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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____ MAY 20 2010	04/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	600 S MAIN ST MINOT, ND 58701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 04/19/10 and completed on 04/22/10, the sample included 5 residents for complete review, 12 residents for focused review, and 3 closed records for review. The sample included 3 additional residents to verify specific concerns during the survey.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	**F 164** Corrective action was taken when facility management became aware of the concerns regarding privacy prior to the end of the survey process. On the morning of 4-21-10 signs were posted in work areas and in the staff lounge reminding staff to Knock, Pause/Wait for an answer and announce who they are and what they need to do prior to entering a resident's room. Unit managers provided verbal coaching to nursing staff members on duty the morning of April 21st and to oncoming shifts when they arrived for duty. Residents who receive care and services within the facility are at potential risk for violations regarding the safeguarding of their privacy, personal information or clinical information.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/19/10

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 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy/procedure, facility staff failed to respect residents' privacy and confidentiality during observations of personal care and random observations on 2 of 2 resident care units (first and second floors). Failure to provide privacy and confidentiality is a violation of residents' rights. Findings include: Review of the facility's guide titled "Resident's Rights," occurred on 04/22/10. The guide, revised 06/2004, stated, "Personal and Privacy Rights: Your right to privacy, confidentiality, and use of personal possessions. You have the right: . . . To privacy in medical treatment and personal care. . . ." Review of the facility policy titled, "Incontinence Care," dated 12/2009, occurred on 04/22/10. The policy stated, "Procedure: . . . 2. Knock on door and request entrance 3. Introduce self, explain procedure and provide privacy. . . ." Review of the facility policy titled, "Call light," dated 12/2009, occurred on 04/22/10. The policy stated, "Procedure: . . . 2. Knock on door and wait for response prior to entering room 3. Introduce self and ask how assistance can be provided. . . ." Review of the facility policy entitled, "GLUCOSE BLOOD MONITORING (FINGER STICK BLOOD SUGAR)" occurred on 04/21/10. This policy, dated 12/2009, stated ". . . 3. Knock on door and request entrance. 4. Introduce self, explain	F 164	Written education on privacy and confidentiality was posted in the employee lounge on 04-26-10 through 05-10-10. Staff members were required to read the information and complete a post test. Verbal education was provided in the second floor CNA meeting held on May 4, 2010 and the first and second floor nurses meetings held on May 11, 2010. This information will be shared with the first floor CNA meeting on May 18, 2010 and again at the Staff meeting scheduled on May 19, 2010. Weekly audits will be completed by management staff weekly for four weeks. Ongoing monitoring will be completed as per the recommendation of the facility QAA Committee. Date of completion is June 4, 2010.	

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F 164	Continued From page 2 procedure, and provide privacy. . . ." - During the initial tour of the facility on 04/19/10 from 10:35 a.m. to 11:30 a.m., random observations showed a CNA (Certified Nursing Assistant) (#2) entered six different resident rooms without knocking and waiting for permission to enter the residents' rooms. The CNA (#2) identified a resident by her first name and stated, "[Resident #21] changes her own depends so I have to check her room." Observation showed a housekeeping staff member within close proximity while the CNA made this statement. The CNA failed to assure confidentiality in regards to the resident's right to privacy and dignity. - Observation on 04/20/10 at 3:25 p.m., showed a CNA (#1) passing snacks to residents. The CNA opened the door to Resident #7's room without knocking and waiting for permission and/or giving the resident time to be aware of the CNA's (#1) intent to enter before opening the door to the resident's room. - An observation of medication pass occurred on 04/19/10 at 4:45 p.m. A nursing staff member (#5) performed a finger stick procedure to check Resident #7's blood sugar. The staff member then stated, "It's 120. That's good." (referring to Resident #7's blood sugar reading) During this observation, the staff member performed the procedure at the nurses station. Eight other residents sat in their wheelchairs around the nurses station, waiting to be taken to the dining room for supper. - A random observation on 04/19/10 at 5:00 p.m. showed a nursing staff member (#6) entered a	F 164		

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F 164	Continued From page 3 resident's room to administer medications. The staff member failed to knock or identify herself prior to entering the resident's room. - On 04/19/10 at 4:55 p.m., observation showed two CNAs (#9 and #10) knocked on Resident #10's door and immediately walked into the room before announcing themselves and waiting for a response. - On 04/20/10 at 2:05 p.m., observation showed two CNAs (#11 and #16) knocked on Resident #10's door and immediately entered the room before announcing themselves. The CNAs assisted the resident onto the toilet. At 2:08 p.m., the CNAs (#12), (#13), and (#14) knocked and opened the resident's door before announcing themselves. Observation showed the resident in full view from the door while seated on the toilet. The CNAs (#11 and #16) utilized a Sara lift, assisted the resident to a standing position, and backed the resident out of the bathroom to provide pericares. While the CNA (#16) cleansed the resident's rectal area, another CNA (#9) knocked and immediately entered the resident's room before announcing herself. Observation showed the resident in a standing position exposed from the waist down. - On 04/20/10 at 12:10 p.m., a CNA (#13) knocked on Resident #1's door and entered without announcing herself or waiting for a response before entering the resident's room. - On 04/20/10 at 4:35 p.m., two CNAs (#11 and #9) knocked on Resident #10's door and immediately entered the room before announcing themselves and assisted the resident onto the toilet. The CNA (#11) left the room to obtain	F 164		

