

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

ORIGINAL

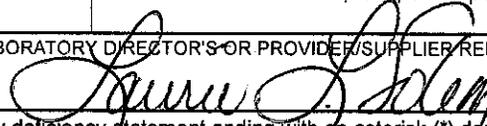
PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2015
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NAME OF PROVIDER OR SUPPLIER SUNQUEST HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 MICHIGAN AVENUE SW HURON, SD 57350
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F 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32355 A Minimum Data Set (MDS) focus survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/3/15 through 8/5/15. SunQuest Healthcare Center was found not in compliance with the following requirements: F164, F278, and F441.</p> <p>F 164 SS=D 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment</p>	F 000	<p>F164 1.) The facility policy for Quality Of Life-Dignity was reviewed to ensure it was appropriate on 08/19/2015 by facility Administrator, D.O.N. and Nursing Management team. Education was provided by the D.O. N. to all C.N.A.'s on 08/20/2015 on the Dignity policy and the proper procedures for providing resident privacy at all times during resident cares.</p> <p>All facility staff were educated by the D.O.N. on 08/26/2015 on the facility Dignity policy and on the proper procedures for providing privacy for all residents at all times during resident cares.</p>	09-15-15
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE 8/27/2015
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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.

AUG 28 2015
If continuation sheet Page 1 of 15
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F 164	<p>Continued From page 1 contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572</p> <p>Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to: *Ensure privacy was maintained for one of six observed residents (2) during personal care by two of two certified nursing assistants (CNA) (C and D). *Maintain residents' personal information in a private and secured manner on two of two observed medication carts (Rushmore dining room and C wing). Findings include:</p> <p>1. Observation on 8/3/15 at 5:00 p.m. of CNAs C and D with resident 2 revealed: *They had prepared to assist the resident with personal care in her room. *Resident 2 had: -Been laying on her bed that was located across the room from a large picture window. The window shades were open and revealed a parking lot for visitors and staff. -Required the CNAs to assist her with personal care to her perineal area (private area between the thighs) and bottom. -Been incontinent (loss of control) of bowel movement and had required the CNAs to expose those two areas to ensure proper cleaning. *During the resident's personal care the CNAs had not closed the shades on the window.</p> <p>Interview on 8/5/15 at 9:00 a.m. with the director</p>	F 164	<p>Staff members C & D will be provided personal education by the D.O.N. by 09-15-15 to ensure they understand the importance of the Dignity policy especially with providing privacy for all residents at all times while personal cares are being conducted. Audits on personal cares given by C.N.A.'s C & D will be conducted weekly for 4 weeks and then monthly for 3 months to ensure they are maintaining privacy at all times during resident cares. Audits will be conducted weekly for 4 weeks and then monthly for 3 months on resident #2 and 5 other random staff/residents to ensure privacy is maintained at all times during their personal cares.</p> <p>The audits will be conducted by the D.O.N./Designee who will report audit findings at monthly Client Care & CQI meetings for 4 months and will be responsible for overall compliance.</p> <p>2 & 3.) The facility policy for Confidentiality of Information was updated and revised on 08/20/2015 by the Administrator, D.O.N. & Nurse Management Team. Education for all facility staff including nurses and medication aides was conducted by the D.O.N. on 08/26/2015 to ensure</p>	
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F 164	<p>Continued From page 2</p> <p>of nursing (DON) confirmed the CNAs should have closed the window shades to ensure privacy for resident 2.</p> <p>2. Random observations on 8/4/15 from 9:02 a.m. through 9:20 a.m. of registered nurse (RN) B revealed: *She had: -Been administering medications to the residents eating breakfast in the Rushmore dining room. -Positioned the medication cart at the entrance of the dining room. On top of the medication cart had been a computer that contained all of the residents' personal and medical history. -Used that computer to retrieve medication information for four unidentified residents during the above time frame. -Left the medication cart at the entrance of the dining room unattended to administer those medications during four separate times. *Each time she was away from the medication cart she had left the computer screen in the up and open position that revealed: -The name of the medication she had administered to those four residents. -Access to their medication history by other residents and visitors would have been possible.</p> <p>Surveyor:32572</p> <p>3. Observation on 8/4/15 from 11:27 a.m. through 11:34 a.m. revealed an unidentified staff member working within the area of the C wing medication cart. She left the medication cart and went into a resident's room. Upon leaving that medication cart the computer screen had been left readily available for anyone to read it. This surveyor was able to read resident 12's confidential information. At the above time there had been residents, staff members, and visitors passing by that medication</p>	F 164	<p>they understand the importance of keeping computer screens minimized or tipped shut when they are away from their computers to ensure confidentiality of resident information at all times. Personal education was provided to staff member B on 08/26/2015 to ensure she understands the importance of keeping computer screens minimized or tipped shut when she is away from her computer to ensure confidentiality of resident information at all times.</p> <p>Audits will be conducted on staff member B, resident #12 and 5 random audits weekly for 4 weeks and then monthly for 3 months to ensure the facility policy on Confidentiality of Resident Information with computer usage is carried out appropriately. The D.O.N./Designee will be responsible for conducting audits and will report audit findings to monthly Client Care and CQI meetings for 4 months and will be responsible for overall compliance.</p>		

