

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

PRINTED: 07/12/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2007
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NAME OF PROVIDER OR SUPPLIER SHERWOOD NURSING & REHABILITATION CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 245 INDIAN BAY DRIVE SHERWOOD, AR 72120
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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 000 F 312 SS=D	<p>INITIAL COMMENTS</p> <p>Complaint #12609 was unsubstantiated.</p> <p>483.25(a)(3) ACTIVITIES OF DAILY LIVING</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure all areas of the perineum were cleansed during incontinent care for 1 (Resident #7) of 6 (Residents #1, #2, #3, #5, #6 and #7) case mix residents dependent on staff for incontinent care. This failed practice had the potential to affect 45 residents dependent on staff for incontinent care, as identified by a list provided by the Administrator on 6/28/07. The findings are:</p> <p>Resident #7 had diagnoses of Congestive Heart Failure, Urinary Retention and Urinary Tract Infection. The Significant Change Minimum Data Set (MDS) dated 5/25/07 documented that the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance for personal hygiene and toileting and was occasionally incontinent of bowel and bladder.</p> <p>a. The resident's Care Plan dated 5/8/07 documented, as a problem, Urinary incontinence Goal: Staff to provide adequate support approaches: 1. Resident wears attends, chronic loose stools. 2. Needs assistance in the bathroom.</p>	F 000 F 312		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 312	Continued From page 1 b. On 6/12/07 at 1:25 p.m., the resident was in bed with a blue brief on; Certified Nursing Assistant #6 (CNA) and CNA #7 were providing incontinence care for the resident. CNA #6 removed the front of the resident's wet brief and placed it between the resident's legs and then used a wipe wet with Derma wash (no rinse) to cleanse the resident. The CNA wiped front to back down the resident's left groin area and then with a clean wipe, cleansed down the right groin area. The resident was positioned on her right side, the wet brief was removed from the resident and placed in a bag. The CNA took a clean wet wipe cleansed both buttocks and then with a towel, dried the area. CNA #7 placed a clean dry brief on the resident. The CNAs never spread the labia for cleansing or cleansed the resident's rectal area.	F 312		
F 314 SS=E	483.25(c) 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, record review and interview, the facility failed to ensure that residents were turned and repositioned in a timely manner to decrease the potential for skin	F 314		

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F 314	<p>Continued From page 2</p> <p>breakdown for 2 (Residents #3 and #5) and failed to cleanse urine and/or feces from all areas of the perineum/skin to decrease the potential for skin breakdown for 2 (Residents #2 and #7) of 4 (Residents #2, #3, #5 and #7) case mix residents at risk for skin breakdown. This failed practice had the potential to affect 12 residents at risk for skin breakdown, according to a list provided by the Administrator on 6/28/07. The findings are:</p> <p>1. Resident #3 had diagnoses of Alzheimer's Dementia and Incontinence. The Minimum Data Set (MDS) dated 5/30/07 documented the resident had severely impaired cognitive skills for daily decision-making, was incontinent of bowel and bladder, required a pressure relieving device for both bed and chair, was on a turning and repositioning program and received nutrition or hydration for skin and other preventative or protective skin care.</p> <p>a. The Plan of Care dated 5/30/07 documented, "Self care deficit. Turn and reposition every 2 hours and as needed. Monitor for skin breakdown."</p> <p>b. On 6/26/07 at 12:00 p.m., the resident was lying in bed on an incontinent pad, wearing an incontinent brief. The brief was marked by making an 'X' with a blue ink pen on the left side by the tape tab. The resident's position was marked by placing a blue ink line along the resident's left hip line, on the pad.</p> <p>c. On 6/26/07 at 4:00 p.m., Certified Nursing Assistant (CNA) #4 entered the resident's room to provide incontinent care. The Director of Nursing was asked to come to the room. The resident had on the marked brief, with the 'X' on the left tape</p>	F 314			

