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



| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355037 | A. BUILDING _____ B. WING _____ | 07/30/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST ALOISIUS MEDICAL CENTER NURSING HOME | 325 E BREWSTER ST HARVEY, ND 58341 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey started on 07/28/14 and completed on 07/30/14, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review. | F 000 | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><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. | F 441 | 1. No individual resident affected. Reviewed the proper disinfecting of the whirlpool tub which includes leaving the disinfectant on the tub for 10 minutes before rinsing with staff involved during the observation on the morning of July 29, 2014.<br>2. All residents using the whirlpool pool have the potential to be affected.<br>3. A memo was posted on Point Click Care communication bulletin to remind all staff that if they use the whirlpool tub for a resident they must follow the instructions for disinfecting, which includes leaving the disinfectant on for 10 minutes before rinsing. The whirlpool has had a timer placed in the whirlpool room to assure staff completes the disinfectant task for 10 minutes. The policy for cleaning and disinfecting of the tub is in the tub room available for reference. A reminder | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: PRESIDENT/CEO — (X6) DATE: 8-11-2014

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355037 | A. BUILDING _____ B. WING _____ | 07/30/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST ALOISIUS MEDICAL CENTER NURSING HOME | 325 E BREWSTER ST HARVEY, ND 58341 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 441 | Continued From page 1<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:<br>Based on observation, review of manufacturer's instructions, and staff interview, the facility failed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of disease and infection regarding 1 of 1 bathing tub. Failure to ensure proper tub sanitation occurred placed resident's utilizing the tub at risk for infection.<br><br>Findings include:<br><br>Review of the "Safe Operation & Daily Maintenance Instructions" for the "Cascade Contour Bathing Systems with Aqua-Aire," utilized for whirlpool tub bathing, stated:<br>"System Cleaning (After Every Bath)<br>Clean and disinfect the tub after every bath with Penner Cleaner/Disinfectant as follows . . .<br>Penner Cleaner/Disinfectant is the only cleaning solution designed and recommended for use with your Cascade Contour Tub. . . . Using the long-handled brush, available from your Penner distributor, thoroughly scrub all interior surfaces of the tub and Swivel Lift chair with the solution that remains in the foot well of the tub. Let disinfectant stay on surface for 10 minutes. . . ."<br><br>On the morning of 07/29/14, observation of the cleaning process of the whirlpool tub occurred. A | F 441 | memo "leave disinfectant on the whirlpool tub for 10 minutes" has been applied on the tub.<br>4. Corrected by August 14, 2014.<br>5. A QI monitor for compliance of the application of the disinfectant for 10 minutes will be done weekly for one month, then monthly for one year and reviewed quarterly at the facility QI meeting. DON will be responsible. | 8-14-14 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355037 | A. BUILDING _____ B. WING _____ | 07/30/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST ALOISIUS MEDICAL CENTER NURSING HOME | 325 E BREWSTER ST HARVEY, ND 58341 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 441 | Continued From page 2<br>staff member (#3) demonstrated how the tub is cleaned by scrubbing the interior surfaces of the tub with the disinfectant. After three minutes, the staff member rinsed out the tub. The staff (#3) stated she rinses off the disinfectant after three to seven minutes, however stated she has been told to rinse after five to 10 minutes. As identified in the manufacturers instructions, the disinfectant solution must be in contact with the tub surface for ten minutes. | F 441 | | |