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	355103	A. BUILDING _____ B. WING _____	01/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS HEALTH CARE INC	483 4TH ST SW FORMAN, ND 58032

(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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started 01/03/12 and completed 01/05/12, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000		
F 241 SS=E	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: Based on observation, record review, and staff interview, the facility failed to provide care in a manner that maintained or enhanced dignity for 2 of 9 sampled residents (Resident #1 and #2) and for one supplemental resident (#11). Observations showed 4 of 9 certified nurse aides failed to knock on residents' doors prior to entering the room and failed to prevent excessive exposure of residents' skin, which may negatively impact residents' self-esteem and sense of self-worth. Findings include: - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included depression and history of a CVA (cerebrovascular accident). The current care plan stated, ". . . Difficulty in making decisions r/t	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbi Cookson, RHIA | TITLE: Administrator | (X6) DATE: 01-28-12

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

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F 241	Continued From page 1 [related to] stroke [and] difficulty communicating . . . Approach . . . Ask yes/no questions as able. Give resident adequate time to respond. . . ." Observation on 01/04/12 at 9:40 a.m. showed a CNA (#10) undressed Resident #2 and removed his brief. Observation showed the resident completely unclothed (except for a slipper sock to his left foot) while two CNAs (#3 and #10) sat him up in bed and transferred him, using a mechanical lift, from his bed to the bath chair. The resident remained unclothed for approximately three minutes. During the transfer, the resident's affect indicated signs of stress and agitation. Once in the bath chair, a CNA (#10) covered the resident with a bath blanket and transported the resident to the tub room. Observation on 01/04/12 at 8:30 a.m. showed a CNA (#7) entered Resident #2's room and failed to knock prior to entering. Observation on 01/04/12 at 9:40 a.m. showed two CNAs (#3 and #10) entered Resident #2's room and failed to knock prior to entering. Observation on 01/04/12 at 10:20 a.m. showed a CNA (#10) entered Resident #2's room and failed to knock prior to entering. Observation on 01/04/12 at 2:30 p.m. showed a CNA (#9) providing cares to Resident #2. Another CNA (#12) knocked briefly on the closed door. The CNA (#9), who was in the room assisting Resident #2, asked who was at the door. The other CNA (#12) failed to respond and immediately entered the room.	F 241	F241 We will provide care to all Residents with respect and dignity. Residents #1-2-11 have been interviewed and have no negative impact on their self-esteem or sense of self worth. To assure protection for all residents, All staff are reinserviced on the importance of knocking on resident doors and waiting for response. In-service done on 01-19-12 New Policy and Procedure on dignity has been written and implemented and presented to all staff. All staff is being monitored on policy and procedure and results submitted to QA Committee Monitoring will on going. QA will be done monthly for 6 month and quarterly for 2 years there after. Audits ongoing - done by random observations by Dept. Heads. Responsible party DON Excessive Exposure of Skin.' Resident 1-2-11 Has been interviewed and no apparent negative impact on their self-esteem or sense of self-worth. In-service held on 01-19-12 on the importance of keeping Residents skin and apparatus from exposure at all times. Staff will approach resident and assist to cover areas. Policy and Procedures on Resident ~~Dignity have been written and presented~~ Rec Lynette, DON phone call 4:15 pm 2/7/12 CT	

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F 241	Continued From page 2 During an interview on 01/05/12 at 11:15 a.m., an administrative nurse (#6) stated she expected staff to keep residents covered to prevent unnecessary skin exposure and expected staff to knock prior to entering a resident's room. - Review of Resident #1's medical record occurred on all days of survey. The resident's diagnoses included status post colostomy. The quarterly Minimum Data Set (MDS), dated 11/22/11, identified Resident #1 as cognitively intact. The current care plan, stated, ". . . I have a new colostomy bag . . . my clothes are to small and my colostomy bag will stick out . . . APPROACH . . . 6. If my bag is out for all to see-please gently remind me to cover it. . . ." Observations made throughout the survey showed Resident #1's abdominal area and colostomy bag (stool in the bag) visible at the following times: *01/03/12 at 4:15 p.m. *01/03/12 at 5:40 p.m. *01/04/12 at 7:45 a.m. *01/04/12 at 11:00 a.m. *01/05/12 at 7:45 a.m. During the above observations, staff failed to assist/encourage Resident #1 to adjust his clothing to cover his exposed skin and colostomy bag. - A random observation on 01/05/12 at 3:55 p.m. showed two unidentified CNAs assisting Resident #11 with ambulation in a hallway. Observation showed the resident's shirt pulled up on his left side, exposing one-third of his back. The staff members failed to adjust the resident's shirt.	F 241	to all staff to protect all residents from unnecessary exposure. Monitoring staff to insure Dignity of all Residents exposure is ongoing. QA will be done monthly for 6 months and quarterly for 2 years thereafter. Results to be presented to QA Committee. Observations Ongoing by all Dept. Heads. Responsible person: DON 01-31-12 per phone call w DON Lynette 2/7/12 4:15pm CT	
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=E	Continued From page 3 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, and staff interview, the facility failed to provide adequate supervision and assistive devices for resident (Resident #4 and #6) transported by staff in wheelchairs on 3 of 3 days of survey. Observations showed 5 of 9 CNAs failed to provide adequate assistive devices (wheelchair foot pedals) which placed the residents at risk for falls and injury during transport. Findings include: - Observations showed (CNAs #1, #2, #3, and/or #4) transporting Resident #6 in his wheelchair to and from the front lounge, dining room, and hallway bathroom. Observation showed no foot pedals on the wheelchair and Resident #6's slippers brushing the floor during transports on the following occasions: *01/03/12 at 4;15 p.m. *01/03/12 at 5:25 p.m. *01/04/12 at 8:55 a.m. *01/04/12 at 9:15 a.m. *01/04/12 at 10:45 a.m.	F 323		