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F 164	Continued From page 4 periwipes. A CNA (#15) knocked and immediately entered the resident's room before announcing herself. None of the CNA's waited for a response from the resident prior to entering the room. - On 04/20/10 at 5:20 p.m., a CNA (#9) knocked on Resident #1's door and immediately entered the room before announcing herself and waiting for a response. - A random observation on 04/22/10 at 8:08 a.m., showed a nurse (#8) passing medications. The nurse (#8) knocked, stated her first name, pushed open the resident's room door, and entered the darkened room in one motion. The nurse (#8) failed to wait for permission and/or give the resident time to be aware of the nurse's need to enter before proceeding into the resident's room. - On 04/20/10 at 8:50 a.m., while two CNAs (#13 and #16) assisted Resident #9 with personal cares in his room, observation identified a CNA (#12) knocked on the door and without identifying himself or waiting for a response, immediately entered the room. - On 04/20/10 at 10:10 a.m., while a CNA (#17) prepared to transfer Resident #11 to bed, a CNA (#12) knocked on the door and without identifying himself or waiting for a response, immediately entered the room.	F 164		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both	F 242		

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F 242	Continued From page 5 inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on individual resident interviews, resident group interview, staff interview, observation, review of the facility's admission packet, and record review, the facility failed to allow residents to make choices regarding their personal schedules for 2 of 5 individual residents interviewed (Residents #2 and #11), and for 5 of 9 residents (Residents C, E, F, G, and H) attending the group interview. Failure of the facility to offer choices regarding important aspects of a resident's life is a violation of resident's rights. Findings include: Review of the facility's admission packet, on 04/22/10, showed a "Resident's Rights" handbook, which is provided to each resident at the time of admission. This handbook, revised 06/2004, stated on page 19, "DIGNITY AND RESPECT . . . You have the right: . . . To make independent personal decisions. . . . To receive reasonable accommodation from the facility for your personal needs and preferences. . . ." - Review of Resident #2's medical record occurred on April 19-21, 2010. Diagnoses included diabetes mellitus, diabetic neuropathy, peripheral vascular disease, and lower extremity stasis ulcers. The resident's most recent Minimum Data Set (MDS), dated 03/04/10, identified the resident as having no problems with	F 242	**F 242** Resident #2 engaged in verbal review of his treatment times on 04-26-10 and initially requested that dressing changes continue to be completed in the evening but that be done prior to 9:00 p.m. Nursing staff was instructed to complete this task in the early evening. On follow up on May 12, 2010 resident reported he does not want dressing changes to be changed to daytime hours. Resident #11's information on the Resident Information Sheet was updated to reflect that she prefers to get up at 7:30 a.m. or later. The care plan was revised to reflect this as well. Residents who are able to actively participate in decision making and in directing their care are at risk for their preferences to be overlooked when cares are provided.	

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F 242	Continued From page 6 short-term or long term memory and independent in daily decision making. The facility identified the resident as interviewable. An interview with Resident #2 occurred on 04/20/10 at 8:10 a.m. During the interview, Resident #2 expressed frustration regarding the time his leg dressings are changed (Resident #2 has diabetic/stasis ulcers to both of his lower legs). Resident #2 stated he has asked the nurses several times to change them earlier in the evening or on the day shift (from 6:00 a.m. to 2:00 p.m.). He stated the doctor ordered the bandages to be changed on the day shift; however, the day shift nurses are too busy. The dressing changes get later and later until eventually, they end up being done on the night shift. Resident #2 further stated his dressings are changed "most always in the middle of the night." The earliest dressing change is between 10:30 and 11:00 p.m. Resident #2 stated an average time is between 12:00 and 1:30 a.m., and one time he remembered waiting until 3:20 a.m. for the nurse to come and change his dressings. He could not sleep at all and had to attend physical therapy at 9:30 that morning. Resident #2 stated he just "dozes on and off" until the nurse comes in to perform the dressing changes. Review of Resident #2's nurses notes revealed the following: * 04/22/10 at 2 a.m.: ". . . Drsg [dressing] changed to lower legs [with] Kerlix. [a type of dry gauze]. . ." * 04/20/10 at 3:30 a.m.: ". . . Drsg [changed] to legs. . . ." * 04/07/10 at 2:45 a.m.: ". . . Dressings [changed]	F 242	Written education on honoring resident's choices and preferences and arranging care to accommodate individual needs was posted in the employee lounge the week of April 26th and May 3rd. Staff were required to read the information and complete a post test on resident rights. Verbal education was provided by nurse managers to the second floor CNA staff on May 4, 2010 and to direct care nurses on May 11, 2010. This information will be shared with the first floor CNA staff on May 18, 2010. Social services will present information on Resident's Rights and honoring preferences on May 19th in the Staff Meeting. The facility administrator or designee will attend the next Resident Council meeting scheduled for May 27th and reiterate that preferences and choices are to be honored by staff and specifically that they can sleep later in the morning and have an alternative breakfast when they do get up for the day. The residents will be informed of the grievance process as well and encouraged to bring forth concerns as they occur.	

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F 242	Continued From page 7 to lower extremities. . . ." * 04/03/10 at 3:40 a.m.: ". . . Legs wrapped [with] Kerlix et [and] aces. [a type of stretchy leg wrap] . . ." * 03/25/10 at 4:00 a.m.: ". . . Kerlix et ace wraps changed to lower extremities. . . ." * 03/24/10 at 3:30 a.m.: ". . . Dressing + Ace wraps [changed] and intact to legs. . . ." * 03/23/10 at 3:00 a.m.: ". . . Kerlex [sic] et Ace wraps [changed] to lower extremities bilaterally. . . ." * 03/20/10 at 4:00 a.m.: ". . . Ace wraps to [lower] ext's [extremities] rewrapped. . . ." * 03/14/10 at 3:35 a.m.: ". . . Ace wraps and kling wrap [changed] to lower legs bilaterally. . . ." * 03/06/10 at 1:30 a.m.: ". . . Drsg changed to bilateral legs. . . . Applied Kerlix et ace wraps. . . ." * 02/22/10 at 2:30 a.m.: ". . . drsgs [changed] to legs. . . ." * 02/21/10 at 3:00 a.m.: ". . . drsg chg [change] to bil. [bilateral] legs [and] feet. . . ." * 02/07/10 at 1:30 p.m.: ". . . Verbalizes anxiety if things are not on schedule for him 'makes me upset' [sic]. . ." * 02/05/10 at 2:45 a.m.: ". . . was very upset this evening about not having his drsg's to his legs done during the day. . . . reassured him that I would do his legs tonite [sic], he said that would be fine but he still wanted them to be done during the day again to get back on schedule, drsg's [changed] @ 2230 [10:30 p.m.]. . . ." * 01/29/10 at 1:45 a.m.: ". . . Drsg changed to lower extremities [with] Kerlix et ace wraps. . . ." * 01/27/10 at 3:05 a.m.: ". . . Dressing changes done to lower extremities. . . ." * 01/26/10 at 4:15 a.m.: ". . . Dressing changes done to legs . . ."	F 242	Management staff will interview five residents at random each week for four weeks to determine if their preferences and choices are being honored. Additional monitoring will be completed as directed by the QAA committee. Date of compliance is June 11, 2010.	

