STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(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 August 3, 2015 and completed on August 6, 2015, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 315	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional standards, and staff interview, the facility failed to provide appropriate services and follow standards of practice to prevent urinary tract infections for 2 of 3 residents (Residents #1 and #6) observed during transfers and having a urinary catheters. Failure to keep the catheter drainage bag below the bladder during transfers may result in urinary tract infections (UTIs). Findings include:	F 315	1. DON re-educated staff on placement of catheter drainage bags during transfers for residents #1 and #6 on August 6, 2015. 2. All residents that have a catheter drainage bag have the potential to be affected. 3. A review of the Policy and Procedure for placement of catheter drainage bag during transfers was conducted by the DON on August 6, 2015. This information was reviewed with CNAs at the CNA	8/25/15

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

Electronically Signed | 08/21/2015

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F 315	Continued From page 1 Kozier and Erb's Fundamentals of Nursing Concepts, Process, and Practice, 9th Edition, Pearson, Boston, Massachusetts, Page 1330, stated, "Urinary Catherization . . . Keep the urine drainage bag below the level of the bladder. . . ." Review of the facility policy titled "Policy for Daily Urinary Indwelling Catheter Care" occurred on 08/04/15. This undated policy stated, ". . .**Points to remember about catheters** 1. Drainage collection bag should never be above the level of the bladder. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included "incomplete bladder emptying (increased Post-Void Residual Urine)" and Alzheimer's disease. The quarterly Minimum Data Set (MDS), dated 05/15/15, identified extensive assist for all personal cares and an indwelling catheter. The current care plan stated, ". . . PROBLEM . . . Indwelling urinary catheter . . . RELATED TO: urinary retention, distention, and Mobility deficit . . . APPROACH . . . Catheter care per policy. . . ." Review of laboratory reports showed a UTI occurred in November 2014. Observation on 08/03/15 at 2:30 p.m. showed two certified nursing assistants (CNA) (#2 and #3) transferred Resident #1 from his bed into his wheelchair with a total body lift (Hoyer). The CNAs held the catheter drainage bag, with urine visible in the tubing, above the resident's bladder several times during the transfer. Observation on 08/04/15 at 10:40 a.m. showed two CNAs (#4 and #5) transferred Resident #1 from his bed to his wheelchair using a Hoyer lift.	F 315	meeting on August 10, 2015. See Attachment 315-A and 315-B. This information will also be reviewed with the nurses at the Nurses meeting August 25, 2015. See Attachment 315-C All residents with a catheter drainage bag will be assessed for proper placement during transfers. 4. Monitor of Residents #1 and #6 for placement of the catheter drainage bag will be completed by DON or designee weekly for 4 weeks, then monthly for 5 months and then Quarterly x2. This monitor will include all residents with a catheter drainage bag. The findings of this quality assurance monitor will be reviewed monthly at the QA interdisciplinary meetings. See Attachment 315-D.	

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F 315	Continued From page 2 The CNAs hung the catheter drainage bag, with urine visible in the tubing, on the Hoyer's sling straps located at the resident's chest level during the transfer. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included urethral stricture and Alzheimer's disease. The quarterly MDS, dated 06/26/15, identified an extensive assist for all personal cares and an indwelling catheter. The current care plan stated, ". . . PROBLEM . . . Indwelling urinary catheter . . . RELATED TO: Suprapubic catheter . . . History of UTI's . . . APPROACH . . . Catheter care per policy. . . ." Observation on 08/03/15 at 3:08 p.m. showed two CNAs (#2 and #3) transferred Resident #6 from his bed to his wheelchair using an EZ-Stand lift. The CNAs held the catheter drainage bag, with urine visible in the tubing, above the resident's bladder several times during the transfer. During an interview on 08/06/15 at 11:05 a.m., a nurse manager (#1) agreed staff should follow the policy to keep the catheter drainage bag below bladder level.	F 315		
F 325	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325		9/1/15

