STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345406	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWN EAST HEALTH AND REHAB CEN	38 CARTERS ROAD GATESVILLE, NC 27938

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: 2. Resident #22 was most recently readmitted on 12/12/14 with diagnoses that included spinal cord injury and neurogenic bladder. A 12/19/14 Significant Change in Status Minimum Data Set (MDS), indicated Resident #22 was cognitively intact. The presence of an indwelling catheter was identified. Resident #22 was identified as totally dependent on staff for toileting needs. The resident's care plan, last reviewed on 12/22/14, identified the use of an indwelling urinary catheter. There was no intervention or direction included for staff to provide a privacy bag for the urinary catheter collection bag. Review of the undated Nurse Tech Information Kardex indicated Resident #22 used a Foley catheter. There was no notation a privacy bag should be utiilized. On 3/9/15 at 3:58 PM, the urinary drainage bag was observed not to be covered. An observation was made on 3/11/15 at 10:35 AM. Resident #22 was on the gurney, waiting to leave the building for an appointment. The urine collection bag was visible and did not include a	F 241	F 241 1. Resident #22 and Resident #69 had dignity bags placed over the catheter bags on 3/13/15 by the Certified Nursing Assistant. 2. Other residents currently residing in the facility with indwelling catheters had dignity bags applied over the collection bags on 3/13/15 by the Director of Clinical Services (DCS). 3. Re-education was provided to the licensed nurses and the certified nursing assistants by the DCS on or before April 9, 2015 about dignity to include ensuring that urinary collection bags remain covered. The DCS or Unit Manager will conduct rounds to audit and document the presence of dignity covers on catheter urine collection bags (3) times per week for (4) weeks, (2) times per week for (4) weeks, then weekly for (4) weeks on Quality Assurance Performance Improvement Form. 4. The DCS will report the findings of the audits to the Quality Assurance Performance Improvement Committee (QAPI) Meeting monthly for (3) months. The QAPI committee will recommend	4/9/15

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

Electronically Signed | 04/07/2015

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F 241	Continued From page 1 privacy cover. On 3/12/15 at 8:30, the urine collection bag was observed not to be covered. Nursing Assistant (NA) #1 was interviewed on 3/12/15 at 8:44 AM. NA #1 was assigned to work with the resident 2 to 3 times per week. The NA stated she had been taught to use a privacy bag to cover the urinary catheter collection bag. Stated she was unaware the resident did not have a privacy bag on his catheter. On 3/13/15 at 8:15 AM, NA #3 was interviewed. She had worked with the resident earlier in the week. NA #3 stated she doubted Resident #22's urinary catheter had a privacy bag over his collection bag since the privacy bag usually got misplaced. NA #3 stated she knew she was supposed to replace the privacy bag when was missing, but added she had not replaced the privacy bag when she had worked with the resident. NA #3 stated she had no reason why she had not replaced the privacy bag for Resident #22. An interview was held with the Director of Nursing (DON) on 3/13/15 at 8:47 AM. She stated the expectation was for all urinary collection bags to be covered in order to provide privacy. The DON stated it was the responsibility of both nurses and NAs to make sure the urinary drainage bags were covered.	F 241	revisions to the plan as needed to assure sustained compliance. 5. The allegation of compliance date is April 9, 2015.	

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F 241	Continued From page 2	F 241		

Based on observation, record reviews and staff interviews the facility failed to a provide privacy bags for 2 of 2 (Resident #69 and Resident #22) residents with an indwelling urinary catheter.
The findings included:
1. Resident #69 was admitted to the facility on 11/10/2014, with diagnoses to include urinary retention secondary to neurogenic bladder. His Minimum Data Set (MDS) assessment dated 1/22/2015 revealed severe cognitive impairment.
On 3/9/2015, at 3:01 PM, an observation was conducted of the resident lying in bed on his back. The urinary catheter collection bag was hanging on the side of his bed, visible from the door, with no privacy cover.
On 3/10/2015 at 2:41 PM, an interview was conducted with the nursing assistant (NA #7), outside of the resident's room. NA stated that she had completed Resident #69's care that morning, which also included catheter care. The resident's uncovered urinary collection bag continued to hang off the bed on the side closest to the door.
An interview was conducted on 3/11/2015 at 8:15 AM, with NA #3. NA stated she had already given a bath and completed catheter care on Resident #69. The resident was observed lying in bed with a clean gown on. His urinary collection bag remained uncovered and hanging on the side of his bed, closest to the door.
A second observation on 3/11/2015 at 4:42 PM, was conducted of Resident #69. His urinary collection bag was hanging uncovered on the side of his bed.
On 3/12/2015 at 8:45AM, an interview was conducted with NA #8, at the bedside of the

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F 241	Continued From page 3 resident. The NA stated that she had given the resident a bath first thing that morning. The resident's uncovered urinary collection bag hung on the side of his bed. On 3/12/2015 at 10:13AM, an observation was conducted of catheter care given to the resident by NA #7 and NA #8. At the completion of care, NA #8 stated the resident is supposed to have a privacy cover over his catheter collection bag all the time. She did not remember the last time she saw a privacy bag over the collection bag. On 3/12/2015 at 10:40 AM, an interview was conducted with the nurse (nurse #2). Nurse #2 stated the resident's urinary collection bag should have a privacy cover over it, and it is the responsibility of the NA or the nurse to make sure it does. She stated she did not know if the resident had a privacy bag cover on the past week. On 3/12/2015 at 11:46 AM, an interview was conducted with the Director of Nursing (DON). She stated that a resident's urinary collection bag should always have a privacy bag over it.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews, observation, staff and	F 242	F 242	4/9/15

