STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345396	A. BUILDING _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	1349 CRABTREE ROAD WAYNESVILLE, NC 28785

(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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, observation and record review, the facility failed to assess the dialysis access site following dialysis for complications from dialysis treatment to include active bleeding, redness or dislodgement of the dressing for 1 of 1 residents (Resident # 102) reviewed that received dialysis. Findings included: Resident # 102 was admitted on 6/27/14 with cumulative diagnosis of end stage renal disease requiring hemodialysis. The physician documented in his initial History and Physical (H & P), dated 6/27/14, the resident had full decision making capacity. Further review of the H & P, indicated the Resident 102's hemodialysis port was in her right upper chest and she received hemodialysis three times weekly. Additionally, in the H & P, in the section titled, CHEST, the MD documented the dialysis access site had no surrounding erythema, induration or discharge. Resident # 102's care plan, dated 6/30/14, identified a problem of end stage renal disease (ESRD): at risk for complications due to hemodialysis. Interventions included in the care plan to assure Resident # 102 would not	F 309	F309: Smoky Mountain Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegiation of compliance. Smoky Mountain Health and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further Smoky Mountain Health and Rehabilitiation Center reserves the right to refute any of the deficiencies on this Statement of Deficiences through informal Dipsute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F0309:	8/20/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/15/2014

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.

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F 309	Continued From page 1 experience complications from dialysis treatment included assessing the resident upon return from the dialysis treatment included maintaining the dressing as ordered and monitoring the access site for bleeding and/or signs of infection. Review of progress notes, QI Skin/Wound reviews and review of notes under the Assessment tab of the electronic medical record from 06/27/14 through 07/24/14 revealed there had been no documented assessment of Resident # 102's dialysis access site on any day including the days the resident had returned from dialysis. A 7/4/14 Admission Minimum Data Set (MDS) indicated the resident was cognitively intact, scoring 15/15 on the Brief Interview for Mental Status (BIMS). The MDS also indicated an active diagnosis of ESRD. An interview was held with Resident # 102 on 7/23/14 at 9:40 AM. Resident # 102 stated that on return from dialysis staff did not take her vital signs or evaluate her right upper chest dialysis access port for bleeding or infection. The resident stated she had recently started dialysis in June 2014. During the interview with the resident, the right upper chest dialysis access site was visualized. The dressing was dry and intact. The skin surrounding the dressing was without redness or swelling. An interview was held with Nurse # 1 on 7/23/14 at 2:52 PM. Nurse # 1 stated when a resident returned from dialysis the nurse's responsibility included checking the dialysis access site for infection (heat, abnormal redness, soreness) and/or any sides of bleeding. The post dialysis assessment, per Nurse # 1 was documented in the nurse's progress notes. Nurse # 1 stated she was not the nurse on duty when the resident returned from dialysis.	F 309	Resident #102 was assessed and documented on upon return from dialysis on 7/24/14. Resident #102 was discharged home on 7/25/14 after successful rehabilitation. One other resident residing in the facility that received dialysis treatments was assessed by nursing staff. No complications of shunt site were found. Licensed Nurses were 100% in-serviced by 8/11/14 by the Director of Nursing on proper documentation of assessing residents that are on dialysis, including time of return, assessing the type and location of access, if dressing is clean and intact with no active bleeding, assessing for pain and/or discomfort, performing vital signs, and new orders. Using an audit tool developed by the facility, the Director of Nursing and/or Quality Improvement (QI) nurse will audit all dialysis residents for complete documentation of site assessment three times a week for four weeks; then all dialysis residents three times a week every other week for one month then monthly to ensure compliance on an ongoing basis. Any concerns will be addressed at the time of the audit which may include staff re-education. Weekly, then monthly audits will be turned into the Adminstrator for review. The Administrator will present audit findings to the executive QI committee. The executive QI committee will review	