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F 325	Continued From page 3 nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to implement interventions to prevent weight loss and maintain nutritional status for 1 of 1 sampled resident (Resident #13) who experienced weight loss. Failure to initiate interventions may have resulted in severe weight loss. Findings include: Review of the facility policy titled "Standards of Nutritional Care" occurred on 08/06/15. This undated policy stated, ". . . Procedure: . . . 3. Identification of residents requiring nutrition intervention: . . . B) Weight change of 5% in 1 month or 10% in 6 months. . . ." Review of the facility "Emergency Care Statement" occurred on 08/06/15. This statement, dated February 2003, stated, ". . . Level 3 - Keep comfortable in nursing facility. No transfer to hospital, no defibrillation, no chest compression, no artificial respiration. . . ." Review of Resident #13's medical record occurred on August 05-06, 2015. Diagnoses included Alzheimer's disease and Dementia. The annual Minimum Data Set, dated 05/23/15, identified short and long term memory problems, required total assist of one staff member for eating and no weight loss.	F 325	1. On August 14, 2015 the ADM, DON, SWD and MDS Nurse were able to conduct a conference call with the POA of resident #13 to discuss residents overall condition and weight loss. DPOA did verbalize understanding of expected weight loss due to Advance Dementia. DPOA agreed to try nutritional supplement to attempt to maintain current weight. Orders were received and care plan was updated on August 14, 2015. See Attachments 325-A and 325-B. 2. All residents have the potential for weight loss and could be affected. 3. Facility will continue to weigh all residents weekly. Review of Standards of Nutritional Care policy completed by DON and Dietary Manager on August 20, 2015. The QA team will continue to review all residents weights at the monthly QA interdisciplinary meetings but with focus to be on residents exhibiting a weight loss of 5% in one month and/or 10% in 6 months. Interventions on these residents will be discussed as well as updating the care plan at the monthly meetings. 4. Weight loss monitor will be completed by the dietary manager or designee for resident #13 and a random selection on a weekly basis for 12 weeks and then monthly. Findings from the QA monitor will be discussed at our monthly QA	

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F 325	Continued From page 4 Review of Resident #13's weights showed the following weight loss: * 02/03/2015 - 189 pounds * 03/10/2015 - 183 pounds * 04/07/2015 - 180 pounds * 05/19/2015 - 169 pounds * 06/23/2015 - 170 pounds * 07/14/2015 - 167 pounds * 08/04/2015 - 167 pounds - a severe weight loss of over 10% in 6 months Resident #13's care plan stated, "Self Care Deficit related to Decreased mobility, Muscle weakness, Dementia and has jerky uncoordinated movements . . . Eating: Dependent, 1 assist . . . Pudding thickened liquids. . . . . Alteration in Nutritional Status R/T [related to] Inadequate fluid intake, Alzheimer's, Constipation, Hx [history of] chewing concerns, Hx swallowing concerns . . . Goal . . . To maintain weight through next review. Approach Dietary: Monitor weight and meal intake. Provide ordered diet Pureed Diet with pudding thick liquids. 6 oz [ounces] Fiber juice at breakfast, 4 oz fiber juice at dinner and Supper. Offer/encourage to attend [sic] snacks to increase calorie intake . . ." The care plan failed to address Resident #13's weight loss. Resident #13's physician orders stated, " 06/25/2014 Code Status: Level III . . . Diet: Pureed Fluids: Pudding liquids . . ." Resident #13's social service note, dated 03/23/15, stated, "Son, dau [daughter] & son in law here for mtg [meeting] and w/o [without] res. [resident] Rev'd [reviewed] Code Level & policies & much discussion w/ [with] family re [regarding]: the Code Level III res. is on & what that means	F 325	interdisciplinary meetings. See Attachment 325-C.	

