

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

PRINTED: 02/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1384 505282	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF RITZVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 506 SOUTH JACKSON RITZVILLE, WA 99169
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INITIAL COMMENTS

This report is the result of an unannounced Off-Hours Quality Indicator Survey conducted at Life Care Center of Ritzville on 2/6/13, 2/7/13, 2/8/13, 2/11/13, 2/12/13, and 2/13/13. The survey included data collection on 2/11/13 from 7:00 p.m. to 9:00 p.m. A sample of 31 residents was selected from a census of 36. The sample included 30 current residents and the records of 1 former and/or discharged resident.

The survey was conducted by:

- _____, R.N. B.S.N.
- _____, B.S.W.
- _____, R.N. B.S.N.
- _____, R.N. B.S.N.

The survey team is from:

Department of Social & Health Services
Aging & Disability Services Administration
Residential Care Services, District 1, Unit B
Rock Pointe Tower
316 West Boone Avenue, Suite 170
Spokane, Washington 99201-2351

Telephone: (509) 323-7303
Fax: (509) 329-3993

Leanne Heiner 2/26/13
Residential Care Services Date

F 000

This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.

RECEIVED

MAR 06 2013

DSHS ADISA RCS
SPOKANE WA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

Regional Vice President

(X6) DATE

3/5/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	<p>Continued From page 2</p> <p>1. Resident #6 had a diagnosis of [REDACTED] and required extensive assistance with most activities of daily living. The resident had short and long - term memory problems and required assistance with decision - making. On 2/6/13 at 1:15 p.m., Staff #A entered Resident #6's room while the surveyor completed an interview with the resident's roommate. Staff #A assisted Resident #6 into her bathroom to use the toilet. The staff member left the door open in order to transfer the resident onto the toilet but she did not pull the privacy curtain. The resident was visible from her roommate's side of the room and the resident did not have any privacy. In an interview on 2/13/13 at 10:15 a.m., Staff #B confirmed the resident's privacy curtain should have been pulled to protect the resident's privacy and ensure dignity with cares. The facility failed to ensure privacy curtains were used for resident's privacy during personal care.</p> <p>2. Per observation on 2/6/13 at 3:50 p.m., Staff #D entered Resident #35's room without knocking and did not acknowledge that the resident's phone call was interrupted.</p> <p>3. On 2/7/13 at 10:50 a.m., the surveyor was interviewing Resident #18. During the interview, Staff #C walked into the room without knocking in order to provide care for the resident's roommate. Staff #C did not acknowledge the resident. During the above interview on 2/7/13 at 11:23 a.m., the surveyor was still interviewing the resident when Staff #E knocked on the door and walked in without waiting for a response from the resident.</p>	F 164	<p>F 164</p> <p>SPECIFIC RESIDENTS Resident's #6's privacy curtain is pulled when personal cares are provided. Staff are knocking and announcing themselves before entering the room for resident's #35, #16 and resident #18.</p> <p>OTHER RESIDENTS Other residents had the potential to be affected. Staff are knocking and waiting for a response if the resident is able to verbally respond, if unable to respond staff will knock and announce self and enter. Privacy curtains are pulled when providing personal cares to residents.</p> <p>SYSTEMIC CHANGES In-service staff on providing dignity with personal cares. In-serviced staff on knocking on residents doors and wait for a response if resident unable to respond to staff, staff will knock and announce themselves. In-serviced also on pulling privacy curtains when providing personal cares.</p> <p>MONITOR DON/ED/RCM will audit personal cares to ensure the residents are provided dignity. Audits will be performed to ensure the staff are knocking on doors and introduce themselves before entering a residents room or announce themselves if the resident is unable verbalize. Audits will begin 3/11/13 they will be done weekly x 4 weeks then monthly x 3 months. ED will bring audits to PI for review.</p> <p>DATE OF COMPLIANCE: 3/26/13</p>	
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F 164	Continued From page 3 During an observation on 2/13/13 at 10:00 -10:15 a.m., multiple staff were observed entering Resident # 16 and Resident # 18's room without knocking or announcing themselves. Per review of facility procedures, staff were expected to knock on residents' doors and introduce themselves before entering a resident room. The facility did not ensure staff consistently respected resident's personal space and resident's privacy.	F 164		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide medically-related social services for 2 of 2 residents reviewed for psychosocial concerns (#16, 28) in a sample of 31. Failure to consistently establish an effective way to provide necessary care and services to ensure psychosocial needs were being met placed the residents at risk for not attaining the highest practicable well-being. Findings include: 1. Resident #28 had diagnoses including [REDACTED]. Per record review, the resident had no short-term memory problems, symptoms of depression, and no recent behavior problems. The resident was independent in	F 250	F 250 SPECIFIC RESIDENTS Resident #28 has had her discharge plan reviewed and is currently in process to find other placement. Resident # 16 has had a follow up Social Service assessment and no longer is making statements of wanting to end her life. OTHER RESIDENTS Other residents had the potential to be affected. Residents discharge plans were reviewed and updated per the wishes of the residents. No other residents have made the statements of wishing to die.	

