### Summary Statement of Deficiencies

**Revised 2567: F441 was revised per Health Care Facilities Director.**

**483.10(c) Resident Self-Administer Drugs if Deemed Safe**

An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(c)(2)(ii), has determined that this practice is safe.

This **REQUIREMENT** is not met as evidenced by:

Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure residents did not keep medications at the bedside and failed to ensure the interdisciplinary team determined 1 of 14 (Resident #16) observed sampled residents were capable of self administration of medications.

The findings included:

- Review of the facility’s ‘Medication [meds]: Sample Procedure for Resident Self-Administration...’ policy documented,...

- PROCEDURE 1. During the assessment, the Interdisciplinary Team (IDT) must ask the resident, if interviewable, whether he/she wishes to self-administer drugs... 3. If a resident responds in the affirmative regarding self-administering medication during his/her assessment he/she must demonstrate the ability; cognitively, physically and visually, to complete the task..."

Medical record review for Resident #16 documented an admission date of 3/8/07 and a...
Continued From page 1

readmission date of 2/10/10 with diagnoses of Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Malaise, Macular Degeneration and Legally Blind. Review of the physician’s recertification orders dated 10/6/10 documented "...ALBUTEROL MDI [metered dose inhaler] GIVE 2 PUFFS EVERY 6 HOUS [S] [HOURS] LEAVE AT BEDSIDE..." Review of the resident’s Medication Administration Record (MAR) for July 2010, August 2010 and September 2010 documented the inhaler was signed off as given every 6 hours at 8:00 AM, 12:00 Noon, 6:00 PM, and 12:00 Midnight. There was no documentation of a self-administration evaluation for Resident #16.

Observations in Resident #16's room on 10/11/10 at 11:05 AM and on 10/12/10 at 2:40 PM, revealed Resident #16 sitting in a recliner in her room holding an inhaler in her left hand while unattended by staff.

During an interview in the hallway outside room 20 on 10/12/10 at 2:55 PM, Nurse #4 was asked how do you know that Resident #16 takes the inhaled medication as ordered. Nurse #4 stated, "I don't."

During an interview in the conference room on 10/13/10 at 10:15 AM, Nurse #6 was asked to locate Resident #16's self-administration evaluation. After looking through the medical record, Nurse #6 stated, "...I can't find it either..."

During an interview at the nurses' station on 10/13/10 at 12:05 PM, the Director of Nursing (DON) was asked if she had been able to find the self-administration evaluation for Resident #16. The DON stated, "No... can't find it..." The DON

This plan of correction will be reviewed and followed in the facilities monthly CQI Committee comprised of Administrator, DON, MDS, Therapy Director, Dietary Supervisor, Care Plan Coordinator, Social Services, Activity Supervisor, Treatment Nurse, Risk Manager, Medical Director, and Restorative Supervisor. The facilities CQI Committee will make recommendations to the Director of Nursing and develop plans of action if areas of noncompliance are noted. The DON will immediately begin to implement any new plans of actions recommended. The DON will monitor monthly new recommendations to ensure recommendations are followed.
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was asked how the medication was secured. The DON stated, "...it's in her [Resident #16] hand... family supplies it, I guess they [family] have a script [prescription] for it at home... We don't supply it [Albuterol MDI]." The DON was asked how the staff ensures that Resident #16 takes the medication appropriately. The DON stated, "...We [staff] don't know when she [Resident #16] takes it [Albuterol MDI]."

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SS=D

483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on policy review, observations and interview, it was determined the facility failed to ensure that 1 of 5 (Nurse #1) staff members observed during dining failed to respectfully address residents by name.

The findings included:

Review of the facility "COURTESY TITLE POLICY" documented, "It is the policy of [named facility] to use courtesy titles (Mr. [Mister], Mrs. [Misses], Ms. [Miss])... when addressing residents."