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F 325	Continued From page 5 for us & that res's intakes are [up and down] & she's losing some wt. [weight] They are O.K. w/ whats [sic] being done for her . . ." No documentation noted of any further communication with the family regarding the 11 pound weight loss during a one month period in April and May 2015. Resident #13's dietary progress note, dated 05/20/2015, stated ". . . Annual Review Wt: 169 lbs. Resident's weight was 193 lbs. 9 months ago. She in now a code III, so we will not intervene with supplementation. Intakes vary from 0-75% of meals. . . .Currently, she is on a pureed diet with pudding thick liquids. No need for nutritional intervention at this time." During an interview on the afternoon of 08/06/2015, a supervisory nurse (#1) confirmed residents with a code level III may receive nutritional interventions due to weight loss. The facility failed to initiate nutritional interventions for Resident #13's severe weight loss and update the care plan regarding the resident's weight loss.	F 325		
F 327	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide fluids to	F 327	1. DON reviewed the Hydration Policy and re-educated staff on offering fluids to	8/25/15

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F 327	Continued From page 6 maintain adequate hydration for 4 of 7 sampled residents (Resident #1, #4, #6, and #10) observed during cares. Failure to offer fluids frequently to residents who cannot access them independently placed them at risk for dehydration, constipation, and/or urinary tract infections (UTIs). Findings include: - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, history of UTI, and pressure ulcers. The quarterly Minimum Data Set (MDS), dated 05/15/15, identified moderately impaired cognition, extensive assist of 1 for eating, and an indwelling catheter. The current care plan stated, ". . . PROBLEM: Self Care Deficit . . . APPROACH . . . Encourage fluids throughout the day and night . . . PROBLEM: Alteration in Nutritional Status . . . RELATED TO: Alzheimer's, Constipation . . . APPROACH . . . Nutritional supplement . . . Nectar thick liquids. . . ." Observation on 08/03/15 at 2:30 p.m. showed two certified nursing assistants (CNA) (#2 and #3) completed personal cares for Resident #1 in his room and failed to offer fluids. Further observation at 3:35 p.m. showed the resident seated at a table in the Great Room during an activity with no fluids at the table. Observation on 08/04/15 at 10:40 a.m. showed two CNAs (#4 and #5) completed personal cares for Resident #1 in his room and failed to offer fluids. Further observation showed the resident seated in his wheelchair in the Great Room with no fluids at the table. At 11:20 a.m. staff placed	F 327	all residents including residents #1,4,6,10 with all cares on August 6, 2015. 2. All residents have the potential to be affected. 3. Re-education to the CNAs in regards to offering fluids with cares and review of the Hydration Policy was completed at the CNA meeting on August 10, 2015. See Attachments 327-A and 327-B. This policy will be reviewed with the nurses at the Nurses meeting August 25, 2015. See Attachment 327-C. The facility will continue to provide fresh water in all resident rooms throughout the day. Review of all residents fluid intakes will be done during monthly interdisciplinary meetings as well as with completion of the scheduled MDS. Residents showing inadequate fluids will continue to have fluids monitored in the resident room as well as with meals and snacks. 4. Monitoring of Residents #1, 4, 6 and 10 as well as a random selection in regards to being offered fluids with cares will be completed by DON or designee on a weekly basis for 4 weeks then monthly for 5 months and Quarterly x2. The findings will be discussed at the monthly QA interdisciplinary meetings. See Attachment 327-D.	

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F 327	Continued From page 7	F 327		

him in the hallway near the dining room and failed to offer him fluids until lunchtime at 11:45 a.m.

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, constipation, and urethral stricture with catheter. The quarterly MDS, dated 06/26/15, identified severely impaired cognition and extensive assist of 1 for eating. The current care plan stated, ". . . PROBLEM: Self Care Deficit . . . EATING: . . . Encourage fluids at all meals and throughout the day and night . . . History of UTI's. . . ."

Observation on 08/03/15 at 3:08 p.m. showed two CNAs (#2 and #3) completed personal cares for Resident #6 in his room and failed to offer fluids. Further observation at 3:35 p.m. showed the resident seated at a table in the Great Room with no fluids at the table.