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F 309	Continued From page 2 An interview was held with the Director of Nursing (DON) on 7/23/14 at 3:15 pm. The DON stated it was the responsibility of hall nurse, assigned to care for the dialysis resident, to check the overall appearance of the resident on return from dialysis. This included assessing the dialysis access site for bleeding or to make sure the dressing was dry and intact. Documentation of the dialysis access site should be found in the Progress Note. Additionally, the DON stated that even if a dressing is managed by dialysis center, with orders not to remove the dressing, the expectation was for the hall nurse to check the access site. The DON acknowledged there was no assessment of the dialysis access site in Resident # 102's progress notes, under the Assessment tab or in the QI Wound notes. During the 7/23/14 interview with the DON, the Treatment Nurse interjected that she had not been assessing the dialysis access site since there was an order not to remove the dressing. An interview was held with Nurse # 2 on 7/23/14 at 3:29 PM. The nurse stated she worked with Resident # 102 at least 3 out of 7 days. The nurse stated this included days when the resident returned from dialysis, usually 3:00 PM to 5:00 PM. Nurse # 2 stated the nurse on the hall was expected to generally check over any resident returning from dialysis. The assessment included vital signs and checking the dialysis access site for bleeding and/or infection. Documentation of the dialysis access site assessment was found in the progress notes. The nurse stated she worked with the resident yesterday after return from dialysis and was pretty sure she had not documented an assessment on the dialysis access site. The nurse reviewed all her notes she had authored for Resident # 102 and was unable to find any documentation related to	F 309	audits to determine the continued need for frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	

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F 309	Continued From page 3 assessment of the right upper chest dialysis site. The nurse had no answer to why there was no documentation.	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 resident's clinical condition demonstrates that catheterization 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, policy and record review, the facility failed to receive a complete order for an indwelling urinary catheter, did not secure the indwelling urinary catheter to prevent pulling or dislodgement and did not complete a voiding trial for 1 of 2 sampled residents (Resident # 31) reviewed that used an indwelling urinary catheter. Findings included: The facility's policy, titled, "Catherization-Foley", dated April 2013, indicated under EQUIPMENT & (and) Supplies, that the nurse was to use the catheter size specified by the physician. Under PROCEDURE-INSERTION, the policy indicated under Paragraph 4, that the catheter should be secured to the thigh.	F 315	F0315: The Director of Nursing had a discussion concerning resident #31 on 7/28/14 with the Medical Director. Upon discussion, the Medical Director wrote an order for a voiding trial for resident #31 due to indwelling urinary catheter. The voiding trial was performed on 7/29/14. One other resident residing in the facility has an indwelling urinary catheter with orders stating correct size, how often to change, catheter care, and diagnosis. This resident also had been placed on a voiding trial. The urinary catheter is checked to ensure anchoring device is intact.	8/20/14

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F 315	Continued From page 4 Resident # 31 was admitted on 3/4/11 with diagnoses that included unspecified urinary incontinence. On 2/27/14, a diagnosis of unspecified retention of urine was added. On 1/26, the resident was sent to the hospital for evaluation of abdominal pain and returned to the facility the same day with an indwelling urinary catheter and an order for an antibiotic for a urinary tract infection (UTI). The Emergency Department report, dated 1/26/14, indicated a catheter was placed due to retention. Return of greater than 1000 mls (milliliters) of urine was documented in the report. Physician progress notes, dated 1/27/14, indicated the chief complaint/nature of presenting problem was the management of a UTI and urinary retention. Within the notes the physician noted a urinary residual of 2000 mls, so the catheter was left in place. Under "Diagnosis, Assessment and Plan", the physician indicated he would leave the indwelling urinary catheter in place for decompression for 2 weeks. The physician added he would consider removing in a couple of weeks to see if Resident # 31 could tolerate the removal of the indwelling urinary catheter. Review of orders for 1/27/14, did not indicate the physician had written an order for the indwelling urinary catheter or the removal of the catheter in 2 weeks. Review of Resident # 31's the care plan, with an initiation date of 1/27/14, indicated an altered pattern of urinary elimination with an indwelling catheter (16 French- this indicated the size of the catheter used). The goal was to be free of	F 315	Licensed nurses were 100% in-serviced by 8/11/14 by the Director of Nursing (DON) that indwelling urinary catheters require a written order with the size of the catheter, the size of the bulb, the frequency in which the catheter can be changed and catheter care. Residents that are admitted with indwelling urinary catheters and or/ residents having indwelling urinary catheters placed in the facility for retention will be reviewed with the physican for removal and voiding trials. The Licensed nurses and Certified Nurses Assistants were 100% in-serviced by 8/11/14 by the DON to enusre drainage tubings are secured with an anchoring device and to replace anchoring device if accidentally removed of falls off. Using an audit tool developed by the facility, the DON and/or Treatment nurse will audit all residents with indwelling urinary catheters for orders, to ensure voiding trials and/or diagnosis on all orders and ensure anchoring devices are present, three times a week for four weeks; then three times a week every other week for one month then monthly to ensure compliance on an ongoing basis. Any concerns will be addressed at the time of the audit which may include staff re-education. Weekly, then monthly audits will be turned into the Administrator for review. The Administrator will present audit	

