| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **045427** | A. BUILDING _____ B. WING _____ | **09/04/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **SHILOH NURSING AND REHAB, LLC** | **1092 WEST STULTZ ROAD SPRINGDALE, AR 72764** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0584<br><br>**Level of harm** - Potential for minimal harm<br><br>**Residents Affected** - Many | **Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and interview, the facility failed to ensure resident walls in their rooms were free from scrapes, peeling paint, and holes in the walls to prevent potential to provide a safe, clean and sanitary environment on 4 of 4 Halls. This failed practice had the potential to affect 66 residents who resided in the facility based on the Resident Census and Condition of Residents form provided by the Administrator on 8/28/2020. The findings are:<br><br>1. On 09/02/2020, the following observations were made on the 300 hall: a. At 03:10 PM, Resident room [ROOM NUMBER]A the left wall by the head of the bed had multiple wall scrapes that measured approximately 1/2 to 1 inch across by 6 inches wide and 7 inches long with plaster exposed. On the lower end of the side rail of the bed there were multiple scrapes approximately 1 inch to 1.5 inch wide and 6 inches long with plaster visible. b. At 3:10 PM, in Resident room [ROOM NUMBER]B, there was an approximately 1 foot by 8 inch area with peeled painted and the wall was covered with plaster that was visibly hanging down the wall adjacent to the right side of the resident's bed. Wall plaster scrapings were visible at the top of the wallboard torn area protruding approximately 4 to 5 inches upward. A photograph of the wall was taken at this time. c. At 03:12 PM, in Resident room [ROOM NUMBER]B the walls had scraped area with white plaster exposed that measured approximately 1/2 inch wide by 4 to 5 inches in length on the left side of the electric wall outlet approximately 6 to 7 inches from the floor on the left wall with the bed in the middle of the room. A photograph of the resident's wall was taken at this time.<br><br>2. On 9/02/2020 at 2:30 p.m., in Resident room [ROOM NUMBER] there were several large wide scratches in the corner behind the resident's chair, in the corner, and on opposing walls. 3. On 9/02/2020 at 2:34 p.m., in Resident room [ROOM NUMBER], there was no less than 3 scrapped areas of missing paint approximately 1 inch by 2 inches and no less than 1 larger scraped area that measured approximately twice the size of the others. There were 4 smaller scratched areas on the wall beside the night stand. On the wall below the television there were 2 small that measured approximate half-dime sized scrapes on the darker green wall. Located behind her bed there were 2 long scratches no shorter than 4 inches that measured approximately one half inch wide and above the bed numerous smaller round scratches and beside her chair, there were 3 scuffs that measured approximately the size of a half dollar and, 1 larger deeper scratch approximately the size of two half dollars. 4. On 09/02/2020 the following observations were made on the 100 hall: a. At 12:14 p.m., in Resident room [ROOM NUMBER]B, the wall by the head of the bed had multiple areas that were scratched, sheet rock scraped, and peeling paint with the longest part that measured approximately 8 inches long by 1 inch wide. Down on the wall next to resident's bed were deep scratches and peeling paint almost in the shape of an X approximately 12 inches long by 4 inches wide. A photograph of the walls were taken at this time. b. At 12:16 PM, in Resident room [ROOM NUMBER]B, on the wall by the residents recliner, there were 3 areas with peeling paint that were approximately the size of a quarter. There was peeling paint behind the recliner on the wall. The wall that separates the room had peeling paint up and down the divider and loose base board on the A side of the room. A photograph was taken at this time. c. At 12:18 PM, in Resident room [ROOM NUMBER]B, there was a hole in the wall behind the recliner that measured approximately 2 by 3 inches round. A photograph was taken at this time. d. At 12:19 PM, in Resident room [ROOM NUMBER]B, on the wall behind the nightstand, were multiple scratched areas, sheet rock that was scraped, and the paint was peeling. A photograph was taken at this time. e. At 12:20 PM, in Resident room [ROOM NUMBER]B, on the wall behind the head of the bed there were multiple areas that were scratched, the sheet rock was scraped, and the paint was peeling. A photograph was taken at this time. f. At 12:22 PM, in Resident room [ROOM NUMBER]B, on the wall behind the head of the bed were multiple areas that were scratched, the sheet rock was scraped, and the paint was peeling. A photograph was taken at this time. |
| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation and interview, the facility failed to ensure 2 of 2 clothes dryers remained free of lint build-up to decrease the potential for fire and loss of laundry services for 1 of 1 laundry room. This failed practice had the potential to affect all 66 residents due to the potential for the interruption of laundry services due to the proximity of the laundry room, according to the Resident Census and Conditions of Residents form dated 8/31/2020. The facility failed to ensure an oxygen concentrator was stored on a flat surface to prevent a potential fire hazard in 1 (Resident (R) #5) of 1 resident rooms. This failed practice had the potential to affect 10 residents that required oxygen according to a list provided by the Director of Nursing (DON) on 9/2/2020 at 2:55PM. The facility to ensure a damaged and or torn Geri chairs were free of potential accident hazards as possible, for 1 of 1 (Resident #8) sample resident who used a geri chair. This failed practice had the potential to affect 4 residents who required the use of a Geri chair as documented on a list provided by the Director of Nurses on 9/3/2020 at 1:05 p.m. The findings are: 1. Resident #18 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/20/2020 documented the resident scored 6 (0-7 indicates severe cognitive impairment) on a Brief Interview of Mental Status (BIMS); required extensive assistance of two people for bed mobility, toileting and dressing; and totally dependent for transfers. a. The most recent Care Plan documented, .Resident has had an Actual Fall: 6/8/19, 7/14/19, 7/24/29, 11/16/19, 11/18/19, 4/28/2020, 5/31/2020 . The resident will not sustain serious injury through the review date . b. On 08/31/2020 at 12:17 PM, there was a Geri chair with a torn section on the Geri chair. The torn material on the bar that supports the chair was ripped and measured approximately 6 to 8 inches. A photograph was taken at this time. c. On 08/31/2020 at 03:20 PM, the resident was sitting in the Geri chair at the end of the 100 Hall. The material was torn at the top of the chair that supported the backrest cushion. d. On 09/01/2020 at 9:53 AM, there was a Geri chair with a torn section on the Geri chair. The torn material on the bar that supports the chair was ripped and measured approximately 6 to 8 inches. e. On 09/01/2020 at 01:20 PM, the resident was sitting in the Geri chair at the end of the 100 Hall. The material was torn at the top of the chair that supported the backrest cushion. f. On 09/03/2020 at 08:37 AM, the DON provided a copy of the resident's Incident and accident report that documented, . 4/28/2020 resident with an unwitnessed fall .no injury neuro checks started . intervention: winged mattress . g. On 09/03/2020 at 12:37 PM, Certified Nursing Assistant (CNA) #5 was asked, Can you tell me what you see you see is wrong that material on (R# 18's) Geri chair? She stated, It's torn. CNA #5 was asked, What can |

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>happen with it torn? She stated, A fall. h. On 09/03/2020 at 12:41 PM, the DON was asked, What is wrong with his chair? She stated, It's ripped. The DON was asked, What could happen? She stated, It could rip more and come off. The DON was asked, What would happen if it came off? She stated, It could cause him to fall and fall out of the chair. i. On 09/03/20 at 01:11 PM, the DON provided a copy of the manufacture's guidelines for the Geri chair that documented, .Warning .12. Immediately remove from service; Any recliner with broken recline mechanisms, torn upholstery, or other mechanical or visible damage . 