

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

PRINTED: 10/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145972	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2008
NAME OF PROVIDER OR SUPPLIER PROVENA COR MARIAE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114	
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F 000	INITIAL COMMENTS	F 000		
F 281 SS=D	<p>Annual Licensure and Certification Survey An extended survey was not conducted.</p> <p>483.20(k)(3)(i) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, and record review the facility failed to administer medications through residents' gastrostomy tubes in a method to prevent g-tube clogs.</p> <p>This applies to 2 of 2 residents observed receiving medications through gastrostomy tubes. (R2, R13)</p> <p>The example includes:</p> <p>1. On 2/4/08 at 12:30 PM, E8 (Registered Nurse - RN) was observed preparing medications for R2. E8 crushed a 500 mg tablet of Flagyl (treatment of protozoal infections). E8 mixed the crushed tablet with 7.5 ml of Ferrous Sulfate (Iron Supplement) and 30ml of 2-Cal HN (nutritional supplement). E8 mixed the 3 substances in a small cup. E8 withdrew the medication solution into a piston syringe and administered the medication through R2's gastrostomy tube. At 12:50 PM, E8 crushed 2 Tramadol (pain medication) tablets and a Compazine (anti-nausea) 5 mg tablet and mixed them together with a small amount of water and administered the solution with the piston syringe</p>	F 281	2/25/08	

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

TITLE

(X6) DATE

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 281	Continued From page 1 to R2 through the gastrostomy tube. The Physician Order Sheet dated 1/1/08 lists R2's diagnoses as Dysphagia and Gastrostomy Infection. Department notes in R2's record on 1/8/08 at 4:47 PM states, "Attempted to administer patient's medications via g-tube, but g-tube is clotted... Unable to push either water or meds through g-tube. Received order to send patient to (Hospital) Emergency Department. 2. On 2/4/08 at 1:20 PM, E8 (RN) crushed Lopressor (antihypertensive) 25 mg tablet and 2 Norco (pain medication) tablets and mixed them together with a small amount of water. E8 administered the solution to R13 through a gastrostomy tube. The facility policy, "Best Practice Guidelines for Tube Feeding" states to prevent the tube from clogging: D.4. Before and after giving medications, give 5 ml of water between each medication if more than one is given at the same time. E. Do not mix medications or mix with formula.	F 281			
F 309 SS=D	483.25 QUALITY OF CARE 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 observation, interview and record	F 309		2/25/08	

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F 309	<p>Continued From page 2</p> <p>review the facility failed to communicate and coordinate a diabetic resident's meal plan, blood glucose checks, insulin administration and dialysis schedule for dialysis treatments and failed to follow up on the detailed nutrition report from the dialysis center.</p> <p>This applies to 2 of 2 resident receiving dialysis services. (R14, R22)</p> <p>The example includes:</p> <p>1. The Physician order sheet dated 1/1/08 documents R14 has End Stage Renal Disease and Diabetes Type II. The hospital discharge transfer record dated 1/23/08 states R14 is to go to Hemodialysis three times a week.</p> <p>On 2/7/08 at 2:45 PM, R14 was observed leaving the facility accompanied by transport staff.</p> <p>On 2/5/08 at 3:25 PM, E14 (Licensed Practical Nurse - LPN) stated, "R14 leaves for dialysis before I get here. I'm not sure who transports him." E14 stated she was not sure which dialysis facility R14 goes to for treatment. E14 questioned the other nurse on duty. E19 (LPN) states, "Doesn't he go to Hospital 1?". E14 was still unsure and called the unit clerk (E20). E20 stated, "I think he goes to Hospital 2. I'm not sure though because I did not make the arrangements." E20 (Unit clerk) stated, "I'll call the dialysis center to find out (where he goes)." E20 called the first dialysis center and asked if R14 was there. The dialysis stated he was not there to call the other facility.</p> <p>On 2/5/08 at 3:30 PM, E14 (LPN) stated, "I have not received any information or report from the</p>	F 309			

