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

PRINTED: 01/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING ____ B. WING ____	C 01/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA LANE NURSING AND REHABILITATION CENTER	107 MAGNOLIA DR MORGANTON, NC 28655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to provide activities that met the needs and interests of two (2) of five (5) sampled residents. Resident #4 and #6. The findings are: 1. Resident #4 had diagnoses including acute renal heart failure, falls, cellulitis, chronic renal insufficiency, diabetes and dementia with psychotic features. The annual Minimum Data Set (MDS) dated 7/17/11 coded her with long and short term memory impairment, moderately impaired decision making skills, and requiring extensive to total assistance with most activities of daily living skills (ADLs). Preferred activities included she was somewhat interested in books and very interested in music, news, and religious activities. The Cognitive Care Assessment Area (CAA) dated 8/2/11 stated Resident #4 was constantly confused to place, time and situation and she preferred to stay in bed in her room. The CAA also stated that Resident #4 yelled out with care or upon being moved. The activity progress note	F 248	For those residents affected #4 & #6 their care plan was re-evaluated and updated for activities by Minimum Data Set nurse on 1-18-12, 1-19-12 & 1-24-12. Based upon this re-evaluation, a radio was purchased for residents #4 for in-room activities. These residents will be encouraged to get OOB to attend activities of the resident's choice at least 2x/wk. An interim Activity	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lois "Jean" D Carter RN LNHA
TITLE: Administrator
(X6) DATE: 2-3-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FEB 08 2012
BY: MH

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F 248	Continued From page 1 dated 7/15/11 stated her current interests included church, music, singing and socials and she enjoyed the individual activities of television, music, reading, and visits. This note stated Resident #4 did not want to get out of bed and one on one activities were provided and the Activity Director (AD) would visit and encourage her to come to group activities and offer supplies for in room activities. The quarterly MDS dated 10/10/11 coded her with severely impaired cognition and requiring extensive to total assistance with most activities of daily living skills. The activity progress note dated 10/11/11 stated Resident #4 was interested in bingo, music, spiritual programs and simple arts and crafts as well as television, magazines, and visits. The note stated the resident participated in three activities per week when she felt like getting up in her wheelchair. There was no care plan developed for activities. Resident #4 was observed in bed with no television or music on 1/11/12 at 9:40 AM, 10:35 AM, 11:20 AM, 11:38 AM, 12:21 PM, 2:25 PM, 4:05 PM and 4:33 PM and on 1/12/12 at 9:50 AM. Resident #4 was observed awake and fed herself meals in bed. During interview on 1/12/12 at 8:36 AM the Activity Director (AD) stated Resident #4 did not like to attend activities. Review of notes kept by the AD revealed Resident #4 received in room visits on 11/17/11 and on 12/22/11. The AD stated she would go and ask Resident #4 daily how she was and if she needed anything. She stated that when Resident #4 would get upset,	F 248	Director was appointed on 1-27-12. All in room residents care plans were reviewed by 1-27-12 for activities planning. All staff were inserviced on providing activities by the QI nurse with completion by 1-31-12. The QI nurse will audit 10 residents/day for inroom providing of activities that meet the needs and interests of residents daily x 5, weekly x4 then monthly x3 utilizing a QI tool. Results of the audits will be reported to QI	

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F 248	Continued From page 2 she would go in to calm her down. She could not produce any evidence of these visits. There were no activity attendance logs maintained by the facility. The AD could provide no activity plan or routine specific to meet Resident #4's interests. Follow up interview with the AD on 1/12/12 at 1:10 PM revealed the AD has only visited with the resident and had not supplied arts and crafts or music to her. Interview on 1/12/12 at 9:45 AM with the nurse aide (NA) #6 revealed Resident #4 only got up on shower days twice per week. 2. Resident #6 had diagnosis including chronic kidney disease, dementia and Alzheimer's disease. The activity supplemental assessment dated 8/13/11 stated he preferred small groups, in room and individual activities which included listening to music specifically to gospel, country, bluegrass and rock and roll. The annual Minimum Data Set (MDS) dated 8/26/11 coded him with moderately impaired cognition and requiring extensive assistance with activities of daily living skills. Resident #6's indicated that reading books was most important however, he was unable to do that. He indicated he was somewhat interest in music and news. The quarterly MDS dated 10/10/11 coded him with severe cognitive impairment and requiring extensive assistance with most activities of daily living skills. There were no activity progress notes since 8/13/11.	F 248	committee monthly for follow-up and/or continued monitoring.	2-8-2012

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F 248	Continued From page 3	F 248		

There was no care plan for activities.

