

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/25/2014
NAME OF PROVIDER OR SUPPLIER PUYALLUP NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372	
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Puyallup Nursing and Rehab Center on 6/25/2014. The sample included 11 residents out of a census of 90. The sample included 7 current residents and the records of 4 former residents.</p> <p>The following are complaints investigated as part of this survey:</p> <p>#3016430 #3018365</p> <p>The survey was conducted by:</p> <p>Donna J. DeVore, RN, MSN</p> <p>The surveyor is from:</p> <p>Department of Social and Health Services Aging and Long-Term Support Administration Division of Residential Care Services District 3, Unit B PO Box 45819, MS: N27-24 Olympia, WA 98504-5819</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>[Signature]</i> 7/9/14 Residential Care Services Date</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Puyallup Nursing & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p style="text-align: center;">RECEIVED JUL 22 2014 DSHS - ADSA RCS - REGION 5</p>	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>		TITLE Administrator		(X6) DATE 7/16/14

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 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure timely and thorough assessment of pain for 1 of 4 residents reviewed for pain assessments (Former Resident #1) and failed to ensure staff reported incidents that potentially could cause injury (Resident #1).</p> <p>Failure to assess pain at the time it was reported and failure to report an incident of possible injury placed Resident #1 at risk for delay in physical assessment and potentially a delay of treatment.</p> <p>Findings include:</p> <p>Record review revealed Resident #1 admitted during [REDACTED] 14 with medical diagnoses including dementia, history of falls, nasal fracture and facial bruising/lacerations. Resident #1 discharged from the facility to the hospital on [REDACTED] 2014.</p> <p>Review of the resident's hospital admission record dated [REDACTED] 14 revealed admission diagnoses included, in part, [REDACTED] infection. Review of the admission history and physical revealed the resident's [REDACTED] was very</p>	F 309	<p><u>F-309</u></p> <p>Resident #1 has been discharged.</p> <p>Residents have been interviewed regarding pain and those that have unrelieved pain have had an assessment and appropriate interventions and/or changes to their Pain Management program.</p> <p>LN's, NAC's and Therapy staff have been educated on the use of the "Stop and Watch" Early Warning Tool for reporting acute changes and complaints of pain and the Facility policy for identification and notification of Incidents/Accidents.</p> <p>LN's and NAC's have been educated on the Facility Policy for Accident Prevention.</p> <p>Resident's with acute changes and new onset of pain will be monitored routinely by the Resident Care Mangers (RCM's) per the MACC process (Managing Acute Condition Changes) and ensure necessary follow-up on new onset of change of condition.</p>		

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F 309	<p>Continued From page 2</p> <p>swollen, cyanotic, and cold with palpable pulses.</p> <p>Review of nursing progress notes dated 6/10/14 revealed the resident self-transferred and fell in the bathroom during the evening shift (fall was at 7:30 p.m according to review of the facility's investigation). Documentation revealed the resident denied pain or discomfort at the time and range of motion was intact. The resident was placed on alert monitor for changes.</p> <p>Further review of nursing progress notes revealed the resident woke up at midnight moaning and appeared to be in pain. Tylenol 650 milligrams was given. There was no evidence of a pain assessment prior to administering the medication.</p> <p>Review of nursing progres notes timed at 9:30 a.m. on 6/11/14 revealed Staff D assessed the resident "this AM"; vital signs were stable and there were no latent injuries from the fall the previous night.</p> <p>Review of nursing progress notes dated 6/11/14 at 11:28 a.m. revealed the resident's son reported the resident's cognition was different and felt something was wrong. Staff D (licensed nurse) notified the physician; orders for blood work, urinalysis and chest x-ray were ordered.</p> <p>Nursing progress notes timed at 11:52 documented the resident's son reported a further change of condition to Staff D. Assessment revealed diminished lung sounds, pulse 56 and low oxygen saturation level of 82%. The resident's left extremity was noted cold, red and swollen the entire length. The resident subsequently transferred to the hospital for further evaluation and treatment.</p>	F 309	<p>DNS or designee will randomly audit the "Stop and Watch" tools received weekly X 3 weeks, then monthly X 3 months to validate compliance. Results of the audits will be trended and forwarded to QAPI monthly X 3 months.</p> <p>Administrator will ensure compliance.</p>	8/1/14

