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	355092	A. BUILDING _____ B. WING _____ MAR 1 2010	02/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 02/02/2010 and completed on 02/04/2010, the sample included 2 residents for complete review, 9 residents for focused review, and 1 closed record for review. In addition, 2 residents were added to the sample to verify specific concerns during the survey.	F 000		
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a comprehensive assessment for 1 of 11 sampled residents (Resident #6) whose Minimum Data Sets (MDSs) showed a decline. Failure to complete a significant change assessment, due to a decline in Resident #6's physical function and bowel and bladder continence, limited the facility's ability to determine if the decline would resolve, or required further assessment/intervention, and placed the	F 274	F 274 1. Resident # 6 had a MDS assessment on 12/3/09. Her assessment and care plan reflect her status and plan of care. 2. Residents with a significant change in their condition have the potential to be affected. 3. The interdisciplinary MDS team will attend morning report which will inform them of changes in resident condition. The team will monitor the resident's condition to identify significant changes. A significant change MDS will be done when indicated and interventions put in place after a significant change was identified. 4. 10% of residents will be reviewed for significant change and appropriate intervention monthly x 3 and at 6 months by the QA Coordinator and/or nursing management. Findings will be reported to the QA Committee.	3/11/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Corey Armitage	Administrator	2/25/10

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 274	Continued From page 1 resident at risk for further functional decline. Findings include: Centers for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, Revised December 2008, Chapter 2: Using the RAI (Resident Assessment Instrument), pages 2-7 to 2-9 states: "A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical intervention, is not self-limiting, 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . . The final decision regarding what constitutes a significant change in status must be based upon the judgement of the clinical staff and the guidelines shown below. Decline in two or more of the following: . . . Any decline in an ADL, physical functioning area where a resident is newly coded as 3, 4, or 8 . . . for Item G1A. . . . Resident's incontinence pattern changes from 0 or 1 to 2, 3 or 4 . . . " Review of Resident #6's medical record occurred February 2-4, 2010, and showed the facility completed an annual (MDS) for Resident #6 on 06/03/09 and a quarterly MDS review on 09/03/09. The MDS completed 06/03/09 identified Resident #6 as continent of bowel and bladder, and ambulating in her room with the extensive assistance of two staff. The quarterly review completed 09/03/09 identified Resident #6 as frequently incontinent of bladder, occasionally incontinent of bowel, and no longer ambulating in her room.	F 274		

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F 274	Continued From page 2 The record lacked evidence the facility completed a comprehensive MDS following the significant change in health/physical status, nor did the record reflect the facility determined the areas of decline would resolve, and the changes did not require interdisciplinary review and revision to Resident #6's plan of care. Resident #6's record included no assessment of cause/contributing factors (including any relationship to the decline in ambulation) resulting in Resident #6's significant change in bowel/bladder continence. The plan of care for Resident #6 showed no changes in regard to the management of the residents bowel and bladder continence, and included no interventions to assist Resident #6 in restoring bowel and/or bladder continence. On the morning of 02/04/10, during an interview with an MDS coordinator for the facility (#12), the staff person confirmed Resident #6 experienced a significant change in function at the time of the 09/03/09 quarterly review, and the facility did not complete a comprehensive assessment and/or address the significant change.	F 274		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION 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	F 323	F323 1. Residents # 2 and # 10 will be transferred using gait belts. A therapist did assess resident # 7's transfers on 2/22/10 and ordered "Standup lift transfers with 2 assist. If resident fails to hold on with arms or use feet, stop and use a full lift."	3/11/10

