STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355064	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CENTER OF GARRISON	609 4TH AVE NE GARRISON, ND 58540

(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 on May 29, 2012 and completed on May 31, 2012 the sample included two (2) residents for complete review, eight (8) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278	F 278 Assessment accuracy 1) Neighbor #6's most recent MDS was corrected to accurately reflect that he was not on a scheduled toileting program. Neighbor #5's most recent MDS was corrected to accurately reflect her level of assistance with eating and that she did not receive any restorative dining minutes. Neighbor #5's restorative dining program was discontinued. 2) All MDS from 7/1/12 forward are audited to ensure that sections G, H and O are accurate. 3) MDS coordinators will be in serviced individually by the DON regarding incorrect sections identified. Sections G, H and O of all MDS's will be double checked by the MDS coordinators to ensure that each MDS is entered accurately.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: administrator — (X6) DATE: 6/26/12

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.

PRINTED: 06/14/201
FORM APPROVED
OMB NO. 0938-039

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

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F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $[illegible],000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278	F 278 Assessment accuracy 1) Neighbor #6's most recent MDS was corrected to accurately reflect that he was not on a scheduled toileting program. Neighbor #5's most recent MDS was corrected to accurately reflect her level of assistance with eating and that she did not receive any restorative dining minutes. Neighbor #5's restorative dining program was discontinued. 2) All MDS from 5/31/12 to 7/1/12 will be reviewed for issues in the coding of section G (eating), H (toileting programs) and O (restorative dining). 3) MDS coordinators will be inserviced individually by the DON regarding incorrect sections identified. Sections G, H and O of all MDS's will be double checked by the MDS coordinators to ensure that each MDS is entered accurately.	

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

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 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0) and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 1 of 2 sampled residents regarding a toileting program (Resident #6) and 1 of 1 sampled residents (Resident #5) coded for restorative dining program and incorrectly coded for assistance during meals. Failure to accurately code the MDSs for these residents limited the facility's ability to develop and implement individualized care plans consistent with their needs and functional status. Findings include: The Long-Term Care Facility RAI User's Manual dated October 2011 stated on: * Page O-34, "Training and Skill Practice . . . Eating and/or Swallowing Code activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record." - Review of Resident #5's medical record occurred on all days of survey. An annual MDS,	F 278	4) Sections G, H and O will be audited to ensure the accuracy of the MDS for a minimum of 8 weeks. The audit will be completed on 2 MDS's starting July 1, 2012 per week x4 weeks, then 1 MDS x 4 weeks by designated RN. If any issues are discovered within the audit, the length of the time will be extended. The audit will be completed once there has been 8 consecutive weeks with no incorrect data being found on the MDS. Results of audits, tracking and trending will be reviewed by QA committee monthly. (Audit form attached – attachment #1.) 5) Date certain will be 7/5/12.	

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F 278	Continued From page 2 dated 03/08/12, identified the resident received restorative training and skill practice for "Eating and/or swallowing" 7 of the past 7 days. The medical record lacked evidence of a planned restorative dining program for Resident #5. This MDS also indicated the resident required limited assistance of two persons for eating. During an interview on the morning of 05/31/12, an administrative nurse (#3) indicated that coding was an error. Observation during meals on 05/29/12, and 05/30/12 showed Resident #5 ate independently after setup and at times fed by one staff person. - The Long-Term Care Facility RAI User's Manual, October 2011, page 2-1 states, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . ." Page H-6 states, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to: * simply tracking continence status, * changing pads or wet garments, and * random assistance with toileting or hygiene . . ." Page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for the development of: * an individualized care plan * The Medicare Prospective Payment System * Medicaid reimbursement programs * quality monitoring activities . . . * the data-driven survey and certification process	F 278		

