STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355052	A. BUILDING _____ B. WING _____	02/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON COUNTY HEALTH SYSTEM CARE CENTER	108 E NYHUS AVE MCVILLE, ND 58254

(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 Medicare/Medicaid recertification survey started on 02/07/10 and completed on 02/10/10 the sampled included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review.	F 000	F 280: 1. Residents #2, #6, #8, & #9 have all had bladder assessments completed. resident #8 is not an appropriate candidate for bladder retraining or a toileting schedule and will be on a check and change schedule. The other residents have been placed on a toileting schedule. Resident #9 is being tested for a possible UTI, and residents #2, #6, #8, and #9 have had their care plans updated to reflect the current toileting schedule. Resident #2 now has an updated care plan to include the Hx of an antibiotic resistant infection. Specific precautions for VRE have been added to Resident #2's care plan. The AANC manual for MDS assessment states in Section I, 2. Diseases a.: the item should be checked "only if the infection has a relationship during the observation period to current ADL nursing monitoring or at risk of death". Unless the infection falls into one of these areas in future assessment periods, the area will not be checked on the MDS, but will remain on the resident's care plan. 2. All residents have the potential to be affected by this deficient practice. All residents will be assessed yearly and with any significant changes for incontinence. Residents who are incontinent on admission and existing residents who exhibit new incontinence or a decline in continence will have an assessment done. The MDS or QA nurse will update the care plan regarding incontinence and a toileting schedule. The QA Coordinator or DON will review incontinent assessments.	
F 280 SS=B	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedures, and staff interview, the facility failed to ensure residents' care plans were reviewed and revised to include current treatment approaches for toileting needs for 3 of 9 sampled residents (Resident #2, #6, and #8) and the	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathy Swenson	CEO	3/10/2010

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 000	INITIAL COMMENTS For the Medicare/Medicaid recertification survey started on 02/07/10 and completed on 02/10/10 the sampled included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review.	F 000	F 280: 1. Residents #2, #6, #8, & #9 have all had bladder assessments completed. resident #8 is not an appropriate candidate for bladder retraining or a toileting schedule and will be on a check and change schedule. The other residents have been placed on a toileting schedule. Resident #9 is being tested for a possible UTI, and residents #2, #6, #8, and #9 have had their care plans updated to reflect the current toileting schedule. Resident #2 now has an updated care plan to include the Hx of an antibiotic resistant infection. Specific precautions for VRE have been added to Resident #2's care plan. The AANC manual for MDS assessment states in Section I, 2. Diseases a.: the item should be checked "only if the infection has a relationship during the observation period to current ADL nursing monitoring or at risk of death". Unless the infection falls into one of these areas in future assessment periods, the area will not be checked on the MDS, but will remain on the resident's care plan. 2. All residents have the potential to be affected by this deficient practice. All residents will be assessed yearly and with any significant changes for incontinence. Residents who are incontinent on admission and existing residents who exhibit new incontinence or a decline in continence will have care planning regarding incontinence and a toileting schedule completed. The QA nurse or DON will review incontinent assessments upon completion to verify accuracy and interventions appropriate to enabling each resident to maintain or improve to their highest level of care. All residents with a diagnosis of a MDRO have	
F 280 SS=B	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedures, and staff interview, the facility failed to ensure residents' care plans were reviewed and revised to include current treatment approaches for toileting needs for 3 of 9 sampled residents (Resident #2, #6, and #8) and the	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy Swenson — TITLE: CEO — (X6) DATE: 3/10/2010