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F 242	Continued From page 8 A doctor's order, dated 02/03/10, stated the following, "Please schedule dressings on legs after lunch and before afternoon therapy." During an interview on 04/21/10 at 4:30 p.m., a nursing staff member (#1) stated Resident #2's dressing change is a lengthy process that can take up to an hour to complete. During an interview on 04/22/10 at 9:20 a.m., a nursing staff member (#1) stated dressing changes are supposed to be done before 9:00 p.m., but it is evidently not being done if the resident is still upset. - A group interview occurred on 04/20/10 at 2:15 p.m. When asked to explain different rules of the facility, one of the members present (Resident G) stated, "We have to get up when they [referring to the certified nursing assistants] come or we miss breakfast." Five of the nine residents at the group meeting agreed that this is accurate. - Resident #11's medical record, reviewed on all days of survey, identified diagnoses including fibromyalgia, chronic anxiety, and depression. A significant change in status MDS, completed on 04/09/10, identified no short or long term memory problems, modified independence with daily decisions (some difficulty in new situations only), and usually understands (may miss some part/intent of message). The MDS also identified Resident #11 required total assistance with transfers and extensive assistance with personal hygiene. Resident #11's current care plan, revised 04/09/10, identified a focus, "[Resident #11] is an alert decision maker with strong verbal skills with	F 242		

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F 242	Continued From page 9	F 242		

occasional/situational forgetfulness." Interventions identified for the focus included, "Afford opportunity to creatively express self based upon past interests." The care plan identified a goal of "Will be able to make decision about ADL [Activities of Daily Living] /activity choices or preferences." The resident's care plan for self care deficit, revised 02/24/10, stated, "OK for resident to get up early in am."

An Activity/Recreation Evaluation, dated 02/12/10, identified Resident #11's "preferred wake up time in the morning" as "7:30 - 8 a.m."

When interviewed about her daily life on 04/20/10 at 9:35 a.m., Resident #11 stated she is able to decide when she wants to go to bed, but "It's their decision when we get up." The resident stated today staff got her up at 5 a.m. Resident #11 stated, "I felt that was unnecessary. I didn't have much to do at 5 a.m." She stated she has asked staff not to get her up that early, but they still do it. She stated, "They [staff] say if you want breakfast you have to get up. It's either breakfast or stay in bed." Resident #11 also identified that she chooses to eat all her meals in her room.

Observations on April 20-22, 2010 identified Resident #11 received her breakfast tray in her room between 8:00 and 8:30 a.m. each day.

A brief interview took place with Resident #11 on 04/21/10 at 8 a.m. in her room. She had not yet received her breakfast tray. When asked what time she got up that day, she stated, "7 [a.m.]. It's a lot better than 5 a.m."

An interview with a CNA (#16) occurred on 04/22/10 at 9:15 a.m. When asked what time staff

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F 242	Continued From page 10 usually get Resident #11 up for the day, the CNA stated, "Hopefully at least by 7 a.m. I know she doesn't like to get up at 5:30 or 6:00." On 04/21/10 at 4:30 p.m., two administrative staff members (#1 and #18) stated their expectation is that residents may sleep as late as they like. On 04/22/10 at 8:35 a.m. an administrative nurse (#1) stated if a resident chooses to sleep late, dietary staff will serve breakfast whenever the resident desires. Failure to allow Resident #11 to choose the time she rises each day does not allow her to exercise her right to make choices about aspects of her life that are important to her and could increase her symptoms of anxiety and depression.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to assure residents could move about the dining room without disturbing other residents in 1 of 2 dining areas on the first floor (the small dining room in the South wing). Failure to ensure residents may freely exit the dining room without requiring other residents to move interfered with the meal	F 246	**F 246** Facility immediately addressed the reasonable accommodation with patient #22. He stated that he wanted to stay in that spot in the dining room. Room environment was then modified to accommodate the patient's access in the dining room. Residents who utilize the dining rooms for meals within the facility are at risk for violation of reasonable accommodation of needs/preferences. Education was provided in reference to reasonable accommodation of needs/preferences to Staff members on 5-19-10. Dining audits will be completed by management staff weekly for four weeks. Ongoing monitoring will be completed as per the recommendation of the facility QAA Committee. Date of completion is May 20th, 2010.	

