STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 For the standard Medicare/Medicaid recertification survey started on February 16, 2010, and completed on February 18, 2010, the sample included 2 residents for complete review, 8 residents for focused review, and 1 closed record for review.	F 000	**General Disclaimer** Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225	**F-0225** **1. The incident of alleged abuse from 09/24/2009 was reported to the State on 02/19/2010 A thorough investigation of the allegation was completed on 02/24/2010 appropriate corrective action was taken after the investigation was completed. The results of the investigation were reported to NDDH within 5 working days on 02/25/2010**	

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

M K Crane — Administrator — 3-9-10

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 225	Continued From page 1 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedures, and staff interview, the facility failed to report 1 of 1 allegation of abuse to the state survey and certification agency upon receiving notification of the allegation, failed to complete a timely, thorough investigation of the allegation, and failed to report the results of that investigation within 5 working days to the state survey and certification agency. Failure to report and thoroughly investigate all alleged violations involving mistreatment, neglect, or abuse has the potential to place all residents at risk of possible abuse and neglect. Findings include: Review of the facility policy and procedure titled "ABUSE AND NEGLECT" occurred on 02/18/10. The policy, revised 10/09, stated: "The resident has the right to be free from verbal, sexual, physical and mental abuse . . . Residents must not be subjected to abuse by anyone . . . Alleged or suspected violations involving any mistreatment, neglect or abuse including injuries of unknown origin will be reported immediately to the center administrator and to other officials in accordance with state law, including the state survey and certification agency. The center will have evidence that all alleged or suspected	F 225	**2. All residents who live in the facility have the potential to be affected in this area. The Good Samaritan Society is dedicated to the care and services of our residents and any and all allegations of abuse or neglect will be reported to the NDDH, investigated, and appropriate action will be taken to protect our residents from abuse and neglect.** **3. A mandatory all staff meeting was held on 03/03/2010. The staff were re-educated on the policy and procedure for abuse and neglect reporting and the need for timely reporting.** **A mandatory Licensed Staff meeting will be held on 03/10/2010 to re-educate the nurses on the policy and procedure for abuse and neglect reporting. Emphasis was put on the need for timely reporting, immediate investigating, and taking appropriate action for all allegations of abuse or neglect of a resident.**	

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F 225	Continued From page 2 violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress. Results of all investigations will be reported to the administrator or designated representative and to other officials in accordance with state law, including to the state survey and certification agency within five working days of the incident . . . If the alleged or suspected violation is verified, appropriate corrective action will be taken. . . ." The Abuse and Neglect procedure, revised 10/09, stated: "PURPOSE . . . To ensure that all identified incidents of alleged or suspected abuse/neglect are promptly investigated and reported . . . To identify and remedy any abusive situations . . . To ensure that a complete review of existing incidents is documented . . . PROCEDURE 1. If a staff member receives an allegation of abuse, neglect . . . or witnesses suspected abuse . . . the staff member will immediately report this to a supervisor . . . 2. The charge nurse or licensed nurse will be notified immediately, assess the situation to determine if any emergency treatment or action is required, and complete an initial investigation. . . . 5. Notification Procedures: a. Notify the center administrator immediately of any incidents of resident abuse . . . alleged or suspected abuse . . . In case of absence of the administrator, follow the chain of command for notification (DNS [Director of Nursing Service], SW [Social Worker], etc.) b. Notify the designated agencies in accordance with state law, including the state survey and certification agency. . . . Document	F 225	**4. March 25th, 2010** **5. An audit will be developed to monitor the daily review of all incident reports, if any allegation of abuse or neglect were reported to the NDDH within 24 hours, if an investigation was completed, if appropriate action was taken to protect the resident, and if the results of the investigation were reported back to the NDDH within 5 working days. The audit will be completed weekly for one month, then monthly times two months. The results of the audits will be reported to the QA/CQI committee for future recommendations. The audit will be completed by the social worker or her designee.**	