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F 250	<p>Continued From page 4</p> <p>transfers to and from the wheelchair, eating, toileting, and personal hygiene, totally continent, and required limited assistance with bathing and ambulation. The resident was admitted 1/11 and the care plan for discharge was to remain in the facility long-term.</p> <p>Review of the facility comprehensive assessment dated 3/28/12 noted the resident had symptoms of _____ and was at times _____ wanting to return to her home. The resident's son was noted as refusing to talk with the resident about returning to her home.</p> <p>A nursing note dated 1/17/13 at 1:40 p.m. noted the physician visited the resident and the resident was unaccepting of the situation of remaining in the facility.</p> <p>Per record review, after the resident expressed a concern to the physician about discharge, the facility did not provide follow-up to evaluate for unmet psychosocial and/or discharge planning needs.</p> <p>In an interview on 2/7/13 at 2:34 p.m., the resident stated she talked with the doctor recently who told her she might be able to go home if she had someone with her. She stated she came for knee surgery and has never been able to go home. During the interview, she repeatedly stated she was very unhappy and did not want to live in the facility. She stated the people that sued to be in charge of the facility told her she had to stay. She stated she did not know if the new people in charge knew about her situation. She stated since she talked to the doctor she has wondered if she should get an attorney.</p> <p>In an interview on 2/12/13 at 1:30 p.m. with Staff #C and #G, Staff #G the resident periodically brought up concerns about wanting to be discharged home, which was not a viable</p>	F 250	<p>SYSTEMIC CHANGES</p> <p>In-service provided to Social Service Director on documenting discharge plans for residents. Social services will work with family and residents and assist with discharge plans as needed. In-service provided to LN's to ensure when residents make negative statements they are placed on alert charting and a referral given to Social Service.</p> <p>MONITOR</p> <p>SS director will audit residents for individualized discharge plans on admit then quarterly per mds schedule x 4 months. SS director will audit residents for making statements of desires to die weekly x 4 weeks then monthly x 3 months. SS will bring result to PI. Audits will begin 3/11/13.</p> <p>DATE OF COMPLIANCE: 3/26/13</p>	