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F 164	Continued From page 3 cart. Surveyor:32355 4. Interview on 8/5/15 at 9:00 a.m. with the DON confirmed: *The computer screen should have been minimized or tipped in the down position when unattended. *Privacy and confidentiality was not maintained for all of the residents. Review of the provider's 1/15/14 Quality of Life - Dignity policy revealed: **"Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality." **"Staff shall promote, maintain, and protect resident privacy and dignity, including bodily privacy during assistance with personal care and during treatment procedures." *No process or procedure in place to ensure the resident's clinical information was secure from access by other residents or visitors during medication administration. The above policy had been given to the surveyor by the administrator. She had confirmed that policy had included privacy.	F 164		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278	F278-1.) The facility Resident Assessment Instrument Policy was reviewed by the facility Administrator, D.O.N. and Nurse Management Team on 08/25/2015 to ensure that it is accurate. The facility MDS Coordinators were educated by the D.O.N. on 08/25/2015 to ensure they understand the importance of MDS Accuracy. Resident #6 & all	09-15-15

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F 278	<p>Continued From page 4</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on interview, record review, and policy review, the provider failed to ensure the Minimum Data Set (MDS) assessments had been completed accurately for 1 of 10 sampled residents (6). Findings include:</p> <p>1. Review of resident 6's medical record revealed: *An admission date of 5/26/15. *Diagnoses of Alzheimer's disease (memory loss), hypertension (high blood pressure), and urinary tract infection (UTI). *She had been: -Admitted to the facility after an acute hospital</p>	F 278	<p>residents who had an admission diagnosis of a UTI will be audited by September 3rd to ensure the UTI's are/were coded correctly on the MDS. According to the RAI manual. Audits will be conducted weekly for 4 weeks and then monthly for 3 months to ensure UTI's are recorded properly on admission MDS's for resident #6 and 3 random newly admitted residents.</p> <p>Audits will be conducted by the D.O.N. and/or Designee who will report audit findings to monthly Client Care and CQI meetings for 4 months and who will be responsible for overall compliance.</p>	

