

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

PRINTED: 11/24/2014
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

DEC 08 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445490	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
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NAME OF PROVIDER OR SUPPLIER AVE MARIA HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2805 CHARLES BRYAN RD BARTLETT, TN 38134
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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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F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to follow care plan interventions for fall prevention for 2 of 35 (Residents #26 and 32) sampled residents included in the stage 2 review.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #26 documented an admission date of 2/1/12 with diagnoses of Alzheimer's Disease, Hypotension, Anxiety, Muscle Weakness, Personal History of Fall, Failure to Thrive and Osteoporosis.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated 7/9/14 documented a Brief Interview for Mental Status (BIMS) score of 3 indicating Resident #26 was severely cognitively impaired. Review of the quarterly MDS dated 9/24/14 documented a BIMS score of 2 indicating Resident #26 was severely cognitively impaired.</p> <p>A fall review dated 5/8/14 documented, "...Place dycem strip under shoes to prevent sliding..."</p> <p>Review of fall risk assessments for Resident #26 documented the following: a. a score of 17 on 5/2/14. b. a score of 17 on 7/15/14.</p>	F 282	<p>The care plan for Resident #26, Resident #32, and Resident #87 has been reviewed and revised for inclusion in the "Shooting Star" program and to ensure that the care plan approaches are being followed for each of the above noted residents as identified in the 2567 for being out of compliance with the interventions noted on the care plan.</p> <p>All falls will be addressed in the weekly falls meetings to review falls, causes of falls, and interventions to implement to reduce the future risk of falls.</p> <p>PREVENTATIVE ACTION: To ensure that other residents care plans are being followed, the facility's MDS nurses have reviewed and revised the care plan for each of the residents at high risk for falls in the "Shooting Star" program to ensure that each person's care plan notes the intervention of having a "Shooting Star" above the resident's bed as well as specific interventions/ approaches to follow in an attempt to reduce a resident's risk for falls, (i.e., to monitor the resident for wearing proper footwear, to have eye glasses on if worn when awake, referral to rehab for screening when indicated, reduce room and floor clutter, ensure that needed routine items such as drinking water, tissues, call button, and remote control are within the residents' reach while in bed or seated in chair.)</p> <p>Residents in the "Shooting Star" program will be identified with a</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Harlene Siegel</i>	TITLE Administrator	(X6) DATE December 5, 2014
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	<p>Continued From page 1</p> <p>c. a score of 13 on 9/30/14. d. a score of 15 on 11/7/14. e. a score of 16 on 11/17/14. A total score of 10 or above represents the resident is assessed as a high risk for falls.</p> <p>Review of the care plan dated 1/28/14 with revisions documented, "At risk for falls related to history... Fall... 5/1/14... Approaches... Dycem strip under shoes to prevent sliding... 11/6/14 Fall... Approaches... Place colorful tape on locks as a reminder to lock w/c [wheelchair] / when transferring... Fall 11/16/14... Approaches... Therapy screen..."</p> <p>Observations in Resident #26's room on 11/17/14 at 11:27 AM and 3:00 PM, revealed Resident #26 in bed sleeping. Resident #26 did not have a Dycem strip on the bottom of her shoes.</p> <p>Observations in Resident #26's room on 11/18/2014 at 8:22 AM, revealed Resident #26 in bed on her back sleeping. There was no Dycem strip on the bottom of her shoes.</p> <p>During an interview in the Assistant Director of Nursing's (ADON) office on 11/18/14 at 3:00 PM, the Director of Nursing (DON) was asked what a Dycem strip under shoes means. The DON stated, "Therapy got permission to cut a strip of Dycem to place on the bottom of the resident's shoes. It is under the bottom of the shoes."</p> <p>During an interview in Resident #26's room on 11/18/14 at 3:05 PM, the ADON was asked if she could show the surveyor the Dycem strip under Resident #26's shoes. The ADON looked at the bottom of the shoes Resident #26 was wearing and stated, "It's not on this pair. Let me look in</p>	F 282	<p>yellow fall risk bracelet indicating their high risk for falls. The DON will be responsible for keeping up with the bracelets not currently being used.</p> <p>Resident #26 now has dycem on the bottoms of each pair of shoes as of 11/20/14 to help reduce the risk of falls for this resident and a "Shooting Star" placed upon the bed. The care plan team identified one other resident as having the dycem intervention on his care plan and a "Shooting Star" above the resident's bed. The Minimum Data Set (MDS) nurse verified that the bottoms of the other resident's shoes are in compliance as is the resident's care plan for falls.</p> <p>As of 11/19/14, Resident #32 has floor mats in her room next to her bed on the floor and has a "Shooting Star" shaped star above her bed. Resident #32 has also had her care plan reviewed and revised to include that Resident #32 is in the "Shooting Star" program.</p> <p><u>QUALITY ASSURANCE PERFORMANCE IMPROVEMENT AND MONITORING:</u> The facility's MDS Coordinators will report their findings to the QAPI Committee for the next two quarters outlining validation of compliance on fall interventions being followed as outlined on care plans. Based on compliance of the quarterly reports, the DON may determine that the MDS does not need to continue to report on non-compliance. After the first six months, the DON or her</p>		

