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	14A383	A. BUILDING _____ B. WING _____	08/22/2013

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F 000	INITIAL COMMENTS Annual Certification Survey.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure survey results with plans of correction were readily accessible and could be found without having to request them. This deficient practice had the potential to affect all 44 residents in the the facility. The findings include: The Form 672 (Resident Census And Condition of Residents) provided by the facility dated 8/20/2013 showed there were 44 residents in the facility. During the group meeting on 8/20/2013 at 11:00 A.M., R7, R13 through R17 all stated they do not know where the state survey report was posted.	F 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 167	Continued From page 1 During the environmental tour on 8/21/2013 at 11:00 A.M., E4 (Maintenance Director) was not aware where the state survey was posted. This posted notice was located at the reception area. The notice shows the survey result can be found in the Music/Living room. E4 searched the survey results in the Music/Living room. The survey results were not visible and not easily accessible because there was a large reclining lounge chair blocking a small small bookshelf where the survey results were kept. E4 had to move the large reclining lounge chair blocking the bookshelf in order to get the binder containing the survey results. The survey result binder was placed in between multiple books. The binder was labeled "survey." The survey results did not include plans of correction for the cited deficiencies.	F 167		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement pressure	F 314		

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sore treatment according to plan of care in order to promote healing and prevent infection. The facility also failed to obtain physician order to ensure current treatment of the pressure sore was appropriate.

This applies to one of two residents (R6) reviewed for pressure sore in the sample of 11.

The findings include:

R6 was admitted to the facility on 2/15/2010 with multiple diagnoses including vascular dementia, DM (Diabetes Mellitus), bowel incontinence and depression according to POS dated August 2013.

The nurse assessment notes dated 2/15/2010 document R6 has a stage 2 pressure ulcer on the coccyx measuring 1 cm x 0.5 cm.

The " Patient Wound Care" dated 1/12/2012 document R6 has a stage 3 pressure ulcer on the coccyx area. The pressure sore was described as follows: full thickness wound, measuring 0.5 (length) x 0.40 cm (width) and 0.4 depth. The wound also has undermining of 0.5 cm from 4 o'clock position. The dressing treatment documents packing the wound with Calcium Alginate and covering with foam dressing.

The Minimum Data Set (MDS) dated 7/23/2013 and 1/20/2013 document R6 is totally dependent with all aspects of ADL (Activities of Daily Living) including mobility, transfers and personal hygiene. The MDS also documents R6 is incontinent of bowel elimination. This assessment also identified R6 has a stage 3 pressure sore. The MDS also documents interventions for the pressure sore including the application of

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dressing and pressure relieving devices in bed and in chair.

Review of current care plan dated 1/15/2013 and 7/20/2013 showed the intervention for the pressure sore was to apply dry gauze dressing after cleansing with saline solution to prevent development of any signs of infection.

On 8/20/12 at 3:09 P.M., R6's skin was checked with E2 (Acting Director of Nursing) and E24 (Certified Nurse Assistant). R6 was lying on a pressure relieving mattress. There was a bed sheet and an incontinent pad on top of the pressure relieving mattress. R6 has an indwelling catheter and was also wearing an adult incontinence brief. E2 stated the use of pads and bed linens should be to maximize the optimum function of the pressure relieving device. R6's adult incontinent brief was removed by E24. R6 was noted with a pressure sore on the coccyx area. The pressure sore was open and approximately 0.5 cm in circumference. The pressure sore also has a hole. The surrounding area of the wound was whitish in color, wrinkled and macerated. There was no dressing to cover the open pressure sore to prevent possible contamination from the bowel incontinence. E2 stated, " I just applied a gauze dressing this morning to cover the wound.". E24 stated R6 is incontinent of bowel function. E24 also stated R6 had a bowel movement at around 1:30 P.M. (8/20/2013). E24 also added he informed E21 (Licensed Practical Nurse, LPN) after R6 had the bowel movement.

