

10600

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505395	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/01/2013
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NAME OF PROVIDER OR SUPPLIER  STAFHOLT GOOD SAMARITAN CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 456 C STREET BLAINE, WA 98230
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey (QIS) conducted at Staholt Good Samaritan Center on 10/28/13, 10/29/13, 10/30/13, 10/31/13, and 11/01/13. A sample of 20 residents was selected from a census of 56. The sample included 14 current residents and the records of 6 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████, R.N., BSN          ██████████, R.N., BSN, MSEd          ██████████, R.N., BSN          ██████████, MSW</p> <p>The survey team is from:</p> <p>Department of Social and Health Services          Aging and Long Term Support Administration          Residential Care Services, Region 3, Unit B          3906 172nd Street NE, Suite 100          Arlington, WA 98223</p> <p>Telephone: (360) 651-6850          Fax: (360) 651-6940</p> <p>██████████ 11/07/13          Residential Care Services Date</p>	F 000	<p><b>General Disclaimer</b></p> <p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirement of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE  ██████████	TITLE  ADM	(X6) DATE  11/22/13
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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 241 SS=E	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure or promote an environment that maintained or enhanced each resident's dignity and respect in two of two dining rooms. This failure had the potential to diminish the quality of life for approximately 48 residents eating in those two rooms.</p> <p>Findings include:</p> <p><b>MAIN DINING ROOM</b> During observations on 10/28/13 at 11:55 a.m. through 12:45 p.m. revealed a large dining room with a pass through window from the kitchen into the dining room. Dining room staff were to collect a freshly prepared tray at the pass through window and bring it to the table where the resident was seated.</p> <p>During the observation period, several lapses of time passed between when a tray was made in the kitchen and when it was presented to the staff for distribution. The longest lapse was eight minutes.</p> <p>Even though a resident was seated at a table with other residents, he/she may not have been served at the same time. Several observations were made where one individual waited 16</p>	F 241	<p>F 241</p> <p><b>Resident # 33</b> Meals will be served according to policy; first come, first served.</p> <p><b>Resident # 57</b> Staff will assure this resident is in the correct dining room at meal time.</p> <p><b>Residents # 37 &amp; 34</b> Staff will sit down when they are assisting residents with their meal.</p> <p><b>Resident # 16</b> The dining room seating arrangement has been changed to better accommodate residents.</p> <p><b>Resident # 1</b> Meals will be served as quickly as they can be removed from the meal cart.</p> <p>Regular, random, ongoing auditing of the dining room is being done all three meals. Results of the audits will be reported to the QA committee.</p>	
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F 241	<p>Continued From page 2</p> <p>minutes before being served after everyone else at the table was served.</p> <p>Staff J, a Dining Room Assistant, was observed standing over an unidentified resident, cutting his food and feeding him. After 5 minutes, she walked over to a female resident and, while standing, started to feed her. Staff J continued this practice for the next 20 minutes with 3 other residents.</p> <p>On 10/31/13, observations starting at 4: 50 p.m. until 6:25 p.m. revealed lag times of up to 5 minutes between trays being passed to the main dining room from the kitchen pass through window. It took 15 minutes to completely serve a table of 6.</p> <p>A long table was located in the center of the dining room. Nine residents were seated at the table by 5:00 p.m. The last resident, an unidentified male resident was not served until 23 minutes had passed and all other residents at the table had been served.</p> <p>Resident 33 was sitting at a single table and was interviewed by the surveyor at 5:16 p.m. She stated she would sometimes get hungry and tired while waiting to be served. She indicated it made no difference if she was the first or last person in the dining room, she felt she was always served last.</p> <p>Three female residents were observed sitting at a round table near the center of the dining room. Two were served at 5:12 p.m. By 5:33 p.m., the surveyor inquired to a staff member why the third resident, Resident 57 had not been served and the kitchen appeared to be closing down. A</p>	F 241	<p>Policies related to meal service and dining room environment were reviewed and found to be appropriate. The policies will be reviewed with all dietary staff, dining room attendants, and nursing staff.</p> <p>Dietary Supervisor and DNS will monitor. Administrator will assure compliance.</p> <p>Completion date: December 1, 2013</p>	
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F 241	<p>Continued From page 3</p> <p>female staff member informed the surveyor Resident 57 ate at another table in another wing of the facility. When asked why she couldn't eat with the two ladies, the staff member replied they had not noticed the resident. Additionally, Resident 57 was heard to say she was hungry when staff were distributing dinner to the other two residents seated at the same table.</p> <p>At 6:16 p.m., the cook was interviewed. She stated the number of staff in the kitchen was normal and there was no reason for delays to have occurred.</p> <p>During morning observations on 11/1/13 at 8:30 a.m., Staff K, a Nursing Assistant, was observed to be standing over Resident 37 while feeding him. Staff J was observed to be standing over Resident 34, feeding her. After several minutes, Staff J went over to an unidentified female resident and started to spoon food into her mouth while standing over her.</p> <p>A review of the facility policy on 11/1/13 at 9:00 a.m. revealed residents were to be served in the main dining room on a first come-first served basis. It also read there would be no more than a 10-15 minute wait to be served, and residents may or may not eat at assigned seats.</p> <p>The Director of Nursing Services was interviewed on 11/1/13 at 10:15 a.m. She stated staff were not to stand over residents while feeding them.</p> <p><b>WEST DINING ROOM</b> Observations were made on 10/28/13 at 12:45 p.m. until 1:15 p.m. of the noon meal. The dining room had six tables, each with two to four residents seated. Eleven of the twenty residents</p>	F 241		
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F 241	<p>Continued From page 4</p> <p>required extensive to total assistance with their meals.</p> <p>During the distribution of the lunch trays, not all residents seated at the same tables were served at the same time. At four tables, there was a 10-15 minute period before everyone seated at the table had been served their lunch.</p> <p>On 10/31/13 at 5:31 p.m. until 6:20 p.m., observations were made of the dinner meal. Prior to the meal being served, the ending of a movie was being played on the television.</p> <p>At 5:41 p.m., the movie introduction continued to repeat for over ten minutes. At 5:53 p.m., Staff D, a License Nurse, turned off the movie. Resident 65 said "thank you" when the movie was turned off.</p> <p>At 5:54 p.m., Resident 16 was removed from her table to make room for the dining cart to be brought in. Due to spacing, Resident 16 had to be moved again for another resident to be brought into the dining room.</p> <p>At 5:58 p.m., Resident 1 raised her hand to obtain the nursing staff's attention. The resident wheeled herself up to the kitchen area and Staff B, Nursing Assistant Certified (NAC), asked her if she wanted her dinner. Resident 1 nodded her head "yes." Staff B told the resident to return to the table and she would bring her dinner. The resident returned to her table and waited for her tray to be delivered. When the tray did not come, Resident 1 left the dining room and had to be retrieved by a staff member and brought back to the dining room at 6:09 p.m.</p>	F 241		