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F 242	Continued From page 4 resident interviews the facility failed to honor resident choice of high protein, high calorie nutritional supplement requested by 1 of 1 resident and ordered by the physician "prn" (as needed/requested) between meals for resident #64. The findings included: Resident #64 was admitted to the facility on 09/05/14. The last Minimum Data Set (MDS) dated 03/07/15 documented resident #64 had intact cognition, a functional status of one person supervision for locomotion and independent with eating. Active diagnoses included Cerebral Vascular Accident, Hemiparesis, Dysphagia and Neuropathy. Review of resident #64 Medication Administration Record (MAR) dated 2/19/15 documented a physician order for 1 can of nutritional supplement prn between meals. Review of Registered Dietician (RD) Nutrition Evaluation dated 2/23/15 documented the resident was " below IBW (Ideal Body Weight). Resident stated he wants to gain weight. Plan: suggest large portions with each meal to increase weight to IBW. " Resident #64 documented weight on 03/04/15 was 136 pounds (lbs). On 03/10/15 at 09:44AM, an interview with resident #64 indicated that he was losing weight, had lost 4 pounds since admission and wanted to gain weight back. He indicated that he his usual weight was between 140 - 145lbs and he would like to get back to that weight. The resident indicated he receives double food portions and should also receive a nutritional supplement	F 242	1. On 3/12/15, the facility purchased a nutritional supplement from a local vendor to provide the prescribed supplement upon resident request. The Central Supply Clerk informed the resident that the supplement was available on 03/12/15. 2. The Director of Clinical Services (DCS) and the Central Supply Person reviewed the records of residents currently residing in the facility for orders for nutritional supplements on or before 04/09/15. The current stock of supplements was audited to assure there was adequate supply of the supplements prescribed to be available for administration. The Central Supply Person has developed an order log to monitor and order supplements to meet the need as documented from the audit. The DCS will notify the Central Supply Person when a supplement is prescribed to have the supplement included in the demand and supply ordering of supplements to assure the supplement is available to the resident. 3. Re-education was provided by the DCS/Licensed Nurse to nursing staff and the Central Supply Person on or before 4/9/15 regarding the necessity to provide nutritional supplements as prescribed by the physician. The re-education also included notification to the physician by the unit nurse transcribing the order that a supplement is not available to obtain an alternative supplement until the prescribed supplement can be ordered and delivered. The unit nurse is to place the order on a telephone order slip which is reviewed by the DCS or unit manager	

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F 242	Continued From page 5 between meals. The resident indicated the doctor ordered the supplement his request. The resident indicated the nurses had been telling him for over a week the facility is out of nutritional supplements. The resident revealed that he had asked for the nutritional supplement after breakfast today and the nurse indicated a nutritional supplement was not available. On 03/10/15 at 4:00 PM, an interview with resident #64 revealed that when a nutritional supplement was requested after the lunch meal around 3pm the nurse said the facility was out of nutritional supplements. On 03/10/15 at 5:00 PM, in an interview with nurse #1 she revealed documentation on the Medication Administration Record (MAR) of a physician order for 1 can of nutritional supplement prn between meals. The MAR revealed from March 1, 2015 to present date, there was one documentation of a nutritional supplement administered to the resident on 03/05/15 on the 7AM - 3PM shift. Nurse #1 indicated that she recalled giving the resident a can of nutritional supplement yesterday but must have forgotten to document it and she did not recall the resident asking for a supplement today. On 03/11/15 at 9:33AM an interview with nurse #2, indicated that the resident had a prn order for a nutritional supplement, he did not ask for it this am and she " did not know anything about offering a supplement to the resident. " Nurse #2 indicated that nutritional supplements are received in the central supply office and kept in the nourishment room cabinets with some placed in the refrigerator in the nourishment room to serve cold. Upon entry to the nourishment room, nurse #2 opened cabinets and the refrigerator,	F 242	who will review with the central supply person for ordering and supply maintenance. The DCS or Unit Manager will conduct and document and audit of residents currently residing in the facility with physician□s orders nutritional supplements to assure the supplements are in stock, offered and/or administered as prescribed on Quality Assurance Performance Improvement form. The DCS or Unit Manager will conduct an audit of the on hand supply of supplements to assure the supply will meet demand (3) times per week for (4) weeks, (2) times per week for (4) weeks, then weekly for (4) weeks on Quality Assurance Performance Improvement form. 4. The DCS will report the results of the audits to the Quality Assurance Performance Improvement (QAPI) Committee Meeting monthly for (3) months. The QAPI Committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. The allegation of compliance date will be April 9, 2015.	

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nutritional supplements were not present. Nurse #2 indicated she was surprised that supplements were not available. Nurse #2 indicated the central supply manager was in charge of ordering nutritional supplements and the nurses were not responsible for inventory items being available, but she would tell the clinical manager or CMS if she noticed supplies of any kind were not available or getting low.

On 03/11/15 at 9:44AM an interview with the "acting" central supply manager (CSM) revealed that she expected the floor nurses to notify her if nutritional supplements were getting low or not available in the nourishment room. The CSM revealed that she became responsible for ordering supplies February 28, 2015 and did not have a consistent inventory system in place. The CSM revealed she placed a bulk order for nutritional supplements yesterday (3/10/15) when she discovered there was none in the nourishment room as she was preparing to hand out resident snacks. The CSM indicated she did not know of resident #64 physician order for a nutritional supplement prn between meals. The CSM indicated if she had known nutritional supplements were not available, she would have gone to a local store to purchase nutritional supplements. The CSM indicated that she could not find previous purchase orders for nutritional supplements, but she knew which company to call to place the order yesterday and the order should come in today. The CSM revealed that she had residents that did not have physician orders for nutritional supplements but requested her to shop for them and buy them to keep in their room refrigerators. The CSM indicated that she made a trip yesterday to a local store to buy specific resident request for nutritional

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supplements and could have purchased some at that time to be available until the bulk order arrived. The CSM indicated that nutritional supplements may have not been available in the past two weeks since she started the new position as CSM.