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 280	Continued From page 1 appropriate precautions for 1 of 6 sampled residents (Resident #2) diagnosed with a multi-drug resistant organism (MDRO). Failure to review and revise the care plans limited the staff's ability to communicate treatment approaches and ensure continuity of care. Findings include: Review of the facility policy titled ". . . INFECTION CONTROL POLICY AND PROCEDURE MULTIDRUG-RESISTANT ORGANISMS" occurred on 02/10/10. This policy, dated 03/2009, stated, ". . . All patients/residents identified with a MDRO will be prominently identified in their medical record and care plan. . . " - Review of Resident #2's medical record occurred on all days of survey. Medical diagnoses included a urinary tract infection (UTI) identified as vancomycin resistant Enterococci (VRE) on 04/24/09. Resident #2's most current Minimum Data Set (MDS), dated 01/29/10, identified this resident required limited assistance for toilet use, occasionally incontinent of bowel and bladder, and on a scheduled toileting plan. The MDSs, dated 10/30/09, 07/31/09, 05/07/09, and 04/30/09, all identified an antibiotic resistant infection in the past seven days. Review of Resident #2's current care plan, dated 10/27/08, stated, "Problem/Need: Res. [resident] has some bladder incont [incontinence] (nite) [night] - uses incont. pads . . . Approaches . . . 2) uses incont pads & assist [with] pericares prn [as needed] . . ." Resident #2's care plan failed to identify a scheduled toileting plan. The care plan	F 280	had their care plans updated. Residents will not have the MDRO checked on their MDS 's unless it is an active infection or falls under the guidelines for MDS completion. The admitting nurse will document on the initial care plan if a resident has a MDRO and include appropriate interventions as clinically indicated, by the admitting physicians review and subsequent orders re: same based on each resident's individual assessments. All residents considered to have an MDRO will be noted on their care plans unless significant clinical evidence indicates otherwise. Any new MDRO will be placed on the resident's care plan by the charge nurse, MDS coordinator, of ICN. 3. The DON or designee will monitor ADL documentation for evidence of increased/decreased incontinence on all residents monthly. Any resident with new episodes of 5 or more incon--tinence in the preceding month will have an incontinence assessment initiated by the DON or charge nurse. A 3 day incontinence assessment form will be initiated. The QA nurse or DON will review the 3 day incontinence form upon completion. Patterns will be identified and interventions/changes in toileting times will be made as applicable .Documentation of incontinence and a toileting schedule will be placed on the care plan by the QA nurse and/or the MDS nurse. The MDS nurse will notify the CNA staff and note on the residents ADL sheets if a toileting schedule is initiated. The QA nurse will develop a toileting schedule master list to be used by the CNA and the Nursing staff. Quarterly the care plan will be evaluated by the MDS coordinator for the presence of a toileting schedule, as applicable. The SWD and DON will review preadmission information to identify a resident's risk or actual diagnosis of a MDRO/active infection. This information will be provided to the health care	

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F 280	Continued From page 2 also failed to identify VRE and the specific precautions, such as contact precautions, for this MDRO. - Review of Resident #6's medical record occurred on all days of survey. The most current MDS, dated 11/12/09, identified Resident #6 required extensive assistance with toileting, frequent bladder incontinence, and on a scheduled toileting plan. Review of Resident #6's current care plan stated, "Problem/Need: Res. has some bladder incont (dribbles). (usually continent of bowel) . . . Approaches: . . . 4) Report increase [with] incont to C.N. [charge nurse] . . . 9) [check] frequently for urinary incont." The care plan failed to identify a scheduled toileting plan for Resident #6. - Review of Resident #8's medical record occurred on February 9-10, 2010. The most current MDS, dated 12/09/09, identified Resident #8 required total assistance by staff for toileting and all activities of daily living (ADLs), and on a scheduled toileting plan. Review of Resident #8's current care plan, dated 03/17/08, stated, "Problem/Need: Res has problems [with] stress incont. and uses incont pads. Hi [high] pot [potential] for skin breakdown due to incont . . . 8) Assist to BR [bathroom] on demand et [and] prn . . ." Resident #8's care plan failed to identify a scheduled toileting plan. During an interview on the morning of 02/09/10, a licensed staff nurse (#1) stated the certified nursing assistants (CNAs) check and change Resident #8's brief as needed and do not follow a toileting schedule.	F 280	Provider for his/her review. The HCP will identify any additional information needed to ensure we can adequately meet this residents needs and ensure the safety of the other residents on the facility. Additional contacts/consults with an ICP and referring facility may be initiated by the provider, as applicable, to verify infective status (active vs. colonized) and precautions as required. It is noted the charge nurse can implement any additional precautions if a change in status should occur and will notify the DON, provider, and ICN, as applicable. The charge nurse, DON, ICN or MDS coordinator will document on the resident's NCP. The QA nurse will monitor infections on a daily basis. Patterns and trends are assessed monthly at a minimum, or as often as needed by the QA/IC nurse. Documentation on care plans will be evaluated by the MDS nurse and IC/QA nurse on at least a quarterly basis or as often as needed to accurately reflect each resident's status and interventions related to their plan of care. Preadmission information will include if a resident has a MDRO/active infection. Communication between departments will include information all staff must be aware of related to their infection and interventions to be taken. The QA nurse will monitor on admission, with any new infections, and at least monthly the care plan documentation of residents with an MDRO. This will be an ongoing monitor. 5. Incontinence assessments for residents #2, #6, #8, #9 are complete as of 3/5/10. Toileting schedules for Residents #2, #6, and #9 were completed 03/05/10. Toileting schedules are on the resident care plans for Residents #2, #5, and #9. Resident #8 is not a candidate for a toileting schedule. She is on a "check and change" schedule. All other residents with 5 or more episodes of incontinence and who are not already on a toileting schedule will be assessed for incontinence and placed on a schedule as appropriate by March 17th. The CNA meting and inservice regarding toileting will	