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F 278	Continued From page 3 * the quality measures used for public reporting . . ." Review of Resident #6's medical record, on May 29-31, 2012 identified a medical diagnosis of dementia. Resident #6's quarterly MDS, dated 04/23/12, identified the resident as having severely impaired cognition, frequently incontinent of bladder and bowel, and on a urinary and bowel toileting plan. Resident #6's current care plan stated, "PROBLEM: Elimination: I do need assistance with toileting and am incontinent of b/b [bowel and bladder] at times. . . Approach: . . . I am sometimes able to request assistance with toileting, but not always. I need you to anticipate my needs regarding toileting. I need help finding the bathroom . . . if you see me wandering and restless assist me to BR [bathroom] as I am incontinent at times and have a history of voiding in inappropriate places. . . . Routine toileting (take me to BR upon arising, before and after meals, before bedtime and prn [as needed]). Check and change per TENA [incontinence product] guidelines. . . ." During an interview the morning of 05/31/12, a Certified Nursing Assistant (CNA #9) stated staff try to take Resident #6 to the bathroom "about every two hours" or if they see that he is restless or wandering more. The CNA (#9) stated the resident does not always agree to go to the bathroom, but they try to encourage him, as he will void in inappropriate places at times. During an interview on the morning of 05/31/12, an administrative nurse (#12) stated Resident #6 is not on a schedule toileting program and	F 278		

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F 278	Continued From page 4 confirmed the MDS coding was not correct.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy, and staff and resident interview, the facility failed to review and revise the care plan for 1 of 1 sampled resident (Resident #1) who experienced fear and conflict with a spouse. Failure to evaluate and revise the care plan with changes in this relationship has the potential to affect staff's understanding of the resident's problems and interventions.	F 280	F 280 Revising Care Plans 1) Neighbor #1's care plan was updated to include that neighbor's husband is also a resident at BLC, that they live in separate rooms, her concerns and history of conflict between the two. Due to neighbor's husband expiring on 6/15/12, neighbor #1's care plan was again updated to reflect that he had recently passed away. 2) Any neighbor to neighbor conflict/incidents will be reflected in the care plan of all neighbors involved. 3) Neighbor to neighbor conflict/incidents is reviewed at weekly Medicare meetings by the IDT. Appropriate care plans will be updated at that time by SW. 4) Neighbor to neighbor incident tracking and trending will be reviewed by the QA committee monthly. 5) Date certain will be 7/5//12.	

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F 280	Continued From page 5 Findings include: Review of the facility policy titled "Care Plans - Comprehensive" occurred on 05/31/12. This policy, dated October 2012, stated, ". . . 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. . . ." Review of Resident 1#'s medical record occurred on all days of survey. Resident #1's quarterly Minimum Data Set (MDS), dated 04/27/12, identified the resident as cognitively intact. The facility identified the resident as interviewable. During an interview on 05/29/12 at 2:45 p.m., Resident #1 stated she was admitted at the same time as her husband and they had shared a room. Review of Resident #1's "Resident Progress Notes" from 01/09/12 to 05/10/12 indicated Resident #1 and Resident #8 had shared a room in the facility. The progress notes indicated Resident #8 had become verbally abusive to Resident #1 starting on 01/17/12, "she was scared of him and did not want to be left alone with him." Resident #1's progress notes indicated she moved to another room in the facility. The notes continued to address the relationship between Resident #1 and Resident #8 and the interventions discussed by the Social Worker and Resident #1. Resident #1's care plan lacked any information/interventions/plans regarding the relationship with Resident #8. The care plan failed to identify Resident #1's spouse was a	F 280		