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F 225	Continued From page 3 the notifications . . . 9. The social worker or designated staff will report the results of all investigations to the state survey and certification agency and other officials within five (5) working days of the incident . . . 13. If, as a result of a survey, a center receives a citation under the abuse and neglect F-Tags for an incident that was not previously investigated, then the center will treat this citation as an allegation and will proceed with all the steps as outlined above. . . ." - On the morning of 02/17/10, during an interview with a staff member (#8) regarding the facility policies and procedures for reporting abuse and neglect, the staff member (#8) described observing a direct care staff member in the dining room "forcefully feeding" a resident and get angry with the resident "for not eating the way he should have." The staff member (#8) identified the incident occurred approximately six months ago. The staff member reported telling the nurse on duty when the incident occurred, and writing up a written report. The staff member did not know how or if the situation was handled. An interview occurred with an administrative staff member (#4) at 3:00 p.m. on 02/17/10. The staff member (#4) stated an investigation was not completed on the above allegation as the involved employee had an extended absence shortly after the incident due to health reasons. The staff member (#4) stated no reporting occurred to the state survey agency initially, nor was an investigation report completed/made available to submit to the state survey agency, within five working days following the allegation. An interview occurred with two administrative staff	F 225		

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F 225	Continued From page 4 members (#4 and #5) at 5:00 p.m. on 02/17/10. An administrative staff member (#5) stated the allegation was not called to the state survey agency immediately nor within five working days of the allegation as this staff member was not aware of the allegation until four days after it occurred. The staff member (#4) stated the investigation was not completed due to extenuating circumstances. On the morning of 02/18/10, an administrative staff member (#5) provided a copy of the written statement provided by a staff member (#8) following the witnessed allegation. The written statement, dated 09/25/09, stated, "During supper on 9/24/09 (Thursday) it was witness [sic] by myself that [the alleged's first name] was forcefully feeding [resident's first name]. [Resident's first name] wasn't wanting to eat so he clenched his teeth shut but [the alleged's first name] continued to force the spoon in his mouth. At one point he was forcing the spoon through the dentures so hard that I thought they would break. [Reference to alleged] would lean forward and 'growl' at [Resident's name] that 'he needed to eat.' After this was witness [sic] I asked the charge nurse [name] to stand back and watch [staff member] while [staff member] fed [Resident]. . . . [another staff member's name] also witnessed what went on and we both agree that it was uncalled for and mean." On the morning of 02/18/10, an administrative staff member (#5), at the request of the surveyor, provided a written, chronological review of what occurred after notification of the allegation of abuse. The review, written, dated and signed by two administrative staff members (#4 and #5) on 02/17/10, stated:	F 225		

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F 225	Continued From page 5 * The allegation occurred on Thursday, September 24, 2009. * A staff member (#8) submitted a written statement and gave the statement to an administrative staff member (#4) on 09/25/09 (the following day). * An administrative staff member (#4) checked the affected resident for injury after this notification (on 09/25/09) and "none was noted." The administrative staff member (#4) also reviewed the schedule to determine the alleged "was not scheduled to work the weekend or the entire week." * On Monday, September 28, two administrative staff members (#4 and #5) first initiated an investigation of the allegation which included a review of the written statement and an interview with the charge nurse working on 09/24/09. The report stated the other witness was not available on September 28-29, 2009. * On Tuesday, September 29, the two administrative staff members (#4 and #5) determined "they would have to talk to [the alleged] to proceed but would place [the alleged] on suspension pending investigation." On this same day, the alleged experienced a mishap and was "unavailable to come back to work." * The report summarized: "After speaking to charge nurse and witnesses available for comment, checking [resident's] chart and observing him [the resident] for physical/behavioral changes, no allegations could be verified. No abuse/neglect could be found." The facility failed to notify the state survey agency after receiving notification of an allegation; failed to complete a thorough investigation of the allegation, including documenting the information obtained through the interviews completed;	F 225		

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F 225	Continued From page 6 determined the results of the investigation before completing a thorough investigation (including interviewing the alleged), and failed to notify the state survey agency of the results of the investigation (including extenuating circumstances).	F 225		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policies and procedures and professional	F 329	**F-0329** **1. Resident #10's individual needs will be met by contacting her primary care physician and a new physician order was received to reduce the resident's medication in question on 02/19/2010. The care plan was reviewed and updated as needed.**	