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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 246	Continued From page 11 experience of the other residents. Failure to position the tables in the dining room in a manner that allowed unrestricted access of residents to and from their table had the potential to increase the risk for accidents. Findings include: On the afternoon of 04/20/10, Resident #13 approached a surveyor and voiced concerns about congestion in the small dining room located on the South wing of the first floor. The resident stated he/she had obtained an injury as a result of an incident in that dining room. Review of Resident 13's medical record identified an incident occurred during a meal that could have been related to the congestion in the dining room. Interdisciplinary Progress Notes, dated 03/17/10 at 2:30 p.m. stated, "Pt [patient] received skin tear/bruise to (R) [right] elbow when another resident hooked onto pt's w/c [wheel chair] when leaving the dinner table. Pt's arm got pushed up against the table causing 3 cm [centimeter] x [by] 1.8 cm skin tear [with] 5 cm x 2.3 cm bruise. Scant amt [amount] of bloody drainage and pt denies pain. . . ." Observation of the small dining room on the South wing of the first floor, during the evening meal on 04/20/10, showed Resident #22 sat at the back of the dining room. Resident #22 finished eating and attempted to exit the dining room in his power wheelchair. The space available between the tables did not allow Resident #22 to exit the dining room without moving two other residents and a guest, interrupting their dining experience.	F 246		

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	355031	A. BUILDING _____ B. WING _____	04/22/2010

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F 246	Continued From page 12 Observation of the small dining room, on 04/21/10 at 12:25 p.m., showed 15 residents eating at five tables. Resident #22 sat in the same area as at supper on 04/20/10. Resident #22 attempted to leave the dining room table, but could not do so without moving another resident's walker. Resident #22 could not move the walker himself, so the resident who used the walker moved it for him, interrupting that resident's dining experience. Observation of the small dining room, on 04/22/10 at 7:45 a.m., showed Resident #22 in the same area as noted at the other observations. At the end of the meal Resident #22 attempted to exit the dining room in his power wheelchair. The resident had to move an empty chair to pass unhindered through the space between the two tables. During an interview on the morning of 04/22/10, an administrative staff member (#1) stated facility staff visited with Resident #22 about his place in the dining room, and she would provide documentation for review. The facility provided no documentation to show they had visited with Resident #22 about his placement in the dining room.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 248	**F 248** Resident #6 care plan was updated on 4-27-10 and interventions were added to address need for 1:1 interaction and group activity involvement appropriate for his reduced cognitive and functional status. Resident #11 care plan was revised and updated on 5-7-10 with activity care plan including specific approaches to accommodate poor visual function. This resident was also moved at her request to a different room with a more compatible room. Resident #10 discharged from the facility on 4-22-10. Residents with cognitive and/or physical declines are at risk for a lack of involvement in meaningful activities.	

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F 248	Continued From page 13 by: Based on observation, record review, and staff interview, the facility failed to develop and implement individualized activity programs to meet the interests and physical, mental, and psychosocial needs for 3 of 17 sampled residents (Resident #6, #10, and #11). Failure to involve residents in meaningful, individualized activities could result in increased behaviors and/or increased anxiety and depression. Findings include: - Resident #6's medical record, reviewed on all days of survey, identified the facility admitted the resident in December 2009 with diagnoses including dementia, anxiety neurosis, paranoia, and depression. A significant change Minimum Data Set (MDS), completed on 03/19/10, identified the resident with short and long term memory problems, moderately impaired skills for daily decision making, sometimes understood, and sometimes understands others. The MDS also identified Resident #6 required extensive assistance with transfers and locomotion on and off the unit. Review of the resident's current care plan failed to identify an individualized activity plan for Resident #6. The care plan did identify a focus, revised 03/12/10, "Wants to go Home/elopement risk (roaming the halls, wanting to go home, paranoid behaviors, expressing fear) related to: middle stage dementia, cognitive impairment." Interventions for the focus included "Avoid leaving unattended or unobserved for long periods of time . . . Engage in activities/tasks to keep occupied."	F 248	Activity personnel were educated on 4-22-10 regarding the need to complete documentation for refusal of activity involvement when activities are offered and the resident declines attending. Information will be presented to Staff on May 19, 2010 in the Staff Meeting regarding activity involvement and the importance of regularly interacting with cognitively impaired residents. Documentation of activity refusals and participation will be audited once weekly for four weeks beginning 5-12-10. Additional monitoring will be completed as directed by the QAA Committee. Date of compliance is June 11, 2010.	

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F 248	Continued From page 14 An Activity/Recreation Evaluation, dated 01/04/10, identified the resident would prefer to participate in activities in the afternoon and identified current interests as woodworking, television (TV), entertainment, music, hobbies, and car repair. The evaluation failed to identify which hobbies Resident #6 enjoyed. Observations on 04/19/10 at 3:10 p.m. and 4:55 p.m.; 04/20/10 at 1:45 p.m. and 3 p.m.; and 04/21/10 at 1:15 p.m., 2 p.m., and 3 p.m. identified Resident #6 propelling his Broda chair throughout the halls. Observation showed facility staff failed to approach Resident #6 and attempt to engage him in an activity or task. At no time during the survey did observation identify Resident #6 with a visitor. Additional observations identified the following: * 04/20/10 at 5 p.m. - Resident #6 asleep in his chair in the lounge area. * 04/21/10 at 10:15 a.m. - The resident seated in his room asleep in front of the TV. * 04/21/10 at 3 p.m.: Two CNAs (#5 and #10) assisted Resident #6 into bed. The CNAs turned on the TV, then positioned Resident #6 in his bed with his back toward the television, and left the room. Review of Resident #6's March and April 2010 Daily Activity/Recreation Participation Documentation sheets identified the following: * Resident #6 actively participated in exercise/physical activities daily in March and passively participated four days in April. On four days, staff documented speech therapy as an exercise activity. * Resident #6 passively participated in socializing and television daily both months and actively	F 248		