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F 282	<p>Continued From page 2</p> <p>the closet and see if it is on another pair." The ADON stated, "No these are all of her shoes and they don't have the strip either."</p> <p>The facility was not following the fall prevention care plan intervention related to Dycem strips under the resident's shoes.</p> <p>2. Medical record review for Resident #32 documented an admission date of 1/3/13 with diagnoses of Chronic Kidney Disease, Urinary Incontinence, Dementia with Behavior Disturbance, Alzheimer's Disease, Psychosis, Depression, Hypertension, Hypothyroidism, Osteoarthritis and Hypopotassemia.</p> <p>Review of the fall risk evaluations dated 10/10/13, 1/3/14, 3/29/14 and 4/10/14 documented scores of 19 or 21. A total score of 10 or above represents the resident was assessed as being a high risk for falls.</p> <p>Review of Resident #32's care plan documented "...Problem Onset: 01/08/2014... At risk for falls due to poor safety awareness and unsteady gait..." and interventions included "...Mats at bedside at hs [bedtime]..." The care plan was reviewed, revised and continued following falls on 4/9/14 and 10/30/14.</p> <p>Observations in Resident #32's room on 11/19/14 at 10:54 AM, revealed no mats on the floor as care planned.</p> <p>During an interview in Resident #32's room on 11/19/14 at 10:54 AM, CNA #2 was asked if Resident #32 had mats by her bed. CNA #2 stated, "Oh, she's not had mats since she's been in this house."</p>	F 282	<p>designee, will randomly monitor the care plans for residents at high risk for falls and determine trends or patterns of non-compliance and report their concerns to the Administrator and Medical Director at future QA/QAPI meetings.</p> <p>COMPLETION DATE: 12/15/14</p>		

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F 282	Continued From page 3	F 282			
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to follow the policy for fall preventions related to the shooting star program and failed to follow interventions for fall prevention for 3 of 35 (Residents #26, 32 and 87) sampled residents included in the stage 2 review.</p> <p>The findings included:</p> <p>1. Review of the facility's "FALL RISK ASSESSMENT AND PREVENTION PROGRAM" documented, "...Purpose: To identify the resident at risk for falls and to minimize the frequency and severity of falls within the facility... When a resident is identified as "at risk" by the Fall Risk Assessment, the resident becomes an active participant in the Fall Prevention Program... The therapy department, as appropriate screens all residents in the Shooting Star Program when</p>	F 323	<p>Accident and Hazards will continue to be monitored for improvement in regard to each resident's fall risk. Fall risk has been re-assessed for Resident #26, #32, and #87 as of December 1, 2014. Each of the three residents has a "Shooting Star" placed above the resident's bed according to the "Shooting Star" protocol as of 12/15/14. All staff will receive in service education by 12/15/14 so that the individual staff person will learn the importance of paying extra attention to the residents in the "Shooting Star" program in the facility's attempt to reduce the number of accidents and potentially hazardous situations a resident is faced with in normal everyday living while residing in a nursing home.</p> <p><u>PREVENTATIVE ACTIONS:</u> As of Dec. 5, 2014, the facility's MDS nurses have reviewed all residents for fall risk and added any resident to the "Shooting Star" program as indicated in the fall risk re-assessment review. There are currently thirteen (13) residents in the "Shooting Star" program as of December 5, 2014.</p> <p>To ensure that other residents risk of accidents and hazards is reduced, the facility's MDS</p>		