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F 329	Continued From page 7 reference, and staff interview, the facility failed to ensure 1 of 4 sampled residents currently receiving antianxiety medications (Resident #10) received a gradual dose reduction, unless contraindicated. Failure to monitor and evaluate antianxiety agents for gradual dose reductions has the potential for residents to receive unnecessary medications and experience adverse reactions, including drowsiness related to the medication. Findings include: The Centers for Medicare & Medicaid has outlined the standards of practice regarding the tapering of a medication dose/Gradual Dose Reduction (GDR) which states the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. GDR Tapering Considerations for Psychopharmacological Medications (Other than Antipsychotics and Sedative/Hypnotics) indicates: Tapering may be indicated when the resident's clinical condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. After the first year, tapering should be attempted annually, unless clinically contraindicated. Clinically contraindicated means: The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. The Geriatric Dosage Handbook, 12th Edition, pages 195-197, identified Buspar as an	F 329	**2. All residents who are currently taking anti-anxiety medications have the potential to be affected by this area. A list of residents that receive anti-anxiety medications will be generated. The primary care physicians will be contacted to see if a dosage reduction can be attempted if it has been longer than one year. If the reduction is not order the physician will be asked to document in the medical record the clinical rationale for why any attempted dosage reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.**	

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F 329	Continued From page 8 "antianxiety agent, Use: Management of anxiety Warnings/Precautions: Use in hepatic or renal impairment is not recommended. . . . Causes . . . sedation . . . Adverse Reactions . . . Drowsiness . . ." Review of the facility policy titled "Psychopharmacological Medications and Sedative/Hypnotics," occurred on 02/18/10. The policy stated, ". . . Throughout the administration of the psychopharmacological medications, . . . the following must be completed: . . . Monitoring for side effects of the medication. . . . Gradual Dose Reductions: The purpose of tapering medication is to find an optimal dose or to determine if continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and/or non-pharmacological interventions have been effective in reducing the symptoms." - Review of Resident #10's medical record occurred on February 17-18, 2010. Resident #10's diagnoses included: anxiety, depression, and stage 3 kidney disease. Resident #10's current medication regimen included Buspar (an antianxiety medication) 15 milligrams (mg) twice daily, started on 07/24/07. Record review lacked evidence of monitoring for potential side effects or the facility attempting dose reduction for the Buspar. A Minimum Data Set (MDS), dated 01/23/09, showed Resident #10's weight at 114 pounds. A MDS, dated 01/26/10, showed this resident's weight at 105 pounds, a gradual loss of nine pounds over one year.	F 329	**3. A mandatory in-service will be held on 03/10/2010 by a licensed pharmacist to educate licensed nursing staff on unnecessary drugs, monitoring for adverse consequences and side effects and the need for annual dosage reduction attempt.** **4. Facility will be in compliance by 03/25/2010**	

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F 329	Continued From page 9 Observation on 02/17/10 at 7:50 a.m. showed Resident #10 seated in her wheelchair in the dining room asleep. Observation showed an unidentified staff member approached the resident on several occasions to awaken her and encourage her to wake up and eat her breakfast. Observation on 02/18/10 at 8:10 a.m. showed Resident #10 asleep at the breakfast table. An "Interdisciplinary Assessments and Summary Review," dated 01/26/10, stated,". . . Feeds self but needs monitoring, encouragement, arousing when sleeping et [and] PRN [as needed] assist . . . Aricept and Buspar are taken for cognitive deficits. . . She . . . tends to want to just stay in bed. . . ." An Interdisciplinary Progress Note, dated 01/28/10, stated ". . . eats very poorly @ [at] dinner & [and] supper. She is often very tired & sleeps at the table. . . ." A note, dated 10/04/09, stated ". . . intake per her usual - poor . . . " A Resident Assessment Protocol Key Guideline Report, dated 01/26/10, stated ". . . Buspar taken for cognitive deficits. . . . tends to want to just stay in bed. . . . not motivated to do much for herself . . . " A monthly Medication Review, dated 01/07/09, stated, ". . . Buspar last addressed 4/08." An interview occurred with an administrative nurse (#4) on the morning of 02/18/10. She provided no additional information to show the facility attempted a GDR for Resident #10's Buspar since July 2007. The administrative staff	F 329	**5. An audit will be developed to monitor all residents receiving anti-anxiety medications, the start date of the medication, date the MD last attempted a dosage reduction, or the date of the documentation in the medical record clinical rational for not attempting a dosage reduction for all residents that receive anti-anxiety medications. The audit will be completed weekly times one month and monthly times 2 months by the DNS or her designee. The audit results will be submitted to the QA/CQI committee monthly for further recommendations.**	

