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	355067	A. BUILDING _____ B. WING _____	10/02/2014

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid survey recertification survey started on 09/29/14 and completed on 10/02/14, the sample included 5 residents for complete review, 22 residents for focused review, and 3 closed records for review.	F 000		
F 203 SS=C	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.	F 203	Education has been provided to the licensed nurses about the purpose of the Notice of Transfer and the requirement that it is completed with all hospital transfers. RN Care Coordinators will audit all hospital transfers for six months and as needed thereafter to ensure that the Notice of Transfer form has been completed. Findings will be reported at the monthly Quality Review Team meetings chaired by the Director of Nursing Services.	11-10-2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11/12/2014

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

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F 203	Continued From page 1 The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on record review, policy and procedure review, and staff interview, the facility failed to notify the resident and/or the resident's family/legal representative, in writing, of a transfer, including the destination and the reason for the transfer, and the resident's right to appeal the action, for 9 of 9 sampled residents (Resident #1, #2, #4, #7, #12, #13, #16, #21, and #23) transferred to the hospital. Findings include: Review of the facility policy and procedure titled "Discharge or transfer of a resident to home or assisted living, acute hospitalization, or another SNF [skilled nursing facility]" occurred on 10/02/14. This procedure, dated August 2012,	F 203		

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F 203	Continued From page 2 stated, ". . . II. Procedure . . . C. Once the order is obtained, the following forms need to be completed based on type of leave/transfer/discharge. . . . 3. Hospital Stay: . . . b. VMH [Valley Memorial Homes] Nursing Facility Notice of Transfer for Hospitalization. Original copy to Chart, Yellow copy to Resident and Pink to Family. . . ." Review of Resident #1, #2, #4, #7, #12, #13, #16, #21, and #23's medical records identified the residents transferred to the hospital on the following dates: * Resident #1: 05/20/14 and 05/24/14 * Resident #2: 09/11/14 * Resident #4: 08/10/14 * Resident #7: 09/06/14 * Resident #12: 07/27/14 and 09/18/14 * Resident #13: 06/24/14 * Resident #16: 04/17/14 and 05/13/14 * Resident #21: 08/10/14 * Resident #23: 05/06/14 The records for the above residents lacked evidence the facility provided the residents and/or their family/legal representative written notice of transfers, including the reason for the transfers, the effective date of the transfers, the location transferred to, and the right to appeal the transfer. On 10/01/14 at 6:00 p.m., a nursing supervisor (#10) stated staff completed "bed hold" forms when Resident #16 transferred to the hospital on 04/17/14 and 05/13/14. On the afternoon of 10/02/14, the nurse stated she was unable to locate transfer forms (Notice of Transfer) for those hospitalizations.	F 203		
F 226	483.13(c) DEVELOP/IMPLMENT	F 226	Continued on Page 4 of 35	

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F 226 SS=D	Continued From page 3 ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to implement policies regarding abuse/neglect for 2 of 4 sampled residents (Resident #7 and #8) with injuries of unknown origin. Failure to implement the facility's written abuse prevention policies and procedures and ensure a thorough investigation of injuries of unknown origin placed residents at risk for abuse and mistreatment. Findings include: Review of the facility policy titled "Injury of Unknown Origin" occurred on 10/02/14. This policy, revised July 2011, stated, ". . . It is the policy of Valley Memorial Homes to investigate and treat all injuries of unknown origin by completing an Injury Report Form and following protocol on treatment of wounds. The Injury Report Form is used to investigate all injuries to determine if the injury is a result of mistreatment, neglect, or abuse of a resident. . . . An injury of unknown origin is any bruise, abrasion, skin tear, laceration, etc that occurs and is not witnessed by any individual or cannot be explained by the resident; AND the injury is suspicious because of the extent or location of the injury or the frequency of injuries over time is suspicious. . . .	F 226	An Injury Report Form was completed on Residents #7 and #8. Head –to-toe skin assessments will be completed for all current residents and Injury Report Forms will be completed if indicated. Education has been provided to the nursing staff about the importance of reporting resident injuries. The licensed nurses was inserviced about the action to be taken when the resident has an injury, including the completion of a resident injury report. The RN Care Coordinator will investigate the injury and will document the findings of the investigation in the residents' chart. RN Care Coordinators and Licensed Nurses will audit for six months and as needed thereafter to ensure that the injury Report Form has been completed on any skin issues noted by residents. Findings will be reported at the monthly Quality Review Team meetings chaired by the Director of Nursing Services.	11-07 2014

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F 226	Continued From page 4 The injury will be treated or observed until resolved. This will be documented in the treatment book. . . . An Injury Report Form will be completed. The information contained in this investigation form will include a description of the injury as well as information on potential causes of the injury based on staff interview and professional nursing judgement. . . ." - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia without behaviors. The current Minimum Data Set (MDS), dated 08/02/14, identified severe cognitive impairment and transfer/ambulate independently. A nurse's note, dated 05/23/14 at 4:04 p.m., stated, ". . . Nurse was notifed [sic] by staff that resident was bleeding. There is a [sic] upside down V skin tear on her left shin. Steri strips were applied with a gauze dressing. Resident stated she was in little pain." Staff failed to recognize the skin tear as an injury of unknown origin and failed to initiate an investigation to determine the cause for the skin tear. - Review of Resident #7's medical record occurred on all days of survey. The current MDS, dated 09/12/14, identified intact cognition; extensive assistance of one person for transfers, dressing, and toilet use; extensive assistance of two persons for bed mobility, ambulation did not occur, and independent for locomotion on/off the unit. Nurses' notes stated the following: *09/22/14 at 9:14 a.m.: ". . . rest [sic] skin on body	F 226		