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F 323	<p>Continued From page 4</p> <p>there is a decline in condition or multiple falls occur (2 or more)... All residents in the Shooting Star Program are to have their care plan reviewed, interventions updated, and identified on the interdisciplinary care plan... All residents, regardless of fall risk scores, are to have interventions and appropriate actions implemented to reduce the risk of and prevent falls... When a resident qualifies for the Shooting Star Program an identification reminder is to be used to alert the staff and increase their awareness regarding Fall risk. The identification reminder may be placed at the head of the bed... Residents identified as "high risk" for falls are to have additional interventions appropriate to their condition implemented..."</p> <p>Review of a fall risk assessment form documented, a total score of 10 or above represents the resident is at a high risk for falls.</p> <p>2. Medical record review for Resident #26 documented an admission date of 2/1/12 with diagnoses of Alzheimer's Disease, Hypotension, Anxiety, Muscle Weakness, Personal History of Fall, Failure to Thrive and Osteoporosis.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated 7/9/14 documented a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident's cognition was severely impaired.</p> <p>Review of the quarterly MDS dated 9/24/14 documented a BIMS score of 2 indicating Resident #26's cognition was severely impaired.</p> <p>A fall review dated 5/8/14 documented, "...Place dycem strip under shoes to prevent sliding..."</p> <p>Review of fall risk assessments for Resident #26</p>	F 323	<p>nurses have reviewed and revised the care plan for each of the residents at high risk for falls in the "Shooting Star" program to ensure that each person's care plan notes the intervention of having a "Shooting Star" above the resident's bed as well as specific interventions/approaches to follow in an attempt to reduce the resident's risk for falls, (i.e., to monitor the resident for wearing proper footwear, to have eye glasses on if worn when awake, floor mats next to bed on the floor when resident is in bed, referral to rehab for screening when indicated, reduce room and floor clutter, ensure that needed routine items such as drinking water, tissues, call button, and remote control are within the residents' reach while in bed or seated in chair.)</p> <p>Resident #26 has dycem on the bottoms of each pair of shoes as of 11/20/14. The care plan team identified one other resident as having the dycem intervention on his care plan. The MDS nurse has observed the bottoms of the other resident's shoes and determined that the other resident's shoes are in compliance as is the resident's care plan for falls.</p> <p>As of 11/19/14, Resident #32 has floor mats in her room and has a "Shooting Star" above her bed. Resident #32 has also had her care plan reviewed and revised to include that Resident #32 is in the "Shooting Star" program.</p>		

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F 323	<p>Continued From page 5</p> <p>documented the following:</p> <p>a. a score of 17 on 5/2/14.</p> <p>b. a score of 17 on 7/15/14.</p> <p>c. a score of 13 on 9/30/14.</p> <p>d. a score of 15 on 11/7/14.</p> <p>e. a score of 16 on 11/17/14.</p> <p>The resident was assessed as a high risk for falls.</p> <p>Review of the care plan dated 1/28/14 with revisions documented, "At risk for falls related to history... Fall... 5/1/14... Approaches... Dycem strip under shoes to prevent sliding... 11/6/14 Fall... Approaches.. Place colorful tape on locks as a reminder to lock w/c [wheelchair] / when transferring... Fall 11/16/14... Approaches... Therapy screen..."</p> <p>Observations in Resident #26's room on 11/17/14 at 11:27 AM and 3:00 PM, revealed Resident #26 in bed sleeping. Resident #26 did not have a Dycem strip on the bottom of her shoes.</p> <p>Observations in Resident #26's room on 11/18/2014 at 8:22 AM, revealed Resident #26 in bed on her back sleeping. There was no Dycem strip on the bottom of her shoes.</p> <p>During an interview in the Assistant Director of Nursing's (ADON) office on 11/18/14 at 3:00 PM, the Director of Nursing (DON) was asked what a Dycem strip under shoes means. The DON stated, "Therapy got permission to cut a strip of Dycem to place on the bottom of the resident's shoes. It is under the bottom of the shoes."</p> <p>During an interview in Resident #26's room on 11/18/14 at 3:05 PM, the ADON was asked if she could show the surveyor the Dycem strip under</p>	F 323	<p>As of 11/20/14, the fall risk for Resident #87 was reviewed and re-assessed by the MDS nurse. The care plan for Resident #87 was revised to include that the resident is in the "Shooting Star" program with appropriate interventions.</p> <p>To ensure that resident risk for accidents and hazards is reduced, 100% of the employees will receive in service education on the "Shooting Star" program. The licensed nurse will ensure that any fall prevention equipment, bracelets, or "Shooting Star" reminders will be put in place for the resident immediately upon assessment for future residents at risk for falls.</p> <p>The environment service worker will remove the "Shooting Star" from the resident's room and return any other falls risk equipment to the DON or DON's designee when a resident is transferred, discharged, or moves to another room in the facility. If the resident moves to another room in the facility, all of the fall risk equipment and the "Shooting Star" will be moved to the resident's new room by the moving team member responsible for the resident being moved.</p> <p>100% of the nursing home staff will receive in service education by 12/15/14 on the protocols to be followed when a resident is in the "Shooting Star" program. In addition, the nursing staff educator will continue to provide</p>		