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F 323	Continued From page 3 by: Based on observation, record review, review of facility policy and procedures, review of the E/Z stand operating instructions, and staff interview, the facility failed to ensure 3 of 8 sampled residents (Resident #2, #7 and #10) observed requiring staff assistance with transfers, received adequate assistance devices to prevent accidents. Failure to provide adequate assistance devices has the potential to cause harm to the affected residents. Findings include: Review of the facility policy titled, "RESIDENT TRANSFERS," occurred on 02/04/10. This policy, dated 06/21/04, stated: "NO LIFT POLICY - Use mechanical lifts rather than manual lifting when * The resident is unable to bear weight * The resident is combative and unable to follow simple instructions * The resident is unable to offer assistance . . . If it is expected pushing, pulling, or lifting force will exceed 50# [fifty pounds], the caregiver must use a mechanical lift. A gait belt is not a substitute for a mechanical lift in situations in which the resident is too heavy to be manipulated by staff . . . Procedure: 1. All residents must be transferred as stated in their ADL [activities of daily living] care plan. Assistive devices-gait belts, walkers, canes, mechanical lifts will be used according to the ADL care plan. 2. See procedure manual for proper use of mechanical equipment. 3. All residents will be monitored and appropriate assistance will be offered in an	F 323	2. All residents requiring assistance with transfers have the potential to be affected. 3. The transfer policy was revised to include "Gait belts will be used by staff with residents requiring weight bearing assistance or assistance with balance and stability during ambulation or transfers". The manufacturer's instructions for appropriate use of the standup lift were reviewed at the CNA meeting on 2/23/10 as was the revision to the transfer policy. All residents' transfer methods were reviewed by the Nursing Safety Committee on 2/18/10. Individual resident transfer methods were reviewed for each resident at the CNA meeting on 2/23/10. The nursing safety committee will continue to review all residents monthly for the appropriateness of the current transferring methods and assistive devices needed. Professional therapy services will be consulted when questions remain regarding the appropriate transfer method. 4. The Safety Director or nursing management will audit 20% of CNA's assisting residents with transfers for compliance with care planned transfer	

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F 323	Continued From page 4 attempt to prevent falls and injuries. . . . Staff members who do not follow the transfer as stated in ADL care plan shall be subject to the disciplinary process. Staff members will work with resident to find most comfortable and safest transfer procedure. . . ." Review of the facility E/Z Stand operating instructions occurred on 02/04/10. The instructions stated, ". . . Patients should be able to bear some weight. . . . TRANSFERRING THE PATIENT: . . . RAISE THE PATIENT 1) Position patient's arms on the outside of the harness and place their hands on the padded handles. 2) Take the hand control and stand beside the patient. Press the UP button. Stop lifting when the patient is in a standing position. . . ." - Review of Resident #2's medical record occurred on all days of survey. Resident #2's medical diagnoses included osteoarthritis, lymphoma (cancer), chronic myalgia syndrome, and a right scapular (shoulder) fracture due to a fall which occurred in August of 2009. A "QUARTERLY STATUS REPORT," dated 11/24/09, stated, ". . . Comments: [Resident] requires extensive assist of 1-2 with all activities of daily living. He requires assist of one with transfers and ambulation as well as a walker. . . . had multiple falls after admission to facility. Interventions are in place to minimize injury in case of future falls." A RAP [Resident Assessment Protocol] Summary, dated 08/31/09, stated, ". . . Falls: [Resident] had a fall within the past 30 days prior to admit resulting with a fracture. Interventions are in place to minimize injury in case of future falls. . . ."	F 323	assist and appropriateness of that level of assist weekly x 2 and at 1, 3 and 6 months. Findings will be reported to the QA Committee.	

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F 323	Continued From page 5 Resident #2's current care plan identified the following problems and approaches: * ". . . at risk for falls. He has a history. . . ." with approaches of "Fall committee to be involved as appropriate with fall review and suggestions for preventing falls or injury. . . . Nursing, activities . . . to Observe for decrease or loss of functional status on daily basis . . . See ADL flow sheet for all specific fall precaution measures in place." * ". . . requires extensive assist with . . . transfers, toileting, personal hygiene and mobility" with approaches of ". . . Cna [CNA] staff 1-2 assist with all transfers . . . See current ADL flow sheet." * ". . . health problems or diagnosis that require assist . . . 1/1/10 receiving chemotherapy @ [at] this time in Bismarck . . ." Review of Resident #2's February 2, 2010 ADL flow sheet identified the resident required extensive assistance of one person with transfers. An ADL flow sheet, dated 11/11/09, identified a hand written, circled entry, which stated "gaitbelt." An observation of cares provided by two CNAs (#3 and #5) occurred on 02/03/10 at 8:45 a.m. The two CNAs transferred Resident #2 from his wheelchair to the toilet, and from the toilet to the wheelchair without providing or utilizing any type of assistive device. Observation showed the CNAs reach under the resident's axilla (armpits), steadied the resident by grasping the back of his pants, and guide the resident by the hands. An interview occurred after the observation on the morning of 02/03/10 with a CNA (#3). The CNA (#3) stated, during morning report, nursing staff	F 323		