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F 226	Continued From page 5 all intact and dry, non-red. . . ." "09/23/14 at 2:04 a.m.: ". . . Noted bruising on residents arms. Back of right upper arm 5cm [centimeters] x 4cm, near outer right elbow 7cm x 8cm, right fore [sic] arm 2cm x 2cm. Left arm 2cm x 4cm, and 1cm x 2cm. Resident not sure of cause thinks she may have bumped something. . . ." The record lacked evidence of monitoring of the bruising or an investigation to determine the cause of the bruising. During an interview on the morning of 10/02/14, a supervisory nurse (#12) stated staff should have filled out an Injury Report Form for the above incidents.	F 226		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279	The RN Care Coordinators and the Licensed Social Workers have updated the care plans to add a focus for pain for Residents #14 and #15, constipation for Resident #12, anxiety for Resident #20, and depression for Resident #26. The RN Care Coordinators and the Licensed Social Workers have reviewed all resident care plans to ensure the care plans are in place to address the residents' specific needs.	

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F 279	Continued From page 6 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to develop a comprehensive care plan for 5 of 27 sampled residents (Resident #12, #14, #15, #20, and #26) that included measurable objectives and interventions to meet the resident's medical and nursing needs related to constipation (#12), pain (#14 and #15), anxiety (#20), and depression (#26). Failure to develop a comprehensive care plan based on resident specific needs does not allow staff to communicate care needs and ensure continuity of care for each resident. The findings include: Review of the facility policy titled "Care Plan/Comprehensive Interdisciplinary" occurred on 10/02/14. This policy, dated September 1998, stated, ". . . A comprehensive care plan will be developed for each resident . . . will include measurable objectives and timetables to meet a resident's medical, nursing and psychosocial needs as identified in the comprehensive assessment. . . . The comprehensive care plan will periodically be reviewed and revised . . . after each resident assessment or assessment review or as needed by significant changes in condition. . . ." - Review of Resident #12's medical record occurred from September 30 through October 02, 2014. Diagnoses included constipation and history of small bowel obstruction.	F 279	The Licensed Nurses have been educated on developing care plans to address the residents specific needs. RN Care Coordinators will audit each other's care plans for six months and as needed thereafter to ensure that the residents' care plans address their specific needs. Findings will be reported at the monthly Quality Review Team meetings chaired by the Director of Nursing Services.	11-07 2014

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F 279	Continued From page 7 Resident #12's medications included Senocot S (stool softener) and Lactulose (stimulant laxative) daily. Orders included Lactulose, milk of magnesia, and bisacodyl suppository as needed (PRN). Standing orders included a fleets enema (stimulant laxative) PRN. The facility failed to develop a care plan specific to Resident #12's constipation and history of small bowel obstruction including interventions to aid in prevention of complications related to constipation. Refer to F309 - Review of Resident #20's medical record occurred on October 01-02, 2014. Medication orders included Ativan 1 milligram [mg] twice daily as needed [PRN] for anxiety, initiated on 07/18/14 and changed to 0.5 mg every 8 hours PRN on 07/21/14. On 08/05/14, the medical provider discontinued Ativan and initiated Klonopin 0.5 mg BID for anxiety. Resident #20's Medication Administration Record (MAR) showed Resident #20 received Ativan 13 times in July and five times in August. Refer to F329. The facility failed to develop a care plan related to Resident #20's anxiety, including a description of Resident #20's behaviors and specific interventions to alleviate her anxiety. - Review of Resident #14's medical record occurred from September 30 through October 02, 2014. Diagnoses included peripheral vascular disease, diabetes, and osteoarthritis. Medication orders for pain included Neurontin 100 mg twice daily and 300 mg at bedtime, Tylenol 650 mg at	F 279		

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bedtime, Tramadol 50 mg twice daily, Biofreeze to affected areas twice daily and as needed twice daily (may keep at bedside), and Tylenol 650 mg every 6 hours as needed.

The facility failed to develop a care plan related to Resident #14's pain.

- Review of Resident #15's medical record occurred from September 30 through October 02, 2014. Diagnoses included a history of a fractured hip. The annual MDS, dated 07/29/14, identified occasional mild pain. A physician's progress note, dated 02/11/14, identified an order for Ultram 50 mg twice daily and as needed in addition to Tylenol 650 mg every 4 hours as needed due to lower back pain after a fall on 02/07/14.

The facility failed to develop a care plan related to Resident #15's pain which required multiple medications to manage the pain.

- Review of Resident #26's medical record occurred on October 01-02, 2014. Diagnoses included depression, rectal cancer, and brain and spinal cord cancer. Medications included Remeron 15 mg at bedtime for depression and poor appetite. The resident began Hospice services on 09/09/14. A significant change MDS, dated 09/15/14, identified mild depression and/or hopeless on several days during the assessment period.

Resident #26's medical record failed to include a facility and Hospice care plan to address depression and possible interventions.

During an interview on 10/02/14 at 8:40 a.m. a social worker (#1) agreed Resident #26's care

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F 279	Continued From page 9 plan should address depression.	F 279		
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 record review, review of facility policy and procedure, review of professional literature, and staff interview, the facility failed to provide the necessary care and services to manage constipation for 1 of 1 sampled resident (Resident #12) with a current diagnosis of constipation and a history of small bowel obstruction. Failure to re-assess the resident's bowel status, develop an individualized care plan, including dietary interventions for the resident's bowel management program, placed Resident #12 at risk for constipation, receiving unnecessary suppositories and enemas and possible repeat small bowel obstruction. Findings include: Review of the facility's policy and procedure, "Bowel Management Program," occurred on 10/02/14. This document, dated May 2005, stated, "I. Purpose: To achieve regular patterned bowel movements [BM] without discomfort or straining by identifying those residents at risk and	F 309	A care plan was developed for Resident #12 to address constipation. The RN Care Coordinators have reviewed all resident care plans to identify any other residents affected by this practice. The nursing staff has been educated on Valley Memorial Homes' bowel management program and the necessity of developing an individualized bowel management care plan for residents who do not benefit from the Valley Memorial Homes bowel management program. The RN Care Coordinators will be auditing for six months and as needed thereafter that the VMH Bowel Management protocol is effective for each resident who receives PRN bowel medications. If not, an individualized bowel care plan will be instituted. Findings will be reported at the monthly Quality Review Team meetings chaired by the Director of Nursing.	11-07 2014