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F 323	<p>Continued From page 6</p> <p>Resident #26's shoes. The ADON looked at the bottom of the shoes Resident #26 was wearing and stated, "It's not on this pair. Let me look in the closet and see if it is on another pair." The ADON stated, "No these are all of her shoes and they don't have the strip either."</p> <p>During an interview in the west hall on 11/18/14 at 5:40 PM, certified nursing assistant (CNA) #1 was asked what is done for a resident if they are on the shooting star program and if there was a colored bracelet or something to indicate the resident was high risk for falls. CNA #1 stated, "I think they might have a colored bracelet, maybe pink. No, I don't know. I don't think we have anybody with fall risks."</p> <p>During an interview in the conference room on 11/18/14 at 5:45 PM, the DON was asked what is the criteria for someone to be included in the shooting star program. The DON stated, "We just revised that program in September. I need to read the criteria. I'm not sure." The DON read the policy and stated, "Well it says after 2 or more falls and there is no time range in the policy so yes, she [Resident #26] should be included in the program. Yes, she should have a star above her bed."</p> <p>The facility did not follow the interventions on the resident's care plan related to Dycem strips on the bottom of the resident's shoes and did not follow the policy for the shooting star program.</p> <p>3. Medical record review for Resident #32 documented an admission date of 1/3/13 with diagnoses of Alzheimer's Disease, Depression, Hypertension, Hypothyroidism, Osteoarthritis, Dementia with Behavior Disturbance,</p>	F 323	<p>in service education for staff to ensure that each newly hired staff person understands the "Shooting Star" program.</p> <p><u>QUALITY ASSURANCE PERFORMANCE IMPROVEMENT/MONITORING:</u></p> <p>The Director of Nursing will report an overview of all incidents and accidents reviewed during the quarter to the QAPI Committee to ensure that the facility's staff are attempting to reduce the number of incidents or accidents. The DON or her designee will report the compliance rate on falls to determine if the incidence of falls has increased from the prior quarter. The DON will report any patterns of concern to the Administrator and Medical Director at future QA/QAPI meetings.</p>	12/15/14	

