| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345103 | A. BUILDING _____ B. WING _____ | 04/14/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CARRINGTON PLACE | 600 FULLWOOD LANE MATTHEWS, NC 28105 |

| (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 |
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| F 272 SS=D | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment. | F 272 | CARRINGTON PLACE'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.<br><br>• F-272:<br>**CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:**<br><br>The MDS and CAAs of both resident # 212 and resident # 83 have been modified per directions received from the Branch Manager for Quality Evaluative Systems and have been re-transmitted to the State of North Carolina as complete assessments. Each assessment has been completed in its entirety and a full set of CAAs has been completed and placed on each resident's chart.<br><br>**HOW OTHER RESIDENTS HAVE BEEN IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND THE CORRECTIVE ACTION(S) THAT HAVE BEEN OR WILL BE TAKEN:**<br><br>Any resident has the potential to be affected by this practice. Since MDS version 2.0 did not allow dashes to be entered as answers, the facility is reviewing all resident MDSs and CAAs from the date of October 1, 2010 (implementation date of 3.0) forward and will make modifications as necessary for any MDSs found to be incomplete. Any CAAs found to be | 5/12/2011<br><br>changed per TC 5/17/11 gn |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: ✓Cathy L Alm — TITLE: ✓Administrator — (X6) DATE: ✓May 7, 2011

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 272 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and medical record review, the facility failed to complete an admission (Resident #212) and an annual (Resident #83) minimum data set (MDS) assessment. The MDS assessments were incomplete for hearing, vision, cognition, mood and behavior. Additionally, care area assessments (CAAs) were not completed for these MDS assessments. Two (2) of seventeen (17) sampled residents had incomplete MDS and CAA assessments.<br><br>The findings are:<br><br>1. Resident #212 was admitted to the facility on 11/2/10. Diagnoses included glaucoma, blind left eye and cognitive impairment. An admission MDS dated 11/8/10 was signed on 11/15/10 by all staff completing the MDS.<br><br>Review of the admission MDS for Resident #212 revealed dashes were recorded for the following areas: Makes Self Understood, Ability to Understand Others, Vision, Cognitive Patterns, Mood and Behavior. Additionally the CAA Summary was incomplete for each area that triggered (urinary incontinence, falls, nutrition and pressure ulcers).<br><br>An interview with the administrator occurred on 4/11/11 at 1:00 PM. The administrator stated that the facility identified a problem in February 2011 with incomplete MDS and care plans not individualized for residents. She instructed staff to review MDS/care plans back to January 2011 for errors and to make the necessary corrections. A | F 272 | incomplete or missing will be completed in accordance with RAI guidelines and will be placed in the resident's chart. All modified MDSs will be re-transmitted to the State of North Carolina as required.<br><br>**MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MADE TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR:**<br><br>The MDS Coordinator responsible for singing incomplete MDSs and not completing CAASs has been terminated and a new MDS Coordinator will be hired to replace her. An interim MDS Coordinator will fill the position until a full time replacement can be hired. All MDSs and CAAs identified as needing modification or completion during the chart audit will be modified and completed. For all current and future MDSs and CAAs, the MDS Coordinator will be required to present the complete MDS and CAA to the Director of Nursing and/or Administrator each week at the Care Plan Review Meeting. The Director of Nursing and/or the Administrator will review each MDS and CAA to ensure completion and no MDS will be transmitted until reviewed and verified as complete. For any MDSs that can not be held from transmission for review at the weekly meeting due to time requirement, the MDS Coordinator will bring those assessments to the Director of Nursing and/or Administrator upon completion for review prior to transmission. A list of all MDSs and CAAs reviewed each week will be kept for Quality Assurance review. | |