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F 309	Continued From page 10 developing an individualized bowel program. II. Goal: To establish 'normal' healthy bowel evacuation that is individualized to each resident. To promote regular bowel movements without excessive medication use. . . . IV Procedure: A. Identify those residents that may be at high risk for developing constipation, example: . . . 2. History of bowel impaction 3. Narcotic use . . . 5. Recent surgery / immobility . . . C. A step-wise approach to be considered for treatment of constipation: . . . 2. Dietary evaluation to recommend change to increased fluids and fiber: a. Consider prune juice on 2nd and 3rd day without BM. 2. Other interventions as directed by LRD [licensed registered dietician]. 3. Approaches through use of medication: a. BM [less than] 3 times per week, but normal consistency = Bulk or use stimulant laxative. b. Hard to pass stools = use stool softener. . . . d. Normal to hard stools, but strain = stimulant laxatives. . . ." Nursing 2013 Drug Handbook, Lippincot, Williams & Wilkins, 2013, page 583-585, stated, "ferrous sulfate . . . Adverse Reactions, GI [gastrointestinal]: nausea, constipation . . ." Page 644-646, stated, "gabapentin . . . Adverse Reactions . . . GI: constipation . . ." Page 1025-1027, stated, "oxybutynin chloride . . . Ditropan . . . Adverse Reactions . . . GI: constipation . . ." Page 1432, stated, "Percocet 5/325 . . . generic components 325 mg [milligrams] acetaminophen and 5 mg oxycodone hydrochloride . . ." Page 1027-1028, stated, "oxycodone hydrochloride . . . Adverse Reactions . . . GI: constipation . . ." Review of Resident #12's medical record occurred from September 30 to October 2, 2014.	F 309		

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The record showed Resident #12 was hospitalized July 27-31, 2014 for a urinary tract infection (UTI), then again from September 18-22, 2014 for adult failure to thrive, UTI, possible pneumonia, and recurrent anemia. A quarterly Minimum Data Set, dated 08/06/14, identified the resident displayed moderate impaired cognition, required total assistance of two staff for transfers, extensive assistance of two staff for toileting and continent of bowel.

A physician's progress note, dated 09/02/14, stated, "[Resident #12] was recently hospitalized at the end of July . . . She has a history of small bowel obstruction as well. She has some constipation issues over the last couple days, but did have a small bowel movement today, which she reports is normal. . . . Impression/Plan: Abdominal pain, with history of constipation, small bowel obstruction, and urinary tract infection. We will give her a dose of lactulose today. . . ."

Physician orders dated 09/23/14, showed the following:
* Senocot S (stool softener) two tablets orally every day.
* Lactulose (stimulant laxative) 30 cc (cubic centimeters) orally every day.
* Lactulose 10 gm (grams) per 15 ml (milliliters); take 15 ml orally three times daily as needed (prn).
* MOM (milk of magnesia) (stimulant laxative) 400 mg (milligram) per 5 ml suspension orally prn daily.
* Bisacodyl (stimulant laxative) 10 mg rectally every day prn.
* Regular diet texture and supplements determined by LRD.

These same physician orders included the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 following medications with a probability of causing/contributing to constipation: * Ditropan 5 mg daily. * Gabapentin 300 mg three times a day. * Percocet 5/325 mg one tablet three times a day. * Ferrous Sulfate 325 mg twice a day. Resident #12's care plan, last revised 09/02/14, stated "TOILET USE: I require assist of 2 with toileting. . . . Encourage me to get up on the commode once pershift [sic] to help empty my bladder. I am incontinent of bowel some of the time. . . . Focus . . . I am determined to be at nutritional risk due to unstageable pressure ulcers and hx [history] of laryngeal cancer. Does have a hx of CHF [congestive heart failure]. . . . Interventions . . . I receive medication per MD [medical doctor] order, includes: vitamin D3, iron. Provide and serve regular diet. . . . Notify the dietitian of any dietary concerns. LRD to evaluate and make diet change recommendations PRN [as needed]. Provide, serve diet as ordered. Monitor intake and record [every] meal." Resident #12's care plan lacked dietary interventions regarding constipation. Nurse's notes for Resident #12 included the following: * 09/03/14 at 10:54 a.m., ". . . Senna S was increased to 2 tabs daily . . ." * 09/06/14 at 10:22 p.m., "Data: Resident has not stooled for several days now.She [sic] is concerned about it. Action: Gave resident laxative supplement rectally. Response: will monitor and record." * 09/07/14 at 2:42 p.m., "Data: Resident refused enema. Resident is c/o [complaining of]	F 309		