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F 248	Continued From page 15 participated with visitors nearly daily both months. * Resident #6 actively or passively participated in sensory stimulation daily both months. * Resident #6 passively participated in music three days in March and two days in April. Observations during the survey failed to identify Resident #6 participating in exercise, socializing, television, or sensory stimulation during the days of the survey (April 19-22, 2010). During an interview on 04/21/10 at 4:40 p.m., when asked about activities for Resident #6, an activity staff member (#20) stated sensory stimulation, as documented on the participation sheets, indicated the resident "responded to his environment," and did not mean an individualized activity occurred for the resident. The staff member (#20) stated staff placed Resident #6 on their "Enrichment Program" today. When asked about the Enrichment Program, the staff member stated it is a small group program, which is scheduled three days a week. Failure to develop a plan of individualized, meaningful activities designed to engage Resident #6 contributed to his frequent propelling of his Broda chair up and down the halls which heightened his risk for elopement, and could result in increased anxiety and depression. - Resident #11's medical record, reviewed on all days of survey, identified the facility admitted the resident in December 2009 with diagnoses including macular degeneration, fibromyalgia, chronic anxiety, and depression. A significant change MDS, completed on 04/09/10, identified no short or long term memory problems, modified independence with daily decisions (some difficulty in new situations only), and usually understands	F 248		

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F 248	Continued From page 16 (may miss some part/intent of message). The MDS also identified Resident #11 required total assistance with transfers. Review of the resident's current care plan failed to identify an individualized activity plan for Resident #11. The care plan did identify a focus, revised 04/09/10, "[Resident #11] is an alert decision maker with strong verbal skills with occasional/situational forgetfulness." Interventions identified for the focus included, "Afford opportunity to creatively express self based upon past interests." The care plan failed to identify Resident #11's past interests. An Activity/Recreation Evaluation, dated 02/12/10, identified Resident #11 as "legally blind," considered herself a social person, did not prefer to be alone, and preferred to participate in activities in the afternoon. The evaluation identified current interests as animals/pets, Bible study, church (sometimes), current events, entertainment, radio, sports - football, and beauty shop. The evaluation stated,"Like Bingo. Listens to Radio daily althrough [sic] the night that's where she keeps herself update to current events." An interview with Resident #11 occurred on 04/20/10 at 9:35 a.m. When asked about activities, the resident stated, "they [the facility] don't have that many activities except for bingo. I spend my day staring at space. There isn't much to do." The resident stated she would like to play cards and has large print cards in her room. She stated she doesn't watch TV due to her poor vision. Observation identified Resident #11's radio on during the interview.	F 248		

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F 248	Continued From page 17 Observations during the survey identified the following: * 04/19/10 at 3:15 p.m. - Resident #11 leaving the activity room after playing bingo. * 04/20/10 at 3:10 p.m. - Resident #11 seated in her room with the radio and TV off and the curtain pulled between the beds, not allowing socialization with her roommate. At 3:50 p.m., the resident remained as above. Observation showed an activity calendar, printed in a small font, on her bed. Review of the calendar identified a cards/games activity took place at 2:30 p.m. that day, and was scheduled to take place each Tuesday. The resident stated she was not aware of the game, had not been invited to attend, and could not read the calendar, due to her poor vision. * 04/21/10 at 10:15 a.m. - Resident #11 awake in her bed with the radio and TV off and the curtain pulled. At 2:35 p.m. Resident #11 was seated in her chair in her room with her eyes closed, the radio and TV off, and the curtain pulled. At 2:55 p.m. Resident #11 played bingo in the activity room. *04/22/10 at 7:55 a.m. - The resident in her room in her recliner with the curtain pulled and the radio and TV off. At 9:30 a.m. Resident #11 remained as above. Review of Resident #11's March and April 2010 Daily Activity/Recreation Participation Documentation sheets identified the following: * Resident #11 actively participated in bingo about four days each week, actively participated in education/intellectual activities nearly daily, listened to music in her room daily, was independent in reading/writing daily, actively participated in sensory stimulation (responded to her environment) daily, socialized daily, had	F 248		

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F 248	Continued From page 18 visitors nearly daily, and listened to the television daily. The sheets did not identify the resident refused to attend activities. When interviewed on 04/21/10 at 4:40 p.m. regarding Resident #11's activities, an activity staff member (#20) stated Resident #11 often refused activities and would only attend bingo. She stated large print cards are available in the activity department. She did not know if the resident had been invited to the card game on 04/20/10. Failure to develop and implement an individualized activity program to meet Resident #11's mental and psychosocial needs and accommodate her poor vision, resulted in the resident expressing dissatisfaction with her activity program and stating she spent the day "staring in space." - Review of Resident #10's medical record occurred April 19-22, 2010. Diagnoses included: degenerative cerebellar ataxia, mild cognitive impairment, depression, and encephalopathy. The quarterly MDS, dated 03/18/10, identified short term memory problems, moderate impairment with decision making, usually able to understand others, and requires extensive assist with ADLs (activities of daily living). Resident#10's March and April 2010 Daily Activity/Recreation Participation Documentation listed the following: * attended bingo five times in March and three times in April * read the newspaper independently daily * sensory stimulation * socialized daily	F 248		

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F 248	Continued From page 19 * watched television daily * had visitors 15 times in March and 10 times in April * nail care twice in March and once in April Observation showed Resident #10's routine during the survey as follows: * 04/19/10 at 4:05 p.m., resident lying in bed until staff assisted resident into wheelchair. Resident in dining room awaiting evening meal at 5:25 p.m. * 04/20/10 at 7:40 a.m., resident in lounge area reading newspaper until wheeling self into dining room. Following breakfast, resident in wheelchair watching television in his bedroom at 9:00 a.m. Resident asked this surveyor why staff won't let him go home. At 10:08 a.m., resident sitting in wheelchair in hall by nurses station. At 11:00 a.m., resident in his bedroom with television on. Resident angry with staff, stating, "You guys keep giving me the run around. I have my own house and I can manage just fine on my own. Why won't you let me go home?" At 12:05 p.m., resident in lounge area "waiting to go to dinner". At 12:55 p.m., resident in dining room for dinner. At 2:05 p.m., toileted by staff, laid down to nap. At 5:10 p.m., resident sitting in lounge area, television on. At 5:35 p.m., resident in dining room for evening meal. Random observations throughout the survey showed the resident in the dining room, seated in the lounge, or in his room. Observation showed no involvement in any activity. Resident #10's care plan addressed use of "wanderguard in wheelchair [and wanderer's bracelet] to alert staff if leaves facility (is own decision maker and can leave if he chooses - - staff are not to assist with this; wanderguard is to alert staff of intent to leave facility) . . . interventions: . . . encourage socialization with	F 248		

