STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING ______ B. WING ______	R 02/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD PLACE	2575 W 5TH ST GREENVILLE, NC 27834

(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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to assess and treat 1 of 1 sampled residents (Resident #80) for a red rash on the resident's back. Findings included: Resident #80 was readmitted to the facility on 08/20/12. Cumulative diagnoses included hypertension, dysphagia and diabetes mellitus. A Significant Change Minimum Data Set (MDS) assessment of 08/27/12 indicated Resident #80 had long and short term memory problems. She required total assistance with all activities of daily living and was incontinent of both bowel and bladder. According to the Care Area Assessment (CAA) trigger detail for this assessment, she triggered in 11 care areas including pressure ulcer and activities of daily living (ADL). The ADL CAA information indicated Resident #80 was totally dependent for all care and had communication problems. The Urinary Incontinence and Indwelling Catheter CAA indicated she was at risk for skin breakdown. The Quarterly MDS of 02/09/13 indicated	F 309	F309 1. Nursing Assistant #1 (assigned to Resident #80) was terminated from employment on 3-4-13. Nursing assistant #2 and #3 (assigned to Resident #80) were inserviced on the importance of reporting changes in skin condition to the nurse on 3-14-13 and 3-15-13. Resident #80 was assessed and a treatment was initiated on 2-27-13 for the residents rash. 2. Skin Assessments were completed on all residents from 3-14-13 thru 3-18-13 by License Nurses to assure all changes in skin condition were reported and treatments initiated as needed. The Nursing Assistants were inservices from 3-7-13 thru 3-22-13 regarding the importance of reporting changes in skin condition to the Nurse.	3-26-13 3-26-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 3.15.2013

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	Continued From page 1 Resident #80 required total assistance with all activities of daily living and was incontinent of both bowel and bladder. Resident #80's care plan, last reviewed on 02/12/13 identified problems with needing assistance for activities of daily living and was at risk for development of pressure ulcers related to incontinence. Included in the approach section for both of these problems was to observe her skin during care for red or open areas. Personal care was observed on 02/26/13 at 12:10 AM. It was noted that her perineal area was reddened. As the nurse aide (NA #1) rolled Resident #80 onto her left side she was noted to have a red slightly raised rash which encompassed her entire back extending from the top of her shoulders downward stopping at the waistline. She also had a large dry crusty patchy rash-like area covering most of the upper outer left thigh. Personal care was observed again on Resident #80 on 02/26/13 at 6:00 PM. When NA #2 rolled her onto her right side, she was noted to have the same red slightly raised rash noted to her entire back. There was no change in the rash nor the crusty patchy areas to her left upper outer thigh. When NA #2 finished the personal care, at 6:15 PM on 02/26/13, she stated Resident #80 sweated a lot especially when she was positioned on her back for long periods of time. She stated that was the reason for the rash. The hall nurse (Nurse #1) was interviewed on 02/27/13 at 12:00 PM. She stated she was	F 309	F309 3. Random skin assessments will be completed on at a minimum of 6 residents weekly x 4 weeks then monthly x 4 months to assure compliance with proper reporting of changes in skin condition. 4. The results of these assessments will be taken to the facility QA&A committee. The committee will make recommendations based on the findings of these assessments.	3-26-13 3-26-13

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F 309	Continued From page 2 familiar with Resident #80 and had worked the hall for the last 2 days. When questioned about skin issues for this resident, she stated there were no skin issues that she was aware of. Nurse #1 stated if the nurse aides discovered any changes in the skin they were to report it to the nurses and no one had reported anything to her regarding Resident #80. She added that the treatment nurse usually applied any topical treatments for the residents. Resident #80's chart was reviewed for mention of rashes. There was no documentation of any rash for this resident. The treatment nurse was interviewed on 02/27/13 at 2:30 PM. She stated if a resident developed a rash or any changes in the skin, it was the hall nurses responsibility to assess the area and obtain physician's orders for treatment. She stated the hall nurses also were to implement the treatment and notify the family of the change. The treatment nurse commented that when issues were discovered she would receive a skin referral and would assess. She denied providing any treatments to Resident #80. NA #2 was interviewed on 02/27/13 at 2:55 PM. She stated yesterday was the first time she had worked with Resident #80 in a while. She stated she had been instructed to report any changes in the resident's skin to the hall nurses. NA #2 reported that she had not told the nurse about Resident #80's rash. NA #3 was interviewed on 02/27/13 at 3:00 PM. She stated she had worked with Resident #80 on 02/26/13 but did not notice the rash to her back.	F 309		