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F 280	Continued From page 6 resident at the facility. During an interview on the afternoon of 05/31/12, a social services staff member (#6) agreed Resident #1's care plan lacked information regarding Resident #8.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide care and services in accordance with physician's orders for 1 of 2 sampled residents (Resident #4) with TED (Thrombo-Embolic Deterrent) hose (a medically prescribed tight-fitting stocking used to help prevent the pooling of blood and formation of blood clots). Failure to ensure Resident #4 wore the TED hose as ordered may result in negative physical effects such as blood clot formation, pulmonary embolism (a blockage in the arteries of the lungs), or stroke. Findings include: Review of Resident #4's medical record occurred on all days of survey. Diagnoses included history of pulmonary embolism (PE), congestive heart	F 309	F 309 Care/Services 1) Ted Hose were acquired and applied to neighbor #4 per order parameters. 2) All neighbors with orders for Ted Hose will be evaluated to ensure that they have and are wearing their Ted Hose as ordered. 3) All Ted Hose orders will be included in the daily CNA documentation to be signed off on by the CNA caring for that neighbor that shift. All nursing staff will be in serviced individually by the care coordinator on new procedure. 4) QA will be completed by care coordinator beginning July 1, 2012 on 3 neighbor's who have orders for Ted Hose per week x4 weeks, then 1 per week x 4 weeks, then 1 per month. ongoing This will include neighbor #4. Results of audits, tracking and trending will be reviewed by QA committee monthly. (Audit form attached – attachment #2.) 5) Date certain will be 7/5/12. per phone call E Kim Lies, DON 7-3-12 1539 AA	

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F 309	Continued From page 7 failure, and Alzheimer's disease. The resident's quarterly Minimum Data Set, dated 04/29/12, identified severe cognitive impairment and extensive assistance from one person for dressing. The healthcare provider's [nurse practitioner] progress notes stated the following: *02/16/12: ". . . [Resident name] is a 95-year-old female who is seen today due to swelling in her legs. She also complains of some pain. . . . Trace edema noted to right lower extremity. . . . I am going to order for the patient to utilize ted hose throughout the day. Hopefully this will help alleviate the swelling and pain. . . ." *04/19/12: ". . . Staff question whether or not they can discontinue the usage of Ted hose. Due to her history of PE I do not think it is a good idea to discontinue this order. . . ." Current provider's orders stated, "Ted hose on in AM [morning] off at HS [bed time]." Observations showed Resident #4 without TED hose on her legs throughout all days of survey. Staff failed to apply the TED hose in the morning as per provider order. During an interview on the morning of 05/31/12, a supervisory nursing staff member (#4) stated she thought the healthcare provider had discontinued the TED hose; however, record review failed to show evidence of this.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	F 323 Free of Accident Hazards 1) Neighbors #2, #4, and #9 were given foot pedals so they can be donned anytime they are given a ride	

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F 323	Continued From page 8 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of facility policy, and staff interview, the facility failed to provide assistive devices (wheelchair foot pedals) necessary to prevent accidents for 3 of 8 sampled residents (Resident #2, #4, and #9) observed during staff-assisted wheelchair transport. Failure to apply wheelchair foot pedals may result in avoidable falls and/or injuries. Findings include: Review of the facility policy titled "Wheelchair Mobility" occurred on 05/31/12. This undated policy stated, ". . . PURPOSE: To ensure the safety of the neighbor [resident]. . . . 2. If the neighbor requires assistance with wheelchair mobility, foot rests/leg extenders will be attached to the chair before staff assist the neighbor to the destination chosen unless they are able to propel themselves." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included osteoporosis, osteoarthritis, and unspecified intellectual disabilities. The current Minimum Data Set (MDS), dated 05/21/12, identified impaired cognition and extensive assistance from one person for transfers and	F 323	from staff. Each of these neighbors is able to self-propel and are given that option. However, when staff is giving them a ride, we do don their foot pedals to ensure their safety. 2) Any neighbor who needs a ride, will have leg rests donned onto the wheelchair. If they are able to self propel, we will allow them to do so. However, if the neighbor is able to self propel but asks for or requires a ride, we will don the leg rests until the neighbor gets to their intended destination and then we will remove the pedals. Any neighbor who is unable to self propel will have leg rests on their wheelchair. 3) All staff will be in-serviced on w/c foot pedal policy individually by care coordinator. We will utilize this system for all neighbors in wheelchairs to avoid potential injuries. 4) Starting July 1, 2012, COTA will audit 3 neighbors weekly for a minimum of 8 weeks to ensure this process is being followed and is successful. After 8 weeks we will continue with 3 audits monthly to ensure this system ongoing continues to be utilized and is successful. Results of audits, tracking and trending will be reviewed by QA committee monthly. (Audit form attached – attachment #3) 5) Date certain is 7/5/12.	

