

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

PRINTED: 11/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/06/2016
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NAME OF PROVIDER OR SUPPLIER ALDRSGATE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3220 SW ALBRIGHT DRIVE TOPEKA, KS 66614
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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #104353. A revised 2567 was sent to the facility on 11/28/16.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility identified a census of 180 residents. The sample included 4 residents. Based on observation, record review, and interview, the facility failed to develop an individualized care plan for toileting for 1 resident (#2).	F 279		9/23/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 09/06/2016
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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 279	<p>Continued From page 1</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The Admission Minimum Data Set (MDS) dated 6/23/16 for resident #2 documented a Brief Interview for Mental Status (BIMS) score of 12 (8 to 12 indicated moderately impaired cognition). The resident required extensive assist from staff with toileting, and was frequently incontinent of urine (inability to hold the urine). <p>The Care Area Assessment (CAA) dated 6/23/16 for cognition revealed the resident was at risk for cognitive decline due to adjusting to a new environment. The CAA for Activities of Daily Living (ADLs) noted the resident required staff assistance with ADLs. The CAA for urinary incontinence recorded the resident required assistance with toileting, and was frequently incontinent of urine.</p> <p>The care plan dated 6/14/16 lacked interventions for toileting and urinary incontinence.</p> <p>On 8/24/16 at 2:00 PM, the resident sat in a wheelchair.</p> <p>On 8/24/16 at 4:00 PM, administrative nursing staff D stated he/she expected staff to develop a toileting care plan for a resident who required staff assistance for toileting, or who experienced urinary incontinence.</p> <p>On 8/25/16 at 6:45 PM, licensed nursing staff I reported the resident required assistance with toileting and was incontinent of bladder and bowel. He/she said staff toileted the resident every 2 hours and as needed or requested.</p> <p>The facility's policy "Temporary Care Plan</p>	F 279			

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F 279	Continued From page 2 Development", dated 2/17/11, revealed the licensed nurse implemented a care plan which addressed all of the resident's immediate needs.	F 279			
F 280 SS=D	The facility failed to develop an individualized care plan for toileting for this incontinent and dependent resident. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility identified a census of 180 residents. The sample included 4 residents. Based on observation, record review, and interview, the facility failed to update the care plan after the	F 280		9/23/16	

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F 280	<p>Continued From page 3</p> <p>development of pressure ulcers on 7/21/16 and 8/2/16 for 1 resident (#1).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The Physician's Order Sheet (POS) signed 7/21/16 for resident #1 included diagnoses of heart failure (when the heart muscle doesn't pump blood as well as it should) and dementia (progressive mental disorder characterized by failing memory, confusion). It reported an order for hospice services (special services provided at the end of life). <p>The Quarterly Minimum Data Set (MDS) dated 5/28/16 documented a Brief Interview for Mental Status (BIMS) score of 8 (8 to 12 indicated moderately impaired cognitions). It revealed the resident required extensive assistance from staff with bed mobility, was totally dependent on staff for toileting, and was independent with eating. The resident was always incontinent of urine and frequently incontinent of bowel. The assessment further indicated the resident was at risk for pressure ulcers, did not currently have a pressure ulcer, and had a pressure reducing device for the bed and chair. He/she was on a turning/repositioning program. The resident received hospice care.</p> <p>The Significant Change MDS dated 8/20/16 for resident #1 documented a BIMS score of 4 (less than 8 indicated severely impaired cognition). It revealed the resident required extensive assistance from staff with bed mobility and transfers, and was totally dependent on staff for toileting and eating. The resident was incontinent of urine and bowel (inability to hold the urine or bowel). The assessment further indicated the</p>	F 280			