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F 248	Continued From page 20 others and provide recreational programming . . ." Resident #10's care plan addressed "psychosocial wellbeing, need to adjust to change . . . intervention: . . . encourage involvement in community life of facility and attendance at activities, resident council functions, and outings as appropriate . . ." The care plan failed to show an actual individualized plan of activities for Resident #10 based on an evaluation. An interview with administrative staff member (#20) occurred on 04/22/10 at 3:15 p.m. The staff member stated, "[Resident #10's name] usually attends bingo and attends activities when invited. [Resident's name] has been upset over wanting to go home. This is new for him. He's usually not like this." Failing to develop and implement an individualized activity program to meet Resident #10's needs may be contributing to his irritability, wandering behavior, and his desire to go home.	F 248		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional literature, record review and staff interview, facility staff failed to provide proper incontinence care for 3 of 13 sampled residents (Residents #5, #6, and #10) who	F 312	**F 312** Review and skin assessments completed on residents #5 and #6 revealed intact skin without irritation related to incontinence. Residents requiring assistance with ADL tasks are at risk for receiving an insufficient amount of assistance with ADL tasks.	

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F 312	Continued From page 21 required extensive assistance with personal hygiene. This practice has the potential to affect the residents' skin integrity, increasing their risk for skin irritation and discomfort. Finding include: Review of the facility policy titled "Incontinence Care" occurred on 04/22/07. This policy, dated 12/09, stated, "Purpose: To outline a procedure for cleaning the perineum and buttocks after an incontinence episode or with daily care . . . Procedure: . . . 11. Position on back with knees flexed and feet flat on bed (care may also be provided with patient sitting on commode, shower chair or in a standing position) 12. Cleanse peri-area and buttocks with cleansing agent wiping from front of perineum toward rectum. Turn patient side to side to cleanse entire affected areas, as needed. Rinse with water, if needed, or per incontinent product manufacturer's instructions . . ." - Record review for Resident #5 occurred on April 19-22, 2010. A significant change Minimum Data Set (MDS), dated 04/20/10, identified Resident #5 required extensive assistance of one staff member for personal hygiene and toilet use; an infection of clostridium difficile; and frequently incontinent of bladder. The care plan for Resident #5 identified "Focus: Urinary incontinence related to overactive bladder . . . . date initiated 12/5/2007 . . . Interventions: . . . Assist as needed/remind to toilet . . . Focus: GI [gastrointestinal] distress diarrhea r/t [related to] clostridium difficile infection with contact precautions in place . . . date initiated 04/7/2010 . . . Interventions: Maintain contact precautions as clinically indicated . . ."	F 312	An in-service focusing on completing perineal care was developed and skills validation lab was created on April 26, 2010 with the unit director providing small group training to CNA staff. Return demonstration of skills is required following in-services. CNA staff will be required to complete the training by June 4, 2010. Second floor CNA staff were educated on providing adequate assist with all ADL tasks in the CNA meeting held on May 4, 2010 and the first floor CNA staff will be educated during their unit meeting on May 11, 2010. Random audits of caregivers completing tasks associated with providing ADL assist will be completed a minimum of three times weekly for four weeks. Additional monitoring will be completed at the recommendation of the QAA committee. Date of completion will be June 4, 2010.	

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F 312	Continued From page 22 Observation of incontinence care provided to Resident #5, on 04/19/10 at 4:35 p.m., showed a certified nursing assistant (CNA) (#21) assisted Resident #5 from her wheelchair to the bathroom, wearing a gown and gloves. The CNA (#21) lowered the resident's pants, underwear and liner, the resident sat on the toilet, and the CNA (#21) removed the wet liner, underwear, and pants and applied clean clothes. Upon completion of toileting, the CNA (#21) obtained disposable cleansing wipes and assisted the resident to stand. The CNA (#21) cleansed Resident #5 from the pubis to the rectum in one motion, folded the wipe, and again cleansed the rectal area. The CNA (#21) failed to cleanse the resident's groin and buttocks areas exposed to urine. Observation of incontinence care provided to Resident #5, on 04/20/10 at 3:50 p.m., showed a CNA (#22) assisted Resident #5 from her wheelchair to the bathroom, wearing a gown and gloves. The CNA (#22) lowered the resident's pants, underwear and liner, the resident sat down on the toilet, and the CNA (#22) removed the wet liner. Resident #5 identified to the CNA (#22) her underwear and pants were wet. The CNA (#22) removed the wet clothing and applied clean clothes. Upon completion of toileting, the CNA (#22) obtained disposable cleansing wipes and assisted the resident to stand. The CNA (#22) cleansed Resident #5 twice from the pubis to the rectum in one motion, folding the wipe between cleansing motions. The CNA (#22) failed to cleanse the resident's groin and buttocks areas also exposed to urine. - Resident #6's medical record, reviewed on all days of survey, identified diagnoses including	F 312		