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F 309	Continued From page 3 She commented that she had a rash to her buttocks but she did not remember a rash being present on her entire back. NA #3 stated if she noticed any changes or redness in a resident's skin she had been instructed to notify the nurse. When questioned if she had reported the rash she responded she had not. Nurse #1 was interviewed again on 02/27/13 at 3:10 PM. She stated she was not aware of any rashes on Resident #80's skin. She stated she would assess her and proceeded to Resident #80's room. Nurse #1 assisted by a nurse aide rolled Resident #80 onto her right side. Upon inspection of her skin, Nurse #1 stated the rash was quite extensive and she would need to telephone the physician for the appropriate intervention. She stated Resident #80's physician had been in the facility earlier and if she had known about the rash she would have asked her to evaluate it. Nurse #1 commented that no one had reported it on any shift as she had received report from the offgoing third shift nurse both yesterday and today and it was not reported to her. Nurse #1 also commented that it was the responsibility of the nurse aides providing the care to report any redness, rashes or open areas to the hall nurses. The Director of Nurses (DON) was interviewed on 02/27/13 at 5:30PM. She stated the nurse aides were responsible for reporting any changes in the residents' skin to the nurses. She stated the nurses were responsible for assessing the changes. The DON stated all skin issues were referred to the treatment nurse. A telephone physician's order of 02/27/13	F 309		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 4 indicated to apply clotrimazole (an antifungal topical cream) cream to the back and upper legs twice daily for 7 days.	F 309		
{F 312} SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with resident and staff, the facility failed to thoroughly cleanse the residents' perineal/buttocks area to remove residual urine and/or stool from 2 of 6 dependent residents (Resident #90 and #131) whose personal care was observed. The facility also failed to thoroughly cleanse the resident's buttocks and failed to wipe downward from the posterior vaginal opening towards the rectum for 1 of 6 dependent residents (Resident #69) whose personal care was observed. Findings included: 1. The facility's "Perineal Care/Incontinent Care" policy for females, revised 11/10/09, indicated that perineal care would be done daily during the daily bath, at bedtime if necessary and after urination and bowel movements. The procedure included to drape the patient. Staff were to ask the patient to bend the knees and spread the legs. A wet washcloth and soap was to be used to cleanse gently downward from front to back after separating the labia. A separate section of	{F 312}	F312 1. Nursing Assistant #4 (assigned to Resident #69) was counseled and an individual inservice was conducted on 3-15-13 regarding the importance of following the policy and procedure for proper incontinent care. A skills validation and return demonstration was completed by 3-22-13 to assure compliance with proper incontinent care. Nursing Assistant #1, who was assigned to Resident #90 and Resident #131 was terminated from employment on 3-4-13.	3-26-13