Resident #6 was observed in his room in a gerichair asleep with the television on 1/11/11 at 10:59 AM, 11:17 AM, 12:00 PM, 12:30 PM, 1:25 PM, 1:35 PM, 3:35 PM, 4:05 PM, and 4:29 PM.

On 1/12/12 at 9:00 AM the Activity Director (AD) stated he attended music and religious programs twice per week and watched television. Review of the AD notes revealed he attended Devotions on 12/22/11. As she reviewed other notes (she had no attendance sheets), she cited four other activities she was sure he attended but wrote another resident's name instead of Resident #6's name. These were Devotions on 10/9/11, 12/29/11, 1/5/12, and 1/10/11. Follow up interview on 1/12/12 at 1:04 PM with the AD revealed she had no recent assessments for Resident #6 and she could not explain the reason there was no quarterly assessment. She stated that if Resident #6 was up in the gerichair, she would take him to devotions and sensory class. If not up, then he did not attend. She further stated that she informed the nurse aides when devotions were so he would be up and ready to be taken to the activity.

Interview with the MDS staff on 1/12/12 at 2:15 PM revealed Resident #6 was up in a gerichair every day.

Review of the activity schedules revealed Devotions were scheduled every Tuesday in November 2011, three Tuesdays in December 2011 and every Tuesday in January 2012. Sensory class was scheduled twice on November 23, 2011, twice on December 7, 2011, and twice

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F 248	Continued From page 4 on January 9, 2012.	F 248		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide services to maintain and/or improve the eating abilities for one (1) of four (4) sampled residents. Resident #6. The findings are: Resident #6 had diagnosis including chronic kidney disease, dementia and Alzheimer's disease. The annual Minimum Data Set (MDS) dated 8/26/11 coded him with moderately impaired cognition, severely impaired vision and requiring extensive assistance with activities of daily living skills (ADLs) including eating. The vision Care Area Assessment (CAA) dated 9/9/11 stated Resident #6 was blind and had to have assistance with eating his finger foods. It further stated staff described where the food was located. The ADL CAA dated 9/9/11 stated Resident #6 was legally blind and was able to feed self with finger food when staff oriented him to the location of food on his tray.	F 311	Resident # 6 was re-evaluated by occupational therapy regarding self feeding on 1-13-12 . Any admitted visually impaired residents will be screened by therapy for self feeding deficits. All nursing staff were inserviced by QI and SDC beginning on 1-19-2012 to follow the resident care guide. QI	

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F 311	Continued From page 5 The quarterly MDS dated 10/10/11 coded him with severe cognitive impairment, severely impaired vision and requiring extensive assistance with most activities of daily living skills including eating. The care plan for eating last updated 9/28/11 had the goal that Resident #6 would feed himself finger foods and liquids with cueing, supervision and minimal assistance. Resident #6 was observed on 1/11/12 at 1:35 PM taken to the dining room for the noon meal. His food was served in bowls and placed in front of him by nurse aide (NA) #3. NA #3 did not inform the resident where and in what order the bowls were placed. A fork was placed in the bowl of carrots and a spoon was placed in the noodles. At 1:43 PM, NA #4 was observed feeding Resident #6. When asked about Resident #6's ability to feed himself, she stated she was new and did not know what he could do for himself. She looked to another NA, NA #5 who stated sometimes he fed himself and sometimes he did not. NA #4 continued to feed him. Later in the meal, NA #4 placed the roll in his hand and he proceeded to feed himself the roll. On 1/12/12 at 8:42 AM, Resident #6 was observed being set up by NA #6 for breakfast. The food came in bowls with scrambled eggs and a sausage patty in one bowl, a slice of toast in another and grits in another. NA #6 did not tell Resident #6 in what order the bowls were placed in front of him. NA #6 gave Resident #6 milk in his hand and he independently drank it. She then chopped up the sausage patty into the eggs and fed him the eggs and sausage and grits. She	F 311	audits of 10 residents/day will be done for self feeding and/or prompting daily x 5, weekly x 4, and monthly x 3 utililzing a QI tool. Results of the audit will be reviewed monthly by the executive QI committee for follow up and/or continued monitoring.	2-08-2012