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F 315	Continued From page 5 urinary tract infection. Interventions included: ensure the drainage tubing is secured with an anchoring device, such as a leg strap to prevent tension or accidental removal and indwelling urinary catheter 16 French with a 10 ml balloon. Review of the February 2014 progress notes did not provide documentation the catheter had been removed and a voiding trial attempted as referenced in the 1/27/14 Physician's Progress Note. Progress notes had no documentation the physician had been consulted by facility staff regarding the removal of the indwelling urinary catheter for a voiding trial. Review of an Annual Minimum Data Set (MDS), dated 2/7/14, indicated Resident # 31 was cognitively impaired scoring 5/15 on her Brief Interview for Mental Status. The MDS also indicated the resident was dependent on staff for bathing, grooming, personal hygiene and toileting. An indwelling urinary catheter was coded. Active diagnoses did not include neurogenic bladder or obstructive uropathy, but did include UTI and unspecified urinary incontinence. Urinary retention was not included in the active diagnosis list. Review of the July 2014 physician's orders indicated " Tx: Continue foley cath (catheter), change every 30 days and as needed-May irrigate with sterile water as needed for occlusion". The order did not include a size for the catheter or the balloon or the indication for use. An interview with the Director of Nursing (DON) was held on 7/24/14 at 3:36 PM. The DON stated prior to placing an indwelling urinary catheter the	F 315	findings to the executive QI committee. The executive QI committee will review audits to determine the continued need for frequency of monitoring. Any recommneded changes will be discussed and carried out as agreed upon at that time.	

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F 315	Continued From page 6	F 315		

nurse must obtain an order that included the size of the catheter, when the urinary catheter would be changed and the indication for use. The DON confirmed there was no order from the resident's facility physician for the catheter that had been placed on 01/26/14. She stated since the 26th was a Sunday the expectation would be to wait until the resident's physician arrived in the facility on Monday to notify him of the indwelling urinary catheter. A copy of the ER paperwork would have been placed in the doctor's book for review. The DON stated the physician writes all of his orders during his visit, so if he had intended for the catheter to be removed as stated in the progress note, he would have written the order. Additionally, the DON stated she thought there had been a voiding trial completed for Resident # 31. Review of progress notes revealed no documentation of an attempted voiding trial for the resident.

An observation was made on 7/24/14 at 4:21 PM with the assistance of Nursing Assistant (NA) #1. There was no securing device observed being used by Resident # 31 to prevent the indwelling urinary catheter from becoming dislodged or potentially creating urethral trauma. The NA stated the device used by the resident was the strap that went around her leg and usually the securing device was in place.
Resident # 31 stated at this time "they took it off". She was unable to identify who "they" were or the circumstances surrounding the removal of the securing device.

The DON stated on 7/24/14 at 4:25 PM it was the policy and expectation for all indwelling urinary catheters to be secured in order to avoid trauma and accidental removal.

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F 315	Continued From page 7 At 4:44 PM, the DON supplied a physician's order dated 2/27/14, one month after the catheter was originally placed, that indicated to continue the indwelling urinary catheter and to change the catheter every 30 days. At the top of the order the physician had added "Add dx (diagnosis): urinary retention." There was no size included on the order. The DON stated that while the facility did not have an order written on 1/27/14 for the catheter, the MD was aware and the fact he was aware and did not discontinue the catheter was implied consent. The DON acknowledged there was no order from the MD that contained the size of catheter to be used. At 5:19 PM on 7/24/14, the Treatment Nurse reported the catheter securing device had been removed during the resident's shower on the 7-3 shift. She stated she normally checked the catheter securement daily, but had not yet today. The treatment nurse was unsure what NA had given the resident her shower. She added the expectation was for the NA to report any catheter securement that was missing; adding that no one had reported Resident # 31's catheter was not secure.	F 315		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363		8/20/14