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F 309	<p>Continued From page 3</p> <p>Review of occupational therapy progress notes dated 6/11/14 and written by Staff F revealed documentation of unrelated complaint of knee pain. Nursing notified. Procured footrests for wheel chair and trained resident in upper extremity ambulation using wheel chair. The note indicated "yes" pain limited the resident's functional abilities.</p> <p>During interview on 6/25/14 at 2:45 p.m., Staff F (Occupational Therapist) recalled working with Resident #1 during the morning of 6/11/14; she was unable to recall the exact time. Resident #1 was acting like she was in pain, putting her hands on her left knee. Staff F stated she did not assess the resident's knee. One of the nursing assistants asked her if she would put foot rests on the resident's wheel chair because she saw another aide pushing the resident's wheel chair and something happened with her left foot; she was not able to recall if staff reported it was bent or what exactly happened. Staff F put footrests on the chair and told the resident she would work with her on how to use the wheels to propel instead of her feet. Staff F did not assess the resident's foot at that time of the report. She recalled telling a nurse (she thought it was Staff D) about the resident's knee pain. She stated it was standard to report to the nurse anytime a resident had pain or a change of condition. Staff F did not recall if she told the nurse about the resident's [REDACTED]</p> <p>During interview at 3:00 p.m. on 6/25/14, Staff D (licensed nurse) did not recall Staff F telling her about Resident #1's knee pain or about a potential injury to her left foot.</p>	F 309			

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F 323 SS=D	<p>During interview at 3:40 p.m. administrative staff A stated she was not aware of an incident involving the resident's left foot.</p> <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 record review and interview, the facility failed to consistently provide adequate supervision to prevent accidents for 1 of 4 residents reviewed for falls (former Resident #1). Resident #1 left the hallway where she was being supervised for wandering/exit-seeking and fell in her bathroom.</p> <p>Lack of adequate supervision placed the resident at risk for injuries related to falls and/or wandering.</p> <p>Findings include: Record review revealed Resident #1 admitted during [REDACTED] 14 with medical diagnoses including dementia, history of falls, nasal fracture and facial bruising/lacerations.</p> <p>Review of facility investigations revealed Resident #1 had two prior non-injury falls on 5/31/14 and</p>	F 323	<p><u>F-323</u></p> <p>Resident #1 has discharged.</p> <p>Residents who are at-high risk for falls and elopement have been re-assessed and care plans have been reviewed and updated with appropriate interventions to mitigate falls/accidents and wandering behaviors.</p> <p>LN's and RCM's have been educated on the Facility Policy for Accident/Incident investigation, the Facility Policy for Accident Prevention and following the Plan of Care to mitigate Incidents and Accidents.</p> <p>DNS or designee will audit resident's who fall and to validate that appropriate interventions are in place to help mitigate falls, accidents and wandering behaviors weekly X 3 weeks. The results of the audits will be trended and forwarded to QAPI monthly X 3 months.</p> <p>The Administrator will ensure compliance.</p>	8/1/14	