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F 309	<p>Continued From page 3</p> <p>dialysis center after his treatments." E14 states she does not know how R14 tolerates the treatment or what medications and fluids he received. E20 (Unit Clerk) stated she files the treatment reports in the chart if they return with the resident.</p> <p>On 2/5/08 at 3:25 PM, E14 (LPN) was asked about R14's order for a blood glucose check and sliding scale insulin at 5 PM when R14 is at dialysis. E14 stated, "When R14 is at dialysis, I mark on the Medication Administration Record (MAR) that he is out of the facility (OOF). I take his blood glucose test when he comes back around 6-7 PM. I didn't do it on 2/2/08 because it was between 8-9 PM when he came back. R14 eats while he is at dialysis. If the resident is OOF, I don't give it. The doctor has discontinued the bedtime blood glucose checks and insulin."</p> <p>Record review of R14 chart showed 1 progress note from the treatment center dated 1/24/08. (R14's first visit). R14's February Medication Administration Record (MAR) documents blood glucose checks are to be done before each meal, (scheduled for 6 AM, 11 AM, 5 PM) and to receive sliding scale insulin according to the blood glucose results.</p> <p>The Nursing Note dated 1/26/08 at 4:23 AM documents, "Patient's blood sugar was 28." (According to Mosby's Diagnostic and Laboratory Test Reference 2nd Edition, 1995; Normal blood glucose range is 70-105.) The Physician Order dated 1/26/08 states to discontinue the bedtime blood glucose checks and insulin.</p> <p>R14's care plan dated 1/23/08 does not show R14's dialysis schedule (frequency and treatment</p>	F 309			

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F 309	<p>Continued From page 4</p> <p>times), transport arrangements, the treatment facility and contact number. The care plan does not address the meal plan for R14 while he is out of the facility and how to manage his blood sugar checks and insulin administration when doses are missed during dialysis treatment.</p> <p>2. The February 2008 Treatment Record lists R22's diagnoses including Diabetes Mellitus Type II and Chronic Kidney Disease. The same record shows that R22 receives Hemodialysis three times a week on Monday, Wednesday and Fridays.</p> <p>R22 ' s report from the dialysis center dated 1/17/08, showed that R22 had nPCR HD UKM (nPCR = normalized Protein Catabolic Rate, HD = hemodialysis, UKM = urea kinetic modeling according to the National Kidney Foundation) showed on 1/14/08, those levels were determined to be 0.53. The report states that R22 ' s goal is to have a level of 1.0 or higher. The report includes a note which says " your NPCR is low. This means that you may need to eat more protein and calories " .</p> <p>As of 2/7/08, Departmental Notes for R22 show the last entry by the consultant dietitian was on 1/10/08. The note includes that R22 refuses nutritional supplement. Nursing reports, "She isn ' t taking ice cream mixed with Lactaid milk well. Oral intake is fair to good since returning from the hospital." The conclusion was: "Will monitor for need of additional dietary restrictions." No alternative interventions had been suggested to increase calories or protein.</p> <p>On 2/7/08 at 1:35pm, E16(Consultant Dietitian) states she comes to the facility two times a month. E16 confirmed she was not aware of the report from the dialysis center for R22 . R22 was interviewed at 2pm on 2/7/08. R22 is alert and oriented. R22 stated that she goes to dialysis in</p>	F 309			

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F 309	Continued From page 5 the afternoons. She eats the lunch sent by the facility there. She stated that the facility sends a sandwich, fruit, jello or pudding. Usually she doesn ' t eat the whole lunch and sometimes doesn ' t eat the sandwich. R22 stated sometimes the meat sandwiches are dry. She prefers egg salad. R22 stated she knows she needs to eat more protein and calories. The Care Plan of 1/9/08 does not address any follow up related to R22 ' s intake of the sack lunch. The Care Plan dated 1/10/08 addresses: " Provide diet rx(order)as ordered-recommend General Consistent Carbohydrate-No Added Salt diet. Assist/encourage oral intake as needed. Update food preferences. Monitor appropriateness of diet consistency. Monitor along with dialysis for need of additional dietary restrictions. "	F 309			
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to continue resident tube feedings, flush with prescribed water amounts and failed to keep a gastrostomy site free of drainage. This applies to 2 of 2 residents with continuous	F 322		2/25/08	