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F 323	Continued From page 6	F 323		

informed the CNAs, Resident #2 was weak due to a trip to and from Bismarck the proceeding day. She stated that was why two staff provided assistance on this morning. The CNA (#3) stated previously the resident walked with a walker, and one staff member used a gait belt.

A second assisted transfer observation occurred at 12:40 p.m. on 02/03/10 provided by the same two CNAs (#3 and #5) utilizing a gait belt.

A meeting occurred with three administrative nursing staff members (#1, #6 and #7) on the morning of 02/04/10. A staff member (#6) stated nursing staff are not required to utilize gait belts on all residents who require extensive assistance with transfers which conflicts with the facility's policy.

Failure to provide Resident #2 proper assistive devices/assistance during all transfers has the potential to cause the resident harm or injury. Holding Resident #2 under the axilla for transferring has the potential to cause this resident pain and/or additional injury to his previously injured shoulder.

- Observation of two CNAs (#14 and #15) assisting Resident #10 to the bathroom occurred at 3:45 p.m. on 02/03/10. Observation showed the CNAs transferred Resident #10 from bed to her wheelchair without the use of a gait belt. The CNAs assisted the resident to a standing position by placing their hands/arms under the residents arms/shoulders and pulling the resident upward to a standing position during pivot transfer to the wheelchair.

Transfer of Resident #10 from the wheelchair to

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F 323	Continued From page 7 the toilet showed the CNAs (#14 and #15), held/supported the resident under her arms, grabbed the waistband at the back of the resident's slacks, and lifted/pulled the resident to a standing position. Review of Resident #10's medical record occurred on 02/04/10. Resident #10's most recent MDS review, completed 01/08/10, indicated the resident required extensive assistance of one person with transfers and toilet use, and required partial physical support during standing for balance purposes. The record showed Resident #10's diagnoses included arthritis, osteoporosis, and back pain. A "Pain Management Review Note" dated 01/08/10, stated, "Resident on pain management program for back pain - back pain increased in November - pain medication increased in response. Since pain medication increased resident has had minimal c/o [complaints of] pain to staff." Physician orders showed Resident #10 received ER (extended release) Tylenol 650 mg (milligrams) two tablets twice daily and Lortab 5/500 mg one tablet twice daily. The physician orders showed the physician added the Lortab to Resident #10's pain management medications on 11/05/09. The record lacked any evidence the facility assessed Resident #10's transfer needs in response to the resident's increased back pain. The resident's plan of care did not specify the need for use of a gait belt during transfer, but rather identified the resident's transfer needs as "assist of 1, stand up lift PRN [as needed]."	F 323		

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F 323	Continued From page 8 During an interview with administrative nursing staff members (#1, #6, and #7) on the morning of 02/04/10, the staff members indicated staff would use the standing lift for transfer if the resident were ill. The staff members also indicated the facility no longer used gait belts on a regular basis because a staff member got hurt using a gait belt on a resident. Failure to assess Resident #10's individual transfer needs, and implement transfer approaches to minimize pain and/or injury to the resident and/or staff, placed the resident at risk for avoidable/increased pain and injury. - Observation at 1 p.m. on 02/02/10 showed two CNAs (#3 and #13) assist Resident #7 with transfer from wheelchair to the toilet using a standing lift. Throughout the transfer, Resident #7 showed minimal awareness/alertness to her surroundings and the instructions given by the CNAs. The CNAs continually instructed/prompted Resident #7 to hold onto the grab bars. The resident briefly placed her hands on the grab bars, never firmly gripping the grab bars. Within a few seconds, observation showed the resident's hands repeatedly slipped downward and off the grab bars, only to be cued again by the CNAs to 'hold on." During the transfer process, the lift sling moved upward on the resident's upper torso, placing increased pressure to the resident's underarms and shoulders. Resident #7's plan of care identified the residents transfer needs/approaches included, "Extensive assistance of two, standing lift PRN." The record lacked any evidence of an assessment of Resident #7's transfer needs/problems, and lacked responding/resulting	F 323		

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F 323	Continued From page 9 approaches/interventions to ensure the resident's safety and comfort.	F 323		
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, and staff interview, the facility failed to maintain an infection control program designed to provide a sanitary environment and prevent the transmission of disease and infections for 5 of 9 sampled residents, and one supplemental resident (Resident #2, #5, #6, #9, #11 and #14) observed receiving care by facility staff. Findings include: Review of the facility policy titled, "HAND HYGIENE," occurred on 02/04/10. The policy, dated 11/13/09, stated: "When to perform hand hygiene . . . * Before and after each resident contact or assisting a resident with personal care * After touching a resident or handling his or her belongings * Before and after nursing procedures	F 441	F441 1. Residents # 14, #2, #9, # 6, #8, #5 will receive care observing appropriate gloving and hand hygiene. Disinfection of surfaces will be completed after contamination by body fluids or secretions. 2. All residents requiring assistance with personal cares or treatments have the potential to be affected. 3. The hand hygiene policy was revised to include hand washing with soap and water after toileting. Wording was added to the Toileting and Peri-care policy to include a. "*Staff members will be required to wash hands prior to getting additional supplies from clean areas (ex. glove or wipe boxes, resident's room, etc.) after hands/gloves have been contaminated.*" b. "Remove and discard gloves and wash hands with soap and	3/11/10

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F 441	Continued From page 10 * After invasive procedures or contact with any body fluids * After removal of PPE [personal protective equipment - gowns, gloves, masks, etc.] * After handling any contaminated items (linens, equipment, garbage, etc.) When hands must be washed with soap and water (not alcohol-based hand rub) * When hands are visibly soiled or dirty * When caring for a resident who has a spore forming disease . . . * When hands are visibly contaminated with blood or body fluids . . ." Review of the facility policy titled, "STANDARD PRECAUTIONS," occurred on 02/04/10. The policy, dated 11/13/09, stated: "This facility considers all body fluids and/or secretions to be potentially harmful. There is a possibility that any employee of this facility may be exposed to body fluids at any time. All employees are therefore instructed in appropriate handling of all body fluids/secretions. Use protective barriers whenever you handle body fluids. These include gloves, gowns, aprons, masks, goggles, and resuscitation devices. This PPE is available throughout the building. See the exposure control plan in this manual for specific tasks, specific use of PPE, disposal of PPE, disposal of waste in the biohazard labeled containers, etc. . . ." Review of the facility "Exposure Control Plan" occurred on 02/04/10. The plan, dated 02/28/08, stated: "All employees will utilize Universal Precautions, assuming that all human blood and specified	F 441	water before moving to clean procedures such as applying a clean incontinence product." c. "Wearing gloves and using disinfecting wipes, clean & disinfect any surfaces which may have been contaminated with body fluids or stool. Remove and discard gloves. Wash hands with soap and water." The urinal usage policy had the following change: a. "Rinse urinal with water after each use, using toilet sprayer device. If no toilet spraying device is available, use a paper cup and water from the sink, rinse the urinal. Dump water into the toilet after rinsing. Discard paper cup. Use a clean cup if more rinsing is required. These policy changes and a review of the engineering and work practice controls in the Exposure Control Plan and the Linen Management policy were reviewed at the CNA meeting on 2/23/10 and will be reviewed at the Charge nurse meeting on 3/11/10. Hand washing policy was reviewed (with emphasis on hand hygiene	

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F 441	Continued From page 11 body fluids are infectious for HIV [human immunodeficiency virus], HBV [hepatitis B virus] and other bloodborne pathogens and must be treated accordingly. . . . All employees using PPE must observe the following precautions: * Wash hands immediately or as soon as feasible after removing gloves or other PPE. * Remove PPE after it becomes contaminated and before leaving the work area. . . . * Wear appropriate gloves when it is reasonably anticipated that there may be hand contact with blood or OPIM [Other Potential Infectious Material], and when handling or touching contaminated items or surfaces; replace gloves if torn, punctured or contaminated, or if their ability to function as a barrier is compromised. . . . Housekeeping . . . All equipment and environmental and work surfaces are cleaned and decontaminated after contact with blood or OPIM. Work surfaces are decontaminated: * after the completion of procedures * when surfaces are overtly contaminated * after any spill of blood or other potentially infectious materials . . ." Review of the facility policy titled, "GENERAL CLEANING AND DISINFECTION," occurred on 02/04/10. The policy, dated 01/11/10, stated: "Resident supplies, care equipment, and table tops will be cleaned and decontaminated after use and will be prepared for reuse by the same or another resident. Equipment will be cleaned and decontaminated according to manufacturer's recommendations. * All equipment and supplies will be cleaned and decontaminated after use. Body fluids in/on the equipment (e.g., urine in collection bag/suction	F 441	immediately following contaminating procedures and before moving to clean items) at the charge nurse meeting on 2/11/10. Disinfecting wipes will be available in each resident's bathroom for disinfection of contaminated surfaces. Urinals, bedpans and basins will be stored in areas away from potential contamination by body fluids or secretions. 4. The Infection Control Nurse or nursing management will audit 20% of nursing staff for compliance with hand hygiene, disinfection of surfaces, and proper storage of resident equipment weekly x 2 and at 1, 3, and 6 months. Findings will be reported to the QA Committee.	

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	355092	A. BUILDING _____ B. WING _____	02/04/2010

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F 441	Continued From page 12 bottle contents) will be disposed of in the sewage system. . . . * Manual cleaning - Equipment is first cleaned of surface soil with soap and water or facility disinfectant. - Equipment is then decontaminated with an EPA- [Environmental Protection Agency] and facility-approved disinfectant. . . ." Review of the facility policy titled, "LINEN MANAGEMENT," occurred on 02/04/10. The policy, dated 11/13/09, stated: "All soiled linens will be handled with universal precautions: soiled linen will be held away from the employee's uniform. . . ." - An observation of gastric tube (g-tube) medication administration occurred at 12:00 noon on 02/02/10. Observation showed a staff nurse (#8) failed to perform hand hygiene after administering Resident #14's gastric tube medications, and prior to turning on the resident's television. - The following two observations of cares provided to Resident #2 occurred on 02/03/10: * At 8:45 a.m., an observation of two certified nursing assistants (CNAs) (#3 and #5) providing incontinence cares and toileting cares: The CNAs donned gloves, and assisted Resident #2 to the bathroom by wheelchair. As the resident was assisted to a standing position, observation showed visible stool soiling onto the resident's trousers. Upon removal of Resident #2's heavily soiled incontinent brief by the CNA (#3), a large amount of fecal material fell onto the toilet seat. Using an incontinence wipe, the CNA (#3) wiped/pushed the feces from the toilet seat into the toilet, and disposed of the soiled brief and	F 441		

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F 441	Continued From page 13 wipes into the garbage can. The CNA (#5) assisted the resident to sit down on the toilet while the other CNA (#3) removed her contaminated gloves. Without washing her hands, the CNA (#3) reached into a box of gloves behind the toilet, donned a new pair of gloves, exited the bathroom, opened a drawer in the resident's dresser, obtained a new brief and garbage can liner, and obtained a clean pair of trousers from the resident's closet. The CNA (#3) handed the supplies to the other CNA (#5) who assisted in changing the resident's soiled pants (and placed them inside the garbage bag). The CNA (#3) then obtained several incontinence wipes/cleansing clothes from a plastic box/container on the counter top and placed them on the sink. The CNA (#3) performed frontal pericares while Resident #2 sat on the toilet. Observation showed stool present on all wipes. The CNA (#3) re-entered the box of incontinence wipes with the same gloved hands, and obtained more incontinence wipes in preparation for standing the resident. Upon standing Resident #2, observation showed loose stool present on the rear of the toilet seat. After completion of the incontinence cares, the CNAs (#3 and #5) failed to clean the resident's wheelchair cushion before seating the resident onto the cushion. Observation showed the CNA (#3) wiped off the toilet seat with the incontinence wipes, removed the gloves used for this cleaning, held those gloves in her hand, and used that same hand to flush the toilet. No decontamination of the toilet seat or handle occurred. Observation showed this resident shared a bathroom with another resident. Observation showed the storage of a urinal and	F 441		

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F 441	Continued From page 14 bedpan on the toilet surface between the wall and the back of the toilet seat. Observation also showed two wash basins stored inside of the handle bars adjacent to the toilet and on the wall. The storage of resident use items (urinal, bedpan and wash basins) in close proximity to the incontinence episode has the potential to cause the contamination of these items. The CNAs failed to wash their hands after the removal of gloves contaminated with fecal material, and before they touched the resident's environmental surfaces (dresser and closet) with contaminated hands, and failed to sanitize the toilet seat and the resident's wheelchair cushion after contaminated with fecal material. In addition, the storage of resident use items (urinal, bedpan and wash basins) in close proximity to the incontinence episode has the potential to cause the contamination of these items. * At 12:40 p.m., an observation of two CNAs (#3 and #5) providing toileting and pericares cares: After completing Resident #2's pericares, the CNA (#5) removed her gloves, failed to wash her hands, reached with her contaminated hands into a box of gloves for a new pair of gloves, donned gloves and assisted CNA (#3) to apply a clean brief and pivot transfer Resident #2 from the toilet to wheelchair. - The following two observations of cares provided to Resident #9 occurred on February 03-04, 2010: * At 3:25 p.m. on 02/03/10, two CNAs (#9 and #10) toileted Resident #9. The CNA (#9), with gloved hands, removed Resident #9's wet incontinent brief prior to assisting the resident onto the toilet. The CNA (#9), with the same	F 441		

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F 441	Continued From page 15 gloves on, exited the resident's bathroom, straightened the resident's bed linens, opened the resident's dresser drawer, obtained a clean brief, returned to the bathroom, removed her gloves, and then washed her hands. * At 8:45 a.m. on 02/04/10, two CNAs (#3 and #11) toileted Resident #9. The CNA (#11) removed Resident #9's wet incontinent brief, removed her gloves, failed to wash her hands, reached into a box of gloves, and donned a new pair of gloves. The CNA (#11) then reached inside a box of incontinence wipes, provided pericares, removed the gloves, reached into the box of gloves, and donned a new pair of gloves. The CNA (#11) assisted applying a new brief on the resident, exited the bathroom with the contaminated gloves and assisted in positioning the resident in her wheelchair. The CNA (#11) returned to the bathroom, removed her gloves, and failed to wash her hands. The CNA tied up the garbage, sat the bag on the sink countertop, exited the bathroom, obtained another garbage bag from the resident's dresser drawer, put the bag in the garbage can, and then washed her hands. The CNA (#11) left the bathroom and performed no cleaning of the sink countertop. Resident #9 shared the bathroom with another resident. In a meeting with three administrative staff nurses (#1, #6, and #7) on the morning of 02/04/10, the staff nurse (#6) stated CNAs are taught to remove their gloves after providing pericares and to apply a new pair of gloves. The nurse did not disagree that reaching into a clean box of gloves with soiled hands could contaminate the box of gloves. Another staff nurse (#1) agreed hands should be washed after contaminated gloves are removed and agreed environmental surfaces	F 441		

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F 441	Continued From page 16 should be decontaminated after contaminated with bodily fluids. - Observation of two CNAs (#3 and #13) assisting Resident #6 with toileting and personal care occurred at 12:50 p.m. on 02/02/10. The CNAs transported Resident #6 into the bathroom using a standing lift. Once positioned in front of the toilet, with gloves on, a CNA (#3) removed the resident's soiled incontinent brief. As the CNA removed the brief, a large amount of fecal material fell onto the toilet seat. Using an incontinent wipe, the CNA (#3) removed the feces from the toilet seat. Using the same gloved hands, the CNA (#3) obtained wipes/cleansing cloths from a plastic box/container, and completed Resident #6's perineal care. Following completion of the above described care, no decontamination of the toilet seat occurred after becoming soiling with feces. At 1 p.m., immediately following toileting and assisting Resident #6 into bed, the CNAs (#3 and #13) assisted Resident #6's roommate (Resident #7) onto the toilet. - On 02/04/10 at 7:27 a.m., two CNAs (#2 and #3) provided toileting cares for Resident #8, using a standing lift. After completing pericares, the CNA (#3) failed to remove her soiled gloves. With these same gloves on, the CNA (#3) assisted the CNA (#2) with transferring Resident #8 to her wheelchair by maneuvering the wheelchair into place behind the resident, using the wheelchair hand grips. The CNA (#3) assisted with the harness straps, released the wheel chair brakes, wheeled the resident away from the lift, then opened the bathroom door, entered the bathroom, removed the soiled gloves and failed to	F 441		

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F 441	Continued From page 17 wash her hands. The CNA (#3) re-entered the resident's room and obtained Resident #8's comb and glasses. The CNA (#3) began to comb the resident's hair, went into the bathroom to wet the comb, returned to the resident, and completed combing the resident's hair. The CNA (#3) then went into the bathroom to wash the resident's glasses, cleaned them with a paper towel, and positioned them on Resident #8's face. After assisting with combing the resident's hair, and placement of glasses, the CNA (#3) washed her hands with soap and water. During this observation, the CNA (#2) straightened Resident #8's bed. The CNA (#2) folded two cloth soaker pads into fourths, obtained a plastic bag, braced the soaker pads against her uniform, folded them again and placed them into the plastic bag. Folding the soaker pads, against her clothing, contaminated the CNA's (#2) clothing. - Observation on 02/02/10 at 1:58 p.m., showed two CNAs (#3 and #4) laid Resident #5 down in bed. The CNA (#3) then emptied the resident's bedside catheter drainage bag into a urinal. The CNA (#3) took the urinal into the bathroom, poured the urine into the toilet, then held the urinal under the sink faucet to obtain water to rinse the urinal, and poured the rinse water into the toilet. The CNA (#3) rinsed the urinal twice before she placed the urinal on the back of the toilet. The CNAs (#3 and #4) failed to sanitize the sink prior to washing their hands in the sink. Observation on 02/03/10 at 10:20 a.m., showed two CNAs (#3 and #5) assisted Resident #5 to lay down. The CNA (#5) emptied the resident's bedside catheter drainage bag into a urinal. The CNA (#5) took the urinal into the bathroom, poured the urine into the toilet, then held the	F 441		

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F 441	Continued From page 18 urinal under the sink faucet to obtain water to rinse the urinal, and poured the rinse water into the toilet. The CNA (#5) then placed the urinal on the back of the toilet. The CNAs (#3 and #5) failed to sanitize the sink prior to washing their hands in the sink. During an interview on 02/03/10 at 3:40 p.m., an administrative nursing staff member (#6) stated nursing staff are directed to obtain water to rinse the urinal from the sink if the bathroom does not have a rinsing arm. This staff member (#6) stated staff received instruction not to touch the sink or the water faucet with the urinal while obtaining the rinse water, and staff are instructed to empty the rinse water into the toilet. During an interview on 02/04/10 at 10:04 a.m. with three administrative staff members (#1, #6, and #7), they identified the facility did not have a policy/procedure which covered the rinsing of the urinals. Utilizing a hand washing sink for rinsing urinals has the potential to contaminate the sink with bodily fluids. The Centers for Medicare and Medicaid requires institutions, where bedpans and urinals are used, to provide facilities for cleaning and disinfecting of bedpans and urinals.	F 441		