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F 329	Continued From page 10 nurse (#4) agreed the record should reflect a GDR attempt or include a documented clinical rationale for why the physician did not recommend an attempted dose reduction.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, and staff interview, the facility failed to store and serve food in a safe and sanitary manner in 1 of 1 kitchen and 1 of 1 nourishment center and 3 of 3 resident's personal refrigerators (Resident #8, #12 and #13). Failure to follow safe food sanitation practices has the potential to result in food borne illness and can affect all residents who consume food stored in these areas. Findings included: Review of the facility policy titled "Sanitation Kitchen General" occurred on 02/18/10. This policy, dated January 2001, stated, "All food contact surfaces will be washed, rinsed and sanitized. . . ."	F 371	**F 371** **1. Any foods/fluids found to be improperly stored were discarded during the kitchen tours on 2/16/10 and 2/17/10. New food storage containers have been ordered. Spatulas were discarded and the drawer in which they were stored was cleaned. The deep fat fryer will no longer be used. Broken storage shelf was fixed. Resident refrigerators were cleaned and undated/improperly stored food items were discarded.** **2. All residents and those residents possessing personal refrigerators have the potential to be affected by these food storage practices.**	

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F 371	Continued From page 11 Review of the facility policy titled "Food/Food Preparation/Food Storage" occurred on 02/18/10. This policy, dated January 2001, stated ". . . in dry storage, all foods will be stored six inches off the floor and away from the wall . . . Foods which have been opened or prepared will be placed in an enclosed container, dated and labeled. . . . Expiration dates will be checked on a regular basis and foods/fluids which have expired will be discarded. Potentially hazardous foods will be discarded after three (3) days in refrigerator. . . . Date all frozen food removed from freezer to the refrigerator to thaw. . . . Staff food/fluids will not be stored in the kitchen cooler/freezer or dry storage." Review of the facility policy, (undated), regarding refrigerators in resident rooms occurred on 02/18/10 and identified the following: "1) Family is responsible to date any food product that is brought in for the resident. 2) Family is to monitor foods in the fridge and dispose of in a timely manner. 3) Housekeeping will check refridgerators [sic] weekly for any outdated foods and dispose of theses [sic] foods. 4) Kitchen staff will defrost and wipe out personal refrigerators monthly." - An initial tour of the facility's kitchen occurred on 02/16/10 at 12:35 p.m. with an administrative staff member (#5) and a dietary staff member (#6). Observation showed the following on middle/lowest shelves in the walk-in cooler: * One third of a ten pound roll of hamburger labeled with the date opened 02/10/10 (7 days prior), and one half of a ten pound roll of hamburger, labeled with the date opened 02/07/10 (10 days prior).	F 371	**3. A Food Storage in-service was held on 3/8/10 for dietary staff. Resident's Kitchen Electrical Appliances Policy and Procedure will be reviewed as well. Release for use of electrical appliances will be in place and care planned for those residents.** **4. March 25, 2010** **5. Quality Assurance will be implemented on 3/10/10. Food Storage Checklist (see attached) will be completed per LRD/DM weekly x 2 months. See attachment "A"**	

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F 371	Continued From page 12 * One plastic bag with two pounds of bologna, dated November 1, and identified by dietary staff member (#6) as the date dietary staff had initially placed the meat in the freezer. Dietary staff had not labeled the food item with the date thawed. * One container of potato salad, prepared by dietary staff, labeled with the date opened 02/08/10 (8 days prior). * Three flats of raw eggs not labeled with an expiration date. * One uncut honeydew melon with evidence of spoilage, (discolored brown), stored on a shelf. * One uncut orange stored on a shelf. * One uncut, fresh pineapple stored on a shelf. * One bag shredded mozzarella cheese open to air and undated. * One package of dry, sliced cheese, open to air and undated. * One bag of baby carrots, open to air. Observation of the walk-in freezer showed: * One box of bulk frozen peas open to air. During an interview with a dietary staff member (#6) on the afternoon of 02/17/10, the staff member agreed the stored eggs should be covered and dated, the potato salad should be discarded after three days, hamburger should be discarded after four days, and spoiled fresh fruits and vegetables should be discarded. - The main tour of the dietary department occurred on 02/17/10 at 1:35 p.m. with an administrative staff member (#5) and a dietary staff member (#6). Observation showed: * 11 large and seven small rubber spatulas visibly soiled with frayed rough edges stored in a drawer containing food debris.	F 371		