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F 322	<p>Continued From page 6</p> <p>gastrostomy tube feedings. (R2, R13)</p> <p>The example includes:</p> <p>1. On 2/4/08 at 10:45 AM, R13 was observed lying in the bed. The tube feeding solution and tubing was hanging on the pump stand. The tubing was connected to R13' gastrostomy tube. The feeding pump was off, the solution was not infusing.</p> <p>On 2/4/08 at 1:45 PM, E8 (Registered Nurse - RN) administered R13's medications via the gastrostomy tube. The tube feeding was off. E8 was questioned about R13's gastrostomy tube flush. E8 responded, "The order does not specify the amount of flush, so I give a minimal amount of fluid." E8 used a piston syringe half filled with water for flushing the gastrostomy tube.</p> <p>On 2/4/08 at 1:45 PM, the tube feeding solution bottle was dated 2/4/08 with a start time of 5:50 AM. The feeding pump read that 1446 ml had infused. The 1500 ml bottle was full. E8 stated, "R13 is ordered to receive continuous tube feedings at 65ml/hour." E8 stated, "The feeding was on earlier when the nursing assistants cleaned him up, I don't know why it was off now." E8 explained the procedure is to clear (the volume infused) at the end of the shift. "They probably didn't clear the pump when the new bag was hung at 6 AM,. This looks like a full bag." E8 started the infusion.</p> <p>On 2/5/08 at 11:15 AM, R13 was observed with the tube feeding solution infusing at 65 ml/hour. The same bottle was hanging dated 2/4/08 at 5:50 AM. Approximately 200 ml remain in the bottle.</p>	F 322			

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F 322	<p>Continued From page 7</p> <p>On 2/5/08 at 3:10 PM, E18 (dietician) stated she reviews the intake and output form during the dietary assessment to determine how much fluid intake a resident receives. E18 states she assumes if a feeding is ordered at 65 ml/hr they do receive that amount.</p> <p>On 2/5/08 at 3:15 PM, E14 (LPN) reviewed R13's chart and determined an intake and output form was not being used to record his intake.</p> <p>The Physician Order Sheet dated 1/1/08 shows R13 diagnoses as Bacteremia and Dysphagia. The POS states R13 is to receive tube feeding at 65ml/hour continuous and to receive a 225 ml water flush through the gastrostomy tube three times a day.</p> <p>2. On 2/4/08 at 11:25 AM, R2 was observed sleeping in a low bed. The tube feeding solution and tubing was hanging on the pump stand. The pump was off, the infusion was not running. The tubing was connected to R2.</p> <p>On 2/4/08 at 12:50 PM, E8 (RN) administered R2's medications via the gastrostomy tube. The tube feeding was off. E8 stated, "R2's feedings are continuous. I don't know why the pump was off and it was not running." There were no markings on the tube feeding container. E8 stated, "I can't say when it was hung. It should be marked."</p> <p>On 2/5/08 at 10:50 AM, R2 was observed lying in bed visiting with family. R2's gastrostomy site was open to the air and exposed under her short top. A pool of yellow secretions was noted around the gastrostomy site. The yellow</p>	F 322			

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F 322	Continued From page 8 drainage was noted on the waist band of R2's pants. On 2/5/08 at 11:30 AM, E10 (Registered Nurse - RN) stated, "We are supposed to change the tube feeding solutions and tubings every 24 hours. The container should be labeled with the date and time of when it was hung. If it's not labeled with the date or time, we don't know how long it's been there." E10 was asked about gastrostomy site care. E10 stated, "Skin around the tubing is cleansed and the dressing is changed every shift and as needed." The Physician Order Sheet dated 1/1/08 documents R2's diagnoses of Dysphagia and Gastrostomy infection. The physician order dated 1/18/08 states to run tube feeding continuous at 30 ml/hour. The facility policy, "Best Practice Guidelines for Tube Feeding, appendix C: Tube Care" states C.1. Inspect the skin for drainage or gastric leakage. 2. Clean skin with soap and water. 3. Change dressing frequently and clean skin.	F 322			
F 329 SS=D	483.25(l) 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	F 329		2/25/08	