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F 280	<p>Continued From page 4</p> <p>resident was at risk for pressure ulcers, had 5 pressure ulcers and a pressure reducing device for the bed. He/she was on a turning/repositioning program and underwent pressure ulcer care. The resident received hospice care.</p> <p>The Care Area Assessment (CAA) dated 8/20/16 for cognition documented the resident had a progressive decline in intellectual functioning. The CAA for pressure ulcers revealed the resident had several pressure ulcers on his/her lower extremities and coccyx (tailbone) that required treatment.</p> <p>The care plan dated 7/11/16 for pressure ulcer directed staff to protect the resident's elbows and heels from friction and place pillows under his/her legs while in bed. Staff applied lotion to the resident 's skin daily. There was a pressure reducing mattress on the bed and a cushion in the wheelchair. He/she required extensive assist of 2 staff with turning every 2 hours and as needed. The care plan update on 7/12/16 revealed staff turned the resident every hour. The care plan update on 8/23/16 directed staff to position the resident off of all wounds and to check and change the resident for incontinence every 2 hours and as needed. Staff used a lift sheet for bed mobility and used pillows to position the resident's heels off of the bed. The care plan updated on 8/24/16 noted the resident was totally dependent on staff for eating. The care plan lacked new interventions after the development of pressure ulcers on 7/21/16 and 8/2/16.</p> <p>On 8/24/16 at 1:15 PM, the resident laid in bed on his/her back.</p> <p>On 8/25/16 at 7:18 PM, direct care staff Q stated</p>	F 280			

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F 280	Continued From page 5 the resident had pressure ulcers and was at risk for getting another one. He/she said staff turned the resident every hour, and elevated his/her legs on pillows to protect his/her heels. On 8/25/16 at 6:40 PM, licensed nursing staff I stated the resident had a pressure ulcer and was at risk for getting another one. Staff turned and repositioned the resident every hour and put pillows between his/her legs. Staff I further stated the resident had a special mattress on his/her bed to prevent pressure ulcer development. On 8/31/16 at 9:45 AM, administrative nursing staff D said all licensed nursing staff were expected to update the care plan as needed, and the CAAs to be completed as they triggered. The facility failed to update the care plan after the development of new pressure ulcers for this cognitively impaired dependent resident.	F 280			
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: The facility identified a census of 180 residents.	F 314		9/23/16	

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F 314	<p>Continued From page 6</p> <p>The sample included 4 residents, with 3 residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interview, the facility failed to develop and implement timely and effective interventions to prevent the development of 5 facility acquired pressure ulcers for 1 resident (#1).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The Physician's Order Sheet (POS) signed 7/21/16 for resident #1 included a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The POS recorded an order for hospice services (special services provided at the end of life). <p>The Quarterly Minimum Data Set (MDS) dated 5/28/16 documented a Brief Interview for Mental Status (BIMS) score of 8 (8 to 12 indicated moderately impaired cognition). This assessment revealed the resident required extensive assistance from staff with bed mobility, was totally dependent on staff for toileting, and was independent with eating. The resident was always incontinent of urine and frequently incontinent of bowel. The assessment further indicated the resident was at risk for pressure ulcers, did not currently have a pressure ulcer, and had a pressure reducing device for the bed and chair. He/she was on a turning/repositioning program.</p> <p>The Significant Change MDS dated 8/20/16 for resident #1 documented a BIMS score of 4 (less than 8 indicated severely impaired cognition). This assessment revealed the resident required</p>	F 314			