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F 323	Continued From page 4 - Observation on 01/05/12 at 11:00 a.m., showed (CNA #5) transporting Resident #4 in her wheelchair from her room to the dining room. Observation showed no foot pedals on the wheelchair and Resident #4's slippers brushing the floor during transport. Observation on 01/05/12 did show wheelchair foot pedals in Resident #4's room available for use. During an interview on 01/05/12 at 11:45 a.m., a CNA (#7) and Restorative CNA (#2) identified Resident #4 uses foot pedals "only if she goes out." During an interview on 01/05/12 at 10:55 a.m., an administrative nursing staff member (#6) agreed staff members should put foot pedals on the residents' wheelchairs prior to transport. 2. Based on observation, policy and procedure review, and staff interview, the facility failed to maintain an environment free of hazardous chemicals on 2 of 3 days of survey (January 04-05, 2012). Accessible hazardous chemicals places cognitively impaired and wandering residents at risk for accidents/injury. Findings include: Review of the facility policy titled "General Safety Rules Housekeeping" occurred on 01/05/12. This undated policy, stated, ". . . 5. All equipment should be properly stored and secured. . . ." Observation during survey identified Resident #5 wandered throughout the facility. On 01/04/12 at 10:45 a.m., a nurse (#11)	F 323	F323 On Residents #4 and 6. Carriers have been attached to their wheelchairs to hold foot pedals that will allow them be able to use at any time. When these residents will be pushed by other person, foot pedals will be attached to chair and used to hold feet off the floor. When ~~there~~ they arrive at their destination, pedals will be removed so Resident may remain as ~~indicant~~ independent as possible and able to propel self.. All Staff has been orientated to new policy and procedure. Any resident in wheel chair will be ~~accessed~~ assessed to see if they can propel themselves and staff will follow new Policy and procedure. (re: using carriers for foot pedals) Measures put into place are new policy and procedure, all staff training,. QA to be done monthly for 6 months, quarterly for 2 years thereafter. Results submitted to QA Committee. Observations Responsibility: DON ongoing by all Staff/Dept Heads. F323 New Locks have been put on soiled utility door. Bath aide will carry keys on person and door to be locked when not present in room. 1-19-12 All Staff has been orientated to the importance of keeping doors locked ~~accessible~~ where chemicals may be ~~accessible~~ to a resident when staff is not present in room. QA done monthly for 6 month, quarterly for 2 years thereafter. Responsible DON, Safety Chairman Every shift has a walk-through checklist 01-31-12	

educated 1-19-12

all per DON Lynette via phone call 2/7/12 @ 4:15 pm. CT

Check each shift — includes making sure tubroom & soiled utility rooms are locked. Initialed off. Indefinite.