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F 371	Continued From page 13 * An uncovered deep fat fryer with food debris in the oil. Observation of the dry food storage area during the main dietary tour showed: * One open to air bag of bread stuffing. * One open to air bag of chocolate pudding pie mix. * One large can of mushroom pieces and stems stored on the floor to support a broken storage shelf. During interviews completed on the afternoon of 02/17/10, an administrative staff member (#5) agreed the spatulas should be replaced and stated, "That drawer is dirty." The dietary staff member (#6) and an administrative staff member (#5) agreed the deep fryer should be emptied, cleaned, and kept covered as it had not been used for at least two weeks. A supervisory maintenance staff member (#7) present during the tour indicated a maintenance request work order had not been completed regarding the broken shelf. Observation of the facility nourishment center for resident use occurred following the main dietary tour. The center contained the following employee items: * One opened can of soda, one covered styrofoam cup containing soda, two uncovered coffee cups containing dried coffee residue, a covered plastic container with an unidentified white powder, and an energy drink. During an interview while on the main dietary tour, an administrative staff member (#5) stated, "Employee's beverages should not be stored	F 371		

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F 371	Continued From page 14 here, but should be be stored in the staff lounge" and removed the employee items from the nourishment center. - Observation of personal refrigerators, located in resident rooms, occurred with an administrative nursing staff member (#5) on 02/17/10 at 5:45 p.m. and on 02/18/10 at 7:50 a.m. The refrigerators contained the following items: * Resident #8's, a plastic bag of a food item that appeared to be a dessert bar, with mold covering its surface. * Resident #12, two 4 ounce containers of ice cream, appeared to have thawed and refrozen, in the freezer compartment, lined with a heavy ice buildup. * Resident #13, a dried, dark-colored spill on 3/4 of the bottom of the refrigerator and along the door seal, appeared to have leaked from an empty can of cola, located in the refrigerator door. When interviewed, during these observations, the administrative staff member (#5) discarded the food items and stated facility staff are responsible to clean resident refrigerators.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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;	F 441	**F-0441** **1. Resident #4 individual needs have been met by updating the care plan on 02-17-2010 to inform and communicate to staff the diagnosis of MRSA in the urine. Resident is receiving cares following**	

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F 441	Continued From page 15 (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. (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: Based on observation, record review, review of facility policy and procedure, review of a professional reference, and staff interview, the facility failed to maintain an Infection Control Program designed to provide a sanitary environment during observation of cares for 2 of 10 sampled residents (Resident #4 and #9), one of these (Resident #4) with a multidrug resistant organism. Failing to prevent the transmission of infection has the potential to affect all residents residing within the facility.	F 441	**contact precautions per facility procedure. Housekeepers were alerted on 02-17-2010 to the resident's diagnosis of MRSA, and contact precautions implemented for this resident.** **Resident # 9 individual needs are being met by destroying and replacing the contaminated insulin pen on 03-10-2010 and updating the care plan to inform staff the diagnosis of chronic hepatitis and is receiving cares from staff following standard precautions per facility procedure.**	

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F 441	Continued From page 16 Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding an effective infection prevention and control program. Critical aspects of the infection prevention and control program include recognizing and managing infections throughout the resident's stay, as well as following recognized infection control practices while providing care (e.g., hand hygiene, handling and processing of linens, use of standard precautions, and appropriate use of transmission-based precautions). Review of the facility procedure "HANDWASHING, GOWNS, GLOVES, MASKS, GOGGLES" occurred on 02/18/10. The procedure, dated July 2003, stated, ". . . THE IMPORTANCE OF HANDWASHING: Handwashing is the single most important means of preventing infection and should be a routine practice for all caregivers. Hands of personnel may become a route of transmission if proper handwashing is not practiced. . . . WHEN: . . . After you handle items or persons soiled with body fluids or wastes (blood, vomit, stool, urine, drool or eye matter) . . . Before and after using gloves . . . WATERLESS HANDWASHING: Antimicrobial waterless handwashing products may be used when hands are not visibly soiled. . . . GOWNING: The use of gowns when indicated by the type of isolation applies to all staff and visitors who enter the room. Gowns should also be worn whenever there is a potential for contact with contaminated blood or body fluids. . . . GLOVES . . . Gloves . . . do not need to be bagged except when used in CONTACT	F 441	**2. All residents with MRSA in the urine and Hepatitis C have the potential to be affected in this area. A list of resident that have a diagnosis of MRSA in the urine, Hepatitis C, or any other infectious disease will be generated. These residents will be monitored to see if contact precautions are in place per facility policy during direct care, housekeeping services, and during medication administration. The identified resident's care plans will be reviewed and updated as needed.**	