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F 250	<p>Continued From page 5</p> <p>option. She stated she followed up with the resident after the doctor visit. The resident wanted to go home and Staff #G reviewed the need for 24 hours supervision to return home. The resident responded that she might need to get an attorney and Staff #G had no additional information about facility follow-up for the resident's psychosocial status and discharge options.</p> <p>In an interview on 2/12/13 at 1:45 p.m., Staff #B stated community discharge options were reviewed with the resident about a year ago. She stated the resident's son refused the facility requests to discuss discharge planning with the resident and the resident became upset when the facility reviewed her current financial status. Staff #B stated due to the unresolved discharge issues between the resident and son, the resident had not made a good adjustment to the facility.</p> <p>The facility's lack of providing social services placed the resident at risk for unmet psychosocial needs and poor adjustment to the facility.</p> <p>2. Resident #16 had diagnoses including _____</p> <p>Per record review, the resident had memory problems, symptoms of depressed mood, no behavior problems, and required extensive staff assistance with activities of daily living involving transfers and eating. According to the facility assessment dated 11/9/12, the resident's condition had declined and the facility was evaluating the resident for a continuing overall decline in condition.</p> <p>In a nursing note dated 2/6/13 at 10:08 p.m., the resident had made a statement to a licensed nurse at the beginning of the night shift on 1/29/13 indicating she wished she could end her</p>	F 250		
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F 250	<p>Continued From page 6</p> <p>life. The licensed nurse documented she spent individual time with the resident and noted the resident was in "better spirits" and slept during the night. There was no referral to social services or ongoing monitoring of the resident's mood symptoms.</p> <p>In an interview on 2/8/13 at 1:55 p.m., the surveyor informed Staff #C of the resident's concern. Staff #C confirmed the nursing note was an out-of-sequence note written on 2/6/13 for the resident's statements made on 1/29/13. Staff #C stated nursing staff should have monitored the resident each shift and completed a referral to social services staff on 1/29/13. Staff #C confirmed the facility delayed in following up with the resident's psychosocial concerns.</p>	F 250		
F 252 SS=E	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to promote a home-like environment while dining, related to administering medications in the dining room while residents were consuming their meal. Affected were 4 of 31 sampled residents (#17,22,26,33) and potential were all residents who ate in the dining room.</p> <p>Findings included:</p>	F 252	<p>F 252</p> <p>SPECIFIC RESIDENTS Residents #17, #22, and #26 do not receive their medications during meals, per their choice. Resident # 33 does not receive her insulin injection while in a public area.</p> <p>OTHER RESIDENTS Other resident had the potential to be affected.</p> <p>SYSTEMIC CHANGES LN in-serviced regarding giving medications during a meal, if a resident wishes to have their medications given during a meal this will be honored and care planed as such otherwise medications will be passed prior to or after a meal.</p>	

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F 252	Continued From page 7 1. On 2/06/13 at 12:15 p.m. Resident #17 was seated at the dining table in the assisted dining room. She was eating her lunch. Staff # F approached her table and said to the resident "After you finish those two bites I got some pills for you." She remained standing next to the resident until she appeared to have swallowed her food and then administered the contents of the medication cup. She was again observed administrating medications to two other residents at the same table (Resident #26 and Resident #22). In an interview on 2/07/13 at 2:00 p.m., Staff #F said "meal times are one of the major medication pass times. We don't leave the med cups at the table, we watch the resident take their medications." 2. On 2/07/13 at 5:10 p.m. Staff # D approached Resident #33 whom was in the independent dining room seated at her table. The facility was having a planned dinner function and had many guests seated throughout the dining room. Staff #D went to give Resident #33 her insulin in her arm as she requested but was unable to roll up her sleeve. She then had Resident #33 pull her shirt up to allow access to her abdomen and injected the insulin. She did not request the resident leave the dining room for her injection or wear gloves or wash her hands after administering the insulin. She then proceeded to administer medications to two other residents in the same dining room. Staff were observed throughout the survey administering medications to residents in both dining rooms during meal times. The nursing homes failure was to provide an	F 252	MONITOR DON/RCM will audit for medications given during a meal and/or insulin given in the dining room weekly x 4 weeks then monthly x 3 months. Audits will begin 3/11/13. DON will bring results to PI. DATE OF COMPLIANCE: 3/26/13	

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F 252	Continued From page 8 environment as close to that of a private home. This concept includes the elimination of as many institutional practices as possible. Some good practices that serve to decrease the institutional character of the environment include the elimination of routinely administering medications that can be administered prior to or after meal times which would promote a more homelike setting and positive dining experience.	F 252			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to	F 280	F 280 SPECIFIC RESIDENTS Resident # 24 has a current pain care plan. OTHER RESIDENTS Other residents on a comfort care program have had their pain care plan reviewed and updated as needed. SYSTEMIC CHANGES In-service LN on properly medicating residents on a comfort care program according to their wishes and ensuring their care plan matches their wishes. MONITOR DON/RCM will audit resident's on a comfort care program to include their wishes for individualized pain interventions on admit to the program and quarterly thereafter per MDS schedule. Audits will begin 3/11/13. DATE OF COMPLIANCE: 3/26/13		