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F 323	Continued From page 5 disinfected a bedside table with Virex 256 One-Step disinfectant in the corridor directly outside the soiled utility room. Observation showed the bottle of Virex 256 One-Step disinfectant sitting on an open shelf in the unlocked soiled utility room. Observation of the environment on 01/05/12 at 8:30 a.m. showed the following: *Three bottles of Oxivir disinfectant and one bottle of Dimension III disinfectant in an unlocked cabinet in the tub room, and two bottles of Virex 256 One-Step disinfectant in an unlocked compartment located on the whirlpool tub. Both doors going into the tub room remain unlocked at all times. *One bottle of Virex 256 One-Step disinfectant, one bottle of Oxivir disinfectant, and one bottle of Claire odor eliminator sitting on an open shelf in the soiled utility room. The door going into the soiled utility room remain unlocked at all times. During an interview on 01/05/12 at 9:30 a.m., a supervisory staff member (#14) stated staff should store all chemicals in locked areas.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, facility policy and procedure review, professional literature review, and staff interview, the facility failed to store food under safe conditions in 1 of 1 kitchen. These practices have the potential to increase the risk of foodborne illness and can affect all residents who eat food stored in these areas. Findings include: Review of the facility's policy titled "Food Storage" occurred on the afternoon of 01/04/12. The policy stated, ". . . Refrigeration: All foods should be . . . dated. . . ." Review of the facility's policies titled "Meat and Vegetable Cookery" and "Cooking Temperatures" occurred on the afternoon of 01/04/12. The "Meat and Vegetable Cookery" policy stated, ". . . raw animal foods . . . shall be separated from one another during storage . . . by maintaining adequate spacing or by placing the food in separate containers." The "Cooking Temperatures" policy stated, the cooking temperature for pork as 145 [degrees] F (Fahrenheit) for 15 seconds and the cooking temperature for ground beef as 155 [degrees] F for 15 seconds. The 2009 Food Code, Public Health Reasons, page 386, stated ". . . Raw animal foods shall be separated based on a succession of cooking temperatures since cooking temperatures . . . are	F 371	F371 All Dietary staff in serviced 01-10-12 on food labeling, dating, thawing, preperation, and storage. All Dietary staff will be enrolled in EDUCATION INTERFACE, and will be responsible to complete required courses yearly. QA will be conducted twice weekly to assess staff on the facility's policy and procedure for food labeling, dating. Thawing. Preparation and storage are followed. Results submitted to QA Committee. Twice weekly for 3 months, and once weekly thereafter. Responsibility, Food Service Supervisor	per phone call DON Lynette 2/7/12 @ 4:00 pm. 01-31-12

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F 371	Continued From page 7 based on thermal destruction data and anticipated microbial load . . ." Raw meats should be stored so that meats requiring higher cooking temperatures are stored below meats which require lower cooking temperatures. - An initial dietary tour of the kitchen occurred on 01/03/12 at 12:50 p.m. with an administrative dietary staff member (#8). Observation of the walk-in cooler showed an approximate 12 pound, closed package of raw pork roast thawing in a plastic container with three 5 pound closed packages of raw ground beef. Observation also showed approximately one pound of sliced deli ham stored in an undated, opened plastic bag. This practice of incorrectly thawing and storing meat has the potential to affect all residents eating these items. When interviewed. during the initial dietary tour, the administrative dietary staff member (#8) confirmed the dietary staff should store the pork roast and ground beef in a separate containers. - A main dietary tour of the kitchen occurred on 01/04/12 at 2:00 p.m. with an administrative dietary staff member (#8). Observation showed the sliced deli ham remained not dated. When interviewed. during the main dietary tour, the administrative dietary staff member (#8) confirmed "everything should be dated."	F 371		
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	F 441		

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F 441	Continued From page 8 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to	F 441		

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F 441	Continued From page 9 follow infection control practices on 2 of 3 days of survey (January 03-04, 2012). Observations showed 8 of 9 staff members failed to properly store bedpans, properly disinfect a resident's bedside table, perform hand hygiene and/or use gloves when required, sanitize the floor after a urine spill, and clean stool from a shower chair which placed residents, visitors, and staff at risk of infection. Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, this facility has not sustained correction of this issue. This requirement was found to be out of compliance during the previous survey completed in 2010. Findings include: Review of the facility policy titled "Contact Precautions" occurred on 01/05/12. This policy, dated 01/11/11, stated, "GLOVE: When entering room, remove gloves before leaving and wash hands or use hand sanitizer immediately befor [sic] leaving room. GOWN: Wear a gown when enetring [sic] if you anticipate that your clothing will have substantial contact with the patient. Remove gown before leaving the room and place in red bag. . . ." Review of the facility policy titled "Handwashing-Employee" occurred on 01/05/12. This policy, revised 10/28/09, stated, "Policy: To provide guidelines to employees for the proper and appropriate handwashing that will aid in the prevention of transmission of nosocomial infections. . . . Procedure: . . . 7. Hands are always washed/sanitized after removal of gloves.	F 441		

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Miscellaneous: 1. Appropriate 10-15 second handwashing/sanitizing must be performed under the following conditions; . . . h. Before and after entering resident room. i. Before and after offering incontinence care/Foley care. j. After handling used dressings, urinals, bedpans, catheters, contaminated tissues, linen, etc. [etcetera] . . . l. After contact with blood, urine, feces, oral secretions, mucous membranes, or broken skin. m. After handling items potentially contaminated with any blood/body secretions. . . . 2. The use of gloves does not replace hand washing."