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F 309	Continued From page 13 over [sic] not having a stool. Resident was given a laxative supp [suppository] last night on PM [evening] shift. Action: Response: will monitor and Record." * 09/08/14 at 11:33 a.m., "Data: Started standing order this morning for fleets enema (R) [rectally]. large [sic] hard results. Note in rounding book to increase bowel meds [medications]. . . ." * 09/27/14 at 7:49 a.m., "Data: wrote standing order for fleets enema and administered. Constipated. Action: Response:" The above nurse's notes failed to identify communication with the dietary department concerning Resident #12 experiencing hard stools, the need to increase medications to treat constipation. Dietary notes dated 08/06/14 and 10/01/14 addressed concerns with weight loss, food consumption, and needs related to skin issues. These notes failed to include dietary approaches related to constipation, even after the note from the medical practitioner (09/02/14) identifying a history of small bowel obstruction and constipation while in the facility. August and September 2014 BM records showed Resident #12 failed to have a BM for 3 to 5 days on: * August 2-6 (five days), 15-18 (four days), 22-26 (five days), and 28-30 (three days). * September 2-5 (four days), 10-14 (five days), and 23-26 (four days). The Medication Administration Record (MAR) for August and September 2014 showed nursing staff administered the following prn medications to promote a bowel movement:	F 309		

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F 309	Continued From page 14 August: * Lactulose on the 6th, 18th, 27th and 31st. * Dulcolax suppository on the 7th, 19th, and 23rd. September: * Lactulose on the 3rd and 7th. * MOM on the 4th, 6th, and 26th. * Dulcolax suppository on the 15th and 29th. * Fleets enema the on 8th and 27th. The MARs failed to show staff administered less invasive oral medication prior to the administration of a rectal suppository on 08/23/14, 09/15/14, and 09/29/14, and less invasive rectal suppository medication before administering a fleets enema on 09/08/14 and 09/27/14. Failure to inform dietary of Resident #12's constipation limited their ability to implement dietary interventions to aid in the prevention of further episodes of constipation and the need for a more invasive treatment (suppositories/enemas).	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	The bladder status of Resident #8 has been assessed and the care plans updated to include staff assistance, incontinence products, and a toileting program. The continence status and toileting care plans of all the residents have been reviewed by the RN Care Coordinators.	

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F 315	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care and services to maintain or enhance urinary continence for 1 of 1 sampled resident (Resident #8) with visible soiling of clothing. Failure to assess/re-evaluate Resident #8's toileting needs and provide necessary staff assistance resulted in avoidable incontinence. Findings include: Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia without behaviors and urge incontinence. The current Minimum Data Set (MDS), dated 08/02/14, identified continent of urine and independent with toilet use and personal hygiene. An "Admission Nursing Assessment," dated 05/02/14, identified bladder incontinence and a pull up (incontinence product) used. A "Bladder Assessment Form," (completed quarterly on 05/13/14 and 08/07/14), indicated Resident #8 was "currently continent of bladder." An "Interdisciplinary Care Conference Note," dated 08/29/14, stated, ". . . Action Plan: . . . Incontinence products. . . ." Resident #8's current care plan stated, ". . . I have an ADL [activities of daily living] self-care performance deficit . . . TOILET USE: I am usually independent with toileting. Occ. [occasionally] I require supervision to limited assist of one. . . ." The care plan failed to address Resident #8's diagnosis of urge incontinence	F 315	Education has been provided to all nursing staff on the importance of observing, reporting, and documenting changes in a resident's continence status to the Charge Nurses and the RN Care Coordinators. RN Care Coordinators will audit for six months and as needed thereafter to ensure that CNA documentation related to bowel and bladder is accurate. Findings will be reported at the monthly Quality Review Team meetings chaired by the Director of Nursing Services.	11-07 2014

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F 315	Continued From page 16 and/or use of incontinence products. Observation on 09/30/14 from 07:45 a.m. until 12:44 p.m. showed Resident #8 in a recliner in her room or propelling herself in a wheelchair to/from meals. At 12:44 p.m., a certified nursing assistant (CNA) (#20) assisted Resident into a bath chair. The CNA removed the resident's pants and underwear, which were both wet with urine. Observation showed no incontinence product in place. The CNA then brought the resident to the shower room. The CNA stated Resident #8 toilets herself and is occasionally incontinent. Observation on 10/01/14 at 9:08 a.m. showed a CNA (#19) assisted Resident #8 to the bathroom. Observation showed the resident continent and voided in the toilet, no incontinence product in place, and the CNA failed to offer one to Resident #8 after completing perineal cares. Observation on 10/01/14 at 11:03 a.m. showed Resident #8 seated on her bed, changing her pants and underwear. Observation showed jeans and underwear wet with urine on the floor. A CNA (#19) entered the room and stated, "She had an accident." The CNA failed to assist Resident #8 with personal hygiene and offer an incontinence product. CNA charting for the day shifts on 09/30/14 and 10/01/14 identified Resident #8 as "continent," although observations showed Resident #8 was incontinent of urine on both days. Failure to accurately document Resident #8's continence status may result in a delayed assessment/re-evaluation of her actual toileting needs.	F 315		

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F 315	Continued From page 17 During an interview on 09/30/14 at 4:30 p.m., a staff nurse (#21) identified Resident #8 as independent with toileting, but staff check on her periodically. The nurse stated Resident #8 does not voice a need to use the bathroom or alert staff if she is wet, so staff need to anticipate her needs. The nurse also stated staff have found Resident #8 in her room, washing her wet underwear and pants in the sink. The facility failed to develop and implement a toileting plan and offer adequate assistance to maintain/promote Resident #8's urinary continence. As a result, Resident #8 experienced avoidable urinary incontinence, soiled clothing, and a loss of dignity.	F 315		
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 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: ELOPEMENT 1. Based on record review and review of facility policy, the facility failed to provide supervision and assistive devices necessary to maintain resident safety and prevent accidents for 1 of 2 sampled residents (Resident #8) who eloped from the	F 323	A Roam Alert bracelet was placed on Resident #8 on July 27 and the care plan was updated on July 28. The care plan for Resident #15 was updated so that footrests are to be put on the resident's wheelchair if staff is providing transport assistance. The RN Care Coordinators have reviewed all resident care plans to ensure that Elopement Risk Assessments have been completed and each resident's cognition and mobility have been assessed and Roam Alert bracelets applied if	