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F 314	<p>Continued From page 7</p> <p>extensive assistance from staff with bed mobility and transfers, and was totally dependent on staff for toileting and eating. The resident was incontinent of urine and bowel (inability to hold the urine or bowel). The assessment further indicated the resident was at risk for pressure ulcers, had 5 pressure ulcers and a pressure reducing device for the bed. He/she was on a turning/repositioning program and underwent pressure ulcer care.</p> <p>The Care Area Assessment (CAA) dated 8/20/16 for cognition documented the resident had a progressive decline in intellectual functioning. The CAA for pressure ulcers revealed the resident had several pressure ulcers on his/her lower extremities and coccyx (tailbone) that required treatment.</p> <p>The care plan dated 7/11/16 for pressure ulcer directed staff to protect the resident's elbows and heels from friction and place pillows under his/her legs while in bed. Staff applied lotion to the resident's skin daily. There was a pressure reducing mattress on the bed and a cushion in the wheelchair. He/she required extensive assist of 2 staff with turning every 2 hours and as needed. The care plan update on 7/12/16 revealed staff turned the resident every hour. The care plan update on 8/23/16 directed staff to position the resident off of all wounds, and to check and change the resident for incontinence every 2 hours and as needed. Staff used a lift sheet for bed mobility and pillows to position the resident ' s heels off of the bed. The care plan updated on 8/24/16 noted the resident was totally dependent on staff for eating. The care plan lacked new interventions after the development of a coccyx pressure ulcer on 7/21/16, or after the development of a left heel pressure ulcer on</p>	F 314			

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F 314	Continued From page 8 8/2/16. The wound assessment, dated 7/12/16, documented the right inner calf wound started on 7/12/16 as eschar (thick, leathery, dead skin, frequently black or brown in color) and measured 1.7 centimeters (cm) by 1.4 cm with no depth. The assessment dated 8/23/16 noted the wound was 75 percent (%) slough (dead tissue, usually cream or yellow in color) and increased in measurement to 5 cm by 3 cm by 1 cm deep. The wound assessment, dated 7/12/16, documented the left outer calf wound started on 7/12/16 as 75% eschar and measured 3.5 cm by 1.6 cm with no depth. The assessment dated 8/23/16 noted the wound had increased in measurement to 6.3 cm by 2.8 cm by 2 cm deep. The wound assessment, dated 7/21/16, documented the coccyx wound started on 7/21/16 as epithelial tissue (new skin) and measured 1.5 cm by 0.2 cm with no depth. The care plan lacked evidence of new interventions after the development of this coccyx wound. The assessment dated 8/23/16 noted the wound was 100% slough and had increased in measurement to 2.5 cm by 3 cm by 1.8 cm. The wound assessment, dated 8/2/16, documented the left heel wound started on 8/2/16 as a dark purple area with intact skin, and measured 1.4 cm by 3.4 cm with no depth. The care plan lacked evidence of new interventions after the development of this coccyx wound. The assessment dated 8/23/16 noted the wound remained a dark purple area, but now had a blister in the center.	F 314			

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F 314	<p>Continued From page 9</p> <p>The wound assessment, dated 8/23/16, documented the right inner foot wound started on 8/23/16 as a dark purple area with intact skin, and measured 1 cm by 0.6 cm with no depth.</p> <p>Tissue tolerance test findings dated 8/23/16 noted the resident laid on his/her back in bed for 1 hour. After the hour, the resident laid in the same position, and there were red areas which did not lighten in color when touched which indicated damage to the tissue underneath. The test recorded from past resident interviews, the resident requested to be repositioned after 1 hour.</p> <p>On the Braden Scale for Predicting Pressure Ulcer Risk assessment dated 5/22/16, the resident scored 9 (less than 9 indicated a very high risk for pressure ulcer development). On 8/17/16, the resident scored 8.</p> <p>Lab results dated 6/30/16 recorded the resident's protein level as low at 5.3 gm/dL (grams per deciliter), with the normal range reported as 6.4 gm/dL to 8.3 gm/dL. His/her albumin (blood test used to measure the amount of protein in the blood, used in part to determine a person's nutritional status) level as low at 2.8 gm/dL, with the normal range reported as 3.4 gm/dL to 4.8 gm/dL.</p> <p>The clinical record revealed an order dated 8/11/16 for Cephalexin (an antibiotic) 500 milligrams (mg.) twice daily for a wound infection.</p> <p>The dietician assessment dated 8/15/16 revealed the resident ate poorly at meals, and received one supplement drink every day. It noted the resident was likely not meeting his/her nutritional</p>	F 314			