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{F 312}	Continued From page 5 the wash cloth was to be used for each downward stroke. The purpose for the downward strokes was to prevent intestinal organisms from contaminating the urethra or vagina. After washing, a clean wet washcloth was to be used to rinse thoroughly and then pat dry. The patient was then to be turned onto her side and the anal area was to be cleaned from the posterior vaginal opening wiping front to back toward the patient's back. Once cleaned, the area was to be rinsed and dried. Resident #69 was admitted to the facility on 05/17/10. Cumulative diagnoses included organic brain syndrome, depression and anxiety. The most recent quarterly Minimum Data Set (MDS) of 10/29/12 noted Resident #69 had problems with cognition and decision making. She was independent with bed mobility but needed extensive assistance with toilet use, hygiene and bathing. She was frequently incontinent of both bowel and bladder. Resident #69's care plan identified needing extensive to total assistance for activities of daily living. It also identified a problem with incontinence. Approaches included to provide pericare after each incontinent episode and barrier cream to protect the skin and prevent breakdown. On 02/25/13 at 11:15 PM, Resident #69 was overheard yelling out that she was wet and needed to be changed. At 11:35 PM, Nurse Aide #4 (NA #4) went into the room to see what was needed. NA #4 left the room and gathered supplies to change Resident #69. NA #4	{F 312}	F312 2. A skills fair (to include incontinent care) with return demonstrations and skills validations will be conducted on 3-20-13 & 3-21-13 by Nursing Administration on all nursing assistants to assure compliance with the Incontinent Care Policy and to assure compliance with proper incontinent care. The nursing assistants will be inserviced on 3-7-13 thru 3-22-13 regarding the importance of proper incontinent care. 3. Skills validations and/or return demonstrations will be completed on a minimum of 6 nursing assistants on completing proper incontinent care weekly x 4 weeks then monthly x 4 months by Nursing Administration to assure compliance with proper incontinent care.	3-26-13 3-26-13

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{F 312}	Continued From page 6 returned at 11:40 PM and began personal care. There was a strong urine odor detected. She went into the bathroom and obtained water in a basin. She removed Resident #69's urine soaked gown as the bottom part was noted to be wet where she had been lying on it. She removed the urine soaked brief and bed pad from the bed. NA #4 remarked that the gown and the bed pad were saturated with urine. She used a wet wash cloth to cleanse the pubic area. She wiped down each side and the middle of the perineum but didn't open the labia to cleanse. She didn't use a different section of the washcloth for each downward stroke. She changed the water. NA #4 asked Resident #69 to roll onto her left side. She used a wash cloth to cleanse her rectal area wiping from back to front several times. NA #4 washed the area near the rectum but she did not wash her entire buttock to remove any residual urine from being so wet. She did not ask the resident to turn to her other side to allow her to wash the left buttock. She placed a clean brief and a clean bed pad underneath Resident #69. She assisted her to donn a clean gown. Immediately following the observation at 11:55 PM on 02/25/13, an attempt was made to interview Resident #69 about being left wet. She stated she didn't like being wet. She was unable to answer other questions appropriately concerning the observation. NA #4 was interviewed on 02/26/13 at 1:30 AM. She stated she had been taught to knock on the resident's door and explain what she was about to do before providing care. She stated she usually used disposable wipes but when there were none available she used soap and water	{F 312}	F312 4. The skills validations on proper incontinent care and any deficiencies found will be taken to the facility QA&A committee. The committee will make recommendations based on the finding of the skills validations.	3-26-13

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{F 312}	Continued From page 7	{F 312}		

when providing personal care. She stated she was taught to spread the female resident's legs to visualize the labia. She stated she was taught to spread the labia and wash front to back. NA #4 stated when she washed the resident's posterior body, she always wiped back to front towards the perineum. She was asked to clarify how she always cleansed residents. She demonstrated how she cleaned residents wiping in a back to front manner. When questioned as to the reason for cleaning that way, she responded so as not to introduce germs to the resident's back area plus she was left handed. NA #4 commented that Resident #69 was a heavy wetter.

On 02/26/13 at 12:30 PM, another attempt was made to interview Resident #69 about being left wet the night before. She was confused and not able to answer questions but did state she did not like being left wet and it had happened before.

The Director of Nurses (DON) was interviewed on 02/27/13 at 5:30 PM. She stated staff were expected to gather their supplies and explain the procedure to residents when providing incontinent care. The DON stated staff were taught to use a wet wash cloth or disposable wipes to wipe down the sides of the groins and down the middle opening the labia to cleanse. She stated if using wash cloths staff should be using different corners of the wash cloth each time they wipe. The DON stated if they were using disposable wipes, they should discard the wipe after each time they wiped the resident. She commented staff should always wipe front to back to remove stool and never go back to front for obvious reasons. The DON stated staff were in-serviced less than a month ago on the proper procedure

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{F 312}	Continued From page 8	{F 312}		

for providing personal care. The DON reported the nurse aides had been taught to spread open the resident's buttocks and to spread the legs to make sure that all of the residual stool and/or urine had been removed from the skin. She commented all of the residents should be cleaned completely before the aide leaves the room as that was the purpose of providing the care. The DON remarked that barrier cream was available for all residents.