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F 363	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review the facility did not provide the physician ordered therapeutic diet for 1 of 1 residents (Resident # 102) reviewed that received dialysis #102. Findings include: The facility policy titled, DIETS, with a version date of 08-2013, indicated that "Diets will be served according to the following descriptions." Under RENAL DIET, the policy indicated the renal diet was used for the management of renal or liver diseases with protein, phosphorous, potassium and sodium restricted. Under the policy, DIET ORDER PROCEDURE, with a version date of 08-2013, the last paragraph indicated "no order can vary from the physician's written order including consistency of diet." Resident # 102 was admitted on 6/27/14 with cumulative diagnosis of end stage renal disease requiring hemodialysis and unspecified protein calorie malnutrition. The Hospital Discharge Summary, dated 6/27/14, indicated the resident had acute renal failure, now end stage renal disease (ESRD) and received dialysis. The discharge summary listed renal diet for Resident # 102. The diet was transcribed on 6/27/14 to the facility ' s admission orders and signed by the resident's facility physician. A 7/4/14 Admission Minimum Data Set (MDS) indicated Resident # 102 was cognitively intact. The MDS also indicated no behaviors, supervision required for eating, active diagnosis of ESRD and identified the resident as receiving a therapeutic diet. The care plan, dated 7/8/14, indicated Resident # 102 was on a therapeutic diet. The type of diet was not specified on the care plan. The goal	F 363	F0363: Resident #102 was reviewed by the Dietary Manager on 7/24/14 for the delivery of the diet as ordered by the physican. All residents diet orders were reviewed by the Dietary Manager on 7/28/14 to enusre the residents were receiving the diet ordered. On 8/7/14 the dietary staff was in-serviced by the Dietary Manager on following diet orders and that correct diets are being provided. The Registered Dietician in-serviced the dietary staff, Dietary Manager and the nursing staff on 8/14/14 about the different types of therapuetic diets and the types of foods to be included on the therapuetic diets. Using an audit tool developed by the facility, the Dietary Manager will audit five (5) residents, to ensure the receipt of diets as ordered by the physician, three times a week for four weeks; then three times a week every other week for one month then monthly to ensure compliance on an ongoing basis. Any concerns will be addressed at the time of the audit which may include staff re-education. Weekly, then monthly audits will be turned into the Administrator for review. The Administrator will present audit findings to the executive QI committee. The executive QI committee will review audits to determine the continued need for	

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F 363	Continued From page 9 indicated the resident would adhere to the prescribed therapeutic/supplemental diet through the next review. Review of progress notes and dietary assessment notes from Resident # 102's 6/27/14 admission through 7/23/14 did not document any resident and/or Responsible Party (RP) education regarding a renal diet. An observation was made on 7/21/14 at 12:25 PM of Resident # 102's lunch tray. The tray included ribs with barbeque sauce, sweet potatoes and greens. The resident and spouse stated they upset over the food served. He stated he had spoken with dietary staff who told him the diets in the facility were liberal. The resident's tray card identified her diet as Renal. During the meal, the cook entered the room at which time the resident requested an alternate meal selection. The Dietary Manager (DM) was interviewed on 7/23/14 at 9:00 AM. She identified Resident # 102 as one of the residents that received a renal diet. The DM stated there were specific menus for a Liberal Renal diet and presented spreadsheets of menus for review. The DM stated kitchen staff referred to the menus when plating foods for residents on therapeutic diets. Review of the menu for a renal diet for Monday, July 21, 2014, indicated residents should be served baked ribs with no sauce, 3/4 ounce of rice or noodles, greens with vinegar and cornbread, peaches and creams, margarine and beverage of choice. An interview was held with Resident # 102 on 7/23/14 at 9:40 AM. She and her RP confirmed for lunch on Monday she received ribs with barbecue sauce, greens, and a sweet potato. The resident stated she did not eat the meal because she knew it was not part of her renal	F 363	frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	

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F 363	Continued From page 10	F 363		

diet; adding she requested and received an alternate. Resident # 102 stated no one had been in to interview her about her food preferences and she had received no education from the facility on the renal diet. The resident's RP added when Resident # 102 was admitted he had asked someone about a renal diet and was told the diets in the facility were liberal.