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F 323	Continued From page 18 facility. Failure to ensure Resident #8's safety through re-assessment of elopement risk and implementation of a RoamAlert (personal safety alarm) system resulted in Resident #8's elopement from the facility. Findings include: Review of the facility policy titled "Elopement Risk Assessment" occurred on 10/02/14. This policy, dated 02/27/06, stated, ". . . It is the policy of Valley Memorial Homes to attempt to prevent elopements from its skilled nursing facilities. This is achieved by assessment and implementation of interventions for resident safety. . . . In conjunction with the admission MDS [Minimum Data Set], the Care Coordinator and Social Worker will complete an Elopement Risk Assessment form on every resident with input from the Therapeutic Recreation staff. . . . At the Care Coordinator's discretion the following items could be considered for reassessing residents for elopement risk. a. Change in sleep patter [sic] b. Change in eating pattern c. Increased agitation d. New/change in medical condition/mediations [sic] e. Significant change in patient behavior . . ." Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia without behaviors. The resident's current Minimum Data Set (MDS), dated 08/02/14, identified severe cognitive impairment. An "Elopement Risk Assessment," dated 05/02/14 (the date of Resident #8's admission), identified Resident #8 as a "Low Risk" for	F 323	deemed necessary. The RN Care Coordinators added the statement "Must use leg rests during transport" to the CNA assignment sheets for the appropriate residents. Education was provided for all nursing staff regarding what action is to be taken to prevent and respond to resident elopement and the importance of using foot rests on resident wheelchairs if the staff is transporting a resident. Licensed Nurses will audit for six months and as needed thereafter to ensure the footrests are used during wheelchair transport. Unsafe wandering and elopement events are investigated per facility policy. Footrest audit results, unsafe wandering, and elopements will be reported at the monthly Quality Review Team meetings chaired by the Director of Nursing Services.	11-17 2014

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F 323	Continued From page 19 elopement. Nurses' notes identified the following: *05/05/14 at 11:08 a.m.: ". . . Husband here, wants to take resident out in the car. . . . Note that resident had room all packed this am and stated she is going home today. For safety reasons, will deny pass at present time. . . ." *05/14/14 at 3:56 p.m.: ". . . Today at lunch, resident demanded to go home with him [husband] and got her coat on in order to leave. . . ." *06/12/14 at 6:43 p.m.: ". . . Resident called husband this shift very upset and telling him to come get her, swearing at him. . . . Resident has had increased behaviors with wanting to leave and went to 300 unit this afternoon and was escorted back by staff. . . ." *06/13/14 at 10:57 a.m.: ". . . Resident packed all belongings on her bed and states, 'I'm leaving.' Resident has verbalized frustration with 'husband leaving her here for 2 days.' . . ." *07/16/14 at 9:31 a.m.: ". . . packed up ready to leave, waiting for husband to come. unable to reason with. wanted MD [medical doctor] called 'I am being held against my will.' . . ." *07/19/14 at 2:04 p.m.: ". . . Resident found sitting in VEC [Valley Eldercare] parking lot. Care coordinator notified, will need to get wander guard put on. . . ." *07/19/14 at 3:42 p.m.: ". . . States that her husband is in the hospital so she went to see him. While on her way to see him she states he [sic] car was stolen as she did not see it in the parking lot. Brought back in by security. . . . Communicated to staff to watch resident closely as she will go for the exit doors. Husband [name] did call facility to tell staff she was outside as she called on her cell phone. She told him 'I'm outside	F 323		

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F 323	Continued From page 20 in the parking lot,' and then [husband] called staff to alert. . . ." *07/20/14 at 6:30 p.m.: ". . . Res. [resident] was returned to 400 unit by an off duty staff member. Stated res. was outside by Altru Cancer Center in the parking lot. Res. is weepy and confused. Stated that her car broke down. . . . Applied wanderguard to res. right wrist. . . ." Although Resident #8 expressed a desire to go home, packing behaviors, and wandering into other nursing units staff failed to re-assess her elopement risk and/or place a RoamAlert bracelet until the resident eloped twice from the facility. These elopements had the potential to result in serious harm to Resident #8. WHEELCHAIR FOOT PEDALS 2. Based on observation, record review, and staff interview, the facility failed to provide assistive devices necessary to prevent accidents for 1 of 5 sampled residents (Resident #15) observed without wheelchair foot pedals in place. Failure to apply foot pedals to wheelchairs during staff-assisted transport may result in falls and /or injuries to the residents. Findings include: Review of Resident #15's medical record occurred from September 30 through October 2, 2014. Diagnoses included dementia, abnormal gait, and a history of a hip fracture. The quarterly Minimum Data Set, dated 07/29/14, identified extensive assistance required for transfers. Observation on 09/30/14 at 12:30 p.m., identified a certified nursing assistant (CNA) (#16)	F 323		

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F 323	Continued From page 21 transported Resident #15 down the hall to the resident's room without foot rests in place. At 4:35 p.m. another CNA (#17) transported Resident #15 down the hall to the dining room without foot rests in place. The CNAs did not ask the resident to lift her feet up. Her feet/shoes made an audible noise as they slid along the surface of the floor. During an interview on 10/02/14 at 8:25 a.m., an administrative nurse stated staff do not use wheelchair foot rests when transporting residents within their own nursing units. This practice places the residents at risk of injury during transport in a wheelchair.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to provide adequate fluid intake/monitoring for 1 of 1 sampled resident (Resident #15) with a history of urinary tract infections (UTI) and dependent on staff for fluid intake. Failure to provide adequate fluid intake may result in dehydration and UTIs. Findings include: Review of the facility's policy titled "Hydration/Dehydration" occurred on 10/01/14.	F 327	The Intake and Output for Resident #15 has been monitored since October 2, 2014. The RN Care Coordinators have reviewed all residents for potential dehydration and to ensure that intake is being recorded for these residents. All nursing staff has been educated on the importance of recording Intake and Output. The Licensed Nurses will complete monthly audits for six months and as needed thereafter to ensure that Intake and Output is recorded for the appropriate residents.	