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F 312	Continued From page 23 dementia and osteoarthritis. A significant change MDS, completed on 03/19/10, identified Resident #6 as frequently incontinent of bladder and requiring extensive assistance with transfers, toilet use, and personal hygiene. Observation on 04/20/10 at 9:10 a.m. identified two CNAs (#13 and #16) assisted Resident #6 to the bathroom. Observation showed the resident's brief wet with urine. After removing the brief, one CNA (#13) performed perineal cares, cleansing only the buttocks area, and not cleansing the frontal perineal area of this male resident. During an interview on 04/22/10 at 8:35 a.m. and administrative nurse (#1) stated she would expect complete cleansing after incontinence. - Review of Resident #10's medical record occurred on April 19-22, 2010. Medical diagnoses included degenerative cerebellar ataxia, mild cognitive impairment, debility, peripheral neuropathy, hypertrophy of prostate, and degenerative arthritis. The resident's quarterly MDS, dated 03/18/10, indicated frequently incontinent of bladder, and extensive assist with toileting and personal hygiene. Medications included Amiloride HCL (a diuretic) once daily. Resident #10's care plan identified the following problems: * "Urinary incontinence related to progressive cerebellar ataxia, BPH [benign prostate hypertrophy] . . . apply skin moisturizers/barrier creams . . . monitor for and report any S&S [signs and symptoms] of UTI [urinary tract infection] . . . use absorbent products to assist with moving urine away from skin . . . assist with toileting . . . am [morning], hs [hour of sleep], before and after	F 312		

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	355031	A. BUILDING _____ B. WING _____	04/22/2010

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F 312	Continued From page 24 meals and naps, on rounds at night, and prn [as needed]. . ." * "At risk for alteration in skin integrity related to: decreased mobility, weakness . . . assist with daily hygiene, grooming, . . ." Observation on 04/19/10 at 4:55 p.m., showed two CNAs (#9 and #10) assisted Resident #10 with toileting. The CNA (#9) removed a wet incontinence pad and discarded it. The second CNA (#10) cleansed the rectal area with a periwipe, folded the wipe, and wiped the resident's frontal area (male resident) with one sweeping motion. The CNA (#10) failed to provide incontinence cares to the groin and entire frontal perineal areas. Observation on 04/20/10 at 2:05 p.m., showed two CNAs (#11 and #16) assisted Resident #10 with toileting. The CNA (#11) removed and discarded a wet incontinence pad. The CNA (#11) cleansed the rectal area with a periwipe. The CNA (#11) failed to provide incontinence cares to the remaining groin and perineal areas exposed to urine. Observation on 04/20/10 at 4:35 p.m. identified two CNAs (#9 and #11) assisted Resident #10 with toileting. The CNA (#9) removed and discarded a wet incontinence pad. The CNA (#9) cleansed the rectal area with a periwipe. The CNA (#9) failed to provide incontinence cares to the remaining groin and perineal areas, exposed to urine. During an interview on 04/22/10 at 8:40 a.m. with an administrative nursing staff member (#1), the staff member agreed that thorough pericares should be completed following each episode of	F 312		

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F 312	Continued From page 25 urinary incontinence.	F 312		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	**F 441** Corrective action was taken by the administrative nurse on April 20, 2010 when she was informed by the surveyor that staff had placed a dirty urinal in with clean items in the dishwasher. The administrative nurse removed the soiled urinal from the dishwasher and repeated the hi temp wash and rinse cycle. She also educated the CNA directly involved in the incident and posted written instructions on the dishwasher to remind staff to empty clean items prior to loading soiled items. Residents are at risk for exposure to micro-organisms when infection control guidelines are not followed.	

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F 441	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy/procedure, and staff interview, facility staff failed to implement infection control practices consistent with facility policy/procedure during 5 of 23 observations of personal cares for sampled residents (#5, #7, #10, and #11) and 1 of 2 observations of staff usage of a glucometer (blood sugar monitoring device). Failure to follow infection control practices has the potential to affect the health and safety of all facility residents, visitors, and staff. Findings include: Review of the facility policy "Basic Concepts Hand Hygiene" occurred on 04/22/10. The policy, dated 06/02/06, stated, ". . . Guidelines for Handwashing: Handwashing has been proven to reduce the risk of infections. . . .Use soap and water in the following situations: . . . after contact with blood or body fluids; when Clostridium difficile diagnosed or suspected." Review of the facility policy "Standard Precautions" occurred on 04/22/10. The policy, dated 06/02/06, stated, "Standard precaution principles are designed to reduce the risk of transmitting microorganisms from both recognized and unrecognized sources of infection . . . The following measures are employed with standard precautions. Hand Hygiene: Use a plain non-antimicrobial soap or waterless hand sanitizer for hand hygiene except for specified circumstances; Use an antimicrobial agent or waterless antiseptic hand sanitizer for specific	F 441	Written education was posted in the employee lounge area on April 26 through May 10, 2010 regarding infection control guidelines and specifically focusing on avoiding carrying germs from one resident to the next. A post test was required for this in-service. Infection control information was reviewed at the second floor CNA meeting on May 4, 2010 and the nurses meetings for each unit on May 11, 2010. The first floor CNA meeting on May 18, 2010 will include this information and the Staff meeting on May 19, 2010 will include review of infection control guidelines. Random audits/observations of staff for adherence to infection control guidelines will be completed three times weekly for four weeks. Additional monitoring will be completed as per QAA Committee recommendations. Date of completion is June 11, 2010.	