On 8/20/2013 at 3:20 P.M., E21 stated she did not cover R6's pressure sore with gauze dressing

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F 314	Continued From page 4 because the treatment was only the "Skin Prep." On 8/20/2013 at 3:25 P.M., together with E2, TAR (Treatment Administration Record) and POS (Physician Order Sheet) dated for the month of August 2013 were reviewed. The TAR document "Skin Prep to coccyx daily" There was no documentation on the TAR about the gauze dressing as indicated on the care plan. The POS showed no physician order for the Skin Prep and the gauze dry dressing. E2 stated she will update the TAR to ensure R6's pressure sore is covered with dry gauze dressing. The "Doctor's Progress Notes" dated 8/5/2013 showed no documentation of what would be the appropriate treatment for this chronic, unresolving stage 3 pressure sore. R6's most current "Wound Skin Record" dated 8/16/2013 described the wound as stage 3 , measuring 0.5 cm in length, 0.2 cm in width and 0.3 cm in depth. The record also documents the surrounding tissues/wound edges were macerated.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced	F 318		

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by:
Based on interview and record review, the facility failed to ensure a physician ordered orthotic brace be applied to the resident's left wrist to prevent further decrease in range of motion. This deficient practice applies to one (R3) of seven residents reviewed for range of motion in a sample of 11.

Findings include:

R3 is an alert and oriented 69 year old resident originally admitted to the facility on 7/27/04. Admitting diagnoses include, history (Hx.) of mengioma with craniotomy, Hx. cerebral vascular accident, left sided spastic hemiplegia, obstructive hydrocephalus, pulmonary embolus, asthma, depression, hypothyroidism, gastroesophageal reflux disease and urinary retention with chronic urinary tract infection.

On 8/20/13 at 10:20 AM, during a resident interview, R3 stated she had not worn her left wrist splint for weeks. She was unable to recall exactly how long it had been since it had been applied, but stated she hadn't worn it because neither herself nor nursing staff could get the brace to fit her wrist. R3 stated after a while everyone just stopped attempting to put it on.

Review of physician order forms and care plans found in R3's medical record showed a wrist splint was to be applied to R3's left wrist at bedtime and worn while sleeping.

Review of restorative flow sheets provided by the facility for R3 showed of the 12 focus areas listed at the top of the flow sheet R3, was receiving restorative nursing in the areas of dressing (2),

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F 318	Continued From page 6 eating (5), transfers (6), mobility (7), and hygiene (4). The number corresponding to splint application (8) was not listed on R3's restorative flow sheet for the month of August 2013. On 8/21/13 at approximately 12:00 PM, the facility's Director of Nursing (E2), stated she was responsible for the facility's restorative program. E2 stated she was unaware the resident hadn't been using the splint. She stated the the splint was listed on the Nurse's treatment administration record (TAR) which should be signed by the nurses upon application. E2 stated although the splint application was to be documented on the TAR, Certified nursing assistants were to apply it, which she stated may have been apart of the breakdown in communication. E2 informed the team that on 8/21/13 she made an appointment to have the splint refitted.	F 318		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a personal alarm monitoring device was in place, in good repair and the care plan was revised in order to	F 323		

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prevent fall incidents. The facility also failed to provide a hazard free environment by ensuring staff had visual control of the housekeeping carts and beauty shop supplies stored in a locked storage and not accessible to cognitively impaired residents.

This applies to one of five residents (R8) reviewed for falls in the sample of 11. The environmental hazards applies to two residents (R1 and R2) and 7 residents (R22,R28,R35,R36,R37,R38,R39) in the supplemental sample who were cognitively impaired and had the capability of independent movement and mobility.

The findings include:

1) The Face Sheet documented R8 as an 82 year old resident. The admitting diagnoses includes vascular dementia, CVA (cerebral vascular accident), history of TIA (transient ischemic attack) and OA(osteoarthritis).

The Minimal Data Set (MDS) dated 5/6/2013 documents R8's memory was moderately impaired, decision making was poor and cuing and supervision was required. MDS dated 07/13/2013 documents R8's memory was severely impaired and rarely/never make decisions. The MDS also identified R8 requires extensive assistance of one person for mobility and transfers.

The current care plan dated 8/6/2013 documents the following interventions:

- maintain pressure sensor alarm in wheelchair, recliner chair, bed with functioning batteries so

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staff would be aware with attempted self transfers. This intervention had a start date of 4/29/2013.
- motion sensor alarm when in bed. The sensor alarm should placed pointing at R8, should be on "On" position with a functioning battery.
- " Most transfers are stand/pivot except staff attempting to use Sit to Stand Lift for toilet transfers." This intervention had a start date on 8/6/2013.

