| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355046 | A. BUILDING _____ B. WING _____ | 02/02/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOLDEN ACRES MANOR | 1 E MAIN ST CARRINGTON, ND 58421 |

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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid survey started on 01/31/11 and completed on 02/02/11, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey. | F 000 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, facility policy review, and staff interview, facility staff failed to provide proper perineal care for 2 of 6 sampled residents (Resident #2 and #5) dependent on staff to complete their personal hygiene. This practice has the potential allow the introduction of bacteria to the urinary tract, possibly causing a urinary tract infection.<br><br>Findings include:<br><br>Review of the facility policy titled "Perineal Care Female," occurred on 02/02/11. This policy, dated 06/30/93, stated, " . . . 11. . . Wipe in direction from perineum to rectum. . . . 15. . . Lastly wash anal area going away from vaginal area, rinse and dry."<br><br>- Observation of perineal care for Resident #2 on | F 312 | F312<br>1. Residents #2 and #5 will receive activities of daily living necessary to maintain good nutrition, grooming, personal and oral hygiene as evident by proper perineal cares.<br>2. All residents who are dependent on staff to complete their personal hygiene have the potential to be affected by this practice.<br><br>3. CNA's will be inserviced on proper perineal cares with the use of video and policy and procedure on 3-8-11.<br><br>4. QA committee will monitor a sampling of CNA's performing perineal cares weekly times one month, monthly times one quarter and quarterly times one year and report to QA coordinator.<br>CNA skills evaluations will be performed two times yearly on all CNA's by the nursing staff with education at the time on any areas of concern.<br><br>5. ~~4-15-11~~ 3/18/11 - Per Telephone call to Bobbie Jo Ferguson, RN 2/24/11. DL. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Admin. — (X6) DATE 2-17-11

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

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| F 312 | Continued From page 1<br>02/01/11, at 8:50 a.m., occurred following an episode of incontinence of stool. The CNA (#4) provided perineal care to the anal area first, wiping in a back to front motion then a front to back motion. Resident #2 turned onto her back with assistance from the CNA (#4), who then provided perineal cleansing wiping with disposable wipes, then a washcloth, soap, and water. Resident #2 turned onto her side and the CNA (#4) cleansed the anal area with a washcloth, soap, and water, cleansing first in a back to front wiping motion then a front to back wiping motion. The CNA (#4) then assisted Resident #2 to the bathroom to complete cares. After the resident used the toilet, the CNA (#4) cleansed the anal area in wiping motions from the back to front, and then front to back.<br><br>- Observation of perineal care for Resident #5 occurred on 02/01/11, at 10:25 a.m. While Resident #5 stood, the CNA (#4) provided rectal cleansing in both a back to front and front to back motion. The CNA (#4) then cleansed the groin and perineal area, using the same water and washcloth.<br><br>During an interview on 02/02/11 at 10:10 a.m., two administrative nursing staff members (#1 and #5) identified their expectation would be for the CNA to cleanse the frontal perineal area, then the rectal perineal area. These staff members (#1 and #5) identified the CNAs should have cleansed both Resident #2's and Resident #5's perineal areas using front to back cleansing motions with the disposable wipes and/or the washcloth. | F 312 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS | F 441 | | |

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| F 441 | Continued From page 2<br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by: | F 441 | CNA skills evaluations will be performed two times yearly on all CNA's by the nursing staff with education at the time on any areas of concern.<br><br>QA Coordinator and DON will monitor glucometer procedure on a sampling of residents weekly times one month monthly times one quarter and quarterly times one year and report to QA committee.<br><br>Glucometer skills evaluations with redemonstration are completed annually at nurses meeting.<br><br>5. ~~4-15-11~~ 3/18/11 - Per Telephone call to Bobbie go Ferguson, RN on 3/24/11. DL | |

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| F 441 | Continued From page 3<br>1. Based on observation, review of policy and procedure, record review, and staff interview, the facility failed to properly clean the glucometer (machine that measures blood sugar levels) following 2 of 3 accuchecks (test for blood sugar level) observed and failed to follow proper hand hygiene for 1 of 3 accucheck observations. Failure to follow infection control guidelines may lead to the development and transmission of disease and infection.<br><br>Findings include:<br><br>Review of the facility policy titled "Hand Hygiene" occurred on 02/02/11. The policy, undated, stated, "Hand hygiene continues to be the primary means of preventing the transmission of infection. . . . some situations that require hand hygiene: . . . Before and after resident contact (for which hand hygiene is indicated by acceptable professional practice); Before and after performing any invasive procedure (e.g. [such as], finger stick blood sampling); . . . After removing gloves . . ."<br><br>During an interview on the afternoon of 02/02/11, an administrative nurse (#1) explained the expected infection control procedures for staff to follow when using a glucometer:<br>* Gather the equipment and take only what is needed to perform the accucheck into the resident's room. Leave the case at the nurses' station.<br>* Put a barrier between the equipment/supplies and the working surface.<br>* Complete the accucheck per protocol.<br>* Cleanse the glucometer machine with a disinfectant wipe before leaving the room. | F 441 | F441<br>1. 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 related to proper cleaning of glucometer machines and washbasin has been developed and implemented.<br><br>2. Any resident needing blood sugar monitoring or use of washbasins for activities of daily living have the potential to be affected by this practice.<br><br>3. Nurses will be inserviced on proper policy and procedure of obtaining glucoscans on 2-22-11. CNA's will be inserviced on proper policy and procedure for cleaning of washbasins on 3-8-11.<br><br>4. QA committee will monitor for proper cleaning of washbasins after cares on a sampling of residents weekly times one month, monthly times one quarter, and quarterly times one year and report to QA coordinator. | |