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F 241	<p>Continued From page 5</p> <p>At 6:05 p.m., an unidentified resident was moved away from the table twice. Staff L, a paid feeding assistant, moved the resident away from her tray so she could remove the plate covers from the table. The resident was moved again to enable Staff L to sit down between two residents and assist them with their meal.</p> <p>During the distribution of the dinner trays, not all residents seated at the same tables were served at the same time. At three tables, there was a 10 minute period before everyone at the same table had their dinner served. Residents seated at the same table had to watch their tablemate eat and waited for their own meal to be served.</p> <p>Throughout the dining experience, there was little conversation or interaction between residents and, or staff. Although there was the ability to play music, it was not on.</p> <p>In an interview on 11/1/13 at 9:30 a.m., the Director of Nursing Services stated the normal practice was to serve residents who are able to assist themselves first and then serve residents who need assistance, even if they were seated at the same table.</p>	F 241		
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p>	F 253		

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F 253	Continued From page 6  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain maintenance services to floors in 9 of 14 rooms (2, 6, 7, 9, 10, 11, 12, 13, and 27) located in the East Wing. The failure to patch holes in the flooring under beds had the potential to be a health hazard as the surfaces could not be cleaned. Additionally there was the potential to diminish the quality of life for the residents residing in those rooms. None of the residents were interviewable.  Findings include:  During observations on 10/30/13 at 11:00 a.m., and on 10/31/13 at 10:00 a.m., numerous holes were found in the flooring under the feet and headboard of the beds. The largest of the holes measured approximately 12 X 7 inches and the smallest was 3 X 5 inches. Subflooring was visible through the torn linoleum. Additionally, patches were visible in some rooms using a 12 inch X 12 inch piece of tile secured with with silver duct tape. The duct tape was ripped and missing in some areas. When pressure was applied to the tape, a black liquid leached out.  On 10/31/13 at 10:45 a.m., Staff C, the Maintenance Supervisor was interviewed. He stated the previous maintenance person was aware of the torn flooring and thought the tiles, secured with tape, would protect the flooring from further damage. He also stated there was no money in his budget for repairs to the floors.	F 253	F 253  Rooms 2, 6, 7, 9, 10, 11, 12, 13, and 27 will have the flooring in the affected areas re-patched until they can be replaced. A contractor has been secured to complete the work as soon as possible.  An audit of all resident room floors has been done. Ongoing auditing will be preformed quarterly. Results of the audit will be reported to the QA committee.  Resident room floors will be replaced when needed.  Maintenance Director will monitor. Administrator will assure compliance.  Completion date: December 15, 2013	