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| F 272 | Continued From page 2<br>follow-up interview was also conducted on 4/14/11 at 11:30 AM. The administrator stated that she was unaware that problems had been found with the CAA Summary of the MDS back to November 2010. She directed staff to review for errors back to January 2011 and make corrections. She expected that any errors found with the MDS should have been corrected.<br><br>On 4/14/11 at 2:00 PM, in an interview with MDS Staff #1 and MDS Staff #2, MDS Staff #1 stated that she completed the admission MDS for Resident #212 and recorded dashes for any area in which data was not in the Resident's medical record for the review period to answer these questions. MDS Staff #1 stated the administrator was informed that some residents medical record did not include the necessary data to complete all sections of the MDS, but she was not aware of the follow up to this issue. She also stated that she completed the CAA Summary for the admission MDS for Resident #212, but the data did not save due to problems with the MDS software during this time. MDS Staff #1 further stated that MDS staff realized in November 2010 that there were problems with the MDS software, but she did not go back and complete the CAA on the admission MDS for Resident #212 again. MDS Staff #2 stated she signed the admission MDS for Resident #212 as complete on 11/15/10 because all the information that could be completed at that time was done based on the information that was available in the Resident's medical record. MDS Staff #2 confirmed that she was aware that the admission MDS for Resident #212 was completed and signed with dashes recorded.<br><br>2. Resident #83 was admitted to the facility | F 272 | **HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT its SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLAN WILL BE EVALUATED FOR IT'S EFFECTIVENESS:**<br><br>For all current and future MDSs and CAAs, the MDS Coordinator will be required to present the complete MDS and CAA to the Director of Nursing and/or Administrator each week at the Care Plan Review Meeting. The Director of Nursing and/or the Administrator will review each MDS and CAA to ensure completion and no MDS will be transmitted until reviewed and verified as complete. For any MDSs that can not be held from transmission for review at the weekly meeting due to time requirement, the MDS Coordinator will bring those assessments to the Director of Nursing and/or Administrator upon completion for review prior to transmission. A list of all MDSs and CAAs reviewed each week will be kept for Quality Assurance review. The process of reviewing the MDSs and CAAs weekly will be monitored by the Quality Assurance Committee to ensure that the solution is achieved, effective and sustained. Any changes needed will be implemented by the Quality Assurance Committee, Administrator, and Director of Nursing. | |

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| F 272 | Continued From page 3<br>03/29/07. A review of an annual Minimum Data Set (MDS) dated 11/04/10 revealed Sections B (Hearing, Speech, and Vision), C (Cognitive Patterns), D (Mood), and E (Behavior) were incomplete. Section Z0500 (Signature of RN [Registered Nurse] Assessment Coordinator Verifying Assessment Completion) was observed signed by the MDS Coordinator and dated 11/11/10. No Care Area Assessments (CAA) were observed with this annual MDS.<br><br>An interview with MDS Licensed Nurse (LN) #1 on 4/13/11 at 3:03 p.m. confirmed sections as stated above were incomplete. MDS LN #1 explained the MDS staff does all computer input from written information provided by facility staff responsible for designated sections. She added the Social Worker responsible for Resident #83's assessments did not complete the sections. MDS LN #1 verified CAAs were required with an annual MDS assessment and none were available on Resident #83's chart. She stated the computer system utilized when this annual assessment was done was not saving the completed CAAs. She provided a copy of CAAs dated 11/04/10 which she obtained from the computer. The CAAs contained incomplete or no analysis of findings for multiple triggered MDS sections.<br><br>In an interview on 04/14/11 at 9:09 a.m. the MDS Coordinator (MDSC) stated it was not her responsibility to complete each section on an MDS assessment form. She explained it was this facility's protocol for Social Workers (SW) to complete sections B, C, D, and E. She added if this information was not provided within the allotted time, she placed a dash in the designated boxes on the MDS form to indicate this area was | F 272 | | |