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| F 441 | Continued From page 4<br>- On 01/31/11 at 5:33 p.m., observation showed a licensed nurse (#3) brought a case containing a glucometer, lancets, alcohol swabs, and other supplies into Resident #16's room. The nurse (#3) placed the case on Resident #16's a table without placing a barrier between the case and the table. The nurse (#3) removed the glucometer from the case and placed it on the table next to the case. The nurse (#3) washed her hands, donned gloves and lanced Resident #16's finger. The nurse (#3) held the test strip to the drop of blood wicking blood into the test strip, placed the test strip into the glucometer, and obtained the resident's blood glucose reading. The nurse (#3) removed the test strip from the monitor and discarded the strip, placed the lancet in a small covered plastic bottle in the case and placed the glucometer into the case without disinfecting the monitor. The nurse (#3) washed her hands before leaving Resident #16's room. The nurse (#3) carried the case to the nurse's station and placed the case in the medication room while the nurse (#3) completed another task. The nurse (#3) then returned to the nurse's station, removed the glucometer from the case and cleansed it with a sanitization wipe. The nurse (#3) stated normally she cleaned the glucometer upon return to the nurses station, before doing other tasks.<br><br>- On 02/02/11 at 10:58 a.m., observation showed a licensed nurse (#2) carried a case containing a glucometer, alcohol wipes, and lancets into Resident #1's room. The nurse placed the case on the end of the resident's bed, failing to put a barrier between the case and the bed. The nurse washed her hands, donned gloves, lanced Resident #1's finger, placed the strip with the resident's blood into the glucometer, and obtained a reading. The licensed nurse (#2) removed and | F 441 | | |

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| F 441 | Continued From page 5<br>discarded the test strip from the machine, removed her gloves and placed the glucometer into the case. The nurse failed to disinfect the glucometer prior to placing it in the case and failed to wash her hands before leaving the room. The nurse returned the case to a cupboard in the medication room.<br><br>2. Based on observation and staff interview, the facility failed to clean and store resident care equipment for 2 of 2 sampled residents (Resident #2 and #5) observed receiving morning cares. Improper cleansing of a washbasin after use may spread bacteria to other objects exposed to the contaminated washbasin and/or expose the resident to bacteria when next used which could cause eye and/or skin irritation/infection.<br><br>Findings include:<br><br>The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding infection control practices. For non-critical items (Those that touch intact skin) cleaning and disinfection can be done in one step with an EPA (Environmental Protection Agency) approved (for healthcare use) germicidal/disinfectant cleaning agent. These EPA approved products are generally quaternary ammonium based agents that can in one step con clean and disinfect as is appropriate for non-critical items. Suggest daily the basins be rinsed or sprayed per product recommendations with the cleaning-disinfecting product after removing any visible organic material (i.e. stool).<br><br>- Observation of cares, on 02/01/11 at 8:50 a.m., for Resident #2 showed the certified nurse aide (CNA) (#4) used water from a washbasin to | F 441 | | |

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| F 441 | Continued From page 6 | F 441 | | |

provide hygiene cares beginning with washing the resident's face and ending with washing the resident's perineal area. Observation of the brief showed Resident #2 to be incontinent of feces. Observation of the washcloth showed dark flecks on the washcloth at the completion of perineal cares. The CNA (#4) emptied the water from the basin into the sink, rinsed the washbasin with water, and dried the washbasin with a paper towel. The CNA (#4) then placed a carrying case of Resident #2's hygiene products into the washbasin and placed the washbasin into Resident #2's closet.

- Observation of cares, on 02/01/11 at 10:20 a.m., for Resident #5 showed the CNA (#4) used water from a washbasin, to provide hygiene cares for the resident beginning with having the resident wash her face and upper body, and ending with the CNA (#4) washing the resident's perineal area. The CNA (#4) emptied the water from the basin into the sink, rinsed the washbasin with water, and dried the washbasin with a paper towel. The CNA (#4) then placed the washbasin between the wall and the sink, on its side, with the opening towards the sink.

During an interview on 02/02/11 at 10:10 a.m., administrative nursing staff members (#1 and #5) identified their expectation would be for the CNAs to empty the soiled water from the washbasin into the toilet, cleanse the washbasin with soap and water, then dry it with a towel.

The CNA (#4) failed to pour the soiled water from the washbasin into the toilet, there by contaminating the sink in two different bathrooms. The facility failed to follow CMS guidelines for the cleaning-disinfecting of the washbasin after use

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| F 441 | Continued From page 7<br>for perineal care. | F 441 | | |