Observations in the dining room on 10/12/10 beginning at 5:20 PM, revealed Nurse #1 asked a resident "Is it good baby...do you like that little baby?"
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<th>F 241</th>
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<td></td>
<td>During an interview in the conference room on 10/13/10 at 1:25 PM, the Administrator was asked if she would expect staff to call residents &quot;baby&quot; or &quot;honey&quot;. The Administrator stated, &quot;No, I would expect them to use Mr. or Miss unless they specifically prefer to be called by another name.&quot;</td>
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| F 241 | The DON will immediately begin to implement any new plans of actions recommended. The DON will monitor monthly new recommendations to ensure recommendations are followed. |

| F 278 | Resident #7 MDS has been corrected to accurately coded to reflect current immunization status. |
|-------| The facility will accurately assess residents in the area of current immunizations status. In-service 100% care plan team comprised of DON, Therapy Director, Administrator, Care Plan Coordinator, MDS Director, Social Services, Activities Director, Risk Management Nurse, Treatment Nurse on 10/25/10 by DON on coding current immunization status. |
|       | MDS will audit 100% of residents charts for accurate coding of current immunization status including pneumonia vaccine. DON will monitor for completion of audit. |
|       | This plan of correction will be reviewed and followed in the facilities monthly CQI Committee comprised of Administrator, DON, MDS, Therapy Director, Dietary Supervisor, Care Plan Coordinator, Social Services, Activity Supervisor, Treatment Nurse, Risk Manger, Medical Director, and Restorative |

| SS=D 483.20(g) (l) 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. |
| A registered nurse must sign and certify that the assessment is completed. |
| Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. |
| 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. |
| Clinical disagreement does not constitute a material and false statement. |
| This REQUIREMENT is not met as evidenced |
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by:

Based on medical record review and interview, it was determined the facility failed to complete the Minimum Data Set (MDS) to accurately assess each resident for current immunization status for 1 of 16 (Resident #7) sampled residents.

The findings include:

- Medical record review for Resident #7 documented an admission date of 10/7/09 with diagnoses of Thrombocytopenia, Vascular Dementia, Delusional Disorder, Chronic Obstructive Pulmonary Disease, Hypothyroidism, History of Cerebrovascular Accident, Dysphagia, Hypoplasia, Alzheimer's Disease and History of Aspiration Pneumonia. Review of the 60 day MDS assessment dated 7/18/10 "Section W 3a." revealed Resident #7's Pneumonia vaccine was not up to date.

During an interview in the nurse's station on 10/12/10 at 3:55 PM, Nurse #9 reviewed the MDS dated 7/18/10 and stated, "He [Resident #7] had the pneumonia vaccine. Yes ma'am I coded it [vaccine] wrong, pushed the wrong button."

F 280  SS=9

Supervisor. The facilities CQI Committee will make recommendations to the Director of Nursing and develop plans of action if areas of noncompliance are noted. The DON will immediately begin to implement any new plans of actions recommended. The DON will monitor monthly new recommendations to ensure recommendations are followed.

Resident #9 care plan will be revised to include interventions for safety precautions for seizures.

Resident #16 care plan will be revised to reflect usage of inhaler, prescribed medication, storage and recording. Residents care plans will reflect interventions for safety precautions for seizure and to reflect self administration of
Continued From page 5

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:

Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure the comprehensive care plans were revised to reflect the current status of safety related to seizures or self - administration of medications for 2 of 15 (Residents #9 and 16) sampled residents.

The findings included:

1. Medical record review for Resident #9 documented an admission date of 1/4/09 with diagnoses of Mental Retardation, Delusional Disorder, Convulsions, Osteoarthritis, Diabetes Mellitus and Dysphagia. Review of the comprehensive care plan dated 7/20/10 documented, "...Seizure Disorder... Observe for S [signs] & [and] S [symptoms] of pre-seizure activity. "Observe for S&S of seizures..." The care plan was not revised to include interventions for safety precautions for seizures.

During an interview in the Minimum Data Set (MDS) office on 10/13/10 at 1:40 PM, the MDS
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Nurse was asked what would you expect to be included in the interventions for seizures. The MDS Nurse #9 stated, "Padded side rails, the bed away from the wall, anything that she [Resident #9] could hit herself on, would be removed." The MDS Nurse #9 reviewed the comprehensive care plan and confirmed there were no interventions for safety precautions for seizures.