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F 441	Continued From page 17 PRECAUTIONS (i.e. wound care). . . . " Review of the facility policy and procedure for "MULTIDRUG-RESISTANT ORGANISMS (MRSA [Methicillin-Resistant Staphylococcus Aureus] AND VRE [Vancomycin Resistant Enterococci]) occurred on 02/18/10. The policy, dated July 2003, stated, "PURPOSE: To provide guidance in managing care for residents with multidrug-resistant organisms. DEFINITIONS: Multidrug-Resistant Organism: Bacteria and other microorganisms that have developed resistance to antimicrobial drugs. Examples: . . . (MRSA) . . . Infection: The organism is present and is causing illness . . . Centers can safely care for and manage these residents by following appropriate infection control practices . . . Precaution Procedures Use Standard Precautions for all resident care. Use Contact Precautions when the center (based on national or local regulations) deems the multidrug-resistant microorganism to be of special clinical and epidemiological significance. . . . Contact Precautions These would be in addition to Standard Precautions when indicated. Contact Precautions are indicated for the following: * . . . Residents with fecal or urinary carriage of multidrug-resistant organisms whose urine or stool cannot be contained in incontinent products, urine bags or ostomy bags. . . . Gowns * Clean, non-sterile gowns should be worn for direct care if substantial contact with	F 441	**3. A mandatory all staff meeting will be held on 03/12/2010 to provide staff on the policy and procedure for Multidrug-resistant organisms and VRE and the procedure titled Handwashing, gowns, gloves, masks, goggles. A mandatory licensed nurse meeting will be held on 03/10/10. The nurses receive education on proper medication administration, how to complete the infection surveillance report, the importance for notifying the Infection Control Nurse of resident illness, infections and culture results, and to start contact precautions immediately when an infectious disease is diagnosed or suspected.**	

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F 441	Continued From page 18 secretions/excretions is anticipated. *Wear gowns when contact with environmental surfaces and items in the resident's room are likely to be contaminated. . . ." - Review of Resident #4's record occurred on all days of survey. Review of the record identified nursing staff inserted an indwelling Foley catheter on 01/29/10 due to urinary retention. The physician ordered a urinalysis on 02/09/10 due to the resident experiencing low back pain "numerous" times per day, and not obtaining relief of that pain with the administration of Tylenol extra strength. The urinalysis report, dated 02/10/10, identified nursing staff obtained the urine sample through a catheter specimen. A 24 hour culture report, dated 02/11/10, identified a preliminary culture result of greater than 100,000 colonies of gram positive organisms. The record identified the physician ordered Bactrim DS (an oral antibiotic) two times a day for one week for the urinary tract infection. Resident #4's physician's orders, dated 02/15/10, identified the resident with a diagnosis of MRSA in the urine. A urine culture report, dated 02/15/10, identified MRSA isolated from the urine specimen collected on 02/10/10. Record review on 02/16/10 identified care plan problems, goals and approaches implemented on 02/11/10 of "Alteration in elimination R/T [related to] urine retention - Foley cath [catheter]" with a goal of "Will be free of infection by 2-18-10." The care plan lacked an update for the presence of the MRSA and specific related transmission precautions beginning on 02/15/10. The following observations occurred on 02/17/10: * 7:45 a.m., the resident's bed linens stripped off	F 441	**4. 03/25/2010.** **5. An audit will be developed to monitor staff compliance of proper handwashing, gowns, gloves, masks, and goggle usage during resident cares, cleaning rooms by the housekeeping staff, and with blood glucose checking, and during medication administration. The audits will be done 2 x weekly for 1 month, then monthly x 2 months. The infection control nurse or her designee will complete the audits and report the results to the QA committee for future action recommendations.**	