2. The facility's "Perineal Care/Incontinent Care" policy for males, revised 11/10/09, indicated that perineal care would be done daily during the daily bath, at bedtime if necessary and after urination and bowel movements. The procedure included to drape the patient. Staff were to ask the patient to bend the knees and spread the legs. A wet washcloth and soap was to be used to cleanse downward from front to back. After cleaning, the area was to be rinsed and dried.

Resident #90 was admitted to the facility on 02/13/09 and readmitted on 06/14/10. Cumulative diagnoses included intracerebral hemorrhage and aphasia.

The Annual Minimum Data Set (MDS) assessment of 10/13/12 for Resident #90 indicated he was not cognitively intact. He required extensive to total assistance from staff for bed mobility, dressing, toilet use, bathing and hygiene. He was incontinent of both bowel and bladder. The Care Area Assessment (CAA) trigger detail indicated he triggered for urinary incontinence. The Urinary incontinence/indwelling urinary catheter CAA noted he was incontinent of bowel and bladder

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{F 312}	Continued From page 9 and was at risk for skin breakdown due to his incontinence. The most recent Quarterly MDS of 01/06/13 indicated he required total assistance from staff for all activities of daily living and was incontinent of both bowel and bladder. According to Resident #90's most recent care plan, dated 01/07/13, he was totally dependent on staff for care. Included in the approach section was to provide incontinence care for episodes of incontinence. He was identified as being at risk for pressure ulcer development related to his bowel and bladder incontinence. Approaches for this problem included peri-care after incontinent episodes and applying barrier cream to protect the skin and prevent breakdown. During an observation of personal care being provided to Resident #90, on 02/26/13 at 12:30 AM, Nurse Aide #1 (NA #1) removed the soiled brief and discarded it into the trash can. She stated there were no disposable wipes in the room so she covered Resident #90 with the sheet and left the room to get wipes. She returned in 5 minutes with the wipes. She used the disposable wipes to wipe the pubic area and the groins of Resident #90. She used wipes to clean the penis. She did not wash the scrotal area. She assisted the resident to roll onto his left side. When he rolled over, it was noted that he had smears of dried stool adhered to both outer buttocks as well as inward toward the scrotal sac. NA #1 used several wipes to scrub away the dried stool from the outer buttocks. Once the stool was removed, she began to place the clean brief. She did not open the buttocks to remove	{F 312}		

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the stool from the rectum or cleanse the inner perineum and scrotal area. She was asked to stop applying the brief and to check Resident #90 for residual stool. NA #1 used several disposable wipes reaching just inside the closed legs to remove a moderate amount of dark brownish black stool from the rectal area. She still did not cleanse the scrotal/perineal area. She did not open his legs to check to see if she had removed all of the stool. She did not apply any barrier creams. She placed a clean brief and repositioned him for comfort. NA #1 removed the plastic trash liner with the soiled wipes and brief and exited the room.

NA #1 was interviewed about the observation on 02/26/13 at 1:05 AM. She stated she had been trained to gather all of the necessary supplies before providing care to the residents. She stated if a resident had dried stool on their skin it was acceptable to remove it using disposable wipes. NA #1 reported she had recently been in-serviced on providing incontinent care and was observed. She added that she did not do well and had been re-educated on the procedure for providing incontinent care. NA #1 stated when she was observed by facility staff she didn't spread the resident's buttocks to visualize the rectal/anal area to ensure she had removed all of the residual stool from the resident's skin. NA #1 commented she didn't open the buttocks of Resident #90 to make sure she had removed all of the stool when observed earlier. NA #1 also stated there was barrier cream available but she used it only when residents had reddened skin or when there was a physician's order to apply it.