2. On 9/2/2020 at 2:07 PM, during the Infection Control tour of the Laundry Department with the Housekeeping Supervisor and the Maintenance Supervisor, the following observations were made: a. On 9/2/2020 at 2:07 PM, on the clean side of the laundry room there were two dryers that were in the process of drying. The surveyor requested that Housekeeper #1 to fully remove the lint drawers on both dryers. Dryer #1 had lint in the back of the dryer floor. Dryer #2 had lint in the back and on the dryer floor. A photograph of dryer #1 and dryer #2 with lint on the floor was taken. b. On 9/2/2020 at 2:11 PM, Housekeeper #1 was asked, What could happen with the lint being in there? Housekeeper #1 stated, It could cause a fire. Housekeeper #1 provided the monthly lint logs that documented when lint was removed from the dryer. There was no documentation for lint removal for the month of September (2020). c. On 9/2/2020 at 2:23 PM, the surveyor showed the Administrator dryer #3's lint picture and asked, Can you tell me what you see in the floor of the dryer? The Administrator stated, Lint. The Administrator was asked, Should it be in there? The Administrator stated, No. The Administrator was asked, What could happen? The Administrator stated, It's a fire hazard. d. On 9/2/2020 at 2:45 PM, Housekeeper #1 provided the manufacture guidelines for the dryers. It states, .periodic inspection, cleaning and removal of lint form various areas of the dryer as well as throughout the ductwork system .Lint from most fabrics is highly combustible. The accumulation of lint can create a potential fire hazard . Housekeeper #1 stated, We do not have a policy on lint removal. 3. Resident #5 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/6/2020<br>documented resident scored 12 (8-12 indicates moderately impaired) on Brief Interview for Mental Status (BIMS); required supervision with eating; extensive assistance with bed mobility, dressing, toilet use, personal hygiene, and bathing; was totally dependence for transfers. a. On 08/31/2020 at 12:54 PM, Resident #5 was setting up in bed, and had a nonproductive cough. Resident #5 was receiving O2 (oxygen) via (by way of) nasal cannula at 2.5L (liters). The updraft machine was on the bedside table. The O2 concentrator was sitting on the fall matt on the floor beside the bed. A photograph of the O2 concentrator was taken at this time. b. On 9/1/2020 at 9:20 AM, Resident #5 was resting in bed with her eyes closed. She was receiving O2 via nasal cannula at 2.5L. The O2 concentrator on the fall mat on the floor beside the bed. c. Physician orders [REDACTED].@ 2-3 L/M (liters per minute) VIA NC (nasal canula) every 24 hours as needed for sob/wheezing-O2 sat (saturation) > (less than) 90% (percent) on RA. d. Physician orders [REDACTED]. e. There was no documentation of oxygen therapy on the resident's care plan. f. On 09/02/20 at 12:26 PM, Resident #5 was setting in her recliner with O2 via nasal cannula at 2.5L. She had heel protectors on her feet bilaterally. The fall mat was folded and placed by the resident's wardrobe. The O2 concentrator was sitting on the floor. g. On 09/02/2020 at 2:18 PM, Maintenance #1 was asked, Should the oxygen concentrator be setting on the fall mat? Maintenance #1 stated, No. It shouldn't be. Maintenance #1 was asked, What could happen? Maintenance #1 stated, It could cause the concentrator to overheat and catch fire. f. On 09/02/20 2:21 PM, the DON was asked, Should the oxygen concentrator be setting on a fall mat? DON stated, No. The DON was asked, What could happen? DON stated, The censor light could go off and it not work correctly g. On 09/02/20 02:232 PM, the Administrator was asked, Should the oxygen concentrator be setting on a fall mat? The Administrator stated, No ma'am. The Administrator was asked, What could happen? The Administrator stated, If a resident fell it could cause injury or they could trip and injure themselves. The Administrator was asked, Could it potentially cause a fire? The Administrator stated, Yes. h. On 09/03/20 08:28 PM, The manufacturer's guidelines for oxygen concentrator, .Position your unit at least 6 inches from walls, draperies, or any other objects that might prevent the proper flow of air in and out of your concentrator. The oxygen concentrator should be located so as to avoid pollutants or fumes . |