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F 311	Continued From page 6 made no attempt to hand him any bowl, make a sandwich from the toast and eggs or encourage him to feed himself. NA #6 was interviewed on 1/12/11 at 9:45 AM about Resident #6's ability to feed himself. She stated she usually worked second shift and fed him on second shift so she just fed him at breakfast. On 1/12/12 at 1:30 PM, a hydration aide set Resident #6's tray up for him. Although she did not tell him the location of food items, she did explain each item. When he agreed to try the chicken strips, she encouraged him to hold the chicken and feed it to himself. He held the chicken and took a bite. She also gave him the bowl of french fries which he held and ate most of them. She did not give him his drinks to hold, but instead held the cup to his lips. Interview with the Administrator and Director of Nursing on 1/12/12 at 1:00 PM revealed staff should feed Resident #6 after attempts are made to encourage and cue him to feed himself are unsuccessful.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312		

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F 312	Continued From page 7 Based on medical record review, observation and staff interview the facility failed to use proper technique and to thoroughly clean a resident during incontinence care for three (3) of eight (8) residents. Residents #4, #8 and #9. The findings are: 1. Resident #8 was admitted to the facility with the diagnoses including dementia and seizure disorder. Review of Resident #8's most recent quarterly Minimum Data Set (MDS) dated 10/18/11 revealed she had severe cognitive impairment, required total assistance with all activities of daily living skills and she was always incontinent of bowel and bladder. Review of Resident #8's care plan dated 11/02/11 revealed the problem of urinary incontinence with a goal the resident would be free of urinary tract infection. Interventions included peri-care to be performed after each episode of incontinence. An observation was made on 01/11/12 at 10:05 AM of Nursing Assistant (NA) #1 providing incontinence care for Resident #8. The resident was lifted from her wheel chair using a sit to stand lift. NA #1 donned gloves. She used a wipe and cleaned the resident's peri-area wiping back to front four times using one wipe. She then used another wipe to clean the residents buttock area. Care was performed while resident stood assisted by the sit to stand lift. An interview was conducted 01/11/12 at 10:15 AM with NA #1. She confirmed she cleaned Resident #8 wiping back to front. NA #1 did not give a reason for cleaning the resident back to front. She stated she should have cleaned her	F 312	For those residents affected, # 4, 8 & 9 and any resident requiring assistance with incontinence care, staff will use proper technique to thoroughly clean the resident. Inservices began on 1-12-12 to include all cnas. Resident Care QI audits of 10 residents/day for proper incontinence care will be conducted daily x 5, weekly X 3 and monthly X3 by the Director of Nursing, Staff Development Coordinator , Quality Improvement nurse and/or Administrative nurses utilizing the	

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F 312	Continued From page 8 wiping front to back. An interview was conducted 01/11/12 at 4:20 PM with the Staff Development Coordinator (SDC). She reported upon hire NA staff are given a packet which includes a skills checklist. This checklist included all skills including peri-care that were to be performed correctly prior to the staff working with residents unsupervised. The SDC reported NA staff were instructed when cleaning female resident they are to wipe front to back. An interview was conducted on 01/11/12 at 3:22 PM with the Director of Nursing. She stated it is her expectation when staff provide incontinence care to female residents staff wipe front to back. 2. Resident #9 was admitted to the facility with the diagnoses Alzheimer's disease, hypertension and urinary incontinence. Review of Resident #8's most recent quarterly Minimum Data Set (MDS) revealed she had severe cognitive impairment and was totally dependent for all activities of daily living. Review of the MDS further revealed she was always incontinent of bowel and bladder. Review of Resident #8's care plan dated 12/12/11, revealed the problem urinary incontinence with the goal the resident would be free of urinary tract infection and skin breakdown. An observation was made on 01/11/12 at 1:55 PM of Nursing Assistant (NA) #2 providing incontinence care for Resident #9. Resident #9 was in her bed lying on her back during care. NA #2 donned gloves and using a wipe, cleaned Resident #9's peri-area back to front three times. She then cleaned the resident front to back using a different wipe.	F 312	resident care audit form. Immediate retraining will be provided upon the identification of any potential concern. Results of the QI audits will be reviewed by the monthly QI committee for follow up and/or continued monitoring.	2-08-2012