2. Review of the facility's "Medication [meds]: Sample Procedure for Resident Self - Administration..." policy documented "...PROCEDURE... 3. If a resident responds in the affirmative regarding self-administering medication during his/her assessment he/she must demonstrate the ability; cognitively, physically and visually, to complete the task... 4...this will be recorded on the care plan and a teaching plan will be developed for this resident... 8. If self-administration is accomplished, the resident care plan will describe which medications and routes of administration this applies to. Also, the sequence of storage, obtaining of meds / equipment, recording, and return to storage will be addressed. According to existing federal Interpretive Guidelines, drug storage and recording is the ultimate responsibility of Nursing... The resident must be able to: locate medication container(s); read label and directions; demonstrate how to document administration; and return medication to storage..."

Medical record review for Resident #16 documented an admission date of 3/8/07 and a readmission date of 2/10/10 with diagnoses of Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Malaise, Macular Degeneration and Legally Blind. Review of the physician's

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administration of medications is properly care planned.

This plan of correction will be reviewed and followed in the facilities monthly CQI Committee comprised of Administrator, DON, MDS, Therapy Director, Dietary Supervisor, Care Plan Coordinator, Social Services, Activity Supervisor, Treatment Nurse, Risk Manager, Medical Director, and Restorative Supervisor. The facilities CQI Committee will make recommendations to the Director of Nursing and develop plans of action if areas of noncompliance are noted. The DON will immediately begin to implement any new plans of actions recommended. The DON will monitor monthly new recommendations to ensure recommendations are followed.
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recertification orders dated 10/6/10 documented "...ALBUTEROL MDI [metered dose inhaler] GIVE 2 PUFFS EVERY 5 HOUS [hours] LEAVE AT BEDSIDE..." Review of the care plan dated 12/11/09 and reviewed on 6/15/10 had no documentation to address Resident #16's self-administration of the Albuterol MDI.

Observations In Resident #16's room on 10/11/10 at 11:05 AM and on 10/12/10 at 2:40 PM, revealed Resident #16 sitting in her room holding an inhaler in her left hand while unattended by staff.

During an interview in the hallway outside room 20 on 10/12/10 at 2:50 PM, Nurse #4 was asked about the inhaler being kept at bedside. Nurse #4 stated, "She [Resident #16] self-administers the inhaler and keeps it in her room all the time." On 10/12/10 at 2:55 PM, Nurse #4 was asked how do you know that Resident #16 takes the inhaled medication as ordered. Nurse #4 stated, "I don't."

During an interview in the conference room on 10/13/10 at 10:15 AM, Nurse #6 was asked to locate Resident #16's self-administration evaluation. After looking through the medical record, Nurse #6 stated, "...I can't find it either..."

During an interview at the nurses' station on 10/13/10 at 12:05 PM, the Director of Nursing (DON) was asked if she had been able to find the self-administration evaluation for Resident #16. The DON stated, "No... can't find it..." The DON was asked how the medication was secured. The DON stated, "...It's in her [Resident #16] hand... family supplies it, I guess they [family] have a script [prescription] for it at home... We don't supply it [Albuterol MDI]..." The DON was asked...
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how the staff ensures that Resident #16 takes the medication appropriately. The DON stated, "...We [staff] don't know when she [Resident #16] takes it [Albuterol MDI]."

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure 1 of 6 (Nurse #2) nurses followed the policy for administering inhaled medications.

The findings included:

Review of the facility's "ORAL AND NASAL INHALATION ADMINISTRATION PROCEDURES" policy documented, "...SHAKE INHALER..."

Medical record review for Resident #6 documented an admission date of 5/5/10 with diagnoses of Diastolic Heart Failure, Peripheral Neuropathy, Lymphedema, Gout and Osteoarthritis. The physician's orders documented, "...SYMBICORT 160/4.5 GIVE 1 PUFF BID [twice daily]."