The incident reports showed R8 had four falls for a period of a month and a week. (from July 8,2013 to August 13,2013). The facility's incident reports investigation that included and updates to the physician with regards to the the fall incidents showed the following:

- 7/8/2013 at 8:50 A.M., R8 tipped himself over in his chair in the dining room landing on his right side. R8 sustained 2 skin tears on the right elbow measuring 2.0 cm x 1.5 cm. and 0.6 cm. and 1.0 cm. R8 was not wearing personal alarm but was ordered.
- 7/26/2013 at 10:35 A.M., R8 was found on the floor, lying on his right side in front of his recliner chair. " Pressure Alarm was in placed but did not sound, battery had failed. When checked for function, found battery not working."
- 8/2/2013 at 4:25 A.M., R8 found sitting on the floor next to his bed and was holding sensor alarm. R8 got out of bed, unassisted and lost balance. The facility's investigation showed R8's motion sensor alarm was on the floor in order to catch R8's movement if he tries to get out of bed. The investigation also showed probable cause of fall was R8 exited bed over the foot board avoiding the location of the sensor, had picked the motion sensor and fell on the floor.

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- 8/13/2013 at 8:30 P.M., "(R8) was assisted for transfer from the toilet by a CNA (Certified Nurse Assistant). (R8) lost balance and bumped into the wall causing a skin tear to his right elbow."

On 8/21/2013 at 3:45 P.M., E2(Acting Director Of Nursing) explained the following causes of R8's fall incidents:
- "personal alarm should have been on for the 7/8/2013 fall ."
- "personal alarm battery had failed for the 7/26/2013 fall."
- "sensor alarm was not functioning properly as the alarm did not sound off immediately. The alarm sound off by the time (R8) had moved from the foot of the bed, picked the sensor alarm by the dresser next to the foot of the bed, had walked towards the side of his bed and fell before the alarm sound was activated. This was for the (R8) 8/2/2013 fall incident."
- "the sit to stand lift was not used during the transfer on the toilet on the 8/13/2013." E2 also stated the care plan was not specific what were the indicators when to use the sit to stand lift. E2 verified the care plan was not revised after the 8/13/2013 fall incident.

On 8/21/2013 at around 3:50 P.M., E2 showed R8's room and where the sensor alarm was located when the fall occurred on 7/26/2013. The same sensor alarm R8 used at time of the fall was noted by the dresser next to R8's foot of the bed. The sensor alarm did not detect the motion/ movement and the sound alarm did not activate immediately. The sensor alarm sound was finally activated approximately 2-3 minutes after sensing the movement. E2 added the the sensor alarm sound had a delayed activation.

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2) During environmental tour on 08/21/2013 between 11:00 A.M. to 11:15 A.M. with E4 (Maintenance Director), the following were observed:
- a housekeeping cart in the hallway next to resident room number 3. The cart was left unattended and unsupervised. E9(Housekeeper) was inside resident room number 4 and had no visual control of the cart. E9 stated the bucket of water that was in the cart had a mixture of a disinfectant solution. E9 also showed to surveyor the disinfectant solution container. The label showed "disinfectant; Keep Out of Reach" .
- a housekeeping cart in the hallway next to clean utility room, unsupervised and unattended. E26 (housekeeper) was seen coming out of the Spa room across the clean utility room. E26 stated the bucket of water that was in the cart also has a disinfectant solution.
- The facility's beauty shop was unlocked and unsupervised. Inside the shop were three hair clippers/trimmers and two curling irons on the countertop. There was also a basket full of multiple cans of hair spray in an unlocked shelf.

There were residents observed around the area during the tour.

E2 (Acting Director Director of Nursing) was notified with the environmental hazards immediately after the environmental tour. E2 stated the hair trimmers and curling irons should be stored in a locked cabinet in the beauty shop. E2 also stated there were nine residents (R1, R2, R22,R28, R35,R36,R37,R38 and R39) who are cognitively impaired and move around the facility independently.