An interview was held with the DM on 7/23/14 at 11:31 AM. She stated that residents receiving renal diets could not have tomato sauce or potatoes. She added instead of potatoes, residents receiving renal diets received noodles or rice. The DM stated she was unsure if those residents receiving renal diets could have sweet potatoes without looking on the renal specific diet sheet.

An interview was held with Nursing Assistant (NA) #2 on 7/23/14 at 12:10 PM. The NA stated she was assigned to care for Resident # 102 that day. The NA was unable to state if the resident received a therapeutic diet. She stated special diets were not written anywhere and she would have no way to know if a resident received a special diet. The NA stated she depended on the dietary department to send the right foods to the residents adding if she thought a resident received the wrong foods she would tell her nurse.

Nurse # 1 was interviewed on 7/23/14 at 2:52 PM. The nurse stated that NAs look at the Resident Care Guide and hear by word of mouth any extra/different tasks for a particular resident. Nurse # 1 stated she thought the Resident Care Guide included therapeutic diet. The diet is also included on the tray slip that comes out with the meal. Nurse # 1 added that when a resident received a tray that did not match the diet listed on the slip, dietary was notified and a new tray

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SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	1349 CRABTREE ROAD WAYNESVILLE, NC 28785

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F 363	Continued From page 11	F 363		

delivered. The nurse stated she did not know if a sweet potato was included on a renal diet. The nurse was unsure if barbecue sauce was included on a renal diet, but would question the sauce because of the salt content. She added she had been assigned to care for Resident # 102 on Monday, 7/21/14, but did not see what Resident # 102 had received for lunch.

An interview was held with the DM on 7/23/14 at 3:43 PM. She stated the facility had a process for assuring accuracy of the resident's meal trays. The DM explained the dietary aide calls out the diet as the food is plated. The cook knew check to check the diet sheets to make sure a resident on a renal diet received the correct food. The DM identified the cook for Monday and stated she had spoken with her already and had apologized to the resident. The DM stated the cook told her she was going too fast, forgot to look at the menus and put the ribs with sauce and the sweet potatoes on Resident 102's plate.

The Director of Nursing (DON) was interviewed on 7/23/14 at 3:57 PM. The DON stated the diets could be found on the admission orders or in a box kept at the nurse ' s station that had the diet slips with a resident's diet listed. She added the nurse could also look under Physician's orders in the electronic medical record. Other places staff could find the diet listed is on the tray tracker and on the wall kiosk used by the NAs. The DON stated the NA probably would not have known a sweet potato was not included in a renal diet. The nurses on the hall should be aware. The nurses on the hall should know what is included in a renal diet, but may not have enough time to check each tray. Education about therapeutic diets, the DON stated, should be presented by the Registered Dietician or the DM.

An interview was held on 7/24/14 at 1:09 PM with

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F 363	Continued From page 12 the cook that prepared lunch for Resident # 102 on 7/21/14. The cook acknowledged she provided the resident with a regular diet on Monday. She stated she already had a renal diet plate made, but in the rush of plating, this was overlooked and the resident received a regular diet plate. The cook described the facility process for plating food and stated the dietary aide was responsible to make sure the right diet goes to the resident. The cook stated she was unable to say why the system failed and the resident received the wrong diet.	F 363		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and policy review, the facility failed to wash hands after removing gloves and before initiating a clean task for 1 of 1 dietary staff observed during meal preparation. Findings included: 1. The facility policy, titled "Handwashing Policy", with a version date of 08/2005, stated	F 371	F0371: The Dietary Manager and dietary staff was 100% in-serviced on 8/12/14 by the DON on the imporatnce of hand washing and when to hand wash. The Dietary Manager and dietary staff was given a handout on proper Hand Washing Procedure and Dietary Infection Control Responsibilities. All other facility	8/20/14