Observations of medication administration in Resident #6's room on 10/12/10 at 8:55 AM, revealed Nurse #2 removed the cap from the Symbicort inhaler, placed the inhaler port in Resident #6's mouth and administered 1 puff of
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
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<td>F 281</td>
<td>Continued From page 9 the medication. Nurse #2 did not shake the inhaler before administering the medication. During an interview in the hallway outside room 39 on 10/12/10 at 9:10 AM, Nurse #2 was asked if she shook the inhaler prior to giving the Symcort to Resident #6. Nurse #2 stated, &quot;No, I didn't. I know it [inhaler] should have been shaken.&quot;</td>
<td>F 281</td>
<td>The DON will immediately begin to implement any new plans of actions recommended. The DON will monitor monthly new recommendations to ensure recommendations are followed.</td>
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<td>F 431</td>
<td>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</td>
<td>F 431</td>
<td>Resident #16 inhaler is currently kept in facilities medication cart. Medication carts must be kept locked when unattended and out of view. Unused medication must be disposed per facility's policy. Drugs and biologicals must be stored in locked medication cart when unattended and out of licensed nurses sight. All unused medications must be disposed of properly in &quot;sharps Container&quot; on side of medication cart. All medications for self administration must be stored in a locked container per facility self administration policy. In-service on 10/13/10 by DON to all licensed nurses of &quot;Self Administration of Medication Procedure&quot; including securing of medications in locked container, locking medication cart when out of nurses sight and unattended, and disposing of all unused medications properly.</td>
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537 SPRING STREET, PO BOX 399
DOVER, TN 37058

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abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure medications were stored in locked compartments when 2 of 6 nurses (Nurses #4 and 5) left the medication cart unlocked, unattended and out of their view and/or failed to correctly dispose of an unused medication. The facility allowed Resident #16 to keep a medication unsecured at the bedside.

The findings included:

1. Observations in Resident #16's room on 10/11/10 at 11:05 AM and on 10/12/10 at 2:40 PM, revealed Resident #16 sitting in the her room holding an inhaler in her left hand while unattended by staff.

During an interview in the hallway outside room 20 on 10/12/10 at 2:50 PM, Nurse #4 was asked about the inhaler being kept at bedside. Nurse #4 stated, "She [Resident #16] self-administers that inhaler and keeps it in her room all the time."

2. Observations at the nurse's station on 10/12/10 at 4:10 PM, revealed Nurse #5 unlocked the medication cart, spilled water on top of the cart, left the cart and entered the clean utility room shutting the door. Nurse #5 left the medication cart unlocked, unattended and out of
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<tr>
<th>Prefix Tag</th>
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<td>F 431</td>
<td>Continued From page 11 her view. 3. Observations in the hallway outside room 32 on 10/12/10 at 4:50 PM, revealed Nurse #5 placed a Ferrucus Sulfa 325 mg [milligram] tablet in the trash container on the side of the medication cart. During an interview in the hallway outside room 32 on 10/12/10 at 4:40 PM, Nurse #5 asked where did she dispose of unused medications. Nurse #5 stated, &quot;I shouldn't have put that pill in the trash. It is supposed to go in the sharps container.&quot;</td>
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<td>F 441</td>
<td>483.65 Infection Control, Prevent Spread, Linens</td>
<td>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program: The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</td>
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Nurses 1, 4, 8, CP#1, CNA, SLP will maintain and provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection including hand hygiene prior to beginning meal tray service, after picking items up off the floor or between direct resident contact per CDC guidelines and facility's Infection Control policy. Resident #9 and #16 will have their resident care equipment, including reusable items and durable medical equipment cleaned per CDC guidelines and facility's Infection Control Policy. Nurse will wash hands when removing gloves including after instilling eye gits for resident #16. All Staff will maintain and provide a safe, sanitary...
**NAME OF PROVIDER OR SUPPLIER: MANOR HOUSE OF DOVER**

**STREET ADDRESS, CITY, STATE, ZIP CODE: 357 SPRING STREET, PO BOX 398, DOVER, TN 37058**

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<tr>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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| F441 | Continued From page 12 | (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.

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

This REQUIREMENT is not met as evidenced by:
Deficiency revised per Health Care Facilities Director

Based on policy review and observations, it was determined the facility failed to ensure 1 of 10 Certified Nurses Assistants (CNA #2), 3 of 8 nurses (Nurses #1, 4 and 8), Care Partner (CP #1) and the Speech Language Pathologist (SLP) failed to wash their hands prior to beginning meal tray service in the dining room; after picking items up off the floor or between direct resident contact.