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F 314	<p>Continued From page 10</p> <p>needs, and staff were to encourage the resident to eat and to assist him/her as needed. It did not document further recommendations.</p> <p>The clinical record documented the resident weighed 196 pounds (lbs.) on 2/26/16. On 7/7/16, the resident weighed 162 lbs., for a weight loss of 34 lbs. or 17%, a significant weight loss.</p> <p>Meal intake logs for June 2016, July 2016, and August 2016 were incompletely documented, but revealed the resident ate less than 50% of the meal or refused the meal. In June 2016, there were 32 meal intakes not documented out of 90. In July 2016, there were 52 meal intakes not documented out of 93. The meal intake logs dated August 1, 2016 to August 30, 2016 noted there were 50 meal intakes not documented out of 90.</p> <p>On 8/24/16 at 12:41 PM, the resident was served a mashed sweet potato, squash, cherry cobbler and lemonade. Direct care staff P assisted the resident to eat and drink. He/she ate all of the sweet potato, half of the cobbler and drank half of the lemonade.</p> <p>On 8/24/16 at 1:10 PM, direct care staff R and O turned and repositioned the resident to his/her back. Staff S placed a pillow under the resident's lower legs, but his/her heels still touched the mattress.</p> <p>On 8/24/16 at 1:15 PM, 1:30 PM, 1:45 PM, 2:00 PM, 2:15 PM, and 2:30 PM, the resident laid in bed on his/her back.</p> <p>On 8/24/16 at 2:40 PM, 1 hour and 25 minutes later, direct care staffs O and P turned and</p>	F 314			

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F 314	<p>Continued From page 11</p> <p>repositioned the resident to his/her left side. Prior to repositioning, the resident's heels rested on the mattress and the protective pad under the resident was wet. Staffs O and P changed the protective pad and provided peri-care for the resident, and folded a pillow in half and put it under the resident's legs. The resident's heels touched the mattress.</p> <p>On 8/24/16 at 4:15 PM, 4:30 PM, 4:45 PM, 5:00 PM, 5:15 PM, 5:30 PM, 5:45 PM, and 6:00 PM, the resident laid in bed on his/her left side.</p> <p>On 8/24/16 at 5:55 PM, licensed nursing staff H told the resident it was almost time for supper. The resident refused, and Staff H offered him/her a nutritional drink. Staff H assisted the resident to take a couple of drinks, set the can down, and left the room (per the 8/20/16 MDS, the resident required assistance from staff for eating). Staff H did not reposition the resident or check the protective pad under the resident.</p> <p>On 8/24/16 at 6:15 PM, 2 hours later, administrative nursing staff D and licensed nursing staff H turned the resident from his/her left side to the right side. Staff H moved the nutritional drink out of the way. The container remained full and out of the reach of the resident.</p> <p>On 8/25/16 at 7:13 AM, licensed nursing staff K changed the dressings on the resident's wounds. The wounds on the outside of the left calf, the inside of the right calf, and on the coccyx were open, and the wound beds were covered with slough. The leg wounds were approximately 7 cm long, 3 cm wide, and 2 cm deep each. The coccyx wound was approximately 3 cm long, 2 cm wide, and 0.5 cm deep. The edges to these</p>	F 314			

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F 314	<p>Continued From page 12</p> <p>wounds were pale pink and jagged. There were areas of dark red/purple skin on the left heel and the right foot, which had been identified by the facility as pressure ulcers. The area on the left heel was a circle, approximately 5 cm in diameter. The area on the right foot was crescent shaped, and was approximately 3 cm at the longest point. Staff K cleansed the wounds on the right calf, left calf, and coccyx with wound cleanser, applied medication to the wound bed, and covered them with a foam dressing. Staff K cleansed the areas on the left heel and the right foot with normal saline and covered them with a foam dressing.</p> <p>On 8/24/16 at 3:00 PM, direct care staff P stated the resident had pressure ulcers and staff turned him/her every hour.</p> <p>On 8/25/16 at 7:18 PM, direct care staff Q stated the resident had pressure ulcers and was at risk for getting another one. He/she said staff turned the resident every hour, and elevated his/her legs on pillows to protect his/her heels.</p> <p>On 8/25/16 at 6:40 PM, licensed nursing staff I stated the resident had a pressure ulcer and was at risk for getting another one. Staff turned and repositioned the resident every hour and put pillows between his/her legs. Staff I further stated the resident had a special mattress on his/her bed to prevent pressure ulcer development.</p> <p>On 8/30/16 at 3:47 PM, administrative nursing staff D stated he/she expected staff to turn and reposition the resident every hour as directed on the resident's care plan. He/she stated direct care staff were to report red areas on the resident's skin, and licensed nursing staff were taught to</p>	F 314			