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F 253	Continued From page 7	F 253		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to review and revise the care plan with appropriate interventions to prevent repeated occurrence of falls for 1 of 3 sample residents (8) reviewed for accidents.</p>	F 280	<p>F 280</p> <p>Resident # 8 The resident passed away [REDACTED], 2013.</p> <p>The facility will continue to analyze residents who have a pattern of falls to determine root cause and revise care plans as necessary in an effort to prevent repeat incidents.</p> <p>Fall trends will be analyzed for cause. Care plan interventions will be revised as needed.</p> <p>DNS will monitor and assure compliance.</p> <p>Completion date: December 1, 2013</p>	

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F 280	<p>Continued From page 8</p> <p>Failure to revise fall prevention interventions to meet the changing needs of Resident 8 placed her at risk for serious injury from repeated occurrence of falls.</p> <p>Findings include:</p> <p>According to "Nursing Home Guidelines" February 2012 superficial injuries of unknown source and some falls when abuse or neglect is not alleged or suspected, do not require a thorough investigation, but do require assessment to assist in preventing reoccurrence.</p> <p>Additionally, according to the federal code of regulation, it is necessary to evaluate and revise the care plan as the resident's status changes.</p> <p>Resident 8 had resided in the facility since 2002 and had diagnoses including [REDACTED] [REDACTED] [REDACTED] disease and [REDACTED]</p> <p>According to the most recent Minimum Data Set (MDS) assessment, dated 10/24/13, she required extensive assistance of 1 staff member for most activities of daily living.</p> <p>She had a history of falls as reported in the Care Area Assessment (CAA) summary, which accompanied Resident 8's annual MDS assessment, dated 8/5/13. The CAA summary stated the following: The resident had 8 falls over the past year. She had not suffered any substantial injuries related to falls. Falls and risk for falls occurred mostly due to the resident's poor judgment and disregard for safety issues.</p>	F 280		
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F 280	<p>Continued From page 9</p> <p>The resident attempted to self-transfer, stand without assistance, get self out of bed and stand from her wheelchair. It went on to state the resident had a clip alarm, a pressure mat while sitting in her chair and wheelchair and a pressure mat on the floor beside her bed to alert staff when she moved beyond her safety zone. Staff attended to the alarm immediately to ensure safety. However, the patient may lose her balance and fall before staff reach her.</p> <p>(Definition of a personal alarms - Alerting devices designed to emit a loud warning signal when a person moves.)</p> <p>Review of the Facility Incident Log revealed 4 more falls between 8/5/13 and 11/1/13. Incident Details and Investigations were reviewed for 5 incidents for Resident 8 beginning with 5/22/13. With each incident it was stated the safety intervention of the alarm device had been in place and sounded.</p> <p>The summary of a fall on 10/8/13 was indicative of the circumstances for most of her falls. It stated Resident 8 showed impaired decision-making, was unaware of fall risk, stood frequently, had multiple falls, shortness of breath with anxiety and attention seeking behavior. It went on to summarize the interventions in place to minimize falls: monitored closely, wheelchair pressure mat in place. She sets it off many times per day at which time staff respond at once to cue her to sit, investigate her needs, wants and concerns.</p> <p>The resident was observed multiple times on</p>	F 280		
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F 280	<p>Continued From page 10</p> <p>10/28, 10/29, 10/30 and 10/31/13. She was able to self-propel her wheelchair for short distances. She did not stay in one place or remain engaged in an activity for long. Even at the evening meal observed on 10/31/13 she left her place and needed cueing to return to eat. The personal alarm in her wheelchair did sound intermittently when she leaned forward far enough or raised off the pressure pad to trigger the alarm. Staff most often had her sit back on the pressure pad.</p> <p>On 10/30/13 at 1:50 p.m. Staff E, a Nursing Assistant, was asked what kind of interventions she would use for Resident 8 when she was restless or agitated. Staff E said she toileted her, took her down the hallway with her, such as when she charted; or gave her a sucker, which she really enjoyed. Staff E said she used to ambulate the resident, but her knees were giving out more often now and she's more short of breath with recent respiratory issues so does not tolerate much ambulation.</p> <p>With each of the incidents it was stated alarms were in place and sounded. It was stated, as above, staff attended to the alarm immediately. The alarm had not prevented Resident 8 from falling. Staff failed to analyze Resident 8's pattern of falls, determine the root cause, validate or change interventions and revise the care plan with individualized interventions in an effort to prevent repeat occurrences and serious injury.</p>	F 280			

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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to lock two of three shower rooms when not in use. These shower rooms contained numerous bleaching, disinfecting caustic agents, along with shampoos and soaps. This failure had the potential for a confused resident to gain access to these liquids and ingest them.</p> <p>Findings Include</p> <p>During observations on 10/28/13 at 10:45 a.m., until 11:15 a.m., the shower room by room [redacted] was unlocked. Inside was an unlocked cabinet with cleaning and disinfecting agents with the warning "keep out of reach of children" or "poison".</p> <p>On 10/30/13 at 10:30 a.m., 11:30 a.m., and 1:15 p.m., a shower room by room [redacted] was observed to be unlocked. Inside was an unlocked cabinet with cleaning and disinfecting agents with the warning "keep out of reach of children" or "poison".</p> <p>Observations on the same day at 2:22 p.m., revealed the shower room by room [redacted] to be</p>	F 323	<p>F 323</p> <p>The shower room (by room [redacted]) was immediately locked when pointed out by the surveyor. The shower room door frame (by room [redacted]) had "sagged" and the locking mechanism was not catching when the door was closed. This was fixed immediately.</p> <p>A sign has been placed on both shower room doors indicating they are to be locked at all times. Nursing and therapy staff will be re-instructed to assure these doors are locked at all times when not in immediate use.</p> <p>The shower room door handle mechanisms will be replaced with one that will not open without a key.</p> <p>Maintenance Director will replace door handles. Administrator will assure completion.</p> <p>Completion date: December 15, 2013</p>	

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F 323	Continued From page 12 unlocked as well.  The two shower rooms were located near a central nurse station. Multiple observations revealed cognitively impaired residents in the immediate area.  The Director of Nursing Services was interviewed on 10/30/13 at 3:00 p.m. She stated it was the policy and procedure of the facility to secure all chemicals behind locked, closed doors. Also, shower rooms were to be locked when not in use. At 3:10 p.m., she informed the surveyor the lock was broken on the shower room by room [redacted] and it would be repaired immediately.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329		

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F 329	<p>Continued From page 13</p> <p>given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to evaluate ongoing behaviors, effectiveness of the behavior care plan and therapeutic effectiveness of psychotropic medications for 1 of 5 sample residents (8) evaluated for use of psychotropic medications. This failed practice placed residents at risk for use of unnecessary medications.</p> <p>Findings include:</p> <p>Resident 8 was admitted to the facility in 2002 and had diagnoses including [REDACTED] and [REDACTED].</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 10/24/13, indicated Resident 8 had cognitive deficits, moderately impaired decision-making capacity and required extensive assistance for activities of daily living. She could sometimes understand communication and was sometimes understood.</p> <p>Review of the Medication Administration Record (MAR) revealed staff administration of an</p>	F 329	<p>F 329</p> <p>Resident # 8 The resident passed away [REDACTED] 2013.</p> <p>Nursing and social service staff, in conjunction with our mental health consultant will continue to review and evaluate each resident who uses antipsychotic medications. Residents who receive psychoactive medications will have their chart audited quarterly for medication reviews. Audit results will be reported to the QA committee.</p> <p>Policies related to psychopharmacological medication review process are in place and were reviewed by the DNS and social service staff and found to be appropriate. A formal psychoactive medication review committee meeting will take place monthly.</p> <p>Social workers will monitor. DNS will assure compliance.</p> <p>Completion date: December 15, 2013</p>	

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F 329	<p>Continued From page 14</p> <p>antipsychotic medication three times per day, an antidepressant one time per day and as-needed use of an anti-anxiety medication. Licensed nursing staff documented presence of identified behaviors each shift by a "+" if the resident exhibited a behavior. There was not a documented method to indicate whether any planned interventions were utilized and, if so, whether the intervention had been effective.</p> <p>On 10/30/13 at 3:45 p.m. Staff A was interviewed regarding the facility's Psychotropic Medication Review process. She stated there was no formal process or committee to review residents' use of psychotropic medications. "Staff know the residents so well they just periodically discuss and make recommendations while at the nursing stations." These conversations would often take place when the contracted Mental Health professional was making her visits to the facility. The content of the conversations was not consistently documented. There was no formal means to evaluate resident behaviors or effectiveness of the behavior care plan interventions in relation to therapeutic effectiveness of medication.</p> <p>Documentation by the Mental Health Professional, for a visit completed 10/11/13, stated Resident 8 had required increased use of her anti-anxiety medication related to exacerbation of [REDACTED] and related issues causing anxiousness. It was documented the resident had a decrease in the dosage of her anti-psychotic in July of 2013. There was no information as to consideration for further dose reduction.</p>	F 329		