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F 314	<p>Continued From page 3</p> <p>tab, and the blue ink mark on the pad was along the resident's left hip line indicating the resident had not been changed or repositioned for 4 hours. The resident's brief, the incontinent pad and the top sheet were urine soaked.</p> <p>2. Resident #2 had diagnoses of Dehydration, Insulin Dependent Diabetes Mellitus, Neuralgia, Anemia and Urinary Tract Infection. The Minimum Data Set dated 2/18/07 documented the resident had a history of ulcers. The Minimum Data Set dated 5/18/07 documented the resident had severely impaired cognitive skills for daily decision-making, was incontinent of bowel and bladder and was dependent on the physical assistance of staff for toileting and personal hygiene.</p> <p>a. The resident's Plan of Care dated 5/18/07 documented, "Incontinent of bowel and bladder r/t (related to) Cognitive Deficits AEB (as evidenced by) Frequent Episodes of Incontinence and Need to Use Pads and Briefs, This Puts Resident at Risk for Skin Breakdown... Change incontinent pads when wet every two hours and prn (as needed). Good pericare after incontinent episodes."</p> <p>b. The Nurse's Notes dated 6/27/07 at 6:00 a.m. documented: "...Coccyx tx (treatment) done..."</p> <p>c. On 6/27/07 at 10:00 a.m., the resident had been incontinent of a large amount of liquid stool and urine. The resident's incontinent pad was saturated with brown liquid, extending to all edges of the pad lying under resident, from waist to knees. The resident's top sheet was soiled with a large amount of liquid stool. CNA #5 removed the soiled top sheet and laid it on the arm of the</p>	F 314			

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F 314	<p>Continued From page 4</p> <p>recliner. The CNA cleaned the resident's perineal and anal areas, but did not cleanse the buttocks or thighs that had been in contact with the soiled pad.</p> <p>3. Resident #5 had a diagnosis of Bowel and Bladder Incontinence. The Quarterly MDS dated 5/9/07 documented the resident was moderately impaired in cognitive skills for daily decision making, had short/long-term memory problems, was incontinent of bowel and bladder, was on a turning/repositioning program and was totally dependent on the physical assistance of one to two staff members for transfers, locomotion, toilet use, personal hygiene and bathing.</p> <p>a. The resident's Plan of Care dated 5/9/07 documented: "Resident is at Risk for Skin Breakdown r/t (related to) Incontinence of Bowel and Bladder...Monitor Resident every two hours for incontinence... Change Incontinent pads when wet every two hours and prn (as needed)... Turn and reposition every two hours. Use positioning devices."</p> <p>b. On 6/23/07 at 9:10 a.m., the resident was in her wheelchair in her room. The resident's brief was marked with an 'X' in black ink, under the top fold of the brief, on the right side. The surveyor stayed on the resident's hall with the resident's room in sight until the resident was taken by a CNA to the dayroom beside the dining room at 11:27 a.m. The resident remained in the dayroom, beside the dining room, until a CNA pushed her into dining room for lunch.</p> <p>c. On 6/23/07 at 1:22 p.m., the resident was still sitting at the feeding table in the dining room. At approximately 1:30 p.m., the resident was pushed</p>	F 314			

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F 314	Continued From page 5 to her room and left. d. On 6/23/07 at 1:40 p.m., CNA #1, CNA #2 and CNA #3 came to the resident's room to put the resident to bed. The resident's brief was saturated with urine until the whole stripe that changes color to indicated wetness had changed from yellow to blue the entire length of the stripe. The resident had a medium bowel movement that was stuck in the resident's rectal area when the brief was removed. The brief still had the 'X' marked in the upper right side, under the fold. 4. Resident #7 had diagnoses of Congestive Heart Failure, Urinary Retention and Urinary Tract Infection. The Significant Change MDS dated 5/25/07 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance for personal hygiene and had a pressure ulcer. a. The resident's weekly wound assessment dated 5/29/07 documented, stage two pressure ulcer to the coccyx area. The residents treatment sheet documented that the stage two pressure ulcer to the coccyx area had healed on 6/19/07. b. On 6/27/07 at 1:25 p.m., CNA #6 and CNA #7 did not cleanse the urine from the resident's rectal area during incontinent care.	F 314			
F 322 SS=E	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	F 322			

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F 322	Continued From page 6 possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure dietician recommendations were followed to ensure adequate nutrition was provided and the head of the bed was elevated to minimize the potential for aspiration for 1 (Resident #6) of 2 (Residents #3 and #6) case mix residents with feeding tubes. These failed practices had the potential to affect 4 residents who required tube feedings, as identified by a list provided by the Administrator on 6/28/07. The findings are: Resident #6 had diagnoses of Cerebrovascular Accident with Left Side Weakness, Gastroesophageal Reflux Disorder and Dementia. The Minimum Data Set dated 5/28/07 documented the resident had moderately impaired cognitive skills for daily decision-making, had oral problems of chewing and swallowing, required a feeding tube and received 76% - 100% of total calories through tube feeding. a. The resident's Plan of Care dated 5/24/07 documented, "Resident at risk for complications R/T (related to) feeding tube placement. Ensure that resident has the correct amount of feeding, at correct rate, and hooked up at correct time. HOB (head of bed) to be elevated 30-45 degrees at all times." b. The Dietary Progress Note dated 6/12/07 documented, "Resident is tube fed Glucerna at 55 cc/hr. Weight 109.2. Is at 84% IBW (ideal body weight). Will recommend to change tube feeding	F 322		