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F 278	<p>Continued From page 5 stay.</p> <p>-Diagnosed with a UTI during her stay at the hospital.</p> <p>-Admitted to the facility with UTI as her primary diagnosis.</p> <p>Review of resident 6's 5/26/15 admission progress note confirmed she had been admitted to the facility with a primary diagnosis of a UTI.</p> <p>Review of resident 6's 6/2/15 admission MDS assessment revealed: *That assessment was not accurately coded to support an admitting diagnosis for UTI. *Without the diagnosis of a UTI she had appeared to be healthier upon admission than she was.</p> <p>Interview on 8/5/15 at 8:55 a.m. with the director of nursing (DON) revealed she had not been aware resident 6's admission MDS assessment failed to identify a diagnosis of UTI. She confirmed the resident's primary diagnosis upon admission had been UTI.</p> <p>Review of the provider's 6/29/15 Resident Assessment Instrument policy revealed: **"The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity." **"Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning."</p>	F 278		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	<p>Continued From page 6</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 441	<p>F441-1, 2, 3, 4.) The facility policies For Handwashing/Hand Hygiene and Personal Protective Equipment – Gloves were reviewed by the D.O. N., Administrator and Nurse Management Team to ensure accuracy on 08/25/2015.</p> <p>All facility staff was educated by the D.O.N. on 08/26/2015 at the facility General Inservice on the facility Handwashing/Hand Hygiene and Personal Protective Equipment- Gloves policies and proper procedures on hand hygiene while doing resident personal cares. Staff members K, L, C, D & E will receive personal education from the D.O.N. by 09/15/2015 to ensure they understand the facility policy and procedure on proper hand/glove hygiene usage during personal cares.</p> <p>Weekly audits for 4 weeks and then monthly for 3 months will be conducted on resident #'s 8, 2, 1 & 9; staff members K, L, C, D & E and on 5 random residents to ensure proper hand hygiene and glove usage is conducted during resident personal cares.</p> <p>Audits will be conducted by the D.O.N. and/or Designee who will be responsible for reporting audit</p>	09-15-2015

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F 441	<p>Continued From page 7 Surveyor: 32572 Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions were maintained for: *Four of six sampled residents (1, 2, 8, and 9) who received personal care by five of four certified nursing assistants (CNA) (C, D, E, K, and L). *One of one observed resident (11) who received a dressing change by one of one registered nurse (RN) (B). Findings include:</p> <p>1. Observation on 8/4/15 at 9:20 a.m. of certified nursing assistants (CNA) K and L revealed they did not perform hand hygiene or hand-washing prior to applying gloves to care for resident 8.</p> <p>Surveyor: 32355 2. Observation on 8/3/15 at 5:00 p.m. of CNAs C and D during personal care for resident 2 revealed: *Resident 2 had been laying in her bed resting. The bed had been in a low position with another mattress laying on the floor next to her bed. *She was fully dressed with a blanket covering her. *Both CNAs C and D had washed their hands and put on a clean pair of gloves. *With those gloved hands CNA D had: -Opened a dresser drawer and retrieved a disposable brief (loss of bladder or bowel control). -Grabbed the handles on a mechanical lift (device to assist the residents with transfers from one area to another) and moved it to another part of the room. -Picked up the mattress that had been laying directly on the floor and moved it to another part of the room.</p>	F 441	<p>findings at monthly Client Care and CQI meetings for 4 months and will also be responsible for overall compliance.</p> <p>5.) The facility policy for Dressings, Dry/Clean was reviewed by the facility Administrator, D.O.N. and nurse management team to ensure accuracy on 08/25/2015.</p> <p>All nurses were educated at the facility General Inservice on the facility policy on Dressings, Dry/Clean on 08/26/2015.</p> <p>RN B was educated by the D.O.N. on 08/26/2015 to ensure understanding of the facility dressings, Dry/Clean policy and procedure.</p> <p>Audits will be conducted weekly for 4 weeks and then monthly for 3 months on resident #11; staff member RN B and 5 random residents by the D.O.N. and/or Designee who will also be responsible for reporting audit findings at monthly Client Care and CQI meetings for 4 months and for overall compliance.</p>	