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F 327	Continued From page 22 The policy, dated March 2003, stated, ". . . The RN [Registered Nurse] Care Coordinator and Dietitian will work together in formulating a plan of care to meet the needs of residents that have been identified as being at risk for dehydration . . . interventions may include . . . a. Intake recording with specific goals for each shift . . . The Charge Nurse will be responsible to check intake monitoring at the end of each shift and to ensure it is recorded on the MAR [Medication Administration Record]. . . ." Review of Resident #15's medical record occurred from September 30 through October 2, 2014. Diagnoses included dementia and a history of UTIs. The annual Minimum Data Set, dated 07/29/14, identified severe cognitive impairment and extensive assist for activities of daily living including eating. The current care plan stated, "Focus: . . . at risk for dehydration or potential fluid deficit . . . Date Initiated: 7/31/2014 . . . Goals: . . . drink/take in a minimum of 1650 cc's [cubic centimeters] each 24-hour period . . . Interventions: . . . I need assistance/encouragement with fluid intake . . . Monitor and document intake and output per facility policy. . . Focus: I have a Urinary Tract Infection r/t [related to] Poor oral intake . . . Date Initiated 7/30/14 . . . Interventions: Encourage me to have adequate fluid intake. Monitor my intake and output. . . ." Review of the physician's progress notes identified a UTI with antibiotic treatment in January and July 2014. Review of the "Plan of Care - Intake & Output" record identified staff had not documented intake/output since 07/31/14. Observation on 09/30/14 at 8:15 a.m., showed a	F 327	Findings will be reported at the monthly Quality Review Team meetings chaired by the Director of Nursing Services.	11-07 2014

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F 327	Continued From page 23 certified nursing assistant (CNA) (#16) transferred Resident #15 from the bed to the shower chair. The CNA did not offer the resident any fluids before taking the resident to the shower room. During an interview on 09/30/14 at 12:45 p.m., a CNA (#17) verified staff did not document intake or output for Resident #15. During an interview on 10/01/14 at 4:20 p.m., a nurse manager (#12) stated staff should have documented intake/output for Resident #15 since 07/31/14.	F 327		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	The care plan for Resident #20 has been updated to include a focus to address the resident's anxiety. The resident has a behavior log in place. All resident care plans have been reviewed to ensure any residents who receive antipsychotic medications have a care plan and behavior log in place that addresses the reason for the antipsychotic medication. Residents who have a PRN order for psychotropic medication also have a PRN Psychotropic Medication MAR which	

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F 329	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to ensure a medication regimen free from unnecessary medication for 1 of 3 sampled residents (Resident #20) who received an as needed (PRN) antianxiety medication. Failure to adequately assess Resident #20's behavior; failure to develop a plan of care with individualized non-pharmacological interventions, and implement those interventions prior to administering an antianxiety medication; and failure to distinguish between the resident's need for pain medication or a PRN dose of antianxiety medication may have resulted in Resident #20 receiving unnecessary antianxiety medication and experiencing adverse reactions or consequences related to its use. Findings include: Review of the facility policy and procedure titled "Psychotropic Drugs" occurred on 10/02/14. This procedure, dated December 2012, stated, "I. Purpose: Each resident's drug regimen must be free from unnecessary drugs. II. Procedure: . . . H. Drug Monitoring: 1. Residents receiving psychotropic medications will be monitored using the Psychoactive Monthly Flow Record . . ." Review of Resident #20's medical record occurred on October 01-02, 2014. Medication orders included Ativan 1 milligram [mg] twice daily	F 329	requires the nurse to chart on the behaviors and interventions tried before administering the mediation. The Staff Development/Infection Control Nurse will complete monthly audits for six months and as needed thereafter to ensure that interventions are attempted before giving a PRN medication and that the effectiveness of the PRN medication is being documented. The care plan focus will be audited under the corrective actions for F279. Findings will be reported at the monthly Quality Review Team meetings chaired by the Director of Nursing Services.	11-10 2014

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F 329	Continued From page 25 [BID] PRN for anxiety, started 07/18/14 and changed 07/21/14 to 0.5 mg every 8 hours PRN. On 08/05/14, the Ativan was discontinued and Klonopin 0.5 mg BID for anxiety was started. The facility failed to develop a care plan related to Resident #20's anxiety, including a description of her behaviors and specific interventions to alleviate her anxiety, including non-pharmacological interventions. See F279. Review of Resident #20's July and August 2014 Medication Administration Records (MAR) showed Resident #20 received PRN Ativan 13 times in July and five times in August. Staff documented the reason for administering Ativan as "anxiety" on 14 occasions, "yelling out anxiety" once, "restlessness" once, "agitation" once, and "prior to dressing/anxiety" once. Staff documented the resident's response to Ativan as "relief" or "resting" 14 times, "sleeping" three times, and undocumented once. Staff failed to identify the specific symptoms of her anxiety and failed to try non-pharmacological interventions prior to administering the Ativan. A nursing progress note, dated 08/05/14 at 3:52 p.m., stated, "Received order to DC [discontinue] Ativan d/t [due to] not helpful and start klonopin 0.5mg po [orally] BID for anxiety. . . ." The results charted on the MAR by nursing staff of the effectiveness of the Ativan contradicts this progress note. The MARs also identified staff administered a pain medication at the same time as the Ativan on 10 of the 18 occasions. This practice does not allow staff to evaluate the effectiveness of each medication, and may lead to the resident	F 329		