On 03/11/15 at 10:00AM, review of the facility purchase order dated 03/10/15 indicated a purchase order for 4 cases of nutritional supplement was placed on 03/10/15 and was expected to arrive today 03/11/15.

On 03/11/15 at 12:37PM, the CSM indicated she purchased a nutritional supplement from a local store and resident #64 was consuming the nutritional supplement.

On 03/11/15 at 12:45PM, an observation in resident #64 room revealed a can of empty nutritional supplement on his bedside table. The resident indicated he was happy to have received the supplement and would expect to receive it between meals when requested.

3/12/15 at 9:54AM, an interview with the facility medical director (MD) indicated that he had ordered a nutritional supplement prn at the resident request because resident #64 wanted to gain weight and get stronger. The MD indicated the nutritional supplement was not medically necessary. The MD revealed the resident was alert and oriented and able to make a request/choice if he wanted a nutritional supplement or not, the order was written as prn to allow the resident the choice. I would expect the facility to have nutritional supplements available for resident #64 to receive when requested.

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F 242	Continued From page 8 03/12/15 at 1:46PM, an interview with the facility administrator indicated the CSM's responsibility included conducting an inventory of supplies. The facility administrator indicated the facility always had nutritional supplements available in the nourishment room and was unaware that none were available. The facility administrator indicated she expected a system in place to inventory nutritional supplements. The facility administrator indicated she expected nurses to notify the DON or unit manager when nutritional supplements were getting low in stock or not available for residents.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to provide incontinent briefs in a style that enabled 1 of 1 sampled residents (Resident #48) the ability to remain independent in toilet use. Findings included: Resident #48 was admitted on 5/30/14. Diagnoses included hypertension and stroke with hemiparesis.	F 246	F 246 1. Resident #48 had pull up briefs provided on 4/9/15. The facility has continued to provide pull up briefs for this resident. A full bowel and bladder assessment has been completed to correctly identify the amount of assistance required for toileting and a plan of care developed and implemented. 2. An audit of the continence status of all other residents currently residing in the	4/9/15

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F 246	Continued From page 9 Review of the Admission/Readmission Data Collection form, dated 5/30/14 indicated Resident #48 was oriented to person, place and time. The assessment indicated Resident #48 was usually continent of urine. The Quarterly Minimum Data Set (MDS) with a date of 2/25/15 indicated Resident #48 was moderately cognitively impaired. The MDS identified the resident requiring extensive assistance with toilet use. The resident was coded as having impairment of his lower extremity and upper extremity on one side. Resident #48 was also coded as frequently incontinent of bladder. A toileting program was not identified. Resident 48's care plan, last reviewed on 3/3/15, indicated he had a self care deficit. Interventions included providing unaided assist to achieve increased independence or maintaining current function, promote dignity and to provide adaptive equipment. The care plan also indicated Resident #48 had an alteration in urinary elimination. Interventions included asking the family to bring in clothing that was easy to manipulate for toileting to assist/aid resident in independence. Review of the undated Nurse Tech Information Kardex indicated Resident #48 was incontinent of bowel and bladder at times and wore briefs. The type of brief was not specified. An observation was made of Resident #48 on 3/11/15 at 10:13 AM. Resident #48 was lying in bed. The resident was wearing the same clothing as worn on 3/10/15. He was observed to have on	F 246	facility was completed by the Minimum Data Set (MDS) Nurse and the Director of Clinical Services (DCS) on or before 4/9/15. The Interdisciplinary Team met on or before 4/9/15 and reviewed the audit to determine the most appropriate incontinent products to be used for each resident identified, plans of care updated, and plans implemented. The Central Supply person has been provided with the list of required products for placing on a revolving order. 3. Re-education was provided to the nursing staff on or before April 9, 2015 by the DCS/Licensed Nurse regarding the provision of the appropriate type of incontinent brief in a style that enables the resident the ability to remain as independent as possible with toilet use according to the plan of care. The DCS reeducated the central supply person on the need to assure that all documented types of products are ordered and available for the residents at all times. The DCS or Unit Manager will complete and document an audit of (5) residents with incontinence per week for (4) weeks, then for (3) residents per week for (4) weeks, then for (2) residents per week for (4) weeks on the Quality Assurance Performance Improvement form to ensure that incontinent briefs are provided in a style that is consistent with the care plan and enables the resident the ability to remain as independent as possible in toilet use. 4. The DCs will report the results of the audits to the Quality Assurance Performance Improvement (QAPI)	

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F 246	Continued From page 10 an incontinent brief with tabs on each side. An observation was made on 3/11/15 at 3:53 PM. The resident was wheeling around the facility in his wheelchair. His jeans were seen around his knees exposing an incontinent brief with tabbed sides. At this time, the Treatment Nurse was interviewed. She stated Resident #48 toileted independently, but had problems getting his pants and brief up and down independently. An interview was held with Nurse #1 on 3/12/15 at 11:05 AM. She stated Resident #48 was able to toilet himself. She stated the resident preferred to wear elasticized waist pull up briefs by choice because of incontinent episodes. The nurse stated she thought the resident experienced urinary incontinence at least daily. Nurse #1 was unaware the resident was using briefs with tabs on each side that had to be unfastened and fastened in order to toilet. An interview was held with Nursing Assistant (NA) #1 on 3/12/15 at 8:38 AM. She identified she had worked with Resident #48 on 3/11/15. NA #1 stated Resident #48 could toilet independently. The NA stated she had remind the resident to pull his clothing up and fasten his brief after toilet use since it was difficult for him to fasten the brief by himself. NA #1 stated Resident #48 was incontinent only a few times a week. At one time, she added, Resident #48 had worn incontinent briefs that could be pulled up and down easily. She stated when the facility stopped getting those types of incontinent briefs, the resident had to wear the incontinent briefs with tabs on the side that needed to be fastened and unfastened each time the resident toileted. The resident was not identified as refusing care.	F 246	Committee Meeting monthly for (3) months. The QAPI committee will recommend revisions to the plan as needed to assure sustained compliance. 5. The allegation of compliance date is April 9, 2015.	