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F 441	Continued From page 19 the bed and a sign laying on top of the mattress stated, "Washed." A housekeeping staff member (#9) stood in the room with her cart. Observation showed no gown on, and no indication outside or within the room identifying the resident with contact precautions. * 1:40 p.m., a certified nursing assistant (CNA) (#10) emptied Resident #4's Foley catheter after donning gloves. The CNA opened the drainage port clamp, drained the urine into a graduate, opened an alcohol wipe, wiped the end of the drainage port with the alcohol wipe, disposed of the wipe in the garbage, entered the resident's bathroom, and emptied the graduate in the toilet. The CNA then rinsed the inside of the graduate with the spray arm device at the toilet, removed a PDI (bactericidal, tuberculocidal and virucidal) wipe from a canister, wiped out the inside of the graduate, removed her gloves, and then washed her hands. Emptying the contaminated urine from the Foley catheter bag without recommended transmission/contact precautions runs the risk of splashing/spraying onto the staff members clothing and/or other surfaces, and the potential for transport to other residents and/or surfaces. An interview with the charge nurse (#2) occurred at 12:20 p.m. on 02/17/10. The charge nurse verbalized awareness of Resident #4's current MRSA diagnosis. The charge nurse stated CNAs are informed in report. The charge nurse stated the resident is on contact precautions and stated the contact precautions would be the same as the standard precautions required for contact with any bodily fluids for all residents. An interview with a CNA (#10) occurred at 2:10 p.m. on 02/17/10. The CNA stated she did not know Resident #4 had MRSA in the urine. The	F 441		

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F 441	Continued From page 20 CNA stated when a resident has MRSA, direct care staff are informed of this through a notebook in the report room. The CNA stated direct care staff are instructed to do good handwashing. An interview with an infection control staff member (#11) occurred at 3:00 p.m. on 02/17/10. The staff member stated she would expect standard precautions be utilized by staff when emptying a Foley catheter for a resident infected with MRSA. The staff member stated that is the facility policy. The staff member verbalized not knowing Resident #4 currently had MRSA in the urine. The staff member stated the facility does not have an identification process to inform staff and visitors of special precautions when a resident is infected with MRSA. The staff member stated routing slips are utilized to inform her of resident infections but she had not reviewed these for a few days and was not aware of Resident #4's current MRSA infection. On 02/18/10 at 7:45 a.m. observation showed a housekeeping staff member (#9) cleaning a resident's bed. During an interview at this time, the housekeeping staff member (#9) stated housekeepers are informed when a resident has MRSA: "they tell us and I always wear gloves." When asked if housekeepers ever wear gowns, the housekeeper stated "no." On 02/18/10 at 10:40 a.m., an infection control staff member (#11) agreed hand washing should occur after contact with bodily fluids. The staff member stated signage, and gowns, have been obtained and placed into Resident #4's room for contact precautions during cares. - Review of Resident #9's medical record	F 441		

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F 441	Continued From page 21 identified the resident with a current diagnosis of chronic hepatitis (Hepatitis C). The Centers for Disease Control Internet website defines Hepatitis C as "a liver disease caused by the hepatitis C virus (HCV), which is found in the blood of persons who have this disease. HCV is spread by contact with the blood of an infected person. The spread of HCV from one person to another in healthcare settings is rare, but can occur." The following observation occurred on 02/16/10 at 4:35 p.m. with nursing staff member (#2): * The staff nurse (#2) donned gloves and completed an accucheck (blood glucose check) for Resident #9. The staff nurse removed her gloves, failed to perform hand hygiene, and exited the room to obtain a needle cap for the resident's insulin pen from the medication room. * The staff nurse (#2) returned to the room, administered insulin to Resident #9, removed her gloves, and failed to perform hand washing. * The nurse observed Resident #9 had blood smeared on her hands from the accucheck puncture. The nurse donned gloves, obtained a towel and washcloth, and dampened them at the sink, wiped off the resident's hands, placed the soiled linen or cloths into a plastic bag, returned the resident's insulin pens into a Ziploc bag on the counter top, and then removed her gloves. During the above observations, the nurse failed to perform hand washing after removal of her gloves, and contaminated Resident #9's insulin pen and storage bag by failing to perform hand washing. The nurse then returned the storage bag with the insulin pens to the medication room for future use. Multiple staff members may use these items throughout the day, as Resident #9's record identified twice daily insulin administration,	F 441		

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F 441	Continued From page 22 and sliding scale insulin coverage three times a day.	F 441		