The Director of Nurses (DON) was interviewed on

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{F 312}	Continued From page 11 02/27/13 at 5:30 PM. She stated staff were expected to gather their supplies and explain the procedure to residents when providing incontinent care. The DON stated staff were in-serviced less than a month ago on the proper procedure for providing personal care. The DON reported the nurse aides had been taught to spread open the resident's buttocks and to spread the legs to make sure that all of the residual stool and/or urine had been removed from the skin. She commented all of the residents should be cleaned completely before the aide leaves the room as that was the purpose of providing the care. The DON remarked that barrier cream was available for all residents. 3. The facility 's "Perineal Care/Incontinent Care" policy for females, revised 11/10/09, indicated that perineal care would be done daily during the daily bath, at bedtime if necessary and after urination and bowel movements. The procedure included to drape the patient. Staff were to ask the patient to bend the knees and spread the legs if able. A wet wash cloth and soap was to be used to cleanse gently downward from front to back after separating the labia. A separate section of the wash cloth was to be used for each downward stroke. The purpose for the downward strokes was to prevent intestinal organisms from contaminating the urethra or vagina. After washing, a clean wet wash cloth was to be used to rinse thoroughly and then pat dry. The patient was then to be turned onto her side and the anal area was to be cleaned from the posterior vaginal opening wiping front to back toward the patient's back. Once cleaned, the area was to be rinsed and dried.	{F 312}		

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(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
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Resident #131 was readmitted to the facility on 11/05/12. Cumulative diagnoses included dementia.

The most recent Significant Change Minimum Data Set (MDS) of 12/25/12 indicated she was not cognitively intact. She required extensive assistance from staff for toilet use and hygiene. She was incontinent of both bowel and bladder. The Care Area Assessment (CAA) summary for this assessment noted that she triggered for activities of daily living (ADL) and urinary incontinence. The ADL CAA detail indicated she had declined and needed extensive assistance from staff for personal hygiene. The Urinary incontinence and indwelling catheter CAA detail indicated she was incontinent of urine.

Resident #131's care plan of 12/28/12 identified problems with needing extensive to total assistance for ADLs. Her skin was to be observed daily and pericare to be provided after incontinent episodes. A problem was identified with Resident #131 being incontinent of bowel and bladder. Included in the approach section was to provide incontinent care as needed.

On 02/26/13 at 12:45 AM, Nurse Aide #1 (NA #1) went into Resident #131's room to check her for incontinence. NA #1 commented there were no disposable wipes in the room so she left to retrieve wipes. She returned in about 5 minutes and began care. She removed the soiled brief, used a disposable wipe to wipe down the middle of the vaginal area and discarded the wipe. NA #1 did not open the labia to cleanse it nor did she cleanse the groins and perineum. She asked Resident #131 to roll onto her left side. She used

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the wipes to remove visible stool from the inner buttocks but she did not spread the buttocks to ensure she had removed all of the stool from the rectal area. She did not inspect the perineal area to ensure she had removed all of the stool. NA #1 asked Resident #131 to roll back onto her back. NA #1 was asked to stop applying the brief and to check the resident for remaining stool. She used several disposable wipes to remove a moderate amount of stool from the rectal area as well as the perineum. She did not apply any barrier cream. NA #1 placed a clean brief, bagged her trash and left the room.

NA #1 was interviewed about the observation on 02/26/13 at 1:05 AM. She stated she had been trained to gather all of the necessary supplies before providing care to the residents. She reported she had been taught to open the labia to clean as well as to open the resident's buttocks to clean the entire area. NA #1 reported she had recently been in-serviced on providing incontinent care and was observed. She added that she did not do well and had been re-educated on the procedure for providing incontinent care. NA #1 stated when she was observed by facility staff she didn't open the labia to cleanse the female resident and she didn't spread the resident's buttocks to visualize the rectal/anal area to ensure she had removed all of the residual stool from the resident's skin. When questioned about the observation, NA #1 commented she didn't do well as she didn't open the labia nor did she spread the resident's buttocks to clean her. NA #1 also commented that Resident #131 was capable of having her legs opened for care.