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| F 272 | Continued From page 4<br>addressed by the MDS staff. She stated a dash means the information was not provided to the MDS office. She considered the MDS was complete with dashes. The MDSC verified her signature was at section Z0500 and indicated the MDS was complete. She stated the MDS was transmitted to the Centers of Medicare and Medicaid as written. The MDSC continued unsaved CAAs were not rewritten after the computer problem was fixed.<br><br>An interview with the Administrator on 04/14/11 at 9:29 a.m. revealed she expected the MDSC to assure all sections of the MDS assessment were completed within the allotted time frame. She added there are three (3) SWs in the facility. If one SW was not available to complete MDS assessments as required, she expected the MDSC to ask for assistance from the other two (2). The Administrator verified the annual MDS assessment dated 11/04/10 for Resident #83 was incomplete due to undocumented section assessments and CAAs. | F 272 | • F-276:<br>**CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:**<br><br>The MDS and CAA of resident #91 have been modified per directions received from the Branch Manager for Quality Evaluative Systems and have been re-transmitted to the State of North Carolina as a complete assessment. The assessment has been completed in its entirety and a full set of CAAs has been completed and placed on the resident's chart.<br><br>**HOW OTHER RESIDENTS HAVE BEEN IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND THE CORRECTIVE ACTION(S) THAT HAVE BEEN OR WILL BE TAKEN:**<br><br>Any resident has the potential to be affected by this practice. Since MDS version 2.0 did not allow dashes to be entered as answers, the facility is reviewing all resident MDSs and CAAs from the date of October 1, 2010 forward and will make modifications as necessary for any MDSs found to be incomplete. Any CAAs found to be incomplete or missing will be completed in accordance with RAI guidelines and will be placed in the resident's chart. All modified MDSs will be re-transmitted to the State of North Carolina as required. | 5/12/2011 |
| F 276 SS=D | 483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS<br><br>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) for one (1) of seventeen (17) sampled residents. (Resident #91) | F 276 | | |

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| F 276 | Continued From page 5<br><br>The findings are:<br><br>Resident #91 was admitted to the facility 09/11/09. A review of a quarterly Minimum Data Set (MDS) dated 01/30/11 revealed Sections B (Hearing, Speech, and Vision), C (Cognitive Patterns), D (Mood), and E (Behavior) were incomplete. Section Z0500 (Signature of RN [Registered Nurse] Assessment Coordinator Verifying Assessment Completion) was observed signed by the MDS Coordinator (MDSC) and dated 02/16/11.<br><br>An interview on 04/13/11 at 10:25 a.m. MDS Licensed Nurse (LN) #1 confirmed the listed sections were not completed. She stated the Social Worker (SW) responsible for Resident #91's assessments did not complete these sections as required per facility protocol. MDS LN #1 confirmed the MDSC had signed section Z0500 verifying the quarterly MDS was complete.<br><br>In an interview on 04/14/11 at 9:09 a.m. the MDSC stated it was not her responsibility to complete each section on an MDS assessment form. She explained it is this facility's protocol for SWs to complete sections B, C, D, and E. She added if this information is not provided within the allotted time, she placed a dash in the designated boxes on the MDS form to indicate this area was addressed by the MDS staff. She added a dash means the information was not provided to the MDS office. She considered the MDS was complete with dashes. The MDSC verified her signature at section Z0500 indicated the MDS was complete. She stated the MDS was transmitted to the Centers of Medicare and Medicaid as written. | F 276 | MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MADE TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR:<br><br>The MDS Coordinator responsible for singing incomplete MDSs and not completing CAASs has been terminated and a new MDS Coordinator will be hired to replace her. An interim MDS Coordinator will fill the position until a full time replacement can be hired. All MDSs and CAAs identified as needing modification or completion during the chart audit will be modified and completed. For all current and future MDSs and CAAs, the MDS Coordinator will be required to present the complete MDS and CAA to the Director of Nursing and/or Administrator each week at the Care Plan Review Meeting. The Director of Nursing and/or the Administrator will review each MDS and CAA to ensure completion and no MDS will be transmitted until reviewed and verified as complete. For any MDSs that can not be held from transmission for review at the weekly meeting due to time requirement, the MDS Coordinator will bring those assessments to the Director of Nursing and/or Administrator upon completion for review prior to transmission. A list of all MDSs and CAAs reviewed each week will be kept for Quality Assurance review. | |

**HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT its SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLAN WILL BE EVALUATED FOR IT'S EFFECTIVENESS:**