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F 314	<p>Continued From page 13</p> <p>place pressure relieving devices for residents who had pressure ulcers.</p> <p>On 8/31/16 at 9:45 AM, administrative nursing staff D stated the resident had poor meal intakes, but received a supplement twice a day. The resident was not weighed in August 2016, due to the resident's anxiety level increased when staff worked with him/her, and staff attempted to decrease the resident's anxiety when possible.</p> <p>On 8/31/16 at 10:30 AM licensed dietary staff DD stated the resident had a poor appetite, and because he/she was receiving hospice services, there were not any aggressive interventions put in to place to optimize the resident's nutrition.</p> <p>On 8/31/16 at 11:05 AM, physician KK stated he/she expected staff to turn or reposition a resident every 2 hours who was at risk for a pressure ulcer, and provide good skin care. If the resident developed a pressure ulcer, physician KK further said staff were directed to continue the current interventions, and to add new interventions to heal the pressure ulcers, including nutritional interventions.</p> <p>The facility's "Pressure Ulcer Prevention and Management Policy", dated 1/5/16, directed staff to reposition residents according to their Tissue Tolerance Test findings, to ensure the resident's heels were completely off of the mattress, and to promote nutrition health.</p> <p>The facility failed to provide interventions to prevent the development of new pressure ulcers, and failed to provide care and services to heal current pressure ulcers for this cognitively impaired dependent resident.</p>	F 314			

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F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</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>	F 441		9/23/16	

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F 441	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>The facility identified a census of 180 residents, with 4 residents sampled. Based on observation, record review, and interview, the facility failed to prevent the spread of disease through proper glove use while providing care for resident #1, a dependent resident with 5 pressure ulcers and on an antibiotic for wound infection.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 8/24/16 at 2:40 PM, direct care staffs O and P checked for incontinence and changed resident #1. Staff P donned gloves and provided peri-care. Without removing the gloves, he/she touched clean wipes, bed linens, and the resident. Staff P did not sanitize his/her hands. He/she proceeded to touch his/her nose and hair, the resident's bed linens, and his/her nose again. Staff P then took toilet tissue and dabbed the resident's eyes without washing or sanitizing his/her hands. <p>On 8/25/16 at 7:58 AM, licensed nursing staff J provided peri-care to resident #1. Without changing his/her gloves, he/she touched the bedding and the resident.</p> <p>The clinical record for resident #1 indicated he/she had 5 wounds and started an antibiotic on 8/11/16 for a wound infection.</p> <p>On 8/25/16 at 7:30 PM, direct care staff P stated gloves should be changed immediately after peri-care.</p> <p>On 8/25/16 at 6:40 PM, licensed nursing staff I stated gloves should be changed immediately after peri-care, and before touching anything else.</p>	F 441			

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

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F 441	Continued From page 16 On 8/30/16 at 3:47 PM, administrative nursing staff D stated he/she expected staff to remove gloves right after peri-care and replace if needed. The facility's policy "Standard Infection Precautions", dated January 2007, instructed staff to change gloves between tasks. The facility failed to prevent the spread of infection through proper glove use while providing care for a resident with 5 pressure ulcers and on an antibiotic to treat a wound infection.	F 441			