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F 246	Continued From page 11	F 246		

The Occupational Therapist (OT) was interviewed on 3/12/15 at 2:28 PM. The OT stated if a resident could toilet independently it was not appropriate to place a tabbed sided incontinent brief on the resident. The OT added tabbed sided briefs that had to be released before and after toilet use did not promote independence in toilet use. She added this had been an on-going issue when trying to re-train residents in activities of daily living; trying to promote independence and try to ready residents to return home. The OT stated pull up incontinent briefs had previously been used in the facility for those residents that were independent in toilet use. She stated a few months back, the facility discontinued buying the pull up incontinent briefs. She stated she had been told the pull up briefs had been discontinued due to budgetary issues.

An interview was held with Resident #48 on 3/12/15 at 3:05 PM. Resident #48 stated he toileted independently. He stated he used to wear the pull up type incontinent brief which was his preference since he could get his pants up and down easier with those briefs. The resident added he was more independent with the pull up incontinent briefs. He added at some point, staff told him the pull up incontinent brief was no longer available. Resident #48 stated he was not given a reason.

An interview was held with NA #3 on 3/13/15 at 8:15 AM. NA #3 stated she had worked with Resident #48. He was not identified as refusing care. The NA stated Resident #48 toileted independently. NA #3 identified Resident #48 as wearing incontinent briefs that had tabs on the side. She added since the resident was

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DOWN EAST HEALTH AND REHAB CEN	38 CARTERS ROAD GATESVILLE, NC 27938

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F 246	Continued From page 12 independent in toileting, she could not understand why the tabbed sided incontinent briefs were used. NA #3 added previously, the facility had used the pull up type of incontinent brief with residents who were independent with toileting, but months ago, the facility had quit supplying the pull up type of brief. She added the pull ups were useful for independent residents since the brief promoted their independence. On 3/13/15 at 9:30 AM an interview was held with the staff member responsible for ordering facility supplies. She stated the last time she ordered the pull up type of incontinent brief was March 10, 2014. The staff member stated she had been told it was corporate policy not to use the pull up type of incontinent brief. The Administrator was interviewed on 03/13/2015 at 10:19:19 AM. She stated the corporation had decided not to provide the pull up type of incontinent brief. The Administrator added a while back, there had been one resident that used the pull up brief to promote independence. She added if there were other residents that would benefit from a pull up brief, she and the DON would review the residents. The Administrator added she would also reach out to family members to see if they would provide the pull up brief. The Administrator stated she had received no requests for pull up briefs.	F 246		
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	F 309		4/9/15

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F 309	Continued From page 13 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff and resident interviews, the facility failed to remove the dressing from the dialysis shunt as ordered by the physician for 1 of 1 residents (Resident #26), reviewed for dialysis care. Resident #26 was re-admitted to the facility on 12/23/2014, with diagnoses to include stage IV chronic kidney disease. Her Minimum Data Set (MDS) assessment dated 3/4/2015, revealed her cognition as moderately impaired, and listed dialysis under special treatments. Physician orders dated 3/1/2015 stated remove dressing from left upper arm 24 hours after dialysis. Check upper arm for bruit and thrill every shift. On 3/11/2015 at 8:49 AM, Resident #26 was interviewed in her room. She stated that she was going to dialysis today before lunch. She was lying in bed with a short sleeved shirt on. A dressing to her left upper arm was visible. She stated that the nurse takes the dressing off one day after she comes back from dialysis. She stated she went to dialysis on Monday, Wednesday and Friday. Her last dialysis day was Monday (3/9/2015). On 3/11/2015 at 9:42 AM, an interview was conducted with Nurse #3. The nurse stated that she changed the dressing to the resident's left upper arm dialysis site on the day after the resident received dialysis, which was 3/10/2015, and she checked the bruit and thrill at that time.	F 309	F 309 1. Resident #26 had the dressing removed from the dialysis shunt site on 3/11/2015 by the Licensed Nurse. There were no adverse effects to the resident. The physician orders and Treatment Administration Record (TAR) were audited for proper assessment and documentation of post dialysis site care. 2. The other resident residing in the facility with a dialysis shunt, had a review completed on 3/11/15 by the Director of Clinical Services (DCS) to ensure that the resident has appropriate physician□s orders for monitoring post dialysis site care to include bleeding, swelling, signs and symptoms of infection □ redness, warmth, drainage, swelling. This was added to the resident□s Treatment Administration Record (TAR) to alert nurses to complete the assessment and to document the assessment. 3. Re-education was conducted by the DCS/Licensed Nurse on or before 4/9/15 with currently employed Licensed Nurses regarding completion of assessment and documentation of appropriate post dialysis site care to include bleeding, swelling, signs and symptoms of infection □ redness, warmth, drainage, swelling. This practice is to include any new admissions receiving dialysis.	