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F 322	Continued From page 7 to 60 cc/hr." c. The Dietary Consultant Report dated 6/12/07 provided by the Director of Nursing on 6/27/07 documented, "Is at 84% IBW. Change tube feeding to 60 cc/hr." d. The resident's Medication Administration Record (MAR) for June 2007 documented by nurse's initials that Glucerna was provided at 55 cc/hr from 6/12/07 through 6/26/07. e. On 6/26/07 at 12:35 a.m., 12:30 p.m., 1:00 p.m., 1:55 p.m., 2:00 p.m., 4:30 p.m. and on 6/27/07 at 1:30 p.m., Glucerna was observed to be infusing at 55 cc/hr via the resident's feeding tube per pump. f. On 6/26/07 from 1:55 p.m. until 2:10 p.m., the resident was lying in bed with the head of the bed flat during incontinent care. The resident's tube feeding was running at 55 cc/hr. g. On 6/28/07 at 10:00 a.m., Restorative Certified Nursing Assistant #1 stated the resident was re-weighed this morning and had a weight of 108.5.	F 322			
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that the environment was maintained hazard free as evidenced by a door frame with sharp edges, a	F 323			

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F 323	Continued From page 8 floor buffer in the resident day/activity area left unattended with the electrical cord attached, a medication cart being left unattended and unlocked and that a restraint was applied according to the manufacturer's instructions to prevent the potential for injuries for 1 (Resident #1) of 3 (Residents #1, #2 and #3) case mix residents with physician orders for restraints. These failed practices had the potential to affect 18 residents with physician orders for trunk restraints and 3 residents who were independently mobile and confused on 100-Hall, according to lists provided by the Director of Nursing on 6/28/07. The findings are: 1. On 6/26/07 at 1:45 p.m., during facility environmental rounds with the Maintenance and Housekeeping Supervisors, Resident Room #205 had a door frame with three hinges; each hinge had three separate parts with sharp edges. The Maintenance Supervisor stated that the room had a half door that had been removed and that the hinges must have been forgotten. 2. On 6/26/07 at 2:15 p.m., during the facility environmental rounds with the Maintenance and Housekeeping Supervisors, a floor buffer with the electrical cord attached was left unattended in the residents day activity area. 3. On 6/27/07 at 4:40 p.m., a medication cart was left on the 400-Hall near Resident Room #413. The medication cart was left unattended and unlocked until 4:53 p.m. Licensed Practical Nurse (LPN) #3 was in a residents room administering medication with the medication cart out of her view. Two residents were close to the medication cart, one resident was requesting medication for pain from the surveyor, who was monitoring the	F 323		

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F 323	Continued From page 9 unlocked medication cart, until the LPN returned. 4. Resident #1 had diagnoses of Dementia with Behavior Disturbance, Osteoporosis , Cerebrovascular Accident and Pelvic Fracture. The Medicare 14-Day Minimum Data Set dated 4/20/07 documented the resident had modified independence in cognitive skills for daily decision making, had short-term memory problems, required the physical assistance of staff for transfers and locomotion, was unable to attempt tests for balance while sitting or standing without physical help, had functional limitation in range of motion of both legs with partial loss of voluntary movement, had fallen in the past 30 days and had a fracture in the last 180 days and had a trunk restraint. a. A Physician order dated 4/17/07 documented, Criss Cross Belt while in wheelchair due to decreased safety awareness, check every 30 minutes, release every 2 hours. b. On 6/22/07 at 11:35 a.m. and 12:05 p.m., the resident was in her wheelchair with the Econo-Belt restraint straps coming out of the chair between the arm and back of wheelchair seat. The restraint was not anchored to prevent it from riding up on the resident and creating a potential hazard. c. On 6/22/07 at 4:15 p.m. and 5:15 p.m., the resident was in her wheel chair with the Econo-Belt restraint in place. The straps of the restraint were coming out between the arms of the chair and the back of the seat. The restraint was not anchored to prevent it from sliding up on the resident and creating a possible hazard for the resident.	F 323			