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F 329	Continued From page 26 receiving unnecessary medication, as treating one symptom may alleviate the other symptoms also. During an interview on 10/02/14 at 11:53 a.m., a nursing supervisor (#11) agreed Resident #20's record lacked evidence staff identified her specific anxiety behaviors or tried non-pharmacological interventions prior to administering the Ativan.	F 329		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the attending physician reviewed and acted upon the consulting pharmacist's report of medication recommendations for 5 of 6 sampled residents (Resident #2, #3, #7, #15, and #18) reviewed. Failure to ensure the physician reviewed the consulting pharmacist recommendations has the potential to affect all resident's highest practicable level of functioning.	F 428	The Pharmacy Recommendation Forms for Resident #2, 3, 7, 15, and 18 have been sent to their primary physician for their review and signature. The licensed nurses has been educated that the Pharmacy Recommendations need to be signed by the residents' primary physicians. All pharmacy recommendations made by the consultant pharmacist since September 1st have been sent to the residents' physicians for their review and any order changes. The Director of Nursing Services will audit all pharmacy recommendations for six months and as needed thereafter to ensure that pharmacy recommendations have been signed	

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F 428	Continued From page 27 Findings include: Review of the facility policy titled "Psychotropic Drugs" occurred on 10/01/14. This policy, dated December 2012, stated, ". . . If a Physician does not want to follow Pharmacy recommendations . . . the Physician is required . . . to provide the facility with written justification of why a drug is being used outside the guidelines. The Charge Nurse will request this documentation from the Physician. . . ." - Review of Resident #2's medical record occurred on all days of survey. A pharmacy review with recommendations, completed on 06/30/14, lacked evidence of physician review/recognition of the pharmacist's findings. - Review of Resident #3's medical record occurred on all days of survey. A pharmacy review with recommendations, completed on 08/26/14, lacked evidence of physician review/recognition of the pharmacist's findings. - Review of Resident #7's medical record occurred on all days of survey. A pharmacy review with recommendations, completed on 08/26/14, lacked evidence of physician review/recognition of the pharmacist's findings. - Review of Resident #15's medical record occurred on all days of survey. A pharmacy review with recommendations, completed on 12/19/13, lacked evidence of physician review/recognition of the pharmacist's findings. - Review of Resident #18's medical record occurred on all days of survey. A pharmacy review with recommendations, completed on	F 428	by a physician. Findings will be reported at the monthly Quality Review Team meetings chaired by the Director of Nursing Services.	11-17 2014

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F 428	Continued From page 28 02/17/14, lacked evidence of physician review/recognition of the pharmacist's findings. During an interview on 10/01/14 at 5:30 p.m., a nurse manager (#12) verified either the physician or the nurse practitioner is expected to sign the pharmacist's medication recommendations. This conflicts with the requirement that the attending physician act upon those issues identified that require physician intervention.	F 428		
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.	F 441	CNAs who care for Residents #1, 3, 5, 7, 8, 9, 12, and 14 have been audited and skills validated for appropriate technique for peri cares/toileting, and hand hygiene. The Licensed Nurses have been audited for appropriate technique during dressing changes for Residents #1, 5, and 12. Education has been completed with all nursing staff regarding hand hygiene and peri cares/toileting of residents and with the Licensed Nurses with hand hygiene/instrument cleaning with dressing changes. CNAs will be audited and skills validated for hand hygiene while assisting residents with peri cares/toileting.	

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F 441	Continued From page 29 (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, review of facility policy, review of professional literature, and staff interview, the facility failed to follow standard infection control practices for 8 of 18 sampled residents (Resident #1, #3, #5, #7, #8, #9, #12, and #14) observed during personal cares and/or dressing changes. Failure to follow infection control practices related to handling of medical equipment (scissors), glove usage, and hand hygiene has the potential to spread infection within the facility. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 694, states, "STANDARD PRECAUTIONS . . . 1. Perform proper hand hygiene after contact with blood, body fluids, secretions, excretions, and contaminated objects whether or not gloves are worn. a. Perform proper hand hygiene immediately after removing gloves. . . . 5. Handle client care equipment that is soiled with blood, body fluids, secretions, or	F 441	The Licensed Nurses have been audited for dressing change technique. The Licensed Nurses and the Staff Development/Infection Control Nurse will complete random audits for six months and as needed thereafter to ensure proper hand hygiene during peri cares/toileting. The Staff Development/Infection Control Nurse will audit the Licensed Nurses' for six months and as needed thereafter to ensure hand/instrument hygiene during dressing changes. Findings will be reported at the monthly Quality Review Team meetings chaired by the Director of Nursing Services.	11-17 2014

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excretions carefully to prevent the transfer of microorganisms to others and to the environment. a. Make sure reusable equipment is cleaned and reprocessed correctly. . . ." Page 695 states, ". . . The hands are cleansed each time gloves are removed for two primary reasons: (a) the gloves may have imperfections or be damaged during wearing so that they could allow microorganisms entry and (b) the hands may become contaminated during glove removal. . . ."

Review of the facility policy titled "Hand Hygiene" occurred on 10/02/14. This policy, revised 08/10, stated, ". . . IV. When to wash hands or use waterless antiseptic solution A. Appropriate hand hygiene must be performed under the following conditions: . . . 2. Whenever hands are obviously soiled (hand washing with soap and water); before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice) . . . 7. Before and after assisting a resident with personal care . . . 10. Before and after changing a dressing . . . 13. Before and after assisting a resident with toileting . . . 16. After contact with a resident's mucous membranes and body fluids or excretions . . ."