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F 309	Continued From page 14 The treatment sheet was reviewed with the nurse. The nurse confirmed that she had initialed the treatment sheet on 3/10/2015 verifying that she had removed the dressing from the residents arm and checked the shunt for bruit and thrill. When the nurse was questioned as to why there was a dressing on the resident's upper arm, the nurse stated that she thought she had removed the dressing. The interview continued in the resident ' s room, where the nurse took the dressing off of the resident's arm, but did not check the bruit and thrill at that time. The nurse stated that the dressing that was on the resident's arm was the dressing that had come back with her from dialysis on 3/9/2015. She stated she listened to the bruit and thrill on the next day after she came back from dialysis which was 3/10/2015. On 3/11/2015 at 3:23 PM, a second interview was conducted with Nurse #3. The nurse stated that she thought she had removed the dressing, so she documented it on the treatment sheet. She stated that it was called false when a person documented something that hadn't been done. A review of the treatment sheet with the nurse revealed that her initials remained on the date of 3/10/2015, with no documentation completed on 3/11/2015, when the dressing was removed. On 3/12/2015 at 11:48 AM, an interview was conducted with the Director of Nursing (DON). The DON stated it was a nursing standard that a dialysis shunt should be felt for a thrill and listened for a bruit daily. The DON stated that falsification of records called for a suspension for the individual and an investigation.	F 309	The DCS or Unit Manager (UM) will conduct and document an audit of the 2 resident records and any new admissions with dialysis for documentation of delivery of appropriate post dialysis site care as defined above (3) times per week for (4) weeks, (2) times per week for (4) weeks, then weekly for (4) weeks on the Quality Assurance Performance Improvement form. 4. The DCS will report the findings from the audits to the Quality Assurance Performance Improvement (QAPI) Committee Meeting monthly for (3) months. The QAPI committee will recommend revisions to the plan as needed to assure sustained compliance. 5. The allegation of compliance date will be April 9, 2015.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312		4/9/15

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F 312	Continued From page 15 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to remove the facial hair for 1 of 4 sampled residents (Resident #48) reviewed for daily care. Findings included: The facility policy for shaving, with an effective date of 11/30/14, indicated residents requiring assistance would be shaved by self or nursing personnel to ensure personal hygiene. Resident #48 was admitted on 5/30/14. Diagnoses included hypertension and stroke with hemiparesis. Review of the Admission/Readmission Data Collection form indicated Resident #48 was oriented to person, place and time. The assessment indicated Resident #48 was usually continent of urine. The Quarterly Minimum Data Set (MDS) with a date of 2/25/15 indicated Resident #48 was moderately cognitively impaired. The MDS identified the resident required limited assistance with bed mobility, dressing and eating. He required extensive assistance with toilet use and supervision with hygiene and bathing. The resident was coded as having impairment of his lower extremity and upper extremity on one side.	F 312	F312 ADL Care for Dependent Residents 1. Resident was shaved on 3/11/2015 by the CNA to remove any unwanted facial hair. There were no adverse effects to the resident. 2. All residents currently residing in the building and needing assistance with ADL have the potential to be affected. On 3/11/15, rounds were made by the Director of Clinical Services (DCS) and any resident in need of shaving and grooming had the cares provided immediately. The DCS and Unit Manager (UM) reviewed and updated the resident Kardex for each resident to assure all residents had accurate planning documented to guide the care for grooming and shaving. 3. Re-education was done on or before 4/9/15 by the DCS/UM with currently employed Licensed Nurses and Certified Nursing Assistants (CNA) regarding provision on shaving and grooming. Each resident□s Kardex will be reviewed and updated with each care conference by the Minimum Data Set/Care Plan Nurse with each scheduled assessment/review date and with each significant change. The MDS nurse will review changes with the UM who will provide training for the CNAs	

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F 312	Continued From page 16 The undated Nurse Tech Information Kardex indicated the resident was independent with bathing, bed mobility, personal hygiene, eating and dressing. Resident 48's care plan, last reviewed on 3/3/15, indicated he had a self care deficit. Interventions included providing unaided assist to achieve increased independence or maintaining current function, promote dignity and to provide adaptive equipment. On 3/10/15 at 3:30 PM, Resident #48 was observed sitting in the hallway by the dining room. The resident stated he was trying to get a shave. Observation of the resident's beard revealed facial hair so long it appeared as a close shaven beard. The resident added he had been trying to get a shave all week, but could not get anyone to shave him. Resident #48 stated the facial hair was "irritating." Resident #48 was observed on 3/11/15 at 10:13 AM. The resident was lying in bed. He stated he had not had his bath yet. The resident was wearing the same clothing as worn on 3/10/15. He was unshaven. An observation of Resident #48 was made on 3/11/15 at 3:53 PM. The resident's long facial hair was still present. Resident #48 stated he had asked the nursing assistant (NA) to shave him, but she had not. He could not recall the NA's name. The Director of Nursing (DON) was made aware of the resident's facial hair and request to be shaven on 3/11/15 at 4:00 PM. She observed the	F 312	providing care to the resident. The DCS or UM will complete and document an audit to include review of the kardex and observations that care was provided as planned for 10 residents for proper grooming/shaving (3) times per week for (4) weeks, (2) times per week for (4) weeks, then weekly for (4) weeks on Quality Assurance Performance Improvement form. 4. The DCS will present the results of the audits to the Quality Assurance Performance Improvement (QAPI) Committee Meeting monthly for (3) months. The QAPI committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. The allegation of compliance date will be April 9, 2015.	