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F 312	Continued From page 9 An interview was conducted on 01/11/12 at 2:30 PM with NA #2. She confirmed she wiped back to front. NA #2 did not give an reason why she cleaned the resident from back to front but when she realized she had wiped the wrong way she then wiped front to back. NA #2 stated she should have cleaned the resident wiping front to back. An interview was conducted 01/11/12 at 4:20 PM with the Staff Development Coordinator (SDC). She reported upon hire NA staff are given a packet which includes a skills checklist. This checklist included all skills including peri-care that were to be performed correctly prior to the staff working with residents unsupervised. The SDC reported NA staff were instructed when cleaning female resident they are to wipe front to back. An interview was conducted on 01/11/12 at 3:22 PM with the Director of Nursing. She stated it is her expectation when staff provide incontinence care to female residents, staff wipe front to back. 3. 3. Resident #4 was admitted with diagnoses including dementia, acute renal failure, urinary tract infection and diabetes. The quarterly MDS dated 10/10/11 coded her with severely impaired cognition and requiring extensive to total assistance with most activities of daily living skills including toileting and hygiene. She was coded as always being incontinent. The care plan for toileting last updated 8/18/11 included interventions to provide peri-care after each incontinence. On 1/11/12 at 10:18 AM Nurse Aide (NA) #5 and	F 312		

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F 312	Continued From page 10 #6 were observed providing Resident #4 incontinent care. Resident #4 was observed lying on her back in bed. After removing a urine soiled brief and without separating the resident ' s legs, NA #5 pushed a disposable wet wipe between the resident ' s legs and wiped the perineum repeatedly from front to back three times. NA #5 then took a second disposable wipe and repeated and repeated the same procedure wiping front to back without separating the resident ' s legs. NA #5 did not open the labial folds to thoroughly clean her peri-area. When the NA finished using the disposable wipes, she turned the resident on her side and removed the wipes from underneath the resident. During interview at 2:45PM on 1/12/12, NA #5 stated she thought she had separated Resident #4 ' s legs far enough to adequately provide incontinent care. An interview was conducted on 01/11/12 at 3:22 PM with the Director of Nursing. She stated it was her expectation that staff use a new wipe each time they wiped while providing incontinent care.	F 312		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	For those residents affected, #8 & #9, staff will use proper handwashing technique and removal	

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F 441	Continued From page 11 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. This REQUIREMENT is not met as evidenced by: Based on facility policy, observations, and staff interviews the facility failed to remove gloves after providing incontinence care and prior to touching clean items for two (2) of eight (8) sampled residents. Resident #8 and #9. The findings are: Review of the facility's policy entitled Hand	F 441	of gloves upon contamination when incontinence care is provided. Any resident requiring assistance with incontinence care; appropriate infection control practices will be followed. Inservices were started on 1-18-12 for all licensed nurses and cnas with completion of all nursing staff by 1-31-12. The Quality Improvement and staff development nurse will conduct audits of 10 residents/day for proper handwashing daily x5, weekly x3, then______	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 12 Washing dated 8/2005 read in part: Personnel are required to wash their hands after each direct or indirect resident contact for which hand washing is indicated by acceptable standards of practice. · after removing gloves · when otherwise indicated to avoid transfer of microorganisms to other resident and environments · when indicated between tasks and procedures to prevent cross contamination 1. Resident #8 was admitted to the facility with diagnoses of dementia and seizure disorder. Review of Resident #8's most recent quarterly Minimum Data Set (MDS) dated 10/18/11 revealed she needed assistance with all activities of daily living and was incontinent of bowel and bladder. An observation was made on 01/11/12 at 10:05 AM of Nursing Assistant (NA) #1 providing incontinence care for Resident #8. Resident #8's wet brief was removed and incontinence care was provided. After performing care, NA #1 did not remove her gloves before touching the lift . used to stand Resident #8 during care. She also touched the package of wipes that were sitting on the counter next to the sink and the resident's wheelchair prior to removing the gloves worn during incontinence care. After removing her gloves she wheeled the resident into the hall and placed the package of wipes on the clean linen cart. She then used hand sanitizer from the dispenser in the hall. An interview was conducted at 01/11/12 at 10:15 AM with NA #1. She reported that she kept her	F 441	quarterly x3. The results will be reported to the QI committee monthly for follow-up and/or continued monitoring.	2-08-2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING ______ B. WING ______	C 01/12/2012