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F 323	Continued From page 10 d. On 6/23/07 at 9:00 a.m., the resident was in her room in a wheelchair with the lap Econo-Belt restraint on. The restraint straps came out of the chair between the arms and the back of the chair. There was nothing above the straps to anchor the belt to keep it from sliding up on the resident. e. On 6/28/07 at 9:10 a.m., the Director of Nurses provided instructions for application of the Econo-Belt Restraint (Criss Cross Belt) the resident had been wearing. The instructions documented under application: #3. "Place both straps behind the patient and pass the ends through the space between the wheelchair seat and backrest." Placement of the straps between the seat and backrest anchors the straps under the back of the seat so the belt cannot slide up on the resident.	F 323			
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a personal alarm was in place while in bed as ordered by the physician for 1 (Resident #1) of 2 (Residents #1 and #2) case mix residents who required the use of bed alarms. This failed practice had the potential to affect 10 residents who required alarms for safety, per a list provided by Licensed Practical Nurse (LPN) #1 on 6/28/07 at 9:00 a.m. The findings are:	F 324			

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F 324	Continued From page 11 Resident #1 had diagnoses of Dementia with Behavior Disturbance, Osteoporosis , Cerebrovascular Accident and Pelvic Fracture. The Medicare 14-Day Minimum Data Set dated 4/20/07 documented the resident had modified independence in cognitive skills for daily decision making, had short-term memory problems, required the physical assistance of staff for transfers and locomotion, was unable to attempt tests for balance while sitting or standing without physical help, had functional limitation in range of motion of both legs with partial loss of voluntary movement and had fallen in the past 30 days and had a fracture in the last 180 days. a. The Physician order dated 4/17/07 documented, "Bed alarm as safety device." b. On 6/22/07 at 2:53 p.m. and 4:15 p.m., the resident was in bed with no bed alarm in place. c. On 6/28/07 at 9:20 a.m., LPN #1 and LPN #2 were shown the resident's Physician order for a bed alarm and asked why the resident did not have one. LPN #2 stated, "The resident was on my hall and the alarm probably did not get moved." LPN #1 went to the resident's room and checked her bed for an alarm. The LPN found no alarm on the resident's bed and stated that the resident had been on her hall for about a week.	F 324			
F 333 SS=E	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: Based on observation, record review and	F 333			

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F 333	<p>Continued From page 12</p> <p>interview, the facility failed to ensure physician's orders were followed to ensure the facility was free of a significant medication error for 1 (Resident #16) case mix resident. This failed practice had the potential to affect 35 residents receiving medications on 100/200 halls, as identified by the Roster Sample Matrix provided by the Administrator on 6/26/07. The findings are:</p> <p>Resident #16 had a diagnosis of Cerebrovascular Accident with Hemiparesis. The Minimum Data Set dated 4/13/07 documented the resident had moderately impaired cognitive skills for daily decision-making.</p> <p>a. The Physician's order dated 6/7/07 documented, "Increase Coumadin by 0.5 mg (milligram) = 4.5 mg PO (by mouth) QD (every day) at noon. Continue weekly PT/INR (Prothrombin Time/International Normalized Ratio)."</p> <p>b. The Plan of Care dated 6/7/07 documented, "Increase Coumadin by 0.5 mg = 4.5 mg PO (by mouth) QD (every day) at noon. Continue weekly PT/INR".</p> <p>c. The June 2007 Medication Administration Record (MAR) documented, "Coumadin 4 mg po QD". The June 2007 MAR documented by nurse's initials that Coumadin 4 mg was administered to the resident once every day at noon from 6/8/07 through 6/27/07, a total of 20 times.</p> <p>e. On 6/28/07 during observation of the noon medication pass, Licensed Practical Nurse (LPN) #1 administered Coumadin 4 mg to the resident.</p>	F 333			

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F 333	Continued From page 13 f. On 6/28/07 at 1:00 p.m., LPN #1 stated, "The order to increase the dose did not get carried over to the MAR." g. The Drug Information Handbook for Nursing, 8th Edition, copyright 2006 by Lexi-Comp, Inc., page 1292, documented, "Warfarin. Brand name: Coumadin. High Alert Medication. The Institute for Safe Medication Practices (ISMP) includes this medication among its list of drugs which have a heightened risk of causing significant patient harm when used in error". h. This was a significant error due to the condition (cerebrovascular accident) of the resident, classification of the drug (anti-coagulant) and the frequency of the error.	F 333			
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food stored in the storage area was sealed or covered to prevent the potential for cross contamination, cold food items were maintained at 41 degrees Fahrenheit or below, employees changed gloves or washed hands between handling food, clean dishes and picking up objects and the ice machine was free of debris. These failed practice had the potential to affect 68 residents who received their meal trays	F 371			