The findings included:
1. Review of the facility’s "Personal Protective
**F 441** continued from page 13

Equipment - Gloves policy documented "...3. The use of gloves will vary according to the procedure involved. The use of disposable gloves is indicated... d. When handling soiled linen or items that may be contaminated... 8. Wash your hands after removing gloves."

a. Observations in Resident #16's room on 10/11/10 at 4:17 PM, revealed Nurse #4 donned gloves, instilled ordered eye drops into both eyes of Resident #16. Nurse #4 removed the gloves from her hands and used alcohol hand gel. Nurse #4 did not wash her hands after removing her gloves.

b. Observations in the dining room on 10/12/10 at 12:08 PM, Nurse #1 donned gloves and adjusted the oxygen on a resident, removed her gloves and used alcohol hand gel. Nurse #1 did not wash her hands after removing her gloves.

2. Review of the facility's "Handwashing and Hand Hygiene - All Staff" policy documented "...POLICY This facility recognizes the importance of handwashing or use of alcohol-based hand rubs in controlling the spread and acquisition of nosocomial infections. The following is based upon CDC [Centers of Disease Control] Guidelines for Handwashing, 2002... Caregivers are believed to be the mode of transmission for most preventable nosocomial infections... WHEN 1. Before and after contact with a resident... 4. After touching a source that is likely to be contaminated... soiled dishes... 5. After taking care of an infected resident, even when gloves are worn... 7. Before preparing medications... 8. Before and after feeding a resident... 11. Before handling sanitized dishes and utensils and after handling soiled dishes and utensils... 14. After
Handling soiled linens/laundry... 16. Before and after breaks, including before and after eating and smoking... 18. After touching hair..."

Observations in the dining room during the lunch meal on 10/12/10 revealed the following incidents where hands were not washed:

a. At 12:09 PM, Nurse #1 and CNA #2 used alcohol hand gel, and applied clothing protectors to the residents.

b. At 12:19 PM, Nurse #8 (the Director of Nursing (DON)) was dispensing coffee from a decanter, and placed the cups on the meal trays as the other staff came by with trays to serve residents. Nurse #8 dropped a packet of sweetener on the floor, picked it up, and continued to dispense coffee for the staff. At 12:25 PM, Nurse #8 went to the meal cart, got a tray off the cart, and served it to a resident.

c. At 12:26 PM, CP #1 went through the dining room, out to the back break/smoking area, and around the building. At 12:28 PM, CP #1 came through the dining room, went in and out of the kitchen without hair covering twice, got a drinking cup with a lid, went to the ice chest cooler, dispensed coffee from the cup to the decanter, placed a lid on the cup, then went back into the kitchen without a hair cover, and got a straw, and brought the cup to a resident. CP #1 did not use alcohol hand gel, or wash his hands prior to going in and out of the kitchen or serving the resident.

d. At 12:42 PM, Nurse #8 sat to assist a resident who was not eating. Nurse #8 patted the resident on the back, and attempted to get the resident to eat. At 12:55, the SLP came into the dining room to assist the resident, and used alcohol hand gel prior to assisting the resident.

e. At 12:55 PM, Nurse #8 (the DON) went to another resident, patted their arm, and said her hair...
Continued from page 15:

3. Observations in the dining room during the supper meal on 10/12/10 revealed the following incidents where hands were not washed:
   a. At 5:20 PM, Nurse #8 (DON) came into the dining room, did not wash or use alcohol hand gel.
Continued From page 16

when entering the dining room. Nurse #8 served a tray to a resident, touched the resident's straw with her fingers, went to the chest and got a clothing protector and placed the clothing protector on the resident. The DON picked up a cup that had been dropped on the floor by a resident, put it on the dirty cart, went to the clean cart and got a clean cup, filled it with coffee, added sweetener and creamer and gave it to the resident that had dropped his. Nurse #8 pushed her hair behind her left ear, left the dining room, and told more staff to come in to assist residents and went back into the dining room. At 5:28 PM, Nurse #8 went to the clean cart, got a tray off, and served the tray to another resident. Nurse #8 patted the resident's right hand and shoulder, and attempted to wake the resident up to eat. Nurse #8 used alcohol hand gel, brought a chair over to the resident, adjusted his glasses, and put her hand on his right shoulder. Another resident began coughing, and the DON went over to that resident, patted him on the shoulder, and instructed the resident to raise his arms.

b. At 5:22 PM Nurse #1 placed the meal tray on the table, repositioned the resident's geri chair, went across the dining room and got a clothing protector from the chest, returned and placed the clothing protector on the resident, went to another table and got a chair and then used alcohol hand gel before feeding the resident.