- During an observation on 09/30/14 at 9:25 a.m., the nurse (#2) donned gloves, removed the dressing on Resident #1's right ischial ulcer, and removed her gloves. Without performing hand hygiene, the nurse (#2) donned and removed her gloves on three occasions during the dressing change. The nurse (#2) washed her hands when the dressing change was completed.

During an observation on 09/30/14 at 2:54 p.m., the nurse (#2) donned gloves, removed the dressing on Resident #1's right achilles ulcer, and

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F 441	Continued From page 31 removed her gloves. Without performing hand hygiene, the nurse (#2) donned and removed her gloves on two occasions during the dressing change and used hand sanitizer when completed. The nurse (#2) donned gloves, and using the same gloves removed the dressing on Resident #1's left medial knee ulcer, left lateral knee ulcer, and left posterior knee ulcer and then removed her gloves. Without performing hand hygiene, the nurse (#2) donned and removed her gloves on four occasions during the dressing changes. The nurse (#2) donned gloves, removed the dressing on Resident #1's left lower lateral leg ulcer, and removed her gloves. Without hand hygiene the nurse (#2) donned and removed her gloves on two occasions during the dressing change. The nurse (#2) used hand sanitizer when the dressing changes were completed. - During an observation on 09/30/14 at 09:40 a.m., a nurse (#13) donned gloves and removed a dressing from Resident #5's right forearm. Without removing her gloves, the nurse (#5) cleansed the skin tear with normal saline, applied xeroform (sterile mesh gauze) and telfa (non-stick pad) to the wound. The nurse failed to remove her gloves and perform hand hygiene before applying a clean dressing. - During an observation on 10/01/14 at 9:25 a.m., two nurses (#3 and #8) provided a dressing change for Resident #12. The nurse (#3) removed the soiled dressing from the resident's right heel/ankle with a bandage scissors. The nurse (#3) then cleaned the scissors with normal saline and a gauze pad. Using the same scissors, the nurse (#3) cut clean gauze from a roll and wrapped Resident #12's heel/ankle. The nurse failed to properly sanitize the scissors before	F 441		

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F 441	Continued From page 32 using it to cut the clean dressing. During an interview on 10/01/14 at 5:00 p.m. an administrative nurse (#15) stated she expected staff to change gloves and perform hand hygiene after removing a dressing. - During an observation on 09/30/14 at 7:50 a.m., a CNA (#14) went into Resident #14's room, donned gloves, emptied the resident's urinal into the toilet, changed the resident's soiled incontinence brief, cleaned off the toilet seat with a sani-wipe, and removed his/her gloves. The CNA failed to perform hand hygiene before leaving the room and entering another resident's room to assist a CNA with a mechanical lift transfer. The CNA (#14) assisted with the transfer, donned gloves, cleaned the lift with a sani-wipe, removed gloves, combed the resident's hair, removed the lift from the room, removed clean towels from a linen cart in the hall, and entered another resident's room without performing hand hygiene. - Observation on 09/30/14 at 8:46 a.m. showed a CNA (#18) assisted Resident #9 with morning cares. The CNA performed a bed bath (including perineal care), removed her gloves, assisted the resident with dressing, and transferred the resident to her wheelchair using a mechanical lift. The CNA then washed Resident #8's glasses, combed her hair, assisted her to brush her teeth, and brought the resident to the parlor area. Without performing hand hygiene, the CNA then put on gloves and made toast for the resident. The CNA failed to perform hand hygiene after completing perineal care. - During an observation on 09/30/14 at 11:10	F 441		

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F 441	Continued From page 33 a.m., two CNAs (#4 and #5) transferred Resident #12 to a commode using a full body mechanical lift. A CNA (#4) provided perineal cares after Resident #12 voided. Without removing the gloves, the CNA (#4) adjusted the resident's oxygen tubing, assisted in positioning the resident in bed, and removed the toileting sling from under the resident. The CNA (#4) then removed her gloves. Without completing hand hygiene, the CNA (#4) placed a different sling under the resident, assisted to transfer the resident from her bed to her wheelchair with the lift, changed the oxygen supply from the concentrator to the oxygen tank on the resident's wheelchair, made the resident's bed, and gave the resident her hair brush. The CNA failed to complete hand hygiene after performing perineal cares and before completing other tasks. - During an observation on 09/30/14 at 12:56 p.m., two certified nursing assistants (CNAs) (#6 and #7) utilized a full body mechanical lift and transferred Resident #3 from her wheelchair to the bed. The CNA (#7) donned gloves, removed the resident's brief soiled with stool, removed her gloves, and used hand sanitizer. The CNA (#7) donned gloves, completed perineal cares, removed her gloves, and applied a clean incontinent product. The CNA (#7) adjusted Resident #3's pillow, covered her with a blanket, handed the call light to the resident, gave her a drink of water, and then used hand sanitizer before exiting the room. The CNA (#7) failed to perform hand hygiene after completing perineal care and prior to completing other tasks. - Observation on 10/01/14 at 9:08 a.m. showed a CNA (#19) assisted Resident #8 with perineal cares in the bathroom. The CNA then removed	F 441		

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F 441	Continued From page 34 her gloves, pulled up Resident #8's underwear/pants, ambulated with the resident to her wheelchair, removed the gait belt, and transported Resident #8 to the lounge area. The CNA failed to perform hand hygiene after completing perineal care and before exiting the room. - Observation on 10/01/14 at 10:52 a.m. showed a CNA (#19) checked and changed Resident #7's brief as she lay in bed. The resident was incontinent of urine, and the CNA performed perineal care. The CNA then removed her gloves, assisted the resident to transfer from her bed to the wheelchair, removed the gait belt, and left the room without performing hand hygiene.	F 441		