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F 441	Continued From page 27 circumstances, e.g. [such as] control outbreaks; Wash hands with soap and water after touching blood, body fluids, secretions, excretions and contaminated items; Wash hands or use waterless hand sanitizer immediately after gloves are removed, between patient contacts and when otherwise indicated to avoid transfer of microorganisms." Review of the facility policy "Bedpan/Urinal" occurred on 04/22/10. The policy, dated 12/09, stated, ". . . 16. Empty bedpan/urinal and disinfect following standard precautions. . . ." Review of the facility "Shift Routine for Dishwasher Use in Soiled Utility Room" policy occurred on April 21-22, 2010. The undated policy stated, "Non-disposable toileting items (bedpans, urinals) for patients that do not keep these items at bedside are emptied in the toilet then transported to the soiled utility room for cleaning purposes. . . . Items are placed in the dirty utility room and/or loaded into the dishwasher throughout the shift. At the end of the shift soiled items are added to the dishwasher and it is set to run on the high temp wash and rinse cycle. . . . The oncoming shift empties the clean items and puts them away in the storage area prior to adding any soiled items to the dishwasher. . . ." - Record review for Resident #5 occurred on April 19-22, 2010. A significant change Minimum Data Set (MDS), dated 04/20/10, identified Resident #5 required extensive assistance of one staff member for personal hygiene and toilet use; an infection of clostridium difficile; and frequently incontinent of bladder.	F 441		

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F 441	Continued From page 28 Observation of incontinence care provided to Resident #5, on 04/20/10 at 3:50 p.m., showed a certified nursing assistant (CNA) (#22) assisted Resident #5 from her wheelchair to the bathroom. The CNA (#22) lowered the resident's pants, underwear and liner, the resident sat down on the toilet, and the CNA (#22) removed the liner wet with urine. Resident #5 felt her pants and underwear, and told the CNA (#22) the clothing was wet. The CNA (#22) removed the wet clothing and applied clean clothes. Upon completion of toileting the CNA (#22) failed to assist or offer Resident #5 to wash her hands, which had contact with bodily fluids. After the CNA (#22) assisted Resident #5 back to bed, Resident #5 reached for a package of cookies off her bedside table and started to open the cookies. Upon request of the surveyor the CNA (#22) provided hand hygiene for Resident #5. During an interview on the afternoon of 04/21/10, with an administrative staff member (#1), this staff member identified it would be her expectation the CNA assist Resident #5 to wash her hands after toileting. - Resident #11's medical record, reviewed on all days of survey, identified diagnoses including colon cancer and methicillin resistant staphylococcus aureus, unspecified site. A significant change MDS, completed on 04/09/10, identified Resident #11 as having an indwelling catheter. Observation on 04/19/10 at 3:25 p.m. identified two CNAs (#5 and #9) assisted Resident #11 from her wheel chair to her recliner. Observation identified the resident with a foley catheter. After transferring the resident, one CNA (#9) emptied	F 441		

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the catheter drainage bag into a urinal. She then took the urinal into the bathroom, emptied it in the toilet, and placed it in a plastic bag.

After removing her gloves and washing her hands, the CNA (#9) took the bagged urinal into the soiled utility room. She removed the urinal from the plastic bag and placed it in the dishwasher. Observation showed several urinals in the dishwasher, which were covered with drops of water and appeared to be clean. When the CNA closed the dishwasher door, observation identified the "clean" light illuminated on the dishwasher. When asked how she knows whether the items in the dishwasher are clean or dirty, the CNA (#9) stated, "If I'm not sure, I run it again." The CNA then washed her hands and left the room without starting the dishwasher.

Immediately following the observation, the surveyor asked an administrative nurse (#23) to accompany her to the soiled utility room. When shown the dishwasher, with the "clean" light still illuminated, and the soiled urinal placed there by the CNA (#9), the nurse stated the CNA should have left the urinal bagged in the sink. She stated a staff member is assigned each shift to remove the clean items, fill the dishwasher with dirty items from the sink, and run the dishwasher.

On the afternoon of 04/19/10, the administrative nurse provided a "One-On-One Inservice Record" for the CNA (#9), dated 04/19/10, which stated, "Soiled urinals & [and] bedpans are to be bagged & placed in soiled utility room sink until washed in dishwasher. It is not acceptable to placed [sic] soiled urinal in [with] clean urinals in the dishwasher."

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F 441	Continued From page 30 Placing the soiled urinal in the dishwasher with clean items could result in staff assuming the urinal to be clean and taking it to another resident's room for use, creating the opportunity for spreading infections to other residents. - On 04/19/10 at 5:15 p.m., observation identified two CNAs (#3 and #7) assisted Resident #7 with toileting. Both CNAs wore gloves. After assisting the resident with toileting, the CNA (#3) performed pericares, removed her gloves, transferred the resident into her wheelchair, and placed the resident's call light within reach. The CNA (#3), without washing her hands after providing pericare, left the resident's room, walked down the hallway, and entered another resident's room. - An observation of medication pass occurred on 04/19/10 at 5:10 p.m. A nursing staff member (#6) used a glucometer (shared by multiple residents) to check Resident #23's blood sugar. After the staff member used the meter, she brought it out of the resident's room and placed it on the medication cart. The staff member then signed the medication administration record, sanitized her hands, and placed the glucometer into a plastic bag which also contained alcohol wipes and gauze pads. The staff member failed to sanitize the meter after use. An interview with a nursing staff member (#5) occurred on 04/19/10 at 4:45 p.m. The staff member stated nursing staff are expected to clean glucometers with pre-moistened bleach wipes after each use. An interview with a nursing staff member (#1) occurred on 04/22/10 at 10:30 a.m. The staff	F 441		

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F 441	Continued From page 31 member stated the nurses know they are supposed to use the bleach wipes to clean glucometers. - On 04/19/10 at 4:55 p.m., observation identified two CNAs (#9 and #10) assisted Resident #10 with toileting. The CNAs gloved, utilized a Sara lift (sit to stand lift) and transferred the resident onto the toilet. The CNA (#9) removed a urine saturated pad, and provided pericares. The CNA then walked across the room, opened the cupboard door with the same gloves used to provide pericares, and obtained a new pad. Touching surfaces in the resident room with contaminated gloves has the potential to spread disease causing microorganisms.	F 441		