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F 312	Continued From page 17 resident, confirmed he needed to be shaven and stated she would make sure the resident received a shave. An interview was held with NA #1 on 3/12/15 at 8:38 AM. She acknowledged she had been assigned to care for Resident #48 on 3/11/15. NA #1 stated Resident #48 required assistance for shaving because of his hemiparesis. She added someone else, whose name she could not remember, had set the resident up for his morning bath. NA #1 acknowledged it had been her responsibility to make sure all the resident's care had been completed. She added typically, the resident would ask when he wanted to receive a shave. NA #1 added she overlooked shaving the resident because he did not ask for a shave. NA #5 was interviewed on 3/12/15 at 5:27 PM. The NA stated he was familiar with Resident #48. The NA confirmed the resident required assistance with shaving. NA #5 added he had not worked with the resident this week. NA #3 was interviewed on 3/13/15 at 8:15 AM. The NA stated she worked with Resident #48 at times. She stated he did not refuse care. The NA added Resident #48 was unable to shave independently. She could not remember if she had cared for the resident this week.	F 312		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked	F 356		4/9/15

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F 356	Continued From page 18 by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to distinguish between the number of Registered Nurses (RNs) and the number of Licensed Practical Nurses (LPNs) on the daily nursing staffing form and failed to include only direct care nursing staff for 5 of 5 days of the survey. The findings included: Observation of the "Daily Nursing Staffing Form" on 3/9/15 at 10:55 AM revealed the form had a section entitled "Licensed-RN/LPN Nursing Staff"	F 356	F356 Posted Nurse Staffing Information 1. Facility staffing hours must be posted ensuring accurate staffing data is available for review daily. The facility reposted the Daily Nurse Staffing Form on 3/13/15 to ensure that a clear delineation was made in the hours of LPNs and RNs and only nurses with direct care responsibility will be represented on the form. 2. This practice could affect all residents	

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F 356	Continued From page 19 with no means of distinction between the number of RNs and LPNs. The total number for the day shift was 4 licensed staff. Review of staff postings dated 3/10/15 - 3/13/15 revealed 4 licensed staff working the 7-3 shift each day with no distinction between RNs and LPNs. During an interview on 3/13/15 at 8:50 AM, the Administrator stated she could not determine from the staff posting specifically how many RNs or LPNs were on duty. The Administrator also said the Director of Nursing (DON), Unit Manager (UM) and 2 hall nurses were included in the 4 licensed staff. The Administrator said the DON should not be included.	F 356	in the building should they wish to be knowledgeable about staffing levels. The posting was corrected and posted per regulation. The posting will be planned to be updated by the nurse who works on A/B/E medication cart. 3. Re-education was conducted by the Regional Director of Human Resources with the Executive Director and the Director of Clinical Services (DCS) regarding proper posting of hours on 3/13/15. The DCS educated the licensed nurses who will be assigned A/B/E medication cart on or before 4/9/15 concerning the need to document accurate staffing and census on the posting at the beginning of each shift. The Executive Director or the DCS will conduct and document an audit of the Daily Nurse Staffing to assure the staffing and census is accurate and is posted daily (3) times per week for (4) weeks, (2) times per week for (4) weeks, then weekly for (4) weeks on Quality Assurance Performance Improvement form. 4. The Executive Director will report the results of the audits to the Quality Assurance Performance Improvement (QAPI) Committee Meeting monthly for (3) months. The QAPI committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. The allegation of compliance date will be April 9, 2015.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		4/9/15

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F 371	Continued From page 20 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 review of records the facility failed to maintain cole slaw, ready for resident consumption, at a temperature of 41 degrees or less and failed to store pans as dry and free of food debris and black build up. Findings included: 1. An undated policy, presented by the Regional Director of Nutrition, indicated under the heading, "Keep Cold Foods Cold and Hot Foods Hot" that: Cold foods must be kept colder than 41 degrees Hot foods must be kept hotter than 140 degrees Foods are in the danger zone if they are between 41 degrees and 140 degrees and cannot be kept for more than 4 hours Review of the menu for 3/11/15 indicated for dinner, cole slaw would be served. An observation was made on 3/11/15 at 5:10 PM. Upon entering the kitchen the tray line was in progress preparing meals to be served to the residents. The Dietary Manager was not present	F 371	F-371 1. No residents were injured related to this citation. The dishes that were stacked and stored inappropriately were re-washed, allowed to dry completely and stored appropriately per policy. The pots/ pans and other dishes stored with food debris and build up on them were immediately pulled from service, re-washed, and stored appropriately per policy. The coleslaw on the tray line was immediately placed in the cooler and brought back down to appropriate temperature before serving to residents. 2. All residents have the potential to be affected by this citation. An audit was completed of all dish storage areas by the Food Service Manager to ensure that all pots/ pans and service items were stored dry and without food debris or buildup on 3/11/15. An audit of all cold foods on tray line was done immediately by the Food Service Manager to ensure appropriate temperatures during dinner service on 3/12/15.	

