a nasal cannula in her nose but the oxygen tubing was not connected to a oxygen concentrator or oxygen tank.</p> <p>On 07/26/11 at 4:30 p.m. Resident # 12 was observed sitting in her wheelchair at a table in the restorative dining room and she was coughing. She had a nasal cannula in her nose but the tubing was not connected to a oxygen concentrator or oxygen tank and there was no staff present in the room.</p> <p>On 07/26/11 at 4:51 p.m. LN # 3 entered the restorative dining room with oxygen tubing in his hand, walked over to Resident # 12, turned around and walked back out of the room and down a hallway with the oxygen tubing still in his hand. Resident #12 was sitting in her wheelchair with a nasal cannula in her nose but was not connected to an oxygen concentrator or oxygen tank</p> <p>On 07/26/11 at 5:02 p.m. LN # 3 entered the restorative dining room, put oxygen tubing on Resident #12, hooked the tubing to a oxygen concentrator and turned it on.</p> <p>On 07/28/11 at 9:40 a.m. during an interview with</p>	F 309		

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F 309	Continued From page 8 the Assistant Director of Nurses, she verified Resident # 12's physician orders indicated continuous oxygen at two (2) liters per minute. She stated it was her expectation that oxygen should be administered according to a physician's order. She further stated licensed nurses should check oxygen when they went into a resident's room and when they assessed the resident. She also stated nursing assistants should refer to their daily assignment sheet "The Daily care plan" for instructions regarding a resident's oxygen and should check to see if a resident had their oxygen turned on when they went into a resident's room. On 07/28/11 at 3:00 p.m. during an interview with the Director of Nurses (DON) she stated she verified with LN # 3 that he took Resident # 12 into the restorative dining room on 07/26/11 at 4:15 p.m. She stated LN # 3 told her that he left Resident # 12 in the dining room to get new oxygen tubing for the resident because she had chewed on it but LN # 3 responded to call bells and forgot to go back to connect the oxygen to Resident # 12. She stated Resident # 12 should not have been left in the restorative dining room without her oxygen connected and turned on. She further stated it was her expectation staff should treat oxygen as a priority and Resident # 12 should have had her oxygen on while she was in the restorative dining room at two (2) liters per minute according to the physician's order.	F 309			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the	F 315	During the survey, staff reminders and informal staff re-education began by the ADON and the DON. This included the specific staff member cited in this deficiency.	8/25/2011	

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F 315	<p>Continued From page 9</p> <p>resident's clinical condillon demonstrates that catheterizallon was necessary; and a resident who Is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT Is not met as evidenced by: Based on medical record review, facility policy, observations, and staff Interviews the facility failed to use proper technique when performing incontinence care for one (1) of six (6) residents observed for incontinence care. (Resident # 5)</p> <p>The findings are:</p> <p>Resident # 5 was admilted to the facility 05/31/05 with diagnoses including dementia, weakness, and a history of urinary tract infections. A review of the latest Minimum Data Set (MDS) dated 05/24/11, revealed that Resident # 5 had severe cognitive impairment. Further review of the MDS revealed that Resident # 5 needed extensive assistance with activities of daily living, particularly toileting and personal hygiene.</p> <p>Resident # 5's care plan was reviewed. The care plan revealed that Resident # 5 had recurrent urinary tract infections and was at risk for skin breakdown secondary to incontinence and self care deficit.</p> <p>Further review of Resident # 5's medical record revealed urinalysis done on 11/25/10 that was positive for infection. The urine culture was positive for Escherichia coli.</p>	F 315	<p>On 7/29/11, 08/1/11 and 8/15/11 additional education was provided to the Nursing Department by the Staff Development Director. The facility protocol on proper incontinence care was reviewed with staff along with best practices for infection control. The Staff Development Director and the RN Resident Care Coordinators will randomly observe incontinence care provided to the residents to ensure that all staff are routinely providing care according to facility protocol. Any staff found to be non compliant will be immediately reeducated. These observations will be reported to the Director of Nursing on a weekly basis.</p> <p>The Director of Nursing will report progress in this area, monthly, to the QI Committee. The QI Committee will monitor this issue until the QI Committee has determined that this correction has been consistently achieved.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345328	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2011
NAME OF PROVIDER OR SUPPLIER GIVENS HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803		
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F 315	<p>Continued From page 10</p> <p>The facility's policy entitled Perineal Care dated September 2005, was reviewed. In part this policy read: "Wash the rectal area thoroughly, wiping from the base of the labia toward and extending over the buttocks. Do not reuse the same washcloth or water to clean the labia."</p> <p>On 07/26/11 at 12:50 p.m. NA # 1 was observed providing incontinence care to Resident # 5. NA # 1 washed her hands and donned gloves. Resident # 5 stood in restroom holding onto bar while NA # 1 provided incontinence care. NA # 1 used packaged moist wipes to clean resident. Resident # 5 had a bowel movement. NA # 1 wiped Resident # 5's anal area then, using the same moist wipe, wiped the front peri-area. NA # 1 did this several times using the moist wipes soiled with feces to clean the front peri-area.</p> <p>An interview was conducted on 07/26/11 at 1:30 p.m. with NA # 1. NA # 1 reported she was unaware that she had cleaned Resident # 5's front peri-area with a cloth that had previously been used to wipe her anal area.</p> <p>An interview was conducted on 07/27/11 at 3:45 p.m. with Licensed Nurse (L.N) # 1 who was the facility's care coordinator. She reported that her job is to make sure that nursing assistants and licensed practical nurses do their job correctly. L.N # 1 stated that when staff were performing incontinence care they were expected to use the moist wipe to wipe once, front to back and then were to be thrown away. She further stated that she would expect staff to get a clean wipe after wiping anal area and not use the same wipe to clean the front peri-area.</p>	F 315			