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F 323	<p>Continued From page 7</p> <p>Hypopotassemia, Urinary Incontinence, Chronic Kidney Disease and Psychosis.</p> <p>Review of the incident / accident reports documented the following:</p> <p>a. 4/9/14 - "...Elder observed sitting on floor next to bed. Stated to staff she sat on floor and that she got [up arrow] to put on her socks because the voices told her... Remind elder to use RW [rolling walker] and monitor for 'hearing voices' and report to MD [Medical Doctor] / NP [Nurse Practitioner]... Corrective action taken: Ensure elder has things she need within reach..."</p> <p>b. 10/30/14 - "...CNA [Certified Nurse Assistant] heard Elder yelling went to room observed elder sitting on floor next to bed... Elder assessed for injury none noted elder stated she was trying get into bed missed bed fell in the floor..."</p> <p>Review of the fall risk evaluations dated 10/10/13, 1/3/14, 3/29/14 and 4/10/14 documented scores of 19 or 21.</p> <p>Observation in Resident #32's room on 11/19/14 at 10:54 AM revealed no star above the head of the bed.</p> <p>During an interview in Resident #32's room on 11/19/2014 at 10:54 AM, when asked if Resident #32 had mats by her bed CNA #2 stated, "Oh, she's not had mats since she's been in this house."</p> <p>The facility did not follow the shooting star policy for fall prevention.</p> <p>4. Medical record review for Resident #87 documented an admission date of 7/9/14 with diagnoses of Subdural Hemorrhage, Muscle</p>	F 323		

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F 323	<p>Continued From page 8</p> <p>Weakness, Benign Hypertension, Insomnia and Alzheimer's Disease.</p> <p>Review of the admission MDS dated 7/23/14 documented a BIMS score of 3 and documented the resident had sustained one fall since admission. Review of the quarterly MDS dated 10/16/14 documented a BIMS score of 3.</p> <p>Review of an incident / accident reports documented the following:</p> <p>a. 7/15/14 - "...was sitting in dining room in w/c [wheelchair] tried to get up and fell on floor on buttocks... no injuries... corrective action taken... do not leave elder in dining or other parts of the building unattended..."</p> <p>b. 11/7/14 - "...resident was sitting in w/c... attempted to get up and fell in room... attempted to get up and fell on floor... injury 5 cm [centimeter] knot to head..."</p> <p>Review of the care plan for Resident #87 dated 7/22/14 documented a care plan for "...potential for falls..." his care plan was updated 7/29/14, "...do not leave unattended in dining room..." and updated 11/7/14 "...fall with injury... do not leave elder alone in room, keep her in common area..."</p> <p>During an interview in the west hall on 11/18/14 at 2:59 PM, CNA #3 was asked what type of interventions were in place following Resident #87's recent fall. CNA #3 stated, "We do not leave her in the room by herself. We have a sign on the door to leave her where someone can see her at all times."</p> <p>During an interview in the conference room on 11/18/14 at 4:00 PM, the DON stated Resident #87 was admitted to the facility following a fall</p>	F 323			

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F 323	Continued From page 9 that resulted in a subdural hematoma, "...since she has been over here in the nursing home she has had a couple of falls and we've tried several interventions... now we keep her in the common area or where we can see her... and is not left unattended in her room... she is either in the hall or common area..." During an interview in the conference room on 11/19/14 at 5:45 PM, the DON stated, "Once they have 2 falls they should be put on the [shooting] star program. Se should be on the star program. I'm not sure what the criteria is, but she should have been on the star program because she has had 2 falls. There is no timeframe for the falls." Resident #87 was not placed on the shooting star program until 11/19/14. The facility did not follow the policy for fall prevention.	F 323			
F 371 SS=D	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 This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure food was served under sanitary conditions	F 371	To ensure compliance with the standard of practice regarding hand hygiene, the Activities Director has been counseled and reminded to use good hand hygiene in relation to infection control and the spread of germs. The Activities Director was verbally counseled on 11/28/14 for failing to wash her hands or use an alcohol based hand sanitizer between touching a contaminated item and serving food to a resident. <u>PREVENTATIVE ACTION:</u> The facility will continue to maintain safe infection control practices to prevent the spread of infection during the serving of meal trays to residents.		