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F 363	Continued From page 11	F 363		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to follow the menu for the pureed diet types. The facility also failed to meet the resident's nutritional needs by not providing variety of food selections. This applies to two residents (R5 and R7) in the sample of 11 and 15 residents (R12 through R26) in the supplemental sample. The findings include: 1) On 8/20/13 at 10:10 AM, E11 (Dietary Aide) pureed the Crisp Apricot dessert using a 12 servings recipe. E11 stated she added milk and food thickener to the dessert prior to placing in the blender. The facility recipe #67 " Crisp Apricot Pureed Thick " showed 100% Apple Juice should be added instead of milk. On 8/20/13 at 10:40 AM, E10 (Cook) used water and food thickener to puree the lunch food items (fish fillet, scalloped cabbage & red bliss potatoes). The recipes showed low sodium chicken base should also be used to puree the above referenced food items. The pureed foods was bland and tasteless when sampled. E10 stated on 8/20/13 at 11:00 AM she only used water to puree the food since they ran out of the	F 363		

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F 363	Continued From page 12 chicken base. 2) There were 6 residents (R7, R13, R14, R15, R16 & R17) in attendance during group interview on 8/20/13 at 11:00 AM. The residents stated the chicken dish was served frequently at least 2 X a week. The group stated food concerns were addressed only during the Resident Council Meeting. Review of the six week spreadsheet for Spring/Summer 2013 showed a chicken dish were served 2 X - 4 X per week. The sheets showed on Week 1, Grilled Chicken salad was served on Sunday for dinner, Lemon Ginger Chicken for lunch on Monday, Chicken Florentine for lunch on Wednesday & Breaded Chicken Sandwich for dinner on Thursday. The spreadsheet showed for weeks 2 and 4, chicken was served 3 X. On 8/22/13 at 9:00 AM, R14 stated the quality and taste of food being served was not good. The soup which was served few weeks ago was very salty. R14 said she talked to E3 (Food Service Director) in the past regarding food variety and tasteless quality of the food being served. E3 told R14 she will see what needs to be done.	F 363		
F 371 SS=F	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, interview and record review, the facility failed to store, prepare, distribute and serve food under sanitary conditions by not labeling leftover foods and that the three compartment sink was maintained at an acceptable sanitizing concentration. The facility also failed to follow manufacturer's specification for proper storage of used honey thickened liquids.

This has the potential to affect all 44 residents in the facility.

The findings include:

The Resident Census and Conditions of Residents (Form CMS-672) provided by the facility dated 8/20/13 showed there were 44 residents in the facility.

1) During the initial Kitchen tour with E3 (Food Service Director) on 8/19/13 at 9:50 AM, the following were found:
A) 3 Compartment Sink showed 150 ppm (parts per million) sanitizing concentration using quaternary ammonia solution. E3 stated it should be 200 ppm. E3 also said the sanitation delivery pump would be adjusted to get the proper concentration.
B) Reach In Cooler: 1 large plastic bag of shredded cheese dated 8/3/13
1 tub of butter - opened and undated
7 English muffins - opened and undated
5 Bagels - opened and undated
1 large container of pickle relish - opened and undated

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1 large container of pickle slices - with opened date of 6/20/13
1 large container of barbecue sauce - with opened date of 6/18/13
1 small container of Sweet Relish - with opened date of 7/19/13
bowl of fresh Lettuce - labeled 8/15/13
1 plastic container of Basil Pesto dressing - opened & undated
1 container of ketchup - with opened date of 6/20/13
1 container of raspberry vinaigrette dressing - with opened date of 5/22/13
1 container of Strawberry filling - opened & undated.
C) Walk In Cooler:
balsamic vinegar (1 gallon, 1 quart) - with opened date of 5/23/13
cooking wine (1 gallon) - with opened date of 3/1/13
Worcestershire sauce - opened and undated
4 hot dog buns - opened and undated
1 large plastic container of parmesan cheese - opened with date unreadable
1 large plastic container of shredded cheddar Cheese - opened and undated
D) walk -In freezer:
1 plastic bag of peas - opened and undated
E) reach -in freezer:
2 plastic containers of hot dogs -opened and undated
1 plastic container of unidentified meat patties - partially exposed, freezer burned and undated
2 packages of corn dogs - opened and undated
E3 stated on 8/19/13 at 10:10 AM that all food items should be labeled upon opening & unused portion should be discarded within three days.
The facility policy titled, " Leftover Food, " with revised date of 4/21/11, required, " Leftovers are