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F 280	<p>Continued From page 9</p> <p>review and revise the plan of care for 1 of 22 residents reviewed for care planning (#24) in a sample of 31. Failure to review and revise the care plan placed the resident at risk for ongoing unrelieved pain. Findings include:</p> <p>Resident #24 had diagnoses including heart failure and advanced dementia. Per record review, the resident had memory and decision-making problems, required extensive assistance for most activities of daily living, and had recently experienced a decline in condition. On 12/3/12, the resident was placed on the facility comfort care program.</p> <p>Review of the facility pain assessment dated 12/5/12 noted the resident had chronic [redacted] and [redacted] pain. The resident was noted to be [redacted], did not complain of pain and admitted to pain when asked.</p> <p>Per record review, in an interview with the facility for an assessment dated 1/28/13, the resident reported she had pain frequently, at a pain level of 7 (moderate).</p> <p>Review of the resident's care plan for pain included a goal that the resident would not experience a decline in function related to pain. The care plan did not include resident-specific information, including the resident's goal for a comfortable pain level. There were no new interventions developed to attempt to promote a more comfortable pain level than moderate pain.</p> <p>Review of the January/February 2013 Medication Administration Records (MAR) revealed the resident had both a narcotic and non-narcotic pain medication ordered to be given as needed. In January 2013, the resident was medicated less than daily for pain levels of 6-10 (moderate pain) with good pain relief each time.</p>	F 280		

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F 280	Continued From page 10 From 1/26/13 through 2/7/13 licensed staff documented the resident's pain intensity as a question mark (no intensity rating) with good pain relief each time. During observation on 2/6/13 after lunch, the resident was observed in a recliner chair next to her bed. She appeared sleepy and was unable to answer any questions. In an interview on 2/11/13 at 10:00 a.m., Staff #F stated the resident's hearing aid was out for repair so communication was difficult. She stated since the resident had difficulty answering questions about her pain level, the licensed staff watched her and offered pain medications when she had signs of pain. She stated the narcotic pain medication made her sleepy so they started with the non-narcotic pain medication. On 2/12/13 at 10:00 a.m., the resident's February 2013 MAR and Pain Flow Sheet was reviewed with Staff #C. She pointed to a pain intensity level tool on the pain flow sheet and stated pain tool should be used to document the resident's pain level if she could not verbally communicate. In addition, she had no additional information to offer regarding new interventions to promote a lower pain level before medications were administered.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to	F 281	F 281 SPECIFIC RESIDENTS Resident #26 and Resident #33 receive their medications in a safe manner using the 5 rights of a medication pass.	

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F 281

Continued From page 11

consistently meet professional standards of quality for medication pass procedures for 2 of 18 residents (#26, 33) reviewed for medication accuracy in a sample of 31. The residents were placed at risk for medication errors.

According to Turkoski, Lance and Bonfiglio, Drug Information Handbook for Nursing, Eighth Edition, pages 17 - 22, nurses are to administer medications as ordered by the physician which includes safe administration grounded in the five "Right" principles: Right Drug, Right Dose, Right Patient, Right Route and Right Time.

During observation of medication pass on 2/6/13 at 1151 a.m., Staff #D prepared a medication (██████) for Resident #33. After pouring one pill in a cup, she set the cup aside on the medication cart without labeling the cup or delivering the medication to the resident.

Staff #D then proceeded to prepare one medication (Acetaminophen) for Resident #26 by pouring one pill in a cup. Without labeling the second cup, she stacked one resident's pill cup on top of the other and took the medications to the Sunshine dining room, where she administered each resident one cup of medication.

In an interview on 2/7/13 at 2:00 p.m., Staff #D stated it was not her normal practice but she felt she had to "multi- task" at that lunch medication pass.

The facility procedure for medication administration directed licensed staff to prepare and administer medication to one resident at a time.