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F 323	<p>Continued From page 5 6/5/14.</p> <p>Review of an alert care plan dated 6/5/14 directed staff to monitor for latent injuries and "sight on" supervision; 1:1 supervision when needed.</p> <p>Review of a facility investigation dated 6/10/14 revealed Resident #1 experienced emotional distress during that evening at dinner time; the resident was tearful, wandering, looking for her spouse. Review of nursing progress notes dated 6/10/14 at 11:03 p.m. revealed staff attempted activities, toileting and giving the resident something to eat prior to giving the resident Ativan 0.5 mg at 6:40 p.m.</p> <p>Further review of the facility's investigation revealed the licensed nurse was keeping her eye on the resident during her medication pass as the nursing assistants were caring for other residents. The resident was sitting in the hall for easy visualization and at some point when the nurse went in another resident's room, the resident attempted to toilet herself. The resident's son went into the resident's room to visit and found the resident on the floor in the bathroom. Documentation of an assessment revealed there were no injuries identified at that time.</p> <p>During interview on 6/24/14 at approximately 10:00 a.m., a Resident Advocate (RA) confirmed finding the resident in the bathroom during the evening on 6/10/14; the resident was lying on the floor and had been incontinent. The RA went into the hall to find help and did not see anyone; subsequently he was able to find the nurse who with the assistance of another staff, helped the resident to bed.</p>	F 323			

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F 329 F 329 SS=D	Continued From page 6 483.25(i) 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 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure drug regimens were free from unnecessary medications for 3 of 4 residents receiving anti-anxiety medications (Resident ■ and former Residents ■ & ■). The facility failed to identify target behaviors and non-drug behavioral interventions prior to	F 329 F 329	F-329 Resident #1 and #4 have discharged. Resident #7 has a Behavior Monitor Log in place with specific target behaviors and non-drug interventions. Residents who receive psychotropic medications have been reviewed to ensure they have a Behavior Monitor Log with listed specific target behaviors and non-medication interventions. Social Services, LN's and RCM's have been educated on the Facility Behavior Monitor Policy to include assessing for specific target behaviors and attempting non-drug interventions before administering psychotropic medications on a PRN (as-needed) basis. RCM's will randomly audit Behavior Monitor Logs to validate that specific target behaviors are documented and non-medication interventions are attempted before administering PRN psychotropic medications weekly X 3		

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F 329	<p>Continued From page 7</p> <p>administering anti-anxiety medications for Residents # [REDACTED]</p> <p>Without identifying behaviors and non-drug interventions, the facility placed residents at risk for receiving unnecessary medications and could not adequately monitor the effectiveness of the medications.</p> <p>Findings include:</p> <p>1. Record review revealed former Resident #1 admitted to the facility during [REDACTED] 14 with multiple medical diagnoses including dementia with behaviors, history of falls and [REDACTED]. Review of physician orders revealed, in part, an order dated 6/5/14 for Ativan 0.5 milligrams (mg) every 6 hours as needed for anxiety.</p> <p>During interview at 9:40 a.m. on 6/25/14, Staff D (licensed nurse) stated according to the facility's policy and procedure for residents with orders for anti-anxiety medications included development of a behavior monitor log that identified target behaviors and specific non-drug interventions for staff to try before giving the medication.</p> <p>Further record review revealed there was no evidence of a behavior monitor log that identified target behaviors or non-drug interventions for Resident #1. At 11:55 a.m., Staff A (administrative staff) was notified. Staff A's record review did not provide evidence of a behavior monitor log.</p> <p>Review of Resident #1's Medication Administration Record (MAR) dated 6/2014 revealed the resident received [REDACTED] on 6/6/14 at 9:00 a.m. and 3:00 p.m. There was no evidence</p>	F 329	<p>weeks then monthly X 3 months. The results of the audits will be trended and forwarded to QAPI monthly X 3 months.</p> <p>DNS will ensure compliance.</p>	8/1/14	