| F 0690<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, and record review, and interview the facility failed to ensure all areas if the skin were cleansed during incontinent care to prevent skin breakdown and possible urinary tract infections for 2 (Residents (R) #18) of 27 (Residents #1, #5, #7, #8, #10, #11, #14, #15, #17, #18, #20, #21, #24, #27, #28, #29, #32, #33, #39, #41, #45, #46, #47, #48, #58, #59, and Resident #65) sample residents who required incontinent care. This failed practice had the potential to affect 52 residents required assistance with incontinent care per a list provided by the Nurse Consultant on 9/01/2020 at 2:54 PM. The findings are: Resident #18 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set with an Assessment Reference Date of 6/20/2020 documented resident scored 6 (0-7 indicates severe cognitive impairment) on a Brief Interview of Mental Status; and required extensive assistance of two people for bed mobility and toileting, dressing, and was totally dependent for transfers. a. The most recent Care Plan documented, . The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) Impaired balance . The resident has a HX history) OF Urinary Tract Infection r/t (related to) ESBL (Extended Spectrum Beta-Lactamase) COLONIZATION . Check at least every 2 hours for incontinence. Wash, rinse and dry soiled areas . b. On 09/03/2020 at 09:56 AM, Certified Nursing Assistants (CNA's) #5, #7 and #8 washed their hands, donned gloves and provided incontinent care for resident. The resident had been incontinent of bowel and bladder. The CNA's did not clean the left side of the buttocks prior to placing a clean brief on the resident. c. CNA #5 was asked, Did you clean the right side of his buttock area? She stated, I don't think so, I thought she did. CNA #5 was asked, Are you supposed to clean both sides? She said, Yes. d. On 09/03/2020 at 10:19 AM, the DON was asked, Are you supposed to clean both sides of the buttock area when providing incontinent care? She stated, Yes. The DON was asked, What can happen if you don't? She stated, You can get skin damage. e. A form titled Perineal/Catheter Care policy provided by the DON on 9/3/2020 at 2:44 PM, documented, . 10. Assist resident over to one side and cleanse the anus and coccyx area. Cleansing from front to back (only use washcloth/wipe one time, once used discard wipe and or place washcloth in soiled trash bag). 11. Repeat # 10 once you have assisted resident turning to the other side . |
| F 0758<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to ensure that an antipsychotic medication was not given without an approved [DIAGNOSES REDACTED].#58 and #25) of 5 (Resident #25, #34, #58, #64, and #218) sampled residents. This failed practice had the potential to affect 7 residents who received antipsychotic medication based on a list provided by the Director of Nurses (DON) on 9/03/20 at 10:20 am. The findings are: 1. Resident #25 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with Assessment Reference Date of 7/01/20 documented the resident scored 05 (0-7 indicates severe cognitive impairment) on a Brief Interview for Mental Status. The September 2020 physician's orders [REDACTED].[MEDICATION NAME] Tablet 25 MG (QUEtiapine [MEDICATION NAME]) Give 12.5 mg by mouth at bedtime related to<br>ADJUSTMENT DISORDER WITH ANXIETY . 2. Resident #58 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) Assessment<br>with an Assessment Reference Date (ARD) of 7/01/20 documented the resident scored 10 (8-12 indicates moderate cognitive impairment) on the BIMS. The September 2020 physician's orders [REDACTED]. with a start date of 8/12/20. 3. On 9/03/20 at 10:00 am, the DON was asked what were the approved [DIAGNOSES REDACTED]. She was asked if anxiety was an acceptable [DIAGNOSES REDACTED]. |
| F 0812<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**<br>**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** |

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| F 0812<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 2)<br><br>Based on observation and interview, the facility failed to ensure dented cans were removed from stock and discarded; food items were properly sealed prior to storage; staff wore hair nets when entering the kitchen, and staff washed hands and donned gloves appropriately between clean and dirty tasks while preparing food to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen. These failed practices had the potential to affect all 66 residents who receive meals from the kitchen per the Resident Listing Report provided by Administrator