The Director of Nurses (DON) was interviewed on

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{F 312}	Continued From page 14 02/27/13 at 5:30 PM. She stated staff were expected to gather their supplies and explain the procedure to residents when providing incontinent care. The DON stated staff were taught to use a wet wash cloth or disposable wipes to wipe down the sides of the groins and down the middle, opening the labia to cleanse. She stated if using wash cloths staff should be using different corners of the wash cloth each time they wipe. The DON stated if they were using disposable wipes, they should discard the wipe after each time they wiped the resident. She commented staff should always wipe front to back to remove stool and never go back to front for obvious reasons. The DON stated staff were in-serviced less than a month ago on the proper procedure for providing personal care. The DON reported the nurse aides had been taught to spread open the resident's buttocks and to spread the legs to make sure that all of the residual stool and/or urine had been removed from the skin. She commented all of the residents should be cleaned completely before the aide leaves the room as that was the purpose of providing the care. The DON remarked that barrier cream was available for all residents.	{F 312}	**F371** 1. The 2 employees that were directly responsible for the washing of dishes and the inspection of dishes to ensure cleanliness were counseled on the importance of making sure that all dishes were free of food particles when being placed with the clean dishes that are ready to use. The employee who was responsible for serving food on a dish that was compromised and on a dish that was wiped free of food particles was counseled on the importance of making sure that when serving food that the dishes were free of food particles and that the dishes are in good repair.	3-26-13
{F 371} SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	{F 371}		

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	This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to prevent kitchenware with dried food food particles on it and damaged kitchenware from being placed in storage and from having food placed in it at the trayline. Findings included: At 11:41 AM on 02/26/13 the dish machine was no longer in operation in the kitchen. Kitchenware was air drying in storage racks. A dietary employee stated the dish machine process was completed, and the dietary staff was preparing to begin operation of the trayline at 12:00 noon. 3 of 20 regular plates had dried food particles on them, 5 of 20 sectional plates had dried food particles on them, 1 of 20 sectional plates had a coating which was peeling off, 16 of 20 soup/cereal bowls had dried food particles on them, and 4 of 20 coffee mugs had dried food particles in them. 29 of 80 pieces of kitchenware in storage (36%) were compromised. During observation of the 02/26/13 lunch trayline, between 12:12 PM and 12:27 PM, pureed food was placed in a sectional plate which had chipped dividing walls. In addition, a dietary employee wiped white dried food particles off a plate with her gloved hand, and continued to place food in it for resident consumption. At 9:55 AM on 02/27/13 a dietary employee stated the person removing sanitized kitchenware from the dish machine was supposed to check it for food particles before placing it in storage. If		2. All dietary staff will be inserviced by 3-22-13 on the inspection of all dishes that come out of the dishwasher to make sure that no food particles are still present and on the responsibility of the staff member serving food to inspect dishes to make sure that they are clean and in good repair. 3. Audits will be performed by either the Registered Dietitian, the Kitchen Supervisor or the Administrator weekly x 4 weeks then monthly x 4 months to assure that dishes are in good condition and that washed dishes have no remaining food particles on them.	3-26-13 3-26-13

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{F 371}	Continued From page 16 food particles were found, she reported the kitchenware was supposed to be washed/scrubbed and run back through the dish machine. The employee also commented if kitchenware with food particles was missed as it was placed in storage, the cook would remove it from use at the trayline before putting resident food in it. She stated dietary employees were giving chipped or cracked kitchenware to the Administrator so he could decide whether it needed to be disposed of and replaced. At 2:50 PM on 02/27/13 the facility's Registered Dietitian (RD) reported the facility did not currently have an official dietary manager, but she helped supervise kitchen staff and answered their questions. She stated kitchenware should be clean and dry before placing it in storage. According to the RD, kitchenware with dried food particles could be pulled at three times including when sanitized kitchenware was removed from the dish machine, when the kitchenware was placed in storage, and when the kitchenware was observed by the cook at the trayline before she put food in it. She stated the Administrator was completing audits on dirty and damaged kitchenware.	{F 371}	F371 4. The audits on the cleanliness of dishes and the condition of dishes during tray line and any deficiencies found will be taken to the facility QA&A committee. The QA&A committee will make recommendations based on the finding of the audits.	3-26-13
F 441 SS=D	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	F 441	F441 1. Nursing Assistant #1, who was assigned to Resident #90 and Resident #131 was terminated from employement on 3-4-13.	3-26-13