In an interview on 2/8/13 at 2:10 p.m., Staff #C confirmed that pouring medications for more than

F 281

OTHER RESIDENTS
Other residents had the potential to be affected by this practice. Other residents receive their medications using the 5 rights of a medication pass.

SYSTEMIC CHANGES
LN's in-serviced on the 5 rights of a medication pass one resident at a time will have their medications passed.

MONITOR
DON/RCM will audit medication passes for following the 5 rights to a medication pass weekly x 4 weeks then monthly x 3. DON will bring audits to PI for review.

DATE OF COMPLIANCE:
3/26/13

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

PRINTED: 02/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505282	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF RITZVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 506 SOUTH JACKSON RITZVILLE, WA 99169		
(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 281	Continued From page 12 one resident at a time placed residents at risk for medication errors.	F 281			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	F 441 SPECIFIC RESIDENTS Resident #51 is no longer a resident of the facility. OTHER RESIDENTS Other residents had the potential to be affected. SYSTEMIC CHANGES LN's in-serviced on washing hands before and after flushing a Central Venous Catheter. LN's also in-serviced on washing hands before and after performing a SQ injection. Staff in-serviced on infection control policies in regards to hand washing. LN's in-serviced on hand washing policy with a medication pass. MONITOR Department heads will audit hand washing per protocol weekly x 4 weeks then monthly x 3 months. DON will bring results to PI. Audits will begin 3/11/13. DATE OF COMPLIANCE: 3/26/13		

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F 441	<p>Continued From page 13 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to require staff to follow accepted professional practice related to proper hand hygiene during Central Venous Catheter (CVC) care for 1 of 1 resident with an IV (51); 1 of 1 resident (#33); and between resident contacts for 3 of 31 sample residents (#31, 43, 44). Residents were placed at risk for potential spread of infection and cross-contamination. Findings include:</p> <p>The facility procedure for Common Medication Pass Irregularities directed licensed staff to use alcohol hand rub after each resident and wash hands with soap and water in between every four residents, if no mucous membranes were touched.</p> <p>The facility procedure for CVC care directed licensed staff to wash hands before and after flushing a CVC.</p> <p>The facility procedure for SQ injection directed licensed staff to wash hands before and after the procedure.</p> <p>1. During observation of medication pass on 2/6/13 at 3:50 p.m., Staff #D prepared and administered medications to Resident #43. The resident was coughing and had multiple soiled facial tissues in her lap. After medication</p>	F 441		
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F 441	<p>Continued From page 14</p> <p>administration, Staff #E helped the resident remove a soiled facial tissue stuck to her finger and then disposed of the soiled facial tissues. Without washing her hands, Staff #D prepared the next resident ' s medication.</p> <p>2. Per observation on 2/6/13 at 4:05 p.m., Resident #51 was receiving a dose of intravenous (IV) antibiotic through a CVC. The IV pump alarmed to signal the IV infusion was complete. Staff #D disconnected the IV tubing and flushed the CVC without washing hands before and after the procedure.</p> <p>3. During observation of medication pass on 2/7/13 at 8:45 a.m., Staff #F administered eye drops to Resident #44 using gloves. After administration, Staff #F removed the gloves and did not use a hand sanitizer or wash hands before preparing medications for the next resident.</p> <p>4. On 2/7/13 at 8:55 a.m., Staff #F prepared and administered medications to Resident #31. Included in the medications was an inhaled medication and nasal spray. During administration, Staff #F wore gloves to administer both the inhaled medication and a nasal spray. After medication administration was complete, Staff #F removed the gloves, assisted the resident with positioning, touched the resident's head and pillow, and did not wash her hands or use hand sanitizer upon leaving the resident's room and preparing medications for the next resident.</p> <p>5. During observation of medication pass on 2/7/13 at 5:10 p.m., Staff #D prepared a SQ</p>	F 441		

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F 441	Continued From page 15 injection for Resident #33 without washing her hands before preparation. Staff #D administered the injection without wearing gloves and did not wash her hands upon completion of the injection. In an interview on 2/7/13 at 5:25 p.m., Staff #C offered no additional information regarding the staff members lack of proper implementation of the facility procedures related to hand hygiene.	F 441		