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F 371	Continued From page 14 from the kitchen, according to the Diet List dated 6/25/07. The findings are: 1. On 6/26/07 at 1:35 a.m., the following observations made were: a. Two containers of powered milk, on the shelf in the storage room, were not covered, exposing the contents to air. b. One container of thickener, on the shelf in the kitchen, was not covered. 2. On 6/26/07 at 11:44 a.m., the following observations made were: a. The ice machine top panel, located in the kitchen, had yellow matter on it. The inside back panel had accumulation of mold on it. b. The temperatures of the cold food items, when tested by Dietary Employee #1, were as follows: Pureed Potato Salad 53 degrees Fahrenheit and Regular Salad 61 degrees Fahrenheit. c. Dietary Employee #2, who was on the line serving the lunch meal to the residents, was observed using a wet towel on the shelf of the steam table to wipe off food on her fingers. The employee used the same towel to wipe food that had spilled inside the plates that contained food items to be served to the residents. While she was wiping off the spilled food items inside the plates the towel was touching the food items. 3. On 6/26/06 at 2:50 p.m., Dietary Employee #2 lifted up a trash can lid and threw away a turkey cover. Without washing her hands she proceeded to pick up turkey cubes on the cutting board,	F 371			

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F 371	Continued From page 15 placed them in the blender and then grounded them to be used in the sandwiches that would be served to the residents on a Mechanical Soft Diet at the supper meal. 4. On 6/26/07 at 4:11 p.m., Dietary Employee #2 lifted up the trash can lid and threw away a piece of burnt bread. Without washing her hands, she started using the same hand to pick up slices of bread and placed the slices in the bread toaster to be used in making sandwiches to be served to the residents at the supper meal. 5. On 6/26/07 at 4:45 p.m., Dietary Employee #3 who had gloves on both hands, opened the sink faucet, washed heads of lettuce, broke them apart and placed slices of tomatoes on top of them. She lifted up a trash can lid and threw away the empty bread bag. She the picked up another loaf of bread from the bread rack and placed it on the counter. Without changing gloves, she opened the bread bag, placed her wet gloved hand inside the bag, removed slices of bread from the bag and placed them in the toaster. She then made the sandwiches to be served to the residents at the supper meal, without changing gloves. 6. On 6/26/07 at 4:56 p.m., Dietary Employee #2 scratched her forehead, went and got a container of parsley and placed it on the shelf of the steam table. Without washing her hands, she picked up and separated turkey sandwiches with her bare hands, while placing them in the plates to be served to the residents at the supper meal.	F 371			
F 445 SS=E	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 445			

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F 445	<p>Continued From page 16 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that linens and/or incontinent briefs contaminated with urine or feces were not placed on resident furniture or equipment to decrease the potential for the spread of infection for 2 (Residents #2 and #3) of 6 (Residents #1, #2, #3, #5, #6 and #7) case mix residents who required assistance with incontinent care. This failed practice had the potential to affect 45 residents in the facility who were incontinent of bowel and bladder, as identified by a list provided by the Administrator on 6/27/07. The findings are:</p> <p>1. Resident #3 had diagnoses of Alzheimer's Dementia and Incontinence. The Minimum Data Set dated 5/30/07 documented resident had severely impaired cognitive skills for daily decision-making and was incontinent of bowel and bladder.</p> <p>On 6/26/07 at 4:00 p.m., Certified Nursing Assistant (CNA) #1 entered the resident's room to provide incontinent care. The Director of Nursing was present in the room. The resident's brief, incontinent pad and the top sheet were urine soaked. CNA #1 removed the urine soaked top sheet and incontinent pad and placed them directly on the resident's wheelchair seat; the CNA then removed the urine soaked brief and placed it directly on the resident's night stand. CNA #1 placed the urine contaminated wipes she used to do incontinent care on the night stand with the brief.</p>	F 445			

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F 445	<p>Continued From page 17</p> <p>2. Resident #2 had a diagnosis of Urinary Tract Infection. The Minimum Data Set dated 5/18/07 documented the resident had severely impaired cognitive skills for daily decision-making, was incontinent of bowel and bladder and was dependent on staff for toileting and personal hygiene.</p> <p>On 6/27/07 at 10:00 a.m., the resident had been incontinent of a large amount of liquid stool and urine. The incontinent pad that was under the resident was saturated with brown liquid, extending to all edges of the pad, from waist to knees. The top sheet was soiled with a large amount of liquid stool. CNA #5 removed the soiled top sheet and laid it directly on the arm of the recliner.</p>	F 445			