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F 441	Continued From page 17 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 infection.	F 441	F441 2. A skills fair (to include handwashing) with return demonstrations and skills validations will be conducted on 3-20-13 and 3-21-13 by Nursing Administration on all nursing assistants to assure compliance with the Handwashing Policy and to assure compliance with proper handwashing. The nursing assistants will be inserviced on 3-7-13 thru 3-22-13 regarding the importance of proper handwashing.	3-26-13
	This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to ensure that staff were washing their hands after providing direct patient care for 2 of 9 residents (Resident #90 and #131) whose care was observed. Findings included:		3. Skills validations and/or return demonstrations will be completed on a minimum of 6 nursing assistants on proper handwashing weekly x 4 weeks then monthly x 4 months by Nursing Administration to assure compliance with proper handwashing.	3-26-13

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F 441	Continued From page 18 The facility's hand washing policy, which was undated, noted that "Hands will be washed using proper and appropriate hand washing techniques to aid in preventing transmission of infection." According to the procedure section, "Hands should be washed at a minimum at the following times:"... "before and after direct patient contact, after handling soiled linens and whenever in doubt "...better to be safe than sorry." The procedure also indicated to lather hands with soap and water rubbing them together vigorously for 10 to 15 seconds. It was also noted that the use of a waterless antiseptic hand solution could be used if soap and water was not readily available. On 02/26/13 at 12:30 AM, Nurse Aide #1 (NA #1) was observed making incontinent care rounds. She pushed a large soiled linen barrel down the hall and placed it just outside the resident's doorway. She went into Resident #90's room. She did not wash her hands. NA #1 explained to him that she needed to check him for incontinence. She donned a pair of gloves and removed the soiled brief from Resident #90. She made the statement that there were no disposable wipes in the room. She removed her gloves and left the room. NA #1 did not wash her hands. She returned in 5 minutes with a package of disposable wipes. NA #1 did not wash her hands. She donned a pair of gloves and proceeded to provide personal care to Resident #90. NA #1 used disposable wipes to remove dried stool and soft brownish black stool from his skin. When NA #1 finished the care, she picked up the bag of soiled items and disposed of it in the barrel located just outside the resident's door. She removed her gloves and left the room. NA	F 441	F441 4. The skills validations on proper handwahsing and any deficiencies found will be taken to the facility QA&A committee. The committee will make recommendations based on the findings of the skills validations.	3-26-13

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#1 did not wash her hands. She pushed the large barrel down the hall.

At 12:45 AM on 02/26/13, NA #1 went into Resident #131's room to check her for incontinence. She did not wash her hands. She donned a pair of gloves and explained what she was about to do to the resident. NA #1 stated there were no disposable wipes in the room so she removed her gloves and left the room. She did not wash her hands. She returned at 12:50 AM with a package of disposable wipes. She did not wash her hands. She donned a pair of gloves and proceeded to clean urine and stool from the resident's skin. After NA #1 finished care, she picked up the bag of trash and placed it in the barrel located just outside the resident's door. She positioned the resident for comfort, removed her gloves and left the room. NA #1 did not wash her hands.

At 1:05 AM on 02/26/13, as NA #1 was headed for another resident's room, she was asked to delay her rounds to be interviewed. Upon interview, NA #1 stated staff had been instructed to wash their hands before and after direct care was provided and between residents. NA #1 reported she was not sure when the last hand washing in-service had been held. NA #1 had no explanation as to why she did not wash her hands before providing care. When questioned as to when she last washed her hands, she stated she washed her hands at the beginning of the shift when she came on duty tonight.

The Director of Nurses (DON) was interviewed on 02/27/13 at 5:30 PM. She stated staff were expected to wash their hands before providing

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F 441	Continued From page 20 care to a resident, every time they removed their gloves and after they provided care. She stated staff were expected to wash their hands in between residents. She stated staff were reminded continuously to wash their hands to prevent the spread of infection throughout the building. The DON remarked she had not monitored third shift for hand washing.	F 441		