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F 441	<p>Continued From page 8</p> <ul style="list-style-type: none"> -Assisted CNA C with pulling down the resident's pants and removed a soiled brief. The brief had been urine soaked and contained bowel movement. -Opened a package of disposable wet wipes and cleaned the resident's perineal area (private area) and bottom. -Retrieved a tube of skin barrier cream, opened the tube with her soiled gloves, and placed some of the cream in her hand. -Rubbed the skin barrier cream onto the resident's perineal area and bottom with those soiled gloves. -Recapped the tube of skin barrier cream and placed the soiled tube on top of the resident's dresser. -Assisted CNA C with putting on the disposable brief for resident 2 and pulled up her pants. -Assisted CNA C with placing a cloth sling underneath the resident. -Retrieved the mechanical lift and assisted CNA C with transferring the resident into her geri-chair (geriatric reclining wheelchair). -Grabbed two pillows from the resident's bed. She placed a small pillow behind the resident's neck and the other pillow on the left side of the resident to assist with positioning. -Retrieved a blanket from the bed and covered the resident with it. *At that time she removed her soiled gloves and washed her hands. *CNA D had not removed her gloves or sanitized her hands during the entire process of assisting the resident with personal care. <p>3. Observation on 8/3/15 at 5:15 p.m. of CNAs C and D during personal care for resident 1 revealed: *The resident had been in her room sitting in her</p>	F 441			

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F 441	<p>Continued From page 9 recliner. *Both CNAs C AND D washed their hands and put on clean gloves. *With those gloved hands they: -Placed a gait belt (device placed on the resident to assist with transfers) on the resident and assisted her to stand and sit in her wheelchair (w/c). -Assisted her into the bathroom, pulled down her pants and disposable brief, and sat her on the toilet. -Cleansed her perineal area and bottom with disposable wet wipes after she had finished going to the bathroom. -Pulled on her disposable brief and pants and sat her down in the w/c. *With those soiled gloves CNA C had: -Grabbed the handles on the resident's w/c and pushed her out of the bathroom. -Opened a drawer on the resident's bedside table and retrieved a spray bottle and brush. -Sprayed the resident's hair with the solution in the bottle and brushed her hair. -Placed both the spray bottle and brush back inside of the drawer and closed it. -Retrieved the resident's oxygen concentrator and tubing. *At that time she removed her soiled gloves. She was not observed washing or sanitizing her hands. *With those soiled hands CNA C had: -Pushed the oxygen concentrator and resident down to the dining room. -Grabbed the cord attached to the oxygen concentrator and plugged it in. -Retrieved the oxygen tubing and placed it inside of the resident's nose and face. -Pushed another resident who had been sitting in a w/c up closer to the table.</p>	F 441		
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NAME OF PROVIDER OR SUPPLIER SUNQUEST HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 MICHIGAN AVENUE SW HURON, SD 57350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 10</p> <ul style="list-style-type: none"> -Assisted another resident to put on a clothing protector. -Left the dining room and went into another resident's room. *She had not been witnessed washing or sanitizing her hands: -Upon removal of her gloves. -After assisting resident 1 to the dining room and putting on her oxygen. -When assisting two other residents in the dining room. -Prior to entering into another resident's room to assist that resident with current needs. <p>4. Observation on 8/4/15 at 7:50 a.m. of CNA E during personal care for resident 9 revealed:</p> <ul style="list-style-type: none"> *The resident had been laying in her bed. She had a nephrostomy tube (tube inserted into the kidney that drains urine into a collecting bag) in place. *CNA E washed her hands and put on clean gloves. *With those clean gloves she had: -Pushed a toilet seat high rise into the bathroom. -Moved the resident's w/c to another part of the room. -Retrieved a gait belt and put it on the resident to assist her with transferring into the w/c. -Handled the tubing and collection bag containing urine. She had hung the collection bag from a pocket on her pants. -Pushed the w/c and resident into the bathroom. -Assisted the resident to stand with the use of the gait belt. -Pulled down her disposable brief that had been soiled with bowel movement. -Assisted the resident to sit down on the toilet. -Closed the bathroom door and went over to the sink. 	F 441			