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F 329	<p>Continued From page 8</p> <p>of why the medication was given, what behaviors were manifested, if non-drug interventions were attempted prior to giving the medication or effectiveness of the medication. On 6/9/14 at 10:00 p.m., documentation on the MAR revealed the resident received [REDACTED] Specific behaviors and/or non-drug interventions were not identified.</p> <p>2. Record review for former Resident #4 revealed a physician order for [REDACTED] 0.5 mg three times daily as needed for [REDACTED]</p> <p>Review of the facility's "Behavior Monitoring Log" dated 6/20/14 revealed target behaviors of emotional irritability, tearfulness and anxiousness. Behavioral interventions included reassure, ensure comfortable environment, encourage to voice feelings, encourage activities and assist to identify stressors.</p> <p>Review of Resident #4's MAR dated 6/2014 revealed the resident received 11 doses of [REDACTED] between 6/4 and 6/19/14 for [REDACTED]. There was no evidence of which behaviors were manifested and no evidence of non-drug behavioral interventions attempted by staff prior to giving the medication.</p> <p>3. Record review for Resident #7 revealed a physician order for [REDACTED] 0.5 mg twice daily as needed for anxiety.</p> <p>Review of the facility's behavior monitor log dated 6/2014 revealed target behaviors were identified including, in part, yelling out, [REDACTED] and crying. Behavioral interventions were identified and included, in part, redirection, encourage verbalization and place in quiet environment.</p>	F 329			

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F 329	<p>Continued From page 9</p> <p>Review of Resident #7's MAR for 6/2014 revealed the resident received [REDACTED] on 6/17/14 at 2:00 p.m. Review of nursing notes dated 6/14/14 revealed the medication was given for "agitation". Specific behaviors and behavioral interventions were not identified.</p> <p>During interview on 6/25/14 at 9:40 a.m., Staff E (licensed nurse) stated the facility's policy for use of [REDACTED] medications included identification of behaviors and non-drug interventions for each resident. Staff E stated non-drug interventions should be tried first, then if they were not effective, staff would administer the medication as ordered and monitor the resident for adverse side effects.</p> <p>Review of the facility's Policy and Procedure for Psychoactive Medications (dated 1/2014) revealed, in part, Paragraph #5, behavior monitoring will be initiated to identify problem behaviors and specific behavior interventions will be written on the behavior monitor log for staff to use prior to initiation of PRN (as needed) medications. Under paragraph #7, f., non-pharmacological interventions will be attempted prior to psychoactive medication usage and g., alternatives attempted will be documented on the behavior log and in the progress notes.</p> <p>During interview on 6/25/14 at 3:40 p.m., administrative Staffs A and B were informed about the above record reviews and staff interviews.</p> <p>During telephone interviews on 7/7/14 at 11:55 a.m., Staffs A and B stated there was no additional information available.</p>	F 329			

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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> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p><u>F-441</u></p> <p>Residents #1 and #10 have discharged.</p> <p>Resident #5 is not on Contact Precautions and is without signs or symptoms of infection.</p> <p>Residents who are on Contact Precautions have been evaluated to ensure they are in an appropriate room if they have a roommate.</p> <p>Admission Director and Clinical Liaison, NAC's, LN's and RCM's have been educated on the Facility Policy for Transmission Based Precautions to include appropriate room assignments for persons with infectious diseases when considering a room for a new admission. They have also been educated on the Facility Policy for Standard Precautions including Contact Precautions, Linen Handling and Hand Hygiene.</p> <p>DNS or designee will routinely audit residents who are on Contact Precautions to validate that they are in an appropriate room if they have a roommate.</p>		

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NAME OF PROVIDER OR SUPPLIER PUYALLUP NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 441	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure Transmission Based Precautions and Standard Precautions were followed consistently for 3 of 4 residents reviewed for infection control precautions (Former Resident #1 and Residents #5 & #10).</p> <p>Former Resident #1 was admitted to a room with another Resident that required contact precautions for C-Difficile (infectious diarrhe. This placed Resident #1 at risk for a transmission based infection related to having an open facial laceration.</p> <p>For Resident #10, Staff C did not follow contact precautions while providing care to Resident #10 and did not follow standard precautions while assisting with a transfer of Resident #5. These failures placed Residents # 5 & 10 at risk for transmission based infections.</p> <p>Findings include:</p> <p>Review of facility Policy and Procedure for Transmission Based Precautions dated 11/09 revealed the following precautions under paragraph 5, Contact Precautions: personnel having contact with the infected resident should wear gloves and a gown; prior to leaving the resident's room, gown and gloves are removed and hand hygiene performed; options for residents on contact precautions may include a private room, cohorting with another infected or colonized resident or sharing a room with a resident with limited risk factors (no</p>	F 441	<p>The DNS or designee will randomly audit direct care staff to validate that the Standard Precautions policy and the Hand Hygiene policy is being followed correctly weekly X 3 weeks then monthly. The results of the audit will be trended and forwarded to QAPI monthly.</p> <p>The Administrator will ensure compliance.</p>	8/1/14	