on 8/31/2020. The findings are: 1. On 08/31/2020 at 11:40 AM, there was a box of rice in the dry storage room with the plastic torn and not sealed. The Dietary Manager was asked, Is that rice supposed to be sealed? She said, I don't why it's not tied up. 2. On 08/31/2020 at 11:45 AM, there was a bag of pepperoni in the freezer that was torn with approximately 3 inches at the seam. The bag was open to the air in the freezer and had ice crystals on the pepperoni. Dietary Employee (DE) #2 entered the kitchen where the food was stored without a hair net. DE #2 was asked, Are you supposed to have a hair net on? She stated, Yes. I'm getting one. There was a can of pizza sauce with a dent in the seam. The Dietary Manager was asked, Tell me what you feel on that can? She stated, It has a dent in it. There was a can of black beans that had a dent in the side of the can. 3. On 08/31/2020 at 11:54 AM, DE #3 entered the kitchen where the food was stored without a hair net. She was asked if she was supposed to be wearing a hair net and she said, Yes. 4. On 09/01/2020 at 11:20 AM, the Dietary aide, place large paper on prep table, brought back container of peanut butter, loaf of bread, and 6 single serve packet of jelly and placed on prep table. She washed her hands, donned gloves, opened twist tie on bread, reached inside bread bag and removed 6 slices of bread. She placed the bread slices on the paper, closed bread loaf with twist tie, opened container of peanut butter, used plastic spoon to remove peanut butter and place on one slice of bread. She then picked up the slice of bread with her left hand while still wearing the contaminated gloves and spread the peanut butter on the bread, she repeated this same technique while the same contaminated gloves. The Dietary Consultant approached the dietary aide and spoke softly, the dietary aide stopped, removed her gloves, and washed her hands. She removed 4 gloves from a box and placed two of the gloves inside her right pants pocket that were hanging out partially, and donned the second pair of gloves. She returned to the prep table opened 1 single serve packet of jelly and used a plastic spoon placed the jelly contents on a slice of bread. She opened a second packet of jelly and placed contents on the same slice of bread, picked up repeating this procedure 2 more times with 2 more slices of bread. Wearing the same contaminated gloves she picked up one jelly slice of bread and covering one peanut butter slice of bread, repeated 2 more times, making a total of 3 peanut butter and jelly sandwiches. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and interview, the facility failed to ensure proper infection prevention and control practices were implemented to prevent the development and transmission of COVID-19 and other communicable diseases and infections as evidence by wearing a face mask and wearing a face mask to cover the nose and not storing infectious waste properly. This failed practice had the potential to affect the 66 residents who resided in the facility according to the Resident Census and Conditions of Residents form provided by the Administrator 8/31/2020. The facility failed to ensure staff washed their hands after changing gloves that were soiled during incontinent care for 1 (Residents (R) #59) of 27 (Residents #1, #5, #7, #8, #10, #11, #14, #15, #17, #18, #20, #21, #24, #27, #28, #29, #32, #33, #39, #41, #45, #46, #47, #48, #58, #59, and Resident #65) sample residents who require incontinent care. This failed practice had the potential to affect 52 residents who required assistance with incontinent care per a list provided by the Nurse Consultant on 9/01/2020 at 2:54 PM. The findings are: 1. On 08/31/2020 at 12:12 PM, Registered Nurse (RN) #1 exited residents room into the hallway after passing medication. The RN's mask was down below the nose. Registered Nurse #1 was asked, How are you supposed to wear your mask? RN #1 stated, Over your nose. It slipped down. 2. On 9/1/2020 at 9:41 AM, CNA #1 had the face mask down below the nose. CNA #1 was asked, How are you supposed to wear your mask? CNA #1 stated, Above your nostrils and cover my mouth. CNA #1 was asked, How do you have your mask on now? CNA #1 stated, It is sliding down. 3. On 09/03/2020 at 03:09 PM, Licensed Practical Nurse (LPN) #3 was asked how the staff was instructed to wear their