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F 329	<p>Continued From page 9</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to identify a specific/measurable behavior, failed to quantify episodes of behaviors, and failed to analyze a residents response to behavioral interventions.</p> <p>This applies to 1 of 34 residents receiving psychotropic medications. (R4)</p> <p>The examples include:</p> <p>R4's Physician's Order Sheet of January, 2008 documents that R4's diagnoses includes Dementia and Anxiety.</p> <p>A Physician's telephone order dated 3/9/07 shows an order: "Use Haldol 0.5mg as needed for agitation."</p> <p>Nursing Notes for 3/17/07 documents "verbally abusive towards other residents and staff during morning and evening shifts."</p> <p>R4's Medication Administration Record of 9/19/07</p>	F 329			

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F 329	<p>Continued From page 10 shows that R4's Haldol was discontinued.</p> <p>Facility document entitled Behavior/ Intervention Monthly Flow Record shows the following:</p> <p>May, 2007 - blank/ no target behavior identified/no episodes of behavior. No June tracking sheet found. July, 2007 documents target behavior as agitation/documentation for 5 days out of 31 days. August, 2007 documents target behavior as anxiety/no episodes documented.</p> <p>September, 2007 documents R4's target behavior as agitation. 1 day of 30 days documented episodes of behavior, three times on 9/1/07.</p> <p>R4's September, 2007 medication administration record shows that R4 received Haldol 7 days in September. (9/1, 9/2, 9/3, 9/8, 9/9, 9/15, 9/16)</p> <p>Psychotropic Drug Care Plan dated 10/1/07 shows, " Document negative on behavior tracking form "</p> <p>Facimile to R4 ' s physician dated 10/16/07 shows, " Resident has frequent episodes of yelling out, crying out, " Help me. " Can become angry at times yelling out, " Thanks for nothing. " Multiple attempts to redirect resident without success. " Document shows physician ordered Zyprexa 2.5mg every HS (hours of sleep), Ativan 1mg TID (three times a day).</p> <p>There was no behavior tracking documentation for October, 2007. Nurse ' s note of 10/30/07 documents, " Res continues to yell out in TV</p>	F 329			

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F 329	Continued From page 11 area but can be re-directed. Nurses ' s note of 1/14/08 shows, " Continues to yell out for help. " Pharmacy Review of 12/07 documents, " Behavior documentation needed. " Pharmacy Review of 1/17/08 shows, " Behavior documentation needed. " Review also recommends a dose reduction of Ativan due to decreased use. R4's February, 2008 Physician's Order Sheet shows that R4 receives Zyprexa (Antipsychotic) and Ativan (Anti-anxiety) medication. R4's Minimum Data Set (MDS) assessment of 1/22/08 identifies that R3 has a short and long term memory problem with severely impaired cognitive skills for daily decision making. The same assessment shows R3 had no behaviors. On 2/5/08 at 9:45am, R4 was observed in a reclining chair. Resident was yelling out, " Please help me " during an activity. Activity staff attempted to re-direct and engage R4 in the activity. R4 started to yell, " Get me out of here. " On 2/5/08 at 9:30am, E1 stated, " I don ' t think you will find any behavior tracking. The Pharmacy had recommended a behavior tracking committee.	F 329			
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 333		2/25/08	