per phonecall c Kim Lies, DON 7-3-12/1539 AA

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F 323	Continued From page 9 locomotion. Observation on 05/29/12 at 2:50 p.m. showed a certified nursing assistant (CNA) (#5) transported Resident #2 down the hallway to her room in a wheelchair. The CNA failed to apply wheelchair foot pedals; and as a result, the resident's feet brushed along the floor. Observation on 05/29/12 at 5:20 p.m. showed a CNA (#5) transported Resident #2 from her room to the dining room in a wheelchair without foot pedals in place. The resident's feet skipped along the floor, making scuffing noises as she went. Observation on 05/30/12 at 11:45 showed a CNA (#2) transported Resident #2 from her room to the dining room in a wheelchair without foot pedals in place. The resident made stepping motions with her feet, as if trying to self-propel. The CNA (#2) stated, "Lift your feet." The resident stopped making stepping motions, but her feet continued to brush along the floor. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and osteoporosis. The current MDS, dated 04/29/12, identified severe cognitive impairment and extensive assistance from one person for transfers and locomotion. Resident #4's current care plan stated, ". . . Mobility: I do need assistance with mobility. . . . Approach . . . Assist of [one] with locomotion. I utilize a w/c [wheelchair]. . . ." Observation on 05/29/12 at 5:04 p.m. showed a	F 323		

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F 323	Continued From page 10	F 323		

CNA (#8) transported Resident #4 from her room to the dining room in a wheelchair. The CNA failed to apply wheelchair foot pedals; and as a result, the resident's feet brushed along the floor.

Observation on 05/30/12 at 3:09 p.m. showed a CNA (#4) transported Resident #4 from her room to the activity room in a wheelchair without foot pedals in place. The resident made stepping motions with her feet, as if trying to self-propel. The CNA (#4) asked, "Can you lift your feet [Resident name]?" The resident stopped making stepping motions, but her feet continued to brush along the floor.

- Review of Resident #9's medical record, on 05/31/12, identified medical diagnoses which included dementia and scoliosis. Resident #9's current MDS, dated 04/12/12, identified severely impaired cognition.

Observation on 05/29/12 at 4:00 p.m. showed a licensed nurse (#12) transported Resident #9 down the main hallway to her room in a wheelchair without foot pedals in place. The resident's feet brushed along the floor, making an audible noise.

Observation on 05/30/12 at 12:20 p.m. showed an unidentified CNA transported Resident #9 from the dining room to her room in a wheelchair without foot pedals in place. The resident's feet brushed along the floor, making audible noise as she went down the hallway.

Observation on 05/31/12 at 12:25 p.m. showed a CNA (#11) transported Resident #9 from the dining room to her room in a wheelchair without

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	355064	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CENTER OF GARRISON	609 4TH AVE NE GARRISON, ND 58540

(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 323	Continued From page 11 foot pedals in place. The resident's feet brushed along the floor, making an audible noise. During an interview on 05/31/12 at 2:20 p.m., a supervisory nursing staff member (#3) agreed that failing to place foot pedals on wheelchairs during staff-assisted transport was an accident hazard.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections 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	F 441	F 441 Infection Control 1) Neighbor #2, #5, and #7 have had no negative consequences related to improper hand washing. 2) All neighbors at BLC have the potential to be impacted by improper hand washing/hand hygiene practices. 3) All staff will be in serviced individually by DON and care coordinator on proper hand washing/hand hygiene procedures. A copy of hand washing/hand hygiene policy and procedure will be given to all employees. (See attachment #4 for in-service roster and educational materials.) 4) Audits will be completed by charge nurses (assigned by care coordinator and turned into DON) of random staff, 3 per week x4 weeks, then 1 per week x4 weeks, then 3 random ~~monthly~~ staff per phone c Kim Lies, DON thereafter. Audits will begin July 1, 2012. Results of audits, tracking and trending will be reviewed by QA committee monthly. (Audit form ~~attached – attachment #5.~~) 7-3-12/1539 AK	