Review of the facility policy titled "General Safety Rules Housekeeping" occurred on 01/05/12. This policy, undated, stated, ". . . 2. All spills must be cleaned up. . . ."

- During the initial tour on the afternoon of 01/03/12, observation showed a bed pan uncovered and placed behind the grab bar in a resident's bathroom on the "A" wing, and two bed pans uncovered and placed behind the grab bar in a shared bathroom on the "B" wing.

During an interview on 01/04/12 at 11:15 a.m., an administrative nurse (#13) stated she expected staff to store bed pans in a plastic bag when not in use.

- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included a current methicillin-resistant staphylococcus aureus (MRSA) infection present in the ulcers on the resident's left foot.

The care plan stated, "10/10/11 (MRSA hand

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F 441	Continued From page 11 written under date in left hand column) left heel is very foul smelling, area looking worse . . . 12/30/11 Vancomycin 1000 mg [milligrams] IV [intravenous] every 18 hours . . . Approach, STAFF WILL: . . . 5. Keep area covered . . . 9. Do excellent handwashing, 10. Wipe down wheelchair every shift, 11. Wet to dry dressing to [Left] heel change daily. . . ." The care plan failed to identify the resident required contact precautions. A laminated card stapled to a plastic divider sheet in the treatment book, stated, "Contact Precautions Glove: When entering room, remove gloves before leaving and wash hands immediately before leaving room Gown: Wear a gown when entering if you anticipate that your clothing will have substantial contact with patient. (disposable gown or hospital gown). Remove gown before leaving the room. . . ." Observation showed the laminated contact precaution card was attached to a blank plastic divider sheet and failed to identify Resident #2 by name. Observation on 01/03/12 at 4:10 p.m. showed a CNA (certified nurse aide) (#9) in Resident #2's room. The CNA (#9) stated she just changed the resident's brief, wet with urine, and transferred the resident from the bed to the wheelchair using a mechanical lift. The CNA (#9) bagged the resident's garbage, disposed of it in the soiled utility room, and then sanitized her hands. The CNA (#9) failed to perform hand hygiene prior to exiting the resident's room.	F 441	In service on 01-19-12 for all staff on the revised Policy and procedure to address the proper method to clean, disinfect, and store resident bed pans, urinals, graduates, And commodes. These utensils are placed a plastic bag. Hooks are provided in bathrooms to hang bags. Staff orientated again to proper procedure and product to disinfect any and all exposed areas, i.e. bedside tables, etc. QA monthly for 6 months, quarterly thereafter for 2 years. Results to QA committee/ Responsible: DON and Infection control Coordinator. Checking applicable rooms & bathrooms for the above & staff knowledge - ongoing All Residents, Staff, and visitors are at risk for infection. In service, handouts, and one on one oberservations have been done. All staff has reviewed the policy and procedure on hand washing and on contact precautions. Staff Sign off on sheet when policy read. Proper techniques on disinfecting and sanitizing for spills and equipment have been in serviced. Procedure presented to all staff. QA 3x week for one month. Weekly for 6 months quarterly they're after. Results to QA committee. Random obs. of handwashing in different scenerios on-going. Responsible: DON • New policy written on urine spills & BM spills (disinfecting).	01-31-12

Res #2's CP updated on contact precautions during survey.

changes on entire page per TC phone call DON Lynette on 2/7/12 @ 4:15pm CT

Infection Control nurse working more days. Responsible for reviewing revising care plans (re: infection control/precautions, etc). Also checking placement of laminated contact precaution sheet in tx book.

3 nights a week - night CNAs disinfects bedpans, urinals - replaced if needed.
Housekeeping disinfects commodes daily. All labeled with Res names (urinals, bedpans, etc. if shared room/BR).