mask. She stated, They have all had in-services for proper use of Personal Protective Equipment (PPE) and Certified Nursing Assistant (CNA) #7 and the DON (Director of Nursing) the lead CNA (Certified Nursing Assistant) #7 also monitors for staff compliance. LPN #3 was asked if the facial mask PPE was to be worn below the nose. She stated, No. Absolutely not. It has to cover the whole (mouth and nose) area. d. On 09/03/2020 at 03:11 PM, the Director of Nurses was asked, How are you supposed to wear your mask? She stated, Like me and you. The DON was asked, How is that? She stated, Over your nose. e. On 09/03/2020 at 03:12 PM, the Administrator was asked, How are you supposed to wear your mask? She stated, Over your ears and the bridge of your nose and cover your mouth. f. A form titled Personal Protective Equipment (PPE) Competency Check Off provided by the DON on 9/3/2020 at 3:31 p.m., documented, .Donning of Personal Protective Equipment . Skill Area .Demonstrates application of mask or respirator by securing ties or elastic bands at middle of head and neck .Demonstrates mask fits with flexible band and nose bridge is secured and that it is snug to face and below the chin . 4. Resident #59 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/12/2020 documented the resident scored 5 (0 - 7 indicates severe cognitive impairment) on a Brief Interview of Mental Status (BIMS); required extensive physical assistance of 2 staff for bed mobility and toileting; extensive assistance of 1 staff for dressing, personal hygiene; and was always incontinent of bowel and bladder. a. The Care Plan dated 5/20/19 documented, this resident has frequent and stress urinary incontinence and requires extensive assist with toileting due to decreased mobility, poor balance and coordination. b. On 08/31/2020 at 11:37 AM, Certified Nursing Assistant (CNA) #3 and CNA #4 provided incontinent care to Resident # 59. The resident's brief was removed, and the front perineum was cleansed by CNA #1 with disposable wipes. The resident was rolled to the left side by CNA #3 and CNA #4. CNA #4 cleaned the resident's buttock and anal area of soft brown stool using 9 disposable wipes. While cleansing Resident #59's anal area, CNA #4's gloved right thumb area and edge of her right hand first finger touched the soft stool on the disposable wipe when cleansing the area. After cleaning all stool from the resident, CNA #4 removed her gloves, discarded them in the trash bag, and donned new clean gloves without sanitizing or washing her hands, and continued with the resident's incontinent care. CNA #4 completed the incontinent care and washed her hands. c. On 9/01/2020 at 11:38 AM, CNA #3 and CNA #4 were asked if they recalled performing incontinent care for Resident #59 on 8/31/2020 and if they recalled CNA #4 removing her glove after cleansing bowel movement from the resident, and replacing the glove without using hand sanitizer or washing her hands between the glove change (after cleansing stool with multiple wipes and the edge of her thumb & first finger accidentally touching the stool on a wipe) CNA #4 stated she realized she should have used hand sanitizer or washed her hands and usually would have done that but was nervous and forgot. d. On 09/02/2020 at 1:15 PM, the Director of Nursing (DON) was asked what her expectation is for staff hand sanitizing or changing of gloves between dirty and clean tasks during incontinent care. The DON stated, I expect the staff to wash or sanitize their hands when changing from dirty to clean tasks or whenever their glove is visibly soiled. e. The facility policy on Handwashing/Hand Hygiene copied from the facilities' policy and procedure manual documented, This facility considers hand hygiene the primary means to prevent the spread of infections. 1. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. . 2. Employees mush wash their hands for at lease 20 seconds using (antimicrobial or non-antimicrobial) soap and water for included but not limited to the following situations: 3 A. When hands are visibly soiled; and 4. B. After contact with a resident with infectious diarrhea . 5. An alcohol-based hand rub may be used if no visible soiling. 6. Hand hygiene is the final step after removing and disposing of personal protective equipment. 7. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections . |