

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

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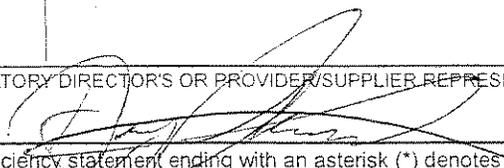
PRINTED: 01/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2014
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NAME OF PROVIDER OR SUPPLIER EVERETT TRANSITIONAL CARE SERV	STREET ADDRESS, CITY, STATE, ZIP CODE 916 PACIFIC AVENUE - 6TH FLOOR EVERETT, WA 98201
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Off Hours Quality Indicator Survey (QIS) conducted at Everett Transitional Care Services on 1/6/14, 1/7/14, 1/8/14, 1/9/14 and 1/10/14. The survey included data collection on 1/8/14 starting at 4:30 a.m. A sample of 27 residents was selected from a census of 30. The sample included 20 current residents and the records of 7 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████, R.N., BSN ██████████, R.N., BSN ██████████ B.S.H.S.</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>██████████ Residential Care Services</p>	F 000	<p>The Plan of Correction is submitted as required under Federal and State statutes and regulations. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the state surveyor's findings constitute deficiencies, or that the scope and severity determinations regarding the alleged deficiencies were correctly applied.</p> <p style="text-align: right;">JAN 29 2013 ADSA/RCS Region 3</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 1-27-14
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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 000	Continued From page 1	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.	F 176	F 176 Self Administration of medications Facility will continue to ensure that patients may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure 1 of 4 residents, (Resident 212) who was observed with a medication at bedside, was assessed for safety of medications at bedside, including self-administration, storage, and monitoring. This failure placed the resident at risk of adverse effects from medication interactions and not taking the medication as ordered by the physician. Findings include: Resident 212 was admitted to the facility on [REDACTED]/13, with diagnosis to include [REDACTED] and [REDACTED]. In an interview with the resident on 1/9/14 at approximately 1:00 p.m., a tube of over the counter [REDACTED] pain medication was observed in the resident's room. When asked about it, the resident stated she used the [REDACTED] pain medication on her back. She further stated she kept it in her room and used it whenever she needed it.		Resident 212 has been discharged from the facility All patients with medication at the bedside have been assessed for safe administration of these medications. Medications will not be left at the bedside without PCP orders. When order is received, an LN will complete the LN Assessment for Self-Administered Medications. Facility Policy has been revised to include assessment of each patient who has PCP orders to ensure the medication is safely administered. All Licensed Staff will be inserviced regarding self-administration of medication policy Periodic audits will be performed to ensure compliance with facility policy and findings reviewed in monthly CQI meetings. Completion Date 2/7/2014 DNS to ensure compliance	

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F 176	Continued From page 2 Record review revealed, the resident had an order for ██████ pain medication dated 1/5/14, the order read, "ok to keep at bedside." No assessment for self administration of medication was found in the medical record.	F 176	Continued from page 2		
F 241 SS=E	In an interview with the Assistant Director of Nursing Services (ADNS), she verified an assessment for self administration of medications was not completed for Resident 212. She further stated, the ██████ pain medication should not be left in the room. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure confidentiality of information and dignity was maintained for 11 of 27 residents reviewed for dignity. The facility failed to ensure resident 270 was appropriately covered while in bed and the urine collection bag was concealed. In addition, the facility failed to protect the privacy of residents 238, 233, 262, 269, 270, 207, 71, 268, 258, 257 and 188's information by publicly	F 241	F 241 Dignity and Respect of Individuality Facility will continue to 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. Resident 270, 233, 262, 207, 71, 268, 257 and 188 have been discharged from the facility. Personal information that can be viewed from the hallways has been removed from all patient rooms including resident 269, 238 and 258. Personal information will not be posted such that it can be viewed by anyone not authorized to view it.		

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F 241	Continued From page 3 posting signs regarding health care information. Failure to maintain resident dignity placed the residents at potential risk for feelings of frustration and/or diminished self-worth. Findings include: PRIVACY Resident 270 was admitted to the facility in [REDACTED] 2013 with a diagnosis to include a [REDACTED]. Resident 270 required extensive to total assist of 1 - 2 staff members to meet her activities of daily living, had an [REDACTED] and was alert to self, but not interviewable. On 1/8/14 at 4:40 a.m., the resident was lying in the bed, with the light over the bed on and the door to the room was open. The resident was visible, from the doorway, exposed from the waist down. She was wearing a brief. The urine collection bag, not covered, was visible from the doorway. Staff F, a Certified Nursing Assistant, was observed outside the resident's room. Staff F walked by the resident's room taking trash from another resident's room. At 5:05 a.m., the resident was observed in the same position exposed from the waist down. Staff F was seen again walking down the hallway past Resident 270's room. At 5:25 a.m., the resident was observed in the same position exposed from the waist down. Staff F then entered the room and closed the curtain between the hallway and the resident's bed. At 5:45 a.m., the resident was observed to be	F 241	F 241 Continued from page 3 Privacy curtains will be used when providing care to maintain privacy. All staff will be inserviced on HIPPA and privacy. Periodic audits will be performed to ensure compliance with facility policy and findings reviewed in monthly CQI meetings. Completion Date 2/7/2014 DNS to ensure compliance	
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F 241	Continued From page 4 properly covered and the urine collection bag concealed. In an interview on 1/8/14 at 8:00 a.m., the Director of Nursing Services (DNS) was asked about resident privacy. The DNS agreed a resident's brief should not be visible and they should be covered in a dignified manner. She also stated urine collection bags were to be covered.	F 241	See Page 3		
	<p>RESPECT OF RESIDENT CONFIDENTIALITY On 1/6/14, 1/7/14 and 1/8/14, all of the occupied rooms on unit 1 had confidential health care information typed on a 8 1/2 x 11 inch piece of paper posted on a board inside the resident doorway visible to visitors and the public.</p> <p>The following signs were posted on the wall, inside the door, visible from the hallway for residents 238, 233, 262, 269, and 270: "weight at NOC (night)," "no b/p (blood pressure) in arm," specific dialysis days, how to transfer a resident, "sit up in chair for 30-60 minutes," "NTL" (indicated the resident was on nectar thick liquids), swallowing precautions, specialized boot to be worn when the resident was out of bed and "TED hose on in am off at hs (hour of sleep)."</p> <p>Similar findings were observed for residents 207, 71, 268, 258, 257 and 188.</p> <p>In an interview on 1/9/14 at 8:45 a.m., the DNS and Staff A, Staff Development Nurse, was asked about the signs visible to the public/visitors. The DNS understood this was private information and should not be posted. The DNS stated the signs would be removed from all resident rooms by the end of the day.</p>				

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F 241	Continued From page 5	F 241	See page 3	
F 285 SS=B	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.	F 285	F 285 PASRR Requirements for MI & MR Facility will continue to coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. Resident 212 and 263 have been discharged from the facility. An audit was performed on all patient PASRR forms, all accurately reflect the status of the patient, none of them required Level II assessment at the time of the audit. PASRR forms will be reviewed by Social Services on admission and before LOS reaches 30 days. All patients who meet the criteria for 30 day review of PASRR with have the appropriate review completed. Social Service staff will be in-serviced regarding requirement for 30 day PASRR review. Periodic audits will be performed to ensure compliance with facility policy and findings reviewed in monthly CQI meetings. Completion Date 2/7/2014 DNS to ensure compliance	

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F 285	Continued From page 6 For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.	F 285	See Page 6
	<p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments were accurately completed for 2 of 3 sample residents (212 and 263). Failure to ensure PASRR assessments were completed accurately placed these residents at risk for receiving less than necessary services for mental health needs.</p> <p>Findings include:</p> <p>RESIDENT 212 Resident 212 was admitted to the facility with diagnosis to include [REDACTED] and [REDACTED]</p> <p>The resident's Level I PASRR dated 11/3/13, documented the resident had a [REDACTED] disorder. A Level II assessment was not requested because the resident was to be a 30 day admission.</p> <p>The 30 day period had passed and the Level I PASRR Assessment should have been updated to request a Level II PASRR.</p>		

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F 285	Continued From page 7 In an interview with the Social Worker, Staff B, on 1/9/14, at 1:30 p.m., she acknowledged the resident's Level I PASRR needed to be updated to request a Level II Assessment and stated she would do it right away. RESIDENT 263	F 285	See page 6		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	F 323 Free Accident Hazards/Supervision/Devices Facility will continue to ensure that the resident environment remains as free of accident hazards as is possible; CO2 tanks in the dietary department were secured during survey. CO2 tanks will be secured at all times.		

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F 323	Continued From page 8 by: Based on observation and interview the facility failed to safely secure 3 full carbon dioxide cylinders. This failure resulted in a potentially unsafe environment. Findings include: On 01/06/14 at 8:05 a.m. during a tour of the kitchen, 3 full carbon dioxide cylinders were observed free-standing in a food storage room. A strap to secure the tanks was laying on the floor in front of the cylinders. The kitchen Production Manager, Staff C, said the tanks were full and they should be secured. He said the bolt holding the strap needed to be replaced and a work order had been submitted.	F 323	F323 continued from page 8 Kitchen staff will be provided with in-service education regarding necessity of securing CO2 tanks at all times Kitchen Manger will conduct periodic inspections to ensure compliance.		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 334	Completion Date 2/7/2014 Dietary Manager to ensure compliance F 334 Influenza and Pneumonia Immunizations Facility will continue to develop policies and procedures that ensure that ; (i) Before offering the influenza/pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization (ii) Each resident is offered a pneumococcal immunization and influenza immunization, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; and		

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F 334	Continued From page 9 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 334	F334 continued from page 9 (iii)The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	
	The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal		(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza /pneumococcal immunization; and (B) That the resident received the influenza/pneumococcal immunization or did not receive the influenza/pneumococcal immunization due to medical contraindications or refusal Resident 233, 188 and 165 have been discharged from the facility. All patients in the facility without documented influenza and/or pneumonia immunization received education about the benefits and potential side effects of immunization and have been offered the opportunity to receive the immunizations in the facility. Facility will continue to provide education about the benefits and potential side effects of immunization and offer influenza and/or	

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F 334	Continued From page 10 immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to have a system in place to ensure the pneumococcal and influenza immunization was offered and/or administered for 4 of 6 residents (233, 188, 265 & 238) reviewed for immunizations. This placed the residents at risk for acquiring, transmitting and experiencing complications from pneumococcal pneumonia and influenza. Findings include: The facility's policy and procedures regarding the influenza and pneumococcal vaccine stated ". . . all patients will be offered the opportunity to receive. . ." the annual flu and pneumococcal vaccine. Resident 233 Minimum Data Set (MDS), an assessment tool, dated 12/21/13, indicated the pneumococcal and influenza immunizations were offered and the resident declined. Resident 233's immunization record was blank. There was no other documentation in the resident's record regarding these two immunizations and the resident's refusal. Resident 188's MDS dated 12/31/13, indicated the influenza immunization was offered and the resident declined. The pneumococcal vaccine	F 334	F334 continued from page 10 pneumonia immunization to patients per CDC guidelines. Immunization record sheet has been updated to include documentation of side effects and benefits education provided, immunization given or refusal of immunization. Licensed Staff will be inserviced regarding facility policy on patient vaccination for influenza and pneumonia. Periodic audits will be performed to ensure compliance with facility policy and findings reviewed in monthly CQI meetings. Completion Date 2/7/2014 DNS to ensure compliance		

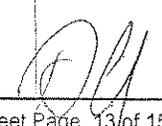
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NAME OF PROVIDER OR SUPPLIER EVERETT TRANSITIONAL CARE SERV		STREET ADDRESS, CITY, STATE, ZIP CODE 916 PACIFIC AVENUE - 6TH FLOOR EVERETT, WA 98201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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 334	<p>Continued From page 11 was identified as "up to date." The resident's immunization record was blank. There was no documentation of the resident's refusal in the medical record.</p> <p>Resident 265's MDS dated 1/4/14 indicated the influenza immunization was received outside of the facility, and the pneumococcal immunization was up to date. The resident's immunization record was blank. There was no documentation indicating when the resident received the two immunizations.</p> <p>Similar findings were found with Resident 238.</p> <p>In an interview on 1/8/14 at 11:02 a.m., Staff A, Staff Development Nurse, was asked about the facility's policy regarding influenza and pneumococcal immunizations. Staff A stated, residents were asked about their immunizations with the MDS. The MDS was typically scheduled to be completed 5-8 days after admission. Immunizations were documented on the MDS and the immunization record. If the resident refused either immunization in the hospital, the facility did not offer it again upon admission.</p>	F 334	See page 11	
F 441 SS=E	<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</p>	F 441	<p>F 441 Infection control, Prevent Spread, Linens</p> <p>Facility will continue to 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>	

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

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F 441	<p>Continued From page 12</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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> <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 and interview the facility failed to implement an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development of transmission of disease and infection. This failure had the potential to compromise the resident's health and ability to</p>	F 441	<p>F441 continued from page 12</p> <p>Residents in rooms [redacted], [redacted] and [redacted] have been discharged from facility.</p> <p>All Housekeeping staff will be inserviced on hand hygiene procedures.</p> <p>Periodic audits will be performed to ensure compliance with facility policy and findings reviewed in monthly CQI meetings.</p> <p>Completion Date 2/7/2014</p> <p>Housekeeping Supervisor to ensure compliance</p> 

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F 441	Continued From page 13 maintain or reach his or her highest practicable level of well-being. Findings include: In an observation on 1/7/14 at 10:05 a.m., Staff D, a housekeeper, was exiting room [redacted]'s bathroom with gloved hands and a toilet brush in a container. Without changing gloves, Staff D entered the next room and proceeded to clean the bathroom. Staff D came out of the room, with the same contaminated gloved hands, reached in her pocket for the keys to open the housekeeping cart and put the toilet brush and container away. Staff D proceeded to clean the floor in the room. When staff D was done in the room, she came out removed her gloves and used hand sanitizer. At the same time, Staff E, came out of room 626 with gloved hands and placed something inside a clear plastic bag, which was hanging off of the housekeeping cart. Staff E, with now contaminated hands, took the full bag to the dirty utility room, opened the door and immediately came back out with a new bag and placed it on the housekeeping cart. Then Staff E removed her gloves and used hand sanitizer. At 2:50 p.m., Staff D was observed, in a common area, moving around on her hands and knees cleaning a stationary bike with a wet cloth in her right hand while her left hand was on the floor. Staff D, then rose and put the wet cloth in her left hand and proceeded to wipe down the rest of the bike and started to clean the chairs and table. In an observation on 1/8/14 at 7:35 a.m., Staff D was cleaning room [redacted]. With gloved hands, she removed the toilet brush from a compartment on top of the housekeeping cart and proceeded to	F 441	See Page 12	
				

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F 441	<p>Continued From page 14</p> <p>clean the bathroom. With now contaminated hands, she reached in her pocket, removed the keys and opened the top of the housekeeping cart to put the toilet brush away. With the same gloved hands she pushed the cart down to room [REDACTED], knocked on the door, entered the room, was not able to clean the room at that time, and pushed the cart back down the hallway to room [REDACTED]. Staff D, knocked on the door, did not enter, and proceeded to push the cart to room [REDACTED]. Staff D was stopped by the surveyor at 7:45 a.m., and interviewed regarding the facility's practice on hand hygiene. Staff D stated she changed her gloves and used hand sanitizer when coming out of a room. This would give her hands a "chance to dry" before she entered another room. She was told this was not observed over the past two days of observation.</p> <p>In an interview on 1/8/14 at 8:05 a.m., the Director of Nursing Services was notified of the above findings.</p>	F 441	See Page 12	
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