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F 371	Continued From page 13 handwashing should occur when otherwise indicated to avoid transfer of microorganisms to other residents and environments. On 7/23/14 at 11:10 AM, the Dietary Manager (DM) was observed pureeing food. After completing the task, the DM removed her gloves, placed the gloves in the trash bin and carried dirty dishes to the sink. Without washing her hands, the DM then removed an oven mitt from a drawer. She removed a pan from the oven and placed the pan on the steam table. The DM then removed the mitts and washed her hands. At 11:18, the DM removed her gloves and placed them in the trash can. Without washing her hands, she removed an oven mitt from a drawer and removed carrots from the oven, placing them in the steam table. After completion of that task, the DM washed her hands donning clean gloves. At 11:22, the DM pulled foil off from around a pan of beef tips that was setting on the steam table. She then pulled the gloves off, disposed of them in the trash can and without washing her hands started taking temperatures of the food on the steam table. An interview was held with the DM on 7/23/14 at 2:40 PM. She stated the policy was to wash hands after removing gloves. The DM added she was nervous and did not realize she had not washed her hands after removing gloves. During an interview with the Director of Nursing (DON) on 7/23/14 at 3:08 PM she stated staff are taught during orientation, annually and as needed to hand wash when gloves are removed	F 371	employees were 100% in-serviced and given a handout on proper Hand Washing Procedure and when to hand wash by 8/12/14. Using an audit tool developed by the facility, the Adminstrator will audit dietary for proper hand washing technique three times a week for four weeks; then three times a week every other week for one month then monthly to ensure compliance on an ongoing basis. Any concerns will be addressed at the time of the audit which may include staff re-education. Weekly, then monthly audits will be turned into the Administrator for review. The Administrator will present audit findings to the executive QI committee. The executive QI committee will review audits to determine the continued need for frequency of montioring. Any recommended changes will be discussed and carried out as agreed upon at that time.	
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		8/20/14

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F 441 SS=D	Continued From page 14 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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.	F 441		

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F 441	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interview the facility did not did not bag dirty linen while transporting the dirty linen in the hallway for 1 of 1 nursing assistant (NA # 3) observed transporting linen from a resident's room. Findings included: The facility policy, titled, LAUNDRY, with a version date of 08/2005, indicated laundry will be bagged or containerized in the residents' rooms, treatment rooms or other locations of use. On 7/22/14 at 8:35 AM, Nursing Assistant (NA) # 3 was observed leaving a resident's room on the 100 hall with linens. The linens were not bagged and the NA was not observed wearing gloves. She placed the soiled linens in the dirty linen hamper located on the hall approximately 4 rooms down from the room she exited. Hand sanitizer was used prior to returning to the room. During an interview with NA # 3 on 7/24/14 at 8:39 AM, the NA stated she was instructed to have one glove on when transporting dirty linen. She added she was instructed to have the dirty linen barrel right outside the door, enabling the NA to open the door, lift the lid and place the soiled items in the dirty barrel without actually having to leave the room. NA # 3 added if the NA should have to walk down the hall, the linen was to be placed in a bag and tied. The NA acknowledged she remembered going down the hall with the unbagged linen on Tuesday morning, adding the morning had been rushed trying to get residents ready for appointments. NA # 3 added	F 441	F0441: All employees were 100% in-serviced by 8/12/14 by the DON for proper transporting and disposing of soiled linens and given a handout on Handling Linen. Employees were instructed to ensure the soiled linen cart is outside the door of the resident room, must have on one glove to hold linen/clothing, hold linens away from the body, open door with the ungloved hand and dispose of linens in soiled linen cart, remove and throw away glove in the trash side of the cart, then wash hands before exiting the room. If cart is unavailable, dirty linens can be placed in a plastic bag then transported down the hall to receptacle. Using an audit tool developed by the facility, the DON and/or QI nurse will audit clincial staff for proper transporting and disposing of soiled linens three times a week for four weeks; then three times a week every other week for one month then monthlty to ensure compliance on an ongoing basis. Any concerns will be addressed at the time of the audit which may include staff re-education. Weekly, then monthly audits will be turned into the Administrator for review. The Administrator will present audit findings to the executive QI committee. The executive QI committee will review audits to determine the continued need for	

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F 441	Continued From page 16 she did have one glove on as she had been instructed. An interview was held with Nurse # 1 on 7/23/14 @ 2:51 PM. Nurse # 1 stated she was unsure if the policy indicated linen had to be bagged when carrying them into the hall. During an interview with the Director of Nursing (DON) on 7/23/14 at 3:08 PM she stated staff are taught during orientation, annually and as needed to hand wash when gloves are removed. NA's are taught to move the soiled linen cart to the room and use one gloved hand to place linen/clothes in the soiled cart. The expectation was not to walk down the hall with soiled linens or clothes, but rather the NA should placed the soiled items in a plastic bag.	F 441	frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	