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F 371	Continued From page 15 to be covered completely or sealed in a Cambro and labeled with the time,date and description of product. Leftovers are to be stored in refrigerator for a period of no longer than 72 hours ... Leftovers that are to be frozen are to be covered completely or sealed in a Cambro and labeled with the date of preparation, date of freezing and description of product ... " 2) During environmental tour on 8/21/13 at 11:15 AM with E4 (Maintenance Director), the following were found: There were two medication carts with an opened one carton of nectar thickened orange juice (46 fluid ounces) and one honey thickened orange juice (46 fluid ounces) on top of each of the medication cart. One cart had the cartons of orange juice with opened date of 8/20/13. The four cartons of honey thickened liquids were left at room temperature for four hours. E22 (Registered Nurse) stated on 8/21/13 at 11:20 AM she opened both cartons of orange juice at 7:30 AM for Med Pass but forgot to label and failed to place it back in the refrigerator. The Manufacturer specification label showed Honey Thickened liquid should be refrigerated after opening and use within five days after opening.	F 371		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the dumpster was in good repair	F 372		

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F 372	Continued From page 16 and had no hole in order to contain the garbage. The facility also failed to ensure the surrounding area of the dumpster was free of debris. The findings include: During the environmental tour on 08/21/13 at 11:30 A.M., with E4 (Maintenance Director), the facility dumpster has a hole in the wall. There was a plastic garbage bag with debris sticking out from the hole. The surrounding area of the dumpster was noted with debris such as disposable gloves, disposables plastic spoons and forks. There were black flying insects around the debris. E4 stated he would call the company to obtain a new dumpster to ensure garbage was contained. E4 also stated he would make sure the surrounding would be free of debris.	F 372		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		

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F 431	Continued From page 17 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals received from the pharmacy were labeled with date opened, resident's name and pharmacy instructions for use. The facility also failed to ensure multi-dose vials of insulin were disposed of after 28 days according to the facility policy and to remove expired medications from the facility's ready to use house stock and to ensure the facility's medication room was accessible to qualified nursing only. This deficient practice applies to two residents (R5, R6) in the sample of 11, 1 resident (12) in the supplemental sample and all residents receiving medications from the facility's stock supply.	F 431		

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Findings include:

On 8/19/13 at approximately 11:00 AM, several multi-dose vials of insulin were discovered in the facility's main medication room either unlabeled or labeled with dates beyond 28 days. One vial of Novolog R insulin 100 units/ml belonging to R6 was found with an open date of 7/18/13 (32 days). Two other vials of insulin belonging to R12 (Novolog 100 units/ml, Lantus 100 units/ml) also exceeded 28 days. The dates included 7/20/13 (30 days) and 7/19/13 (31 days). A fourth vial of insulin (Novolin R 100 units/ml) belonging to R12 was found to be open and undated.

One full container of expired (exp. date 7/13) Vitamin E 400 unit capsules and a full box of Acetaminophen suppositories sent by the pharmacy had the printed label indicating the recipients name and instructions for use removed.

One of the facility's nurse's (E12) present during the observations stated all expired medications and medication to be returned to the pharmacy are to be removed from ready to administer medications, labeled with a pre-printed pharmacy return sticker and returned to the pharmacy. E12 stated medications that can't be returned to the pharmacy are to be destroyed by the facility's Director of Nursing.

According to the facility's Multi-Dose Vials policy, insulin is to be discarded after 28 days. The policy also says all multi-dose vials are to be dated when opened.

On 8/21/13 at 10:10 PM, during the environmental tour of the facility the facility's

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F 431	Continued From page 19 Maintenance Director was observed to enter the medication room with a master key. A delivery of Xanax, lidoderm patches, Miralax were observed on the counter in the room. Facility stock medications were also noted to be in unsecured cabinets.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		