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F 329	Continued From page 15	F 329		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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.</p>	F 441	<p>F 441</p> <p>Kitchen: the lidded trash can is left with the hinged lid open. This began immediately. Laundry: Staff F was immediately re-educated on proper glove usage by the DNS and Infection Control Preventionist (ICP) when the situation was brought to the facilities attention.</p> <p>Random, ongoing auditing will be conducted by the ICP. Audit results will be reported to the QA committee.</p> <p>Infection Control polices and procedures were reviewed and found to be up-to-date and appropriate. Ongoing inservicing will be provided to all staff regarding proper glove use, and hand washing.</p> <p>ICP will monitor. Administrator will assure compliance.</p> <p>Completion date: November 8, 2013</p>	

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F 441	<p>Continued From page 16</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow its policy related to two kitchen staff washing their hands and for one laundry assistant to remove gloves. This failure had the potential to contaminate staff hands and multiple surfaces, thereby placing residents at risk for infections.</p> <p>Findings include:</p> <p><b>KITCHEN</b> During observations in the kitchen on 10/31/13 at 11:55 a.m., a small sink was observed in the dirty dish section. Beside the sink was a large trash can with a secured lid on top. Several posters were on the wall, indicating how to wash hands. When asked by the surveyor if the sink was used for handwashing, the cook stated no, and that staff used other sinks in the kitchen. When asked about the trash can, the cook stated it was used to dispose of trash and uneaten food when the trays were cleaned before going into the dishwasher.</p> <p>Staff G and H were observed to wash their hands at the sink in the dirty dish room. They both retrieved towels and dried their hands. Staff H held the lid of the trash can, using a paper towel as a barrier for Staff G to dispose of her used towels before throwing her own towels inside and</p>	F 441		

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F 441	<p>Continued From page 17 allowing the lid to slam down shut.</p> <p>This process was repeated at least 3 times during the course of the next 10 minutes. At one point, Staff H was observed to wash her hands and reach for the lid of the garbage can using her bare hands.</p> <p>Staff I was interviewed at 3:30 p.m., She informed the surveyor it was the policy for kitchen staff to use a trash can that did not require the touching of any surface except the shoe when performing handwashing.</p> <p><b>LAUNDRY</b> Observations on 11/1/13 from 9:15 a.m. until 9:45 a.m. revealed Staff F, a laundry assistant to be wearing gloves in a hallway of the West Wing. She would retrieve soiled bags of clothing wearing gloves and place the items into a large cart. Throughout the observation period, she retrieved dirty bags of linen, touched numerous doors and pieces of furniture. At 9:45 a.m., Staff F was observed wearing the same gloves while she traversed the entire length of the nursing facility. During that time, she was observed pushing buttons for the automatic door opener in a resident area and into the service hallways, touching hand rails in hallways, touching door handles, and moving storage equipment.</p> <p>When interviewed the same day at 9:50 a.m., the Director of Nursing Services stated the staff member should have removed her gloves and washed her hands between tasks and before going to each hallway.</p>	F 441		
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F 441	Continued From page 18	F 441			
F 463 SS=E	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined the facility failed to identify and ensure the resident call light system remained functional for 5 of 33 rooms ●, ●, ●, ● and ● and reviewed for a communication system. This failure placed residents, staff and/or visitors at potential risk for not being able to summon staff for assistance if needed.</p> <p>Findings include: On 10/29/13 at 1:58 p.m., the call lights in room ● bed ● and room ● bed ● did not function when the call light was activated. The light above the door or next to the resident's bed did not illuminate however, the alarm from the call light control panel was sounding at the control panel.</p> <p>At 2:05 p.m., the Executive Director confirmed the two call lights were not functioning.</p> <p>At 2:15 p.m. Staff C, Maintenance Director, was informed the call lights were not functioning and a</p>	F 463	<p>F 463</p> <p>Call lights in rooms ●, ●, and ● were replaced immediately.</p> <p>All call lights in the facility were immediately audited.</p> <p>Monthly audits will be done of all call lights. Any found in sub-standard working order will be replaced. Audits will be reported to the QA committee.</p> <p>Maintenance Director and DNS will monitor. Administrator will assure compliance.</p> <p>Completion date: November 5, 2013</p>		

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F 463	<p>Continued From page 19 facility audit was conducted.</p> <p>Similar findings were found in rooms ●, ● and ●.</p> <p>At 2:45 p.m., Staff C stated the non-functioning call lights had been replaced.</p>	F 463		
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