The MDS Coordinator responsible for singing incomplete MDSs and not completing CAASs has been terminated and a new MDS Coordinator will be hired to replace her. An interim MDS Coordinator will fill the position until a full time replacement can be hired. All MDSs and CAAs identified as needing modification or completion during the chart audit will be modified and completed. For all current and future MDSs and CAAs, the MDS Coordinator will be required to present the complete MDS and CAA to the Director of Nursing and/or Administrator each week at the Care Plan Review Meeting. The Director of Nursing and/or the Administrator will review each MDS and CAA to ensure completion and no MDS will be transmitted until reviewed and verified as complete. For any MDSs that can not be held from transmission for review at the weekly meeting due to time requirement, the MDS Coordinator will bring those assessments to the Director of Nursing and/or Administrator upon completion for review prior to transmission. A list of all MDSs and CAAs reviewed each week will be kept for Quality Assurance review.

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| F 276 | Continued From page 6<br><br>An interview with the Administrator on 04/14/11 at 9:29 a.m. revealed she expected the MDSC to assure all sections of the MDS assessment were completed within the allotted time frame. She added there are three (3) SWs in the facility. If one SW was not available to complete MDS assessments as required, she expected the MDSC to ask for assistance from the other two (2). The Administrator verified the quarterly MDS dated 01/30/11 for Resident #91 was incomplete. | F 276 | • F-441:<br>**CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:**<br><br>1) The Licensed Nurse that was observed to be administering medications by punching the meds into her bare hand has been taken through an individualized, in depth infection control/hand hygiene/ medication pass re-education. She has been given a copy of the facility policy for Medication Administration and particular attention has been paid to the hand hygiene/medication pass component of this citation. The LPN has completed successful return demonstration in medication pass with adherence to infection control and hand washing policy.<br><br>2) Nursing Assistant #1 has been taken through an individualized, in depth infection control/hand hygiene re-education. She has been given a copy of the facility infection control policy concerning hand hygiene.<br><br>3) Nursing Assistant #2 has been taken through an individualized, in depth infection control/hand hygiene re-education. She has been given a copy of the facility infection control policy concerning hand hygiene. The CNA has completed successful return demonstration in adherence to infection control and hand washing policy. | 5/12/2011 |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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. | F 441 | | |

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| F 441 | Continued From page 7<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, facility record review, and staff interviews the facility failed to implement infection control protocols during medication administration for three (3) of fourteen (14) sampled residents observed during medication pass. (Residents #200, #267, and #261) The facility failed to implement hand hygiene when observed performing multiple tasks during dining for four (4) of six (6) residents. (Residents #171, #22, #49, and #195)<br><br>The findings are:<br><br>1. On 4/13/11 from 8:07 a.m. through 8:37 a.m., Licensed Nurse (LN) #1 was observed administering medications to three (3) sampled residents.<br><br>a. At 8:07 a.m. LN #1 was observed preparing oral medications for Resident # 200 by pressing each tablet or capsule from the blister package directly into her ungloved hand. She then placed the medications into a medicine cup. LN #1 administered the medications to Resident #200. | F 441 | **HOW OTHER RESIDENTS HAVE BEEN IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND THE CORRECTIVE ACTION(S) THAT HAVE BEEN OR WILL BE TAKEN:**<br><br>Any resident may have the potential to be affected by this practice. In addition to the individualized re-education trainings that have been done for the Nurse and Nursing Assistant noted in the 2567, all Nursing staff have been re-inserviced on infection control and hand hygiene. The inservice for all staff that has been conducted was a more in depth inservice than previously conducted inservices and focused on the facility policy for hand hygiene and the need for good hand hygiene.<br><br>**MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MADE TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR:**<br><br>Individualized re-education trainings have been done for the Nurse and Nursing Assistants noted in the 2567 to have not used good hand hygiene. Additionally, all Nursing staff have been re-inserviced on infection control and hand hygiene. The inservice for all staff that has been conducted was a more in depth inservice than previously conducted inservices and focused on the facility policy for hand hygiene and the need for good hand hygiene. The facility Staff Development Coordinator (SDC) conducted these trainings and inservices and will be responsible for making weekly QA checks on each | |