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F 333	<p>Continued From page 12</p> <p>Based on observation, record review and interview the facility failed to measure blood glucose levels and administered ordered insulin before a resident consumed their meal.</p> <p>This applies to 1 of 1 resident observed receiving insulin during med pass. (R14)</p> <p>The examples include:</p> <p>1. On 2/4/08 at 1:10 PM, R14 was observed sitting in his room. R14 stated he ate lunch in his room today. R14's lunch tray was on the overbed table, 100% of the meal was consumed.</p> <p>On 2/4/08 at 1:10 PM, E8 (Registered Nurse - RN) completed a blood glucose test on R14. E8 responded R14's blood glucose was 233 and would receive insulin according to the sliding scale order. E8 administered 6 units of Novolin R insulin into R14's abdomen at 1:15 PM.</p> <p>The Physician order sheet dated 1/1/08 documents R14's diagnoses as Diabetes Type II and End Stage Renal Disease. R14's February Medication Administration Record (MAR) documents (Blood Glucose) checks are to be done before each meal, (scheduled for 6 AM, 11 AM, 5 PM). The MAR shows R14 is to receive 6 units of Novolin R insulin before meals for blood glucose levels between 201-250.</p> <p>On 2/4/08 at 1:20 PM, E8 (RN) was questioned about R14's insulin and blood glucose check schedules. E8 stated, "It depends on when the physician schedules it." E8 confirmed R14's insulin is scheduled before meals and stated that eating his meal before the blood glucose check,</p>	F 333			

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F 333	Continued From page 13 "Would cause his blood sugar to be higher than before he ate."	F 333			
F 356 SS=C	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		2/25/08	

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F 356	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to post current daily staffing information.</p> <p>This applies to all residents and visitors in the facility.</p> <p>The examples include:</p> <ol style="list-style-type: none"> On 2/4/08 at 10:40 AM near the center nursing station, a communication board titled, "Important Information" was observed. On the board, a laminated sign printed with date, titles and number of staff was observed. The sign was blank, there were no staffing numbers, date or other information posted. On 2/7/08 at 1:20 PM, E9 (Assistant Administrator) stated, "It is the Director of Nurses job (to complete the board information). He comes in around 7". On 2/4/08 at 10:30 AM, a white erase board in the resident room (23) stated "RN - (E16), RN - (E15) and CNA - E(17)" was listed. No date was listed. <p>February staffing schedules were reviewed. The nurses and nursing assistant listed (E15, E16, E17) was scheduled for day shift on Sunday February 3.</p> <ol style="list-style-type: none"> On 2/4/08 at 11:20 AM, the white erase board in resident room (28) stated, "Today is February 1, 2008. LPN (E7) and CNA (E17)". On 2/5/08 at 10:45 AM, the white erase board 	F 356			

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F 356	Continued From page 15 in resident room (30) listed the day shift staffing from 2/4/08. On 2/5/08 at 10:50 AM, Z1 stated, "Sometimes that information (on the white boards) doesn't change for several days to a week. That's gotta be hard when you are confused about the date and trying to figure out what's going on." On 2/5/08 at 2:15 PM, E11 (Certified Nursing Assistant - CNA) stated, "It's the CNA job to change the white boards (in the resident rooms). We are to do it (post the shift staffing) at the beginning of each shift."	F 356			
F 442 SS=E	483.65(b)(1) PREVENTING SPREAD OF INFECTION When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to change gloves and wash hands to prevent cross contamination during a dressing change, passing and setting up resident meal trays, and while passing ice water. This applies to all residents receiving dressing changes, meal tray set up, and ice water. The examples include: 1. R23's February, 2008 Physician's Order Sheet documents that R23's diagnoses include Bacteremia, and Pressure Ulcer.	F 442		2/25/08	

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F 442	<p>Continued From page 16</p> <p>On 2/4/07 at 11:00 AM, R23 was observed in his bed. A red isolation bin was observed in R23's room.</p> <p>E3, Registered Nurse/ Wound Care Nurse and E7, Licensed Practical Nurse/ Wound Care Nurse were observed changing the dressing to R23's right heel, and left buttock. E6 Certified Nursing Assistant (CNA) was assisting E3 and E7.</p> <p>E7 was observed to put on a pair of gloves to assist E3 with wound care. After E3 put on the gloves she moved R23's trash can closer to the bed. E3 then removed a soiled dressing from R23's right heel. E7 then handed E3 the clean gauze and a bottle of Betadine solution. E3 applied the Betadine solution to the clean gauze then placed the bottle of Betadine in her uniform pocket. E7 then took the Betadine gauze from E3, and handed her another clean dressing to hold.</p> <p>E3 then removed the original gloves, and without washing her hands, placed another pair of gloves on. R23 was rolled onto his left side, and was observed to have been incontinent of stool. E3 helped E6 remove the soiled linens from underneath R23. E3 then pulled back the privacy curtain with the soiled gloves on, removed the gloves, and without washing her hands left the room to obtain a dressing (Allevyn) for R23.</p> <p>E6 said that R23 had been having 3-4 loose stools per shift. R23's buttocks, and scrotum were observed to be bright red. A white thick cream was observed partially covering R23's peri</p>	F 442			