Observation on 08/04/15 at 8:30 a.m. and at 10:35 a.m. showed two CNAs (#4 and #5) completed personal cares for Resident #6 in his room and failed to offer fluids. Observation at 11:00 a.m. showed the resident seated at a table in the Great Room with no fluids, and at 11:35 a.m. staff placed the resident in front of the chapel near the dining room. Staff failed to provide fluids until lunchtime at 12:15 p.m.

Observation on 08/05/15 at 10:40 a.m. showed two CNAs (#6 and #7) completed personal cares for Resident #6 in his room and failed to offer fluids.

- Review of Resident #4's medical record occurred on all days of survey. Resident #4's quarterly MDS, dated 06/07/15, identified short

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F 327	Continued From page 8	F 327		

and long term memory problems and extensive assistance required with eating. Resident #4's current care plan stated, "PROBLEM: Self Care Deficit related to Dementia . . . APPROACH: . . . Eating: Limited assist, extensive assist, 1 assist to complete meals with cues and reminders. . . . Encourage fluids at all meals and throughout the day and night. . . ."

Observation on 08/04/15 at 10:53 a.m. showed two CNAs (#12 and #13) completed personal cares for Resident #4 in his room and failed to offer fluids. At 12:03 p.m. staff placed Resident #4 in the hallway near the dining room and failed to offer fluids until lunchtime at 12:24 p.m.

Observation on 08/05/15 at 11:15 a.m. showed two CNAs (#14 and #15) completed personal cares for Resident #4 in his room and failed to offer fluids. Staff placed Resident #4 in the hallway near the dining room and failed to offer fluids until lunchtime at 12:23 p.m.

- Review of Resident #10's medical record occurred on August 5-6, 2015. Resident #10's quarterly MDS, dated 07/02/15, identified severely impaired cognition and extensive assistance of one for eating, and in indwelling catheter. Resident #10's current care plan stated, "PROBLEM: Self Care Deficit related to . . . muscle weakness, dementia . . . and left upper extremity amputation. . . . APPROACH: . . . Eating: extensive assist . . . Encourage fluids at all meals and throughout the day and night. . . . PROBLEM: Alteration in Nutritional Status . . . RELATED TO: . . . dysphagia, dementia, constipation, poor meal intakes . . . APPROACH: . . . Offer/encourage to attend snacks to increase fluid intake. . . . "

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F 327	Continued From page 9 Observation on 08/05/15 at 12:55 p.m. showed Resident #10 sitting in wheelchair by the nurses station. Two CNAs (#4 and #10) wheeled the resident to his room, transferred him to his bed, and provided personal cares. The CNAs failed to offer fluids to Resident #10. Observation on 08/06/15 at 10:05 a.m. showed two CNAs (#18 and #19) completed personal cares to Resident #10 in his room and failed to offer fluids. One CNA (#18) then transported him to the Great Room for an activity. Further observation between 10:30 a.m. and 11:00 a.m. showed Resident #10 seated in his wheelchair in the Great Room with no fluids at the table. During an interview on 08/04/15 at 2:50 p.m., a nurse manager (#1) indicated staff should offer fluids to residents during cares, snack times, and meals.	F 327		
F 371	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of professional	F 371	1. Ready to eat food was removed from	9/1/15