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F 371	Continued From page 21 at the tray line. A tray of cole slaw was seen on top of an open food service cart and was identified as cole slaw used on resident trays as meals were prepared. The cole slaw had no ice around the containers. The Dietary Manager (DM) took the temperature and it registered 45 degrees. A cup of slaw was then taken off a resident tray that had been prepared was ready for delivery to the resident care area. The DM took the temperature of the slaw and found the temperature registered at 50 degrees. Staff stated the slaw would be removed from the trays and placed in the freezer to cool down. An interview was held with the DM on 3/12/15 on 9:36 AM. The DM acknowledged cold foods should be served at 40 degrees and below. The DM added the tray of slaw that had been sitting inside the cart was sitting beside the hot food and lost temperature. The DM stated the slaw on the open should have been placed on ice and acknowledged the dietary aide had not placed the slaw on ice. The DM stated she had not noticed the slaw was not on ice. After, notification, the DM stated the slaw had been placed in the freezer until proper temperature was reached and then kept in the cooler until ready to be used. The DM stated the danger of serving cole slaw that was too warm was the mayonnaise could spoil and cause the residents to be sick. 2. An undated policy, titled Storage of Pots, Dishes, Flatware, Utensils", indicated that pots, and flatware were to be stored in such a way to prevent contamination by splash, dust, pests or other means. Under Procedures, Bullet 1, the policy indicated staff should air dry pots, dishes , flatware and utensils prior to storage or store in a self draining position. Bullet 4 indicated carbon	F 371	3. The Food Service Manager in serviced all dietary staff on appropriate ware washing and storage of pots/ pans and other service ware, including allowing service ware to dry completely before storage, beginning on 3/11/15. The Food Service Manager also in serviced all dietary staff on icing down cold foods to maintain temperature <40 F for use on the tray line during meal service beginning on 3/12/15. 4. The Executive Director and/or Food Service Manager will conduct Quality Improvement Monitoring of the dish storage 5 times per week for 2 weeks, 3 times per week for 3 weeks, 2 times per week for 3 weeks and 1 time per week for 4 weeks and until substantial compliance is obtained. The Executive Director and/or Food Service Manager will conduct Quality Improvement Monitoring of proper procedure for icing down cold foods during service 5 times per week for 2 weeks, 3 times per week for 3 weeks, and 2 times per week for 3 weeks and 1 time per week for 4 weeks and until substantial compliance is obtained. Audit results will be recorded on Quality Improvement Data Collection Form. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Food Service Manager or designee for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but are not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical	

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F 371	Continued From page 22 build up should be monitored on pots and pans. On 3/9/15 at 10:45 AM, during the initial tour of the kitchen, an observation was made of steamer pans with food debris present. During an observation on 3/11/15 at 9:00 AM, 3 of 3 cooling racks, identified as ready to use had been stored with a thick build up of black material that could easily be removed with a fingernail. The Regional Director of Nutrition stated the pans probably should not be used because of the heavy build up. Two of ten dinner plates identified as ready to use that were in the plate warmer were seen with food particles. Two of six steam pans, identified as ready for use, were observed to have been stored with and 2 of 6 steam pans were observed to have dried food particles. The Regional Director of Nutrition stated storage of wet pans would increase the bacterial growth on the pans. An interview was held with the Dietary Manager on 3/12/15 at 9:36 AM. The DM stated the dangers of using wet pans would be cross contamination. She added staff were taught to pay attention and not place plates with food debris in the plate warmer.	F 371	Services, Medical Director, Social Services, Activities Director, Maintenance Director, Food Service Manager, and Minimum Data Assessment Nurse. 5. The allegation date of compliance is April 9, 2015	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		4/9/15

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F 431	Continued From page 23 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and manufacturer specifications, the facility failed to discard Advair Discus and Milk of Magnesia (MOM) when expired on 1 of 3 medication carts (cart E/F). The findings included: 1. Manufacturer specifications for Advair Discus included, "discard 1 month after opening foil pouch." On 3/12/15 at 11:45 AM, medication cart E/F was	F 431	F431 1. Drug Records, Label/Store Drugs and Biologicals The Director of Clinical Services (DCS) and Unit Manager (UM) immediately checked each medication and treatment cart and medication storage areas for outdated and unlabeled products on 3/10/15. All expired medications were discarded as per manufacturer	

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F 431	Continued From page 24 observed with Advair Discus opened 1/16/15. Nurse #1 was interviewed at this time and indicated the Advair Discus should have been discarded 28 days after opening. During an interview on 3/12/15 at 12:03 PM, the Director of Nursing indicated she expected Advair Discus to be discarded 1 month after removal from the foil pouch. 2. On 3/12/15 at 11:45 AM, medication cart E/F was observed with bottle of MOM with an expiration date of 2/15. Nurse #1 was interviewed at this time and indicated the MOM should have been discarded when expired. During an interview on 3/12/15 at 12:03 PM, the Director of Nursing indicated she expected stock medications to be discarded when expired.	F 431	instructions and/or company drug storage policies. No residents were harmed as a result of this issue. 2. All residents receiving medications and/or treatments are at risk to be affected. All storage areas were checked by the DCs and UM on 3/10/15 and outdated and unlabeled items were discarded per manufacturer recommendations. The Night nurses will check the medication storage areas for outdated and unlabeled items each week. A schedule has been posted for completing this task. 3. The Director of Clinical Services reeducated all licensed nurses and the Central Supply Coordinator on or before 4/9/15 regarding proper storage of medications, proper disposal of expired medications, and proper labeling of opened medications. The night nurses were reeducated during this session concerning the assignment to check the medication storage areas each week. The DCS or Unit Manager will conduct and document audits of the medication storage areas to ensure they are free of outdated and or unlabeled medications (3) times per week for (4) weeks, (2) times per week for (4) weeks, then weekly for (4) weeks on Quality Assurance Performance Improvement form. 4. The Director of Clinical Services will report the results of the audits to the Quality Assurance Performance Improvement (QAPI) Committee Meeting monthly for (3) months. The QAPI committee will recommend revisions to the plan as needed to assure sustained	

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F 431	Continued From page 25	F 431	compliance. 5. The allegation of compliance date will be April 9, 2015.	
F 441 SS=E	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 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	F 441		4/9/15