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F 441	<p>Continued From page 12 immunosuppression, IV's, indwelling catheters or open skin lesions).</p> <p>Review of a facility Policy and Procedure for Standard Precautions, Paragraph 1., Hand Hygiene included washing with soap and water or alcohol based rubs; hand hygiene will be performed after removing gloves. Paragraph 2., Gloves, directed staff to remove gloves after use, before touching non-contaminated items and environmental surfaces, wash hands immediately after removing and clean non-sterile gloves are worn when in contact with a resident infected with VRE, MRSA, etc.</p> <p>1. Record review revealed Resident #1 admitted during [REDACTED] 14 with medical diagnoses including dementia, [REDACTED] facial bruising and an open facial laceration related to a previous fall.</p> <p>Review of the resident's admission skin assessment on 5/30/14 revealed documented evidence of facial bruising and a laceration on the resident's lip.</p> <p>During interview on 6/24/14 at approximately 10:00 a.m., a resident advocate (RA) stated Resident #1 was admitted to a room with a resident on contact precautions for C-Difficile. The RA stated when questioned, the admitting nurse (Staff G) stated there were no other rooms available at the time.</p> <p>During interview on 6/25/14, Staff A (administrative staff) stated she was not aware of why Resident #1 was admitted to a room with a resident with C-Difficile. She stated the previous interim administrator accepted the resident a few days prior to her admission to the facility. Staff A</p>	F 441			

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F 441	<p>Continued From page 13</p> <p>stated she was not aware Resident #1 had an open laceration on her lip.</p> <p>Record review revealed the resident's legal representative requested a room change a few days after the resident was admitted because of concern with the roommate having diarrhea. Resident #1 was moved to another room on 6/3/14. A test for C-Difficile which was obtained on 6/2/14 was negative for the infection.</p> <p>2. At 9:55 a.m., Staff C (Certified Nursing Assistant) entered Resident #10's room to provide care. Resident #10 was on contact precautions for C-Difficile. Staff C did not wash his hands upon entering the room or put on gloves. Staff C adjusted the bed using the bed control and moved the bedside table away from the bed. He removed the pillow, rolled the resident toward and away from him to complete the bed change and covered the resident with a blanket. Staff C stated he needed to leave the room to get briefs. Staff C washed his hands before leaving the room.</p>	F 441		
	<p>Staff C returned with briefs and did not wash his hands or put on gloves. He proceeded to open Resident #10's brief and stated to the resident "you had a little BM". Staff C put on gloves, provided incontinent care and applied a clean brief. Staff C stated he forgot to apply the ointment; he changed gloves without washing his hands and applied the ointment. Staff C removed his gloves and did not wash his hands prior to closing the resident's brief and placing another draw sheet under the resident. Staff C stated he wears gloves only if he was going to touch anything other than clean linens.</p>			

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F 441	Continued From page 14 3. At 9:05 a.m. Resident #5 was observed sitting fully dressed in her wheel chair. The resident stated she wanted to go back to bed. Staffs C and H (certified nursing assistants) entered the room to assist the resident to bed. Staff H washed his hands and put on gloves; Staff C did not wash his hands or put on gloves. Following the transfer, Staff H removed his gloves and washed his hands before leaving the room; Staff C left the room without washing his hands. During interview at 3:40 p.m. on 6/25/14, Staffs A and B (administrative staff) were informed about the above observations and concerns.	F 441			