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| F 441 | Continued From page 8<br>b. At 8:25 a.m. LN #1 was observed preparing oral medications for Resident # 267 by pressing each tablet or capsule from the blister package directly into her ungloved hand. She then placed the medications into a medicine cup. LN #1 administered the medications to Resident #267.<br><br>c. At 8:37 a.m. LN #1 was observed preparing oral medications for Resident # 261 by pressing each tablet or capsule from the blister package directly into her ungloved hand. She then placed the medications into a medicine cup. LN #1 administered the medications to Resident #261.<br><br>Before LN #1 began preparing each resident's medications, she cleansed her hands with sanitizer.<br><br>A review of a facility document entitled Medication Pass Guidelines revealed LN #1 was last observed administering medications by the Staff Development Coordinator on 01/19/10. An observation related to Infection Control Precautions contained "Tablets and capsules are not touched directly with hands". The form indicated LN #1 complied with this directive.<br><br>An interview with LN #1 on 04/13/11 at 8:48 a.m. revealed her usual practice is to place tablets and capsules into her hand then into the medicine cup. She stated when she pressed pills from the blister pack directly into the medicine cup, the pills had a tendency to miss the cup. She explained placing the medication into her hand then the cup prevented wasted medication. LN #1 added she considered her sanitized hands were clean. | F 441 | nursing unit and will vary between all three shifts to ensure that proper hand hygiene is being practiced by facility nursing staff. The SDC will record her findings on a QA form and these findings will be reviewed in the weekly Department Head Meetings.<br><br>**HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT its SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLAN WILL BE EVALUATED FOR IT'S EFFECTIVENESS:**<br><br>The facility Staff Development Coordinator (SDC) will be responsible for making weekly QA checks on each nursing unit and will vary between all three shifts to ensure that proper hand hygiene is being practiced by facility nursing staff. The SDC will record her findings on a QA form and these findings will be reviewed in the weekly Department Head Meetings. The findings will also be reviewed by the Quality Assurance Committee to ensure that the solution is achieved, effective, and sustained. | |

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| | 345103 | A. BUILDING _____ B. WING _____ | 04/14/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CARRINGTON PLACE | 600 FULLWOOD LANE MATTHEWS, NC 28105 |

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| F 441 | Continued From page 9<br>An interview with the Director of Nursing on 04/13/11 at 12:20 p.m. revealed she expected nurses followed procedure as directed by facility Medication Pass Guidelines. She continued medications should not be touched by ungloved hands.<br><br>2. A dining meal observation was completed on 4/14/11 at 8:33 AM and revealed the following concerns with hand hygiene. Nursing assistant #1 (NA #1), was observed to remove a dirty breakfast tray from the dining area with ungloved hands and placed it on a utility cart just outside the dining area. NA #1 then returned to the dining area and held a cup of iced coffee to Resident #171's mouth while he drank. NA #1 did not complete hand hygiene with hand washing or the use of a hand sanitizer prior to assisting Resident #171 with a beverage.<br><br>At 8:39 AM on 4/14/11, NA #1, with ungloved hands, placed a cup with the remainder of iced coffee for Resident #171 on a dirty tray, which was stored on a utility cart just outside the dining area. NA #1 then picked up a breakfast tray for Resident #22, set up the Resident's tray (opened her milk, removed the wrapping from the straw, inserted the straw into the milk, and seasoned the cream of wheat), then fed the Resident breakfast. | F 441 | | |