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F 371	<p>Continued From page 10 as evidenced by 1 of 16 staff members (Activity Director) failed to practice proper hand hygiene while assisting with meals.</p> <p>The findings included:</p> <p>Review of the facility's "Handwashing" policy documented, "...Hands are to be washed before and after food preparation..."</p> <p>Observations in greenhouse home 1 on 11/17/14 at 12:40 PM, the Activity Director was serving plates of food to elders at a dining table. The Activity Director touched a chair, assisted an elder by touching the elder, touched a walker, moved a chair up to the table, returned to the serving bar to obtain another plate of food and did not perform handwashing before serving another elder. At 11:46 PM, the Activity Director obtained 3 more plates of food and tea and served 3 elders, touched another elder's chair returned to the serving bar touched her own shirt scratching her stomach, obtained another plate of food and served the plate to the elder without performing handwashing. At 12:50 PM, the Activity Director leaned against the serving bar, touched another elder, place a napkin in the lap of the elder, touched her own clothes again, walked over to another elder touched her own blouse, obtained another tray and moved a chair up to the table without performing handwashing.</p> <p>During an interview in the Director of Nursing's (DON) office on 11/19/14 at 4:40 PM, the DON was asked if it was acceptable practice for staff to touch the residents, move the residents and remove a plate from the bar without washing their hands. The DON stated, "No, that is not acceptable. Anytime staff touches a resident or</p>	F 371	<p>The hand washing policy specifically details how a staff person is expected to wash their hands after touching a contaminated item. The policy will be reviewed with all staff of the facility by the ADMINISTRATOR, DON, and ADON, and other department managers.</p> <p><u>QUALITY ASSURANCE PERFORMANCE IMPROVEMENT:</u></p> <p>The DON and or ADON will randomly monitor the hand hygiene practices of staff for proper infection control procedures. The DON, or her designee, will report the findings to the Administrator for the following two quarters at two quarterly QAPI meetings. Reporting shall continue if any compliance issues or patterns of concern are identified. If no compliance issues are noted as a pattern, the ADON and DON will continue to monitor to ensure compliance.</p>	12/15/14	

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F 371	Continued From page 11 wheelchair they should wash their hands."	F 371			
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 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	To ensure compliance with the standard of practice regarding hand hygiene, the Activities Director has been counseled and reminded to use good hand hygiene in relation to infection control and the spread of germs. The Activities Director was verbally counseled on 11/28/14 for failing to wash her hands or use an alcohol based hand sanitizer between touching a contaminated item and serving food to a resident. <u>PREVENTATIVE ACTION:</u> The facility will continue to maintain safe infection control practices to prevent the spread of infection during the serving of meal trays to residents. The hand washing policy specifically details how a staff person is expected to wash their hands after touching a contaminated item. The policy will be reviewed with all staff of the facility by the ADMINISTRATOR, DON, and ADON, and other department managers.		

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F 441	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined 1 of 16 staff members (Activity Director) failed to perform handwashing while assisting with meals. The findings included: Review of the facility's "Infection Control Guidelines..." policy documented, "...3. Employees must wash their hands... under the following conditions... a. Before and after direct contact with residents..." Review of the facility's "Handwashing" policy documented, "...Hands are to be washed before and after food preparation..." Observations in greenhouse home 1 on 11/17/14 at 12:40 PM, the Activity Director was serving plates of food to elders at a dining table. The Activity Director touched a chair, assisted an elder by touching the elder, touched a walker, moved a chair up to the table, returned to the serving bar to obtain another plate of food and did not perform handwashing before serving another elder. At 11:46 PM, the Activity Director obtained 3 more plates of food and tea and served 3 elders, touched another elder's chair returned to the serving bar touched her own shirt scratching her stomach, obtained another plate of food and served the plate to the elder without performing handwashing. At 12:50 PM, the Activity Director leaned against the serving bar, touched another elder, place a napkin in the lap of the elder,	F 441	<u>QUALITY ASSURANCE PERFORMANCE IMPROVEMENT:</u> The DON and or ADON will randomly monitor the hand hygiene practices of staff for proper infection control procedures. The DON, or her designee, will report the findings to the Administrator for the following two quarters at two quarterly QAPI meetings. Reporting shall continue if any compliance issues or patterns of concern are identified. If no compliance issues are noted as a pattern, the ADON and DON will continue to monitor to ensure compliance.	12/15/14	

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F 441	Continued From page 13 touched her own clothes again, walked over to another elder touched her own blouse, obtained another tray and moved a chair up to the table without performing handwashing. During an interview in the Director of Nursing's (DON) office on 11/19/14 at 4:40 PM, the DON was asked if it was acceptable practice for staff to touch the residents, move the residents and remove a plate from the bar without washing their hands. The DON stated, "No, that is not acceptable. Anytime staff touches a resident or wheelchair they should wash their hands."	F 441			

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