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F 441	<p>Continued From page 11</p> <ul style="list-style-type: none"> -Turned on the faucet with her soiled gloves and retrieved a clean wash cloth. -Placed the wash cloth inside of the sink under the running water. -Opened the closet doors and removed clean clothes for the resident to wear. -Turned off the faucet and retrieved the wet wash cloth. -Gave the wash cloth to the resident to wash her face and assisted her with dressing. -Retrieved her shoes that were on the floor. - Assisted the resident with putting them on by handling the soles of the shoes. The soles of the shoes were soiled with brown/tan colored debri. -Opened a package of disposable wet wipes and cleaned the resident's perineal area and bottom. Her perineal area and bottom had been soiled with bowel movement. -Opened a tube of barrier cream, put some on her hand, and applied it to the resident's perineal area and bottom. -Re-capped the tube of barrier cream and placed it on the resident's television stand. -Assisted the resident with putting on a jacket, clean incontinent brief, and pulling up her pants. -Transferred the resident into her w/c and pushed her up to the sink. -Pulled up the blankets on the resident's bed and put two pillows on top of the bed. -Removed her gloves and washed her hands. <p>*CNA E had not removed her gloves or sanitized her hands during the entire process observed above.</p> <p>Interview on 8/4/15 with CNA E at the time of the above observation revealed: *That had been her usual process for assisting residents with personal care. *She had not considered that process to be</p>	F 441		

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F 441	<p>Continued From page 12 unsanitary. *The only time she would have removed her gloves and washed her hands would have been to assist residents with oral care.</p> <p>5. Observation on 8/4/15 at 9:40 a.m. with RN B during a dressing change for resident 11 to his tube feeding site (tube inserted into the stomach for administering nutrition and medication) revealed: *She had: -Retrieved a plastic bag from the medication/treatment cart with supplies for a dressing change. -Entered the resident's room and set the plastic bag on the resident's recliner. No protective barrier had been placed between the two surfaces to prevent the potential of cross-contamination. -Touched the handles on the faucet and turned on the water. -Retrieved a clean washcloth and placed it inside of the sink and underneath of the running water. *Without washing or sanitizing her hands she had put on a clean pair of gloves. *With those clean gloves she touched the faucet handles and turned off the water. *She: -Removed her gloves, left the room, and went back to the medication/treatment cart. She had not been witnessed washing or sanitizing her hands. -Took out keys from her shirt pocket, opened the cart, and retrieved a roll of tape. -Went back to the resident's room and tore pieces of tape off of the roll. She placed those pieces of tape on the resident's recliner armrests. -Washed her hands and put on a clean pair of gloves.</p>	F 441		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 13</p> <p>*With those clean gloves she had:</p> <ul style="list-style-type: none"> -Removed the old dressing from the resident's feeding tube site. The old dressing had a small amount of brown colored drainage on it. -Retrieved the wet wash cloth from inside of the resident's sink. -Cleaned the resident's skin surrounding the tube feeding site. -Opened the plastic bag sitting on the resident's recliner, removed a package, and a tube of ointment. -Opened the package and removed a gauze dressing. -Opened the tube of ointment with her soiled gloves and placed some on one of her fingers. -Rubbed the ointment on the resident's skin surrounding the tube feeding site. -Replaced the cap on the tube of ointment and put it back inside of the plastic bag. -Placed the gauze dressing around the tube feeding site and secured it with the tape that had been attached to the resident's recliner armrests. <p>*She removed her gloves, retrieved the plastic bag with the treatment supplies, and left the room.</p> <p>*She opened the medication/treatment cart and placed the bag inside.</p> <p>*At that time she sanitized her hands.</p> <p>6. Interview on 8/5/15 at 9:10 a.m. with the director of nursing confirmed the above care had been performed by the staff in an unsanitary (not clean) manner. She would have expected the staff to remove their gloves and wash their hands after performing a task that had soiled their gloves. She confirmed the techniques used to provide personal care and a dressing change had not been sanitary. There had been the potential of cross-contamination of bacteria to be transmitted</p>	F 441		
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F 441	Continued From page 14 from one resident to another. Review of the provider's 10/11/12 Handwashing and Hand Hygiene policy revealed: *"This facility considers hand hygiene the primary means to prevent the spread of infection." *"Employees must wash their hands for at least fifteen seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: -Before and after direct resident contact. -Before and after assisting a resident with personal care. -Before and after handling invasive devices. -Before and after changing a dressing. -Upon and after coming in contact with a resident's intact (no breaks in surface) skin. -Before and after assisting a resident with toileting. -After handling soiled or used linens, dressings, bedpans, catheters, and urinals.	F 441			