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| F 441 | Continued From page 10<br>NA #1 did not complete hand hygiene with hand washing or the use of a hand sanitizer prior to assisting Resident #22 with her breakfast.<br><br>At 8:52 AM, NA #1 removed a resident's dirty breakfast tray and the resident's clothing protector from the dining area with ungloved hands and placed the items on the utility cart just outside the dining area. NA #1 recorded resident information in a book and returned to the dining area to remove additional used clothing protectors and a dirty breakfast tray. NA #1 then rolled Resident #195 in his wheel chair from the dining area to his room and set up the Resident to brush his teeth (placed toothpaste on the Resident's toothbrush). NA #1 did not complete hand hygiene with hand washing or the use of a hand sanitizer prior to setting up Resident #195 to brush his teeth.<br><br>An interview on 4/14/11 at 9:05 AM with NA #1 revealed she worked at the facility for approximately one year and received an in-service on hand hygiene during orientation and additional in-services within the last few months. NA #1 confirmed that she was trained to wash hands between caring for residents and after handling dirty items. NA #1 stated that she did not realize that she had not washed her hands between residents because she was rushing to get everything done.<br><br>In an interview with the staff development coordinator (SDC) on 4/14/11 at 11:00 AM, she stated that she provided an in-service on 2/15/11 regarding hand hygiene to nursing staff on the 100 unit. An additional in-service was provided to all nursing staff which started on 3/28/11 regarding hand hygiene and infection control. The | F 441 | | |

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| F 441 | Continued From page 11<br>SDC stated that she instructed staff with a demonstration on hand washing techniques and expected that hand hygiene, using either an antibacterial sanitizer or hand washing with soap/water, would be completed between resident contact or when staff had soiled hands. The SDC further stated that when staff assists residents with meals, hand hygiene should be completed before staff move between residents. She expected that hand hygiene would be completed and gloves used prior to staff assisting residents with brushing their teeth.<br><br>An interview with the director of nursing on 4/14/11 at 11:15 AM revealed that she expected staff to implement hand hygiene with a sanitizer or to wash their hands between resident contact and after removing dirty items from the dining area. She also stated that she expected staff to wash their hands or use a hand sanitizer after feeding a resident and prior to assisting a resident to brush their teeth.<br><br>Review of facility records revealed NA #1 attended the in-services on 2/15/11 and 3/28/11 provided by the SDC regarding hand hygiene to include the following instructions, "Hand washing is very important to prevent the spread of germs. Perform hand hygiene after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn. Perform hand hygiene immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments."<br><br>3. A dining meal observation was completed on 4/14/11 at 8:38 AM and revealed the following | F 441 | | |

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| F 441 | Continued From page 12<br>concerns with hand hygiene. Nursing assistant (NA #2) was observed with ungloved hands and rolled Resident #22, seated in her wheel chair, into the dining area. NA #2 assisted Resident #22 to reposition in her wheel chair by pulling the Resident's pants and brief from behind towards the back of the wheel chair. NA #2 placed her right hand in the top portion of the Resident's brief, grabbing the brief and the Resident's pants together to reposition the Resident. NA #2 then left the dining area. She removed the breakfast tray for Resident #49 from the utility cart, stored just outside the dining area, set up the Resident's breakfast tray and fed the Resident. NA #2 did not complete hand hygiene with hand washing or the use of a hand sanitizer prior to assisting Resident #49 with her breakfast.<br><br>An interview on 4/14/11 at 9:07 AM with NA #2 revealed that she had been trained recently regarding hand hygiene. She confirmed that she should have washed her hands after touching a resident's brief and before helping a resident with her breakfast meal.<br><br>In an interview with the staff development coordinator (SDC) on 4/14/11 at 11:00 AM, she stated that she provided an in-service on 2/15/11 regarding hand hygiene to nursing staff on the 100 unit. An additional in-service was provided to all nursing staff which started on 3/28/11 regarding hand hygiene and infection control. The SDC stated that she instructed staff with a demonstration on hand washing techniques and expected that hand hygiene, using either an antibacterial sanitizer or hand washing with soap/water, would be completed between resident contact or when staff had soiled hands. The SDC further stated that when staff assists | F 441 | | |

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| F 441 | Continued From page 13<br>residents with meals, hand hygiene should be completed before staff move between residents.<br><br>An interview with the director of nursing on 4/14/11 at 11:15 AM revealed that she expected staff to implement hand hygiene with a sanitizer or to wash their hands between resident contact.<br><br>Review of facility records revealed NA #2 attended the in-services on 2/15/11 and 3/28/11 provided by the SDC regarding hand hygiene to include the following instructions, "Hand washing is very important to prevent the spread of germs. Perform hand hygiene after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn. Perform hand hygiene immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments." | F 441 | | |