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F 441	Continued From page 12 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, and review of facility policy, the facility failed to follow acceptable infection control standards for 3 of 8 sampled residents (Resident #2, #5, and #7) observed receiving personal cares. Failure to perform hand hygiene after completing perineal cares does not ensure a safe and sanitary environment to prevent the transmission of disease and infection. Findings include: Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 05/31/12. This policy, dated April 2012, stated, "This facility considers hand hygiene the primary means to prevent the spread of infections. . . 5. Employees must wash their hands . . . n. Before and after assisting a resident with toileting (hand washing with soap and water); . . . u. After removing gloves or aprons . . . 8. The use of gloves does not replace handwashing/hand hygiene. . . . " - Observation on 05/29/12 at 3:00 p.m., showed two Certified Nursing Assistants (CNAs) (#4 and	F 441	5) Date Certain will be 7/5/12.	

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F 441	Continued From page 13 #5) donning gloves and checking and changing Resident #5's brief which was wet with urine and soiled with stool. A CNA (#5) performed perineal cares, and then removed her gloves. After applying a new brief and pulling up the resident's pants, the CNAs assisted Resident #5 to sit in her wheelchair. Without performing hand hygiene, the CNA (#5) brushed the resident's hair, picked up a glass of water and while holding the straw, offered the resident a drink. The CNA (#5) failed to perform hand hygiene immediately after ensuring the resident's safety. - Observation on 05/30/12 at 3:20 p.m., showed two CNAs (#4 and #7) donning gloves and checking and changing Resident #5's brief, which was soiled with stool. A CNA (#4) performed perineal cares, and removed her gloves. After applying a new brief and pulling up the resident's pants, the CNAs assisted Resident #5 to sit in her wheelchair. Without performing hand hygiene, the CNA (#4) brushed the resident's hair, picked up a glass of water and, while holding the straw offered the resident a drink. The CNA (#4) failed to perform hand hygiene immediately after ensuring the resident's safety. - Observation on 05/30/12 at 11:45 a.m. showed two CNAs (#1 and #2) assisted Resident #2 to the bathroom. The resident was incontinent of urine and stool. A CNA (#1) donned gloves, performed perineal cares, and removed her gloves. After applying a new brief and pulling up the resident's pants, the CNAs assisted Resident #2 to sit in her wheelchair. Without performing hand hygiene, the CNA (#1) removed the gait belt, and assisted the resident to change her shirt and drink water by holding the glass and straw.	F 441		

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F 441	Continued From page 14 The CNA (#1) then washed the resident's face with a washcloth before washing her hands. The CNA (#1) failed to perform hand hygiene immediately after ensuring the resident's safety. - Observation on 05/30/12 at 9:40 a.m. showed two CNAs (#9 and #10) changed Resident #7's brief, which was wet with urine. A CNA (#10) donned gloves and performed perineal cares. Resident #7 was incontinent of urine immediately after the CNA finished cares. The CNA (#10) again performed perineal cares and removed her gloves. After applying a new brief, pulling up the resident's pants, and applying a lift harness, the CNAs assisted Resident #7 to transfer from the bed to her wheelchair using a mechanical stand lift. Without performing hand hygiene, the CNA (#10), made the resident's bed, applied foot pedals to the wheelchair, and brushed the resident's hair. The CNA (#10) failed to perform hand hygiene immediately after ensuring the resident's safety.	F 441		