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	355103	A. BUILDING _____ B. WING _____	01/05/2012

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F 441	Continued From page 12 Observation on 01/04/12 at 9:40 a.m. showed two CNAs (#3 and #10) checked and changed Resident #2's brief, incontinent of loose stool, while he remained in bed. One CNA (#10) performed pericares, removed her gloves, placed a lift sling under the resident, transferred the resident from his bed to the bath chair using a mechanical lift, covered the resident with a blanket, and transported the resident to the tub room. The CNA (#10) failed to perform hand hygiene immediately after performing pericares and prior to exiting the resident's room. The other CNA (#3) assisted with the transfer, bagged the resident's garbage in a red bag, disposed of the garbage in the soiled utility room, and then washed her hands. The CNA (#3) failed to perform hand hygiene prior to exiting the resident's room. Observation on 01/04/12 at 10:20 a.m. showed two CNAs (#7 and #10) transferred Resident #2 from the bath chair to his bed using a mechanical lift. Observation showed urine on the floor and dripping from the bath chair seat. Without using gloves, one CNA (#10) wiped up the urine spill with a towel. The CNA (#10) failed to perform hand hygiene after cleaning up the spill. Observation also showed stool visible on the bath chair seat. The CNA (#10) pushed the bath chair down the hall to the tub room on the opposite wing. The CNA (#10) failed to disinfect the bath chair and perform hand hygiene prior to exiting the room. After transferring the resident, the other CNA (#7) left the room to get a brief. The CNA (#7) failed to perform hand hygiene prior to exiting the resident's room. Upon returning to the room, the CNA (#7) donned gloves, dried the resident's perineal area with a towel, placed a	F 441		

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clean brief, finished dressing the resident, removed her gloves, combed the resident's hair, and bagged the garbage. The CNA (#7) failed to perform hand hygiene after drying the resident's perineal area.

During an interview on 01/05/12 at 9:30 a.m., a housekeeping staff member (#14) stated staff should have disinfected the floor in Resident #2's room after wiping up the urine spill. She also stated staff should have wiped off the stool and then disinfected the bath chair prior to taking it out of Resident #2's room.

On 01/04/12 at 10:45 a.m. observation showed a nurse (#11) changed the dressing to Resident #2's left foot ulcer. The nurse (#11) removed the bedside table (used during the dressing change) from the resident's room and pushed it down the hall just outside the soiled utility room. The nurse (#11) sprayed the bedside table with Virex 256 One-Step Disinfectant Cleaner and then wiped the cleaner off immediately. Observation of the Virex 256 One-Step Disinfectant Cleaner label identified the following directions: ". . . Allow to remain wet for 10 minutes. Then wipe or allow to air dry. . . ." The nurse (#11) failed to allow for a contact time of ten minutes, as per the directions on the label.

Observation on 01/04/12 at 2:30 p.m. showed two CNAs (#9 and #12) repositioned Resident #2 up in bed, applied the AFO (Ankle Foot Orthosis) boot to his left foot, and bagged the garbage. Upon leaving the room, both CNAs (#9 and #12) stated they would wash their hands after disposing the garbage in the soiled utility room. The CNAs (#9 and #12) failed to perform hand

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hygiene prior to exiting the resident's room.

Observation on 01/04/12 at 4:10 p.m. showed two CNAs (#9 and #12) transferred Resident #2 from his bed to the wheelchair using a mechanical lift. One CNA (#12) failed to perform hand hygiene prior to exiting the resident's room.

During an interview on 01/04/12 at 9:40 a.m., a CNA (#3) stated staff received information on resident infections and required precautions by: report from the charge nurse, looking in the resident's care plan, and by precaution cards located in the treatment book.

On 01/05/12 at 11:15 a.m., an administrative nurse (#6) stated she expected staff to perform hand hygiene immediately after pericares and prior to exiting the resident's room. She confirmed Resident #2's care plan failed to address the resident was on contact precautions. She also agreed confusion could occur with the placement of the laminated contact precaution card in the treatment book and stated, "it probably should be on the other plastic sheet." (In an area of the treatment book clearly designated to Resident #2.)

- On 01/03/12 at 5:09 p.m., observation showed a CNA (#1) donned gloves and assisted Resident #4 onto the toilet using a mechanical lift. After the resident voided, the CNA cleansed Resident #4's perineal area with several wet wipes and applied powder to the resident's bottom. The CNA removed her gloves, pulled up the resident's brief and pants, and transferred the resident into the wheelchair. The CNA bagged the garbage and left the room carrying the garbage and pushing

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F 441	Continued From page 15 the lift. The CNA disposed of the garbage, used disinfectant wipes to clean the lift, and then washed her hands at the nurses' station. The CNA failed to perform hand hygiene after performing pericares and removing her gloves, before leaving the resident's room, or before cleaning the lift. - Observation on 01/04/12 at 9:35 a.m., showed a CNA (#4) donned gloves and assisted Resident #5 onto the toilet. After the resident voided, the CNA performed pericares, removed her gloves, touched the resident's hand and gave her a drink of water. The CNA (#4) failed to perform hand hygiene before touching Resident #5's hand and giving her a glass of water.	F 441		