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(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to follow current standards of infection control practices by not performing hand hygiene between residents during feeding assistance. This applies to five of 11 residents (R3, R4, R5, R6 & R8) in the sampled residents and 13 residents (R18, R19, R20, R23, R25, R26, R28, R29, R30, R31, R32, R34 & R35) in the supplemental sample.
The findings include:
On 8/20/13 between 12:30 PM & 1:30 PM in the Assistance Dining Room, there were eight staff (E13, E14, E15, E16, E17, E18, E19 & E20) assisting to feed the residents. E13 (Registered Nurse) was seated with R8, R18 & R28. E13 started feeding R18, touched and repositioned the resident's reclining chair, touched the adult clothing protector. E13 turned and started feeding R8. E13 then proceeded to place two straws for R28's milk and water by touching the end of the straws. E13 did not perform hand hygiene in between tasks. At 12:35 PM, E14 (CNA -Certified Nursing Assistant) fed both R6 & R34 without hand hygiene between residents. E15 and E16 both CNAs were assisting to feed R29 and R30. Neither staff washed their hands or use hand sanitizer between each resident. Certified Nursing Assistants (E17, E19 & E20) were feeding two residents each but no one performed

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F 441	Continued From page 21 hand hygiene in between feeding residents. E18 (CNA) was feeding R20, R26 and R32. E18 did not do hand hygiene in between feeding residents. On 8/21/13 between 12:35 PM & 1:30 PM, there were three CNAs (E5, E6 and E7) assisting residents in the Feeding Assistance Dining Room. E5 was feeding both R6 and R18. E5 touched the arms and wiped R6's mouth with the clothing protector, turned and proceeded to feed R18. E5 then touched R34's hands to guide the resident to her lunch plate. E5 did not perform hand hygiene between assisting the residents. E6 was seated between and feeding both R19 and R25. E6 did not do hand hygiene between residents. E7 was feeding both R5 and R35 but did not do hand hygiene between feeding the residents.	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident's room doors, shower rooms, clean utility room, laundry room, resident's living /music room and emergency carts were maintained in manner that is safe, sanitary, organized and in good repair. This applies to 44 residents residing in various areas of the facility.	F 465		

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The findings include:

The Form 672 (Resident Census And Condition of Residents) provided by the facility dated 8/20/2013 showed there were 44 residents in the facility.

During the environmental tour on 8/21/2013 between 10:10 A.M. to 11:15 A.M. with E4 (Maintenance Director), the following were observed:

1) The laminated doors and door frames in resident room numbers 4,5,6,11,13,19,21,22,23,26 and 27 were either have multiple scratches, chipped and gouged. Some doors have laminate material peeling off and was sharp to touch.
2) The Clean Utility/Treatment room was disorganized. There were multiple oxygen gauges, multiple batteries and chargers for the mechanical transfer lift on top of the counter. There were also multiple incontinent pads loosely stored in a shelf of a small linen cart. There were multiple tubes of skin barrier ointments on top of a treatment cart. There was an unidentified dried up white cream on a medicine cup placed on top of the treatment cart. The dusty emergency cart did not have a cardiac board. The suction machine had no cover and was dusty. E22(Registered Nurse) was informed immediately regarding the emergency cart. E22 stated the facility had two emergency carts but no cardiac boards.
3) The Spa Room in the West wing which include shower stall and a separate tub was observed crowded with storage of multiple wheelchairs, shower chairs, large and small linen carts and several mechanical transfer lift devices.

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F 465	Continued From page 23 E22 was called during the observation. E22 identified an aluminum cart with two tier shelving as the facility's emergency cart. The emergency cart had no cardiac board and no readily accessible oxygen supply. E22 stated the oxygen tank supply was located outside the building. The top shelf of the cart also had a dusty suction machine with a reservoir bottle that did not have a lid. The top shelf of the emergency cart had an open bar of soap and the the cart was wet. The cart's second shelf had dusty emergency respiratory bag. The bag was inside a yellow stained plastic bag. There was a small linen cart next to the tub and emergency cart. There were multiple heel protectors and loose towels in the linen cart. The Spa Room was crowded with resident's equipment and supplies and blocking the emergency cart. E22 stated the Spa room is being used by residents. 3) The carpeted floor in the Living /Music Room had multiple scattered brown stains. Furthermore, there was a large carpet hole under a recliner chair in the room. The plywood was exposed due to the hole on the carpet. 4) The two drier machines lint trap compartment in the laundry room were full of lint. There were also accumulation of scattered lint that fell off from the trap compartment.	F 465		