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F 371	Continued From page 10 reference, and staff interview, the facility failed to properly separate raw thawing food from ready-to-eat food, and failed to maintain a sanitary environment in the dishroom in 1 of 1 kitchen. These practices can increase the risk of cross-contamination and/or foodborne illness and can affect all residents who eat food prepared or served from these areas. Findings include: The 2013 Food and Drug Administration (FDA) Food Code, Annex 3 Public Health Reasons/Administrative Guidelines 3-3.302.11 (Preventing Food and Ingredient Contamination) Packaged and Unpackaged Food - Protection Separation, Packaging, and Segregation, states, "It is important to separate foods in a ready-to-eat form from raw animal foods during storage . . . to prevent them from becoming contaminated by pathogens that may be present in or on the raw animal foods. . . ." Observation of the kitchen, with an administrative dietary staff member (#9), occurred at 11:00 a.m. on 08/05/15. Observation showed a roll of raw ground beef thawing on the bottom shelf of the reach-in cooler. The raw ground beef roll did not fit inside the pan, and the end of the roll rested over the top edge of the pan. Observation showed a pan of frosted cake next to the roll of the raw ground beef. Observation also showed a container of "Crustables" (a commercially-made, ready-to-eat sealed sandwich) next to another pan of thawing raw ground beef on the bottom shelf. During an interview at this time, the administrative dietary staff member (#9) confirmed the ready-to-eat foods (frosted cake and sandwiches) should not be stored next to the	F 371	the bottom of the shelf in the refrigerator on August 5, 2015. The fan in the kitchen was cleaned following the walk through on August 5, 2015. 2. All residents have the potential to be affected. 3. Review of food storage was be completed with the Dietary staff on August 5, 2015 . Sign indicating placement of raw meat only has been placed to provide a visual reminder for dietary staff in the refrigerator on August 10, 2015. The fan was placed on a weekly cleaning routine schedule. See Attachment 371-A. The refrigerator will be checked routinely to make sure nothing but raw meat is being placed on the bottom shelf. See Attachment 371-B. 4. Refrigerator will be assessed twice daily for 2 weeks than one time daily by dietary staff. The dietary manager or designee will monitor this weekly. The fan will be assessed weekly for 4 weeks then monthly for 10 months by dietary manager or designee. These findings will be reviewed at the monthly QA interdisciplinary meetings. See Attachment 371-C.	

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F 371	Continued From page 11 raw ground beef. Observation in the dishwashing room during the kitchen tour showed a fan on a shelf above the clean dish area. Observation showed the fan with a layer of dust/debris on the blades of the fan, as well as on the cage covering the fan. The administrative dietary staff member (#9) confirmed staff should clean the dirty fan.	F 371		
F 431	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		8/25/15

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	355110	A. BUILDING _____ B. WING _____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

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F 431	Continued From page 12 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional literature, and staff interview, the facility failed to correctly store medication according to professional recommendations in the medication refrigerator for 1 of 1 supplemental resident (Resident #16) receiving Levemir in a prefilled syringe. Failure of facility staff to store medications according to manufacturer's recommendations may affect the potency and efficacy of the medication. Findings include: "Nursing 2015 Drug Handbook", 35th ed., Wolters Kluwer, Philadelphia, page 763, states, "Levemir . . . Don't store in-use prefilled syringes in a refrigerator. . . ." Review of the manufacturer's instructions for Levemir FlexPen prefilled insulin syringe occurred on 08/05/15. The instructions stated, ". . .After initial use, the LEVEMIR FlexPen . . . must NOT be stored in a refrigerator. . . ." On 08/05/15 at 2:25 p.m. an observation identified one unsealed in-use Levemir FlexPen (insulin cartridge) for Resident #16 stored in the medication refrigerator. During the observation, a licensed staff member (#8) indicated staff store	F 431	1. Insulin pen was removed from the refrigerator by the DON and placed in the lock medication drawer on August 5, 2015. 2. Any resident with diabetes needing an insulin pen could be affected. 3. Insulin storage policy was updated by the DON on August 13, 2015 and given to the nurses to review. See Attachment 431-A. The Policy will again be reviewed with the nurses at the nurses meeting scheduled for August 25, 2015. See Attachment 431-B. 4. Monitoring of the location and storage of insulin pen that is in use will be completed by DON or designee 2 times a week for 2 weeks then weekly for 4 weeks then monthly for 5 months then quarterly x2. These findings will be reviewed at the monthly QA interdisciplinary meetings. See Attachment 431-C.	