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F 442	<p>Continued From page 17</p> <p>anal area. At this time E3 was asked about the isolation bin in the room. E3 said she was not sure which resident in the room was on isolation.</p> <p>E6 place the soiled linens into a yellow bag after cleaning up R23 and stated she placed the linens in the yellow bag because R23's linens needed to be kept separate.</p> <p>On 2/4/08 at 11:15 PM, E3 was asked when she should change her gloves and wash her hands. E3 said she should do this every time that her gloves or hands become contaminated.</p> <p>R23's Physicians's Order Sheet shows an order to obtain a stool culture for C-Diff. (Clostridium Difficile) written on 2/5/08. Review of facility records show that 4 residents on the skilled care unit were currently being treated for C- diff. (R24, R25, R26, R27)</p> <p>2. On 2/4/08 at 12:40 PM, E13 Dietary Aide, was observed in the main dining room. E13 was observed as she assisted with the meal tray distribution. E13 was wearing a pair of gloves, and was going through the meal cart looking for certain resident's trays. E13 said that the trays were usually set up in the cart so they could be passed by tables. E13 said the staff that normally sets up the trays was not there today.</p> <p>E13 was asked to obtain additional silverware because some were missing from the trays. E13 left the dining room wearing the gloves, went to the nurses station and made a call to the kitchen. On the way back to the dining room, E3 assisted R23 by pushing him in his wheel chair to the</p>	F 442			

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F 442	<p>Continued From page 18</p> <p>dining room table. E13 then returned to the meal cart and began distributing trays. E13 was observed opening containers and handling resident silverware.</p> <p>E13 then served R23's meal tray, opened containers, and gave R23 a bite of his food. E13 then returned to the meal cart. E13 continued to wear the same gloves throughout the remainder of time she assisted in the dining room.</p> <p>On 2/7/08 at 10:30 AM, E5, Food Service Manager, was asked why the dietary aid was wearing the gloves while in the dining room. E5 said " she doesn't have to, I have told her that before, I will talk to her again."</p> <p>3. On 2/4/08 at 11:15 AM, E12, CNA was observed passing ice water. E12 was observed putting her hand down into the ice/ cooler to obtain the ice scoop which was submerged in the ice. E12 scooped out the ice, placed in the resident's drinking cups and then filled the cups with water in the residents washroom. E12 was not observed to wash her hands as she continued this process room to room. E12 was asked what the process for passing ice water was. E12 said she should wash her hands before leaving each residents room.</p> <p>On 2/5/08 at 2:10 PM E12 was observed again passing ice water. E12 was observed to submerge her hand into the ice chest to retrieve the ice scoop. E12 would then get a scoop of ice, leave the ice scoop in the cooler, after filling the residents cup. E12 went into the residents washroom to get water, and then would proceed to the ice cooler for more ice.</p>	F 442			

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F 442	<p>Continued From page 19</p> <p>On 2/5/08 at 2:15 E2 Assistant Director of Nursing was advised regarding E12's ice pass procedure. E2 was shown the ice scoop submerged in the cooler of ice. E2 said " I will change that right now."</p> <p>Review of the facilities policy entitled Glove Technique documents:</p> <p>Policy: Wear clean non-sterile gloves when touching blood, body fluids, secretions, excretions, and contaminated items; put on clean gloves just before touching mucous membranes, and non-intact skin. Change gloves between tasks and procedures on the same resident after contact with the material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident, and wash hands/ hand hygiene immediately to avoid transfer of microorganisms to other resident or environments.</p> <p>Page 2 of the same policy shows under item D) Wash hands or use waterless hand antiseptic. It is always possible that gloves have minute leaks.</p>	F 442			