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F 441	Continued From page 26 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record reviews, observation, and staff interviews the facility failed to implement personal protective equipment hazard requirements for sorting soiled laundry for 1 of 1 laundry staff sorting soiled laundry. The findings included: On 03/13/15 at 7:25 am, an observation of the soiled laundry room staffed by one person (laundry staff #1) revealed a large wheeled barrel/trash bin contained soiled laundry in bags. Laundry staff retrieved the bags from the barrel, opened the bags and sorted the white and colored laundry into 2 other "soiled laundry" barrels. Empty trash bags were deposited into a closed lid trash can lined with a trash bag. Laundry staff #1 retrieved the soiled laundry from the bottom of the soiled laundry barrel by bending forward into the barrel with her arms inside the lined barrel. The front of her clothes and sleeves came in contact with the liner that contained soiled linen. Laundry staff #1 donned wrist length resident care gloves, moved one of the sorted barrels to the washing machine, put feces soiled laundry into the washing machine and attempted to keep soiled laundry away from her uniform shirt. Pieces of soiled laundry brushed against the front of her uniform shirt. The shirt did not appear visibly soiled. Laundry staff #1 closed the washing machine door, removed the soiled gloves and did	F 441	F441 Infection Control, Prevent Spread, Linens 1. The Executive Director and the Housekeeping Manager upon being made aware of the deficient practice by the surveyor on 03/13/15 obtained the gloves and the gown and immediately reeducated the employee who began properly using the protective attire. 2. Every resident has the potential to be affected. On 3/13/15, laundry that had the potential for cross contamination was re-washed by the laundry/housekeeping staff using proper protective equipment-gowns and gloves. The Housekeeping Manager also verified that moisture impervious gowns, elbow length rubber gloves, and masks are available to protect the employee and to reduce cross contamination. 3. The Housekeeping Manager reeducated all laundry attendants on 3/13/15 regarding the proper use and wearing of personal protective equipment-gowns, gloves, and masks if needed for handling soiled linen and the importance of preventing cross contamination of dirty and clean linens. The Housekeeping Manager will conduct and document audits to ensure that proper personal protective is in use and that both clean and soiled linens are	

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F 441	Continued From page 27 not wash or sanitize hands. She rolled the empty barrel out of the soiled laundry room and down the hallway to the soiled collection room where the barrel was placed. She exited the soiled collection room and walked to the hallway sanitizing dispenser and sanitized her hands. When folding and sorting clean dried clothes; pieces of laundry brushed against her uniform shirt. 03/13/15 at 7:50 am, an interview with laundry staff #1 revealed that upon employment she was trained to wear resident care wrist length gloves when sorting regular soiled laundry and to use gown, gloves and a mask when transferring red isolation precaution washable bags from the soiled laundry barrel to the washing machine. Laundry staff #1 indicated she was trained to wash hands after handling soiled laundry and before entering the clean laundry room. She revealed that employees were required to attend a once a month in-service training conducted by the housekeeping and laundry manager. She recalled the last training she attended was the end of February 2015 and included wearing personal protective equipment (PPE) when working with red bagged laundry, hand washing and how you can get germs. She indicated she had never been educated or required to wear long or heavy rubber gloves and an apron or protective covering when sorting soiled laundry. 03/13/15 at 8:19 am, an interview with the Housekeeping and Laundry (H&L) Manager indicated she was responsible for training and monitoring of new employees. The H&L Manager indicated new employees attended a 3 day "in-house" 7 step program training module required by corporate office management. The	F 441	handled properly (3) times per week for (4) weeks, (2) times per week for (4) weeks, then weekly for (4) weeks on Quality Assurance Performance Improvement form. 4. The Housekeeping Manager will report the results of the audits to the Quality Assurance Performance Improvement (QAPI) Committee Meeting monthly for (3) months. The QAPI committee will recommend revisions to the plan as needed to assure sustained compliance. 5. The allegation of compliance date will be April 9, 2015.	

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F 441	Continued From page 28	F 441		

H&L Manager indicated all employees are cross-trained in housekeeping and laundry. She trained new employees in housekeeping services and housekeeping staff #2 trained new employees in laundry services. The H&L Manager indicated that the most recent in-service she conducted occurred on February 26, 2015 and included PPE, hand washing and blood-borne pathogens (BBP). The H&L Manager indicated she expected staff to wear wrist-length gloves (like the aides and nurses wear) when sorting soiled laundry and putting soiled laundry in the washing machine then to wear gloves, mask and gown when working with red-bagged isolation precaution laundry, to keep soiled and clean laundry away from uniform shirt and to wash or sanitize hands after removing gloves and before entering the clean laundry area.

03/13/15 at 8:30 am, record review of the February 26, 2015 in-service agenda, program guide and educational materials used revealed hand-washing technique, BBP and PPE. A "Housekeeping/Laundry Service Policy Statement" read "It is the responsibility of the district manager that: A PPE summary must be completed." The completed "PPE Hazard Requirements" summary directed the task of "Sorting soiled personal clothing and soiled linens included the potential hazard of contact with blood and body fluids and required wearing heavy rubber gloves, lab coats/aprons. Handling laundry after washing included the hazard of contact with potentially contaminated water (in washers) and required the use of protective gloves."

On 03/13/15 at 8:45 am, an interview with the H&L Manager indicated that she would seek

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F 441	Continued From page 29 advice from corporate office for wearing PPE when sorting laundry. 03/13/15 at 11:00 am, an interview with housekeeping staff #2 indicated that she was responsible for training new employees in the laundry service room with educational materials provided by the H&L Manager. She indicated she had never been educated or required to wear long or heavy rubber gloves and an apron or protective covering when sorting soiled laundry and did not teach new employees about PPE, the H&L Manager did this at monthly meetings. She recalled the last training was held the end of February 2015 and included wearing personal protective equipment (PPE) when working with red bagged laundry, hand washing BBP. 03/13/15 at 11:15 am, an interview with the facility administrator indicated she expected the housekeeping and laundry manager to train and monitor staff in BBP, PPE and proper hand washing. She expected staff was provided PPE, expected staff to use PPE, use BBP and wash hands as soon as feasible after they remove their gloves or other PPE.	F 441		