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F 315	Continued From page 11	F 315			
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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.</p>	F 441	<p>During the survey, staff reminders and informal staff re-education was provided by the ADON and the DON. This included the specific staff member cited in this deficiency.</p> <p>On 7/29/11, 08/1/11 and 8/15/11 additional formal education was provided to the Nursing Department by the Staff Development Director. The facility Infection Control/hand washing protocols and expectations were reviewed with staff. Staff had ample opportunity to ask questions and run scenarios with the Staff Development Director.</p> <p>The Staff Development Director and the RN Resident Care Coordinators will randomly observe for proper infection techniques which will include proper hand washing. Any staff found to be non compliant will be immediately reeducated. These observations will be reported to the Director of Nursing on a weekly basis.</p>	8/26/2011	

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F 441	<p>Continued From page 12</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, facility policy, and staff interviews the facility failed to maintain infection control practices by not washing hands after performing incontinence care, not changing contaminated gloves prior to handling a tube of barrier cream and touching a door handle for one (1) of six (6) residents observed for incontinence care. (Resident #5)</p> <p>The findings are:</p> <p>Review of facility policy entitled Hand washing/Hand Hygiene, dated April 2010, read in part: "All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: Before and after assisting a resident with toileting (hand washing with soap and water); After handling soiled equipment or utensils; After removing gloves."</p>	F 441	The Staff Development Director will report progress in this area, monthly, to the QI Committee. The QI Committee will monitor this issue until the QI Committee has determined that this correction has been consistently achieved.		

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F 441	<p>Continued From page 13</p> <p>Resident # 5 was admitted to the facility 05/31/05 with diagnoses including dementia, hypertension and a history of urinary tract infections. Resident # 5 was assessed on the Minimum Data Set (MDS) as needing extensive assistance with toileting and hygiene. The MDS further assessed Resident # 5 as incontinent of bowel and bladder.</p> <p>On 07/26/11 at 12:50 p.m. NA # 1 was observed providing incontinence care to Resident # 5. After cleaning the resident, NA # 1 picked up a tube of barrier cream still wearing the gloves used during incontinence care and applied the cream to Resident # 5's buttocks. NA # 1 removed her gloves and assisted Resident # 5 to wash her hands. NA # 1 did not wash her own hands prior to assisting Resident # 5 to bed. NA # 1 touched the resident's merry walker and closed the blinds in her room. NA # 1 then washed her hands. NA # 1 then donned gloves and proceeded to pick up moist wipes soiled with feces in the resident's bathroom. NA # 1 then gathered the trash bags and exited the resident's room, touching the door handle with the contaminated gloves.</p> <p>An interview was conducted with NA # 1 on 07/26/11 at 1:30 p.m. NA # 1 reported that she should have removed her gloves and washed her hands prior to assisting the resident to bed and touching other objects in the room. She further reported she should have used one gloved hand to hold dirty bags and used the clean ungloved hand to open the resident's door.</p> <p>An interview was conducted with Licensed Nurse (LN) # 1 on 07/27/11 at 3:40 p.m. LN # 1 is the care coordinator for the facility. She reports it is her job to make sure nursing assistants and</p>	F 441		

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F 441	<p>Continued From page 14</p> <p>licensed practical nurses are doing their job. She reported that it was her expectation that gloves should be changed before anything clean is touched otherwise it would cause cross contamination. She reported that when using barrier cream, gloves should be changed after cleaning a resident, before touching the tube of cream. She reported that staff should wash hands after removing gloves.</p> <p>An interview was conducted 07/27/11 at 4:30 p.m. with the Director of Nursing (DON). The DON reported that staff should change gloves after incontinence care before handling the tube of barrier cream. She also reported that NA # 1 should have washed her hands after removing gloves and before assisting resident back to bed, touching resident's chair, and closing the window blinds. She further reported NA # 1 should have removed dirty glove prior to opening resident's door to take trash to dirty linen room.</p>	F 441			