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F 431	Continued From page 13 the in-use FlexPen in the refrigerator. During an interview on 08/05/15 at 4:00 p.m., a nurse manager (#1) agreed in-use insulin pens should not be stored in the refrigerator.	F 431		
F 441	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.	F 441		9/10/15

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F 441	Continued From page 14 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 3 of 7 sampled residents (Resident #1, #10, and #12) observed during cares. Failure to follow infection control practices during personal cares has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy titled "Policy of Proper Handwashing" occurred on 08/06/15. This undated policy stated, ". . . Hands must be washed: . . . If gloves are worn, wash hands after removing gloves . . . CDC Hand Hygiene Recommendations . . . h. Decontaminate hands after removing gloves. . . ." - Observation on 08/03/15 at 2:30 p.m. showed two certified nursing assistants (CNA) (#2 and #3) provided personal cares for Resident #1 while he was in bed. After cleaning the resident of an incontinent bowel movement, the CNAs removed their gloves. Without performing hand hygiene, the CNAs assisted with pulling up the resident's pants, placed the lift sling under the resident, transferred the resident to his wheelchair, combed his hair, placed his glasses on his face, and a hat on his head. The CNAs failed to	F 441	1. Re-education of the CNAs on proper hand hygiene following removal of gloves and review of the Proper Hand Washing Policy was completed at the CNA meeting on August 10, 2015. See Attachment 441-A and 441-B. This information will also be reviewed with the nurses at the Nurse meeting on August 25, 2015. See Attachment 441-C. 2. All residents needing assistance after incontinent episodes with personal cares could be affected. 3. A skills assessment in regards to proper hand hygiene after removal of gloves with all primary CNA staff will be completed by August 23, 2015. See Attachment 441-D. A skills assessment in regards to proper hand hygiene after removal of gloves will be completed prior to any PRN CNA staff working. See Attachment 441-D. The skills assessment will be assessed by DON or designee. 4. Hand hygiene monitor will be completed for resident #1, 10 and 12 and a random selection on a weekly basis for 4 weeks then monthly for 5 months and then quarterly x2. All findings will be discussed at monthly QA interdisciplinary meetings. See Attachment 441-E.	

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F 441	Continued From page 15	F 441		

perform hand hygiene after perineal cares and prior to completing other tasks.

Observation on 08/04/15 at 10:40 a.m. showed two CNAs (#4 and #5) provided personal cares for Resident #1 while he was in bed. After cleaning the resident of an incontinent bowel movement, the CNA (#4) removed her gloves. Without performing hand hygiene, the CNA (#4) assisted with pulling up the resident's pants, placed the lift sling under the resident, transferred the resident to his wheelchair, buttoned his shirt, placed glasses on his face, and a hat on his head. The CNA (#4) failed to perform hand hygiene after perineal cares and prior to completing other tasks.

- Observation on 08/05/15 at 2:40 p.m. showed two CNAs (#16 and #17) provided personal cares for Resident #12 while she was in bed. After cleaning the resident of incontinent urine, the CNA (#17) removed her gloves. Without performing hand hygiene, the CNA (#17) assisted with pulling up the resident's pants, placed the lift sling under the resident, transferred her to her wheelchair, combed her hair, and placed glasses on the resident's face. The CNA (#17) failed to perform hand hygiene after perineal cares and prior to completing other tasks.

- Observation on 08/06/15 at 10:05 a.m. showed two CNAs (#18 and #19) provided personal cares for Resident #10 while he was in his bed. After cleaning the resident of an incontinent bowel movement, the CNA (#19) removed her gloves. Without performing hand hygiene, the CNA (#19) assisted with pulling up the resident's pants, applied a gait belt, and removed his oxygen tubing. The CNAs (#18 and #19) pivot transferred

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F 441	Continued From page 16 the resident to his wheelchair. The CNA (#19) then applied foot pedals to the chair, combed the resident's hair, reached into the bedside cabinet and sprayed cologne on the resident. The CNA (#19) then left the room and washed her hands in the soiled utility room. The CNA (#19) failed to perform hand hygiene after perineal cares and prior to completing other tasks. During an interview on 08/06/15 at 11:15 a.m., a nurse manager (#1) agreed staff should follow the facility's policy to wash hands after removing gloves.	F 441		