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F 441	Continued From page 13 gloves on until she was completely finished providing care. She further reported she had been told not to leave the wipes in residents' rooms and to store them on the clean linen cart. She did not give an explanation why she did not remove her gloves after performing incontinence care prior and to touching other clean items in the room. An interview was conducted on 01/11/12 at 4:20 PM with the Staff Development Coordinator (SDC). She reported staff had been taught to remove soiled gloves after providing care for residents prior to touching any clean objects. She further reported she expected staff to remove the amount of wipes they thought they would need prior to entering the resident's room. She stated staff has been instructed not to take the pack of wipes into the resident's room. An interview was conducted on 01/11/12 at 3:22 PM with the Director of Nursing. She reported that it was her expectation that staff remove dirty gloves prior to touching any clean items. She further stated that packages of wipes were not to be taken into resident's rooms. She stated it was her expectation that staff remove the amount of wipes they thought they would need prior to entering a resident's room. 2. Resident #9 was admitted to the facility with the diagnoses Alzheimer's disease, hypertension and urinary incontinence. Review of Resident #8's most recent quarterly Minimum Data Set (MDS) revealed she was totally dependent for all activities of daily living. Review of the MDS further revealed she was incontinent of bowel and bladder.	F 441		

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F 441	Continued From page 14 An observation was made on 01/11/12 at 1:55 PM of Nursing Assistant (NA) #2 performing incontinence care for Resident #9. NA #2 donned gloves and removed wipes from the package sitting on Resident #9's bed. After cleaning Resident #9's buttocks and peri-area NA #2 reached into the package of wipes wearing the same gloves and retrieved more wipes. NA #2 wiped Resident #9's peri-area again. NA #2 then repositioned the resident in the bed, pulled up her covers and lowered the bed with the bed control wearing the same gloves used to provide care. She gave the resident the call bell and opened the window blinds. She then removed her gloves, washed her hands and took the wipes and placed them on the clean linen cart. An interview was conducted on 01/11/12 at 2:30 PM with NA #2. She reported that staff had been given an in-service regarding the use of wipes. She reported that she was told that if the package of wipes went into the resident's room the sanitary thing to do would be to leave them there for use only by that resident. She reported it was common practice for staff to take them room to room and store them on the clean linen cart. She further stated that she should have taken her gloves off prior to touching anything clean in the room. An interview was conducted on 01/11/12 at 4:20 PM with the Staff Development Coordinator (SDC). She reported staff had been taught to remove soiled gloves after providing resident care and prior to touching any clean objects. She further reported she expected staff to remove the amount of wipes they thought they would need	F 441		

PRINTED: 01/27/2012
FORM APPROVED
OMB NO. 0938-0391

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F 441	Continued From page 15 prior to entering the resident's room. She stated staff had been instructed not to take the pack of wipes into the resident's room. An interview was conducted on 01/11/12 at 3:22 PM with the Director of Nursing. She reported that it was her expectation that staff remove dirty gloves prior to touching any clean items. She further stated that packages of wipes were not to be taken into residents' rooms. She stated it is her expectation that staff remove the amount of wipes they thought they would need prior to entering a resident's room. She also stated that if staff runs out of wipes they were to take off their gloves, wash their hands and go get more wipes to complete resident care.	F 441		