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional literature, record review, and staff interview, the facility failed to provide the appropriate treatment and services to maintain or restore as much normal bladder function as possible for 1 of 5 sampled residents (Resident #9) whose Minimum Data Set (MDS) showed a decline in continence. Failure to assess Resident #9's voiding pattern, develop and implement appropriate scheduled toileting times and/or additional interventions to address the incontinence prevented the resident from maintaining the highest level of continence and placed the resident at risk for skin breakdown. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding bladder incontinence which requires a resident to receive the appropriate treatment and services to restore as much normal bladder function as possible. This involves completing an	F 315	be held on March 16th. All residents with an MDRO, had the infections noted on their care polans by Feb. 16h. CNA meeting will be March 16th and is a mandatory meeting/inservice. Nursing inservices have been scheduled re: infections and discussion re: care planning will take place on March 9th at the scheduled care conference time. First QA monitoring will be completed by March 17th. A review of the 2567 and notification /discussion with the Medical Director and Medical providers was done On Feb. 22nd.	

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F 315	Continued From page 4 assessment of factors that may predispose the resident to having urinary incontinence, implementing appropriate, individualized interventions that address the incontinence, monitoring the effectiveness of the interventions, and determining the type of urinary incontinence to allow staff to provide more individualized programming or interventions to enhance the resident's quality of life and functional status. A resident should be evaluated at admission and whenever there is a change in cognition, physical ability, or urinary tract function. Review of Resident #9's medical record occurred on 02/09/10. The record showed Resident #9 admitted in June 2009 and medical diagnoses included Alzheimer's dementia, benign prostatic hypertrophy, and advanced vision loss. The Continence Admission Questionnaire, undated, indicated bladder continence. The chart lacked any further bladder assessments. The admission MDS, dated 06/18/09, noted the resident as usually continent of bladder. The quarterly MDSs, dated 09/12/09 and 12/12/09, identified Resident #9 as occasionally incontinent of bladder. The quarterly MDS, dated 12/12/09, stated the resident had short term memory problem and decision-making impairment, and showed the resident required limited assistance of one person with toileting. The current care plan, dated 06/23/09, stated, "PROBLEM/NEED: Res. [resident] has occ [occasional] urinary incont. [incontinence] (Doesn't use pads) - so potential for skin breakdown . . . APPROACHES: 1) Assist [with] toileting prn [as needed] and pericares prn. 2) Provide privacy and don't rush. 3) Report [changes] [with] B&B [bowel and bladder] status to CN [charge nurse]. . . ."	F 315	F 315: 1. Resident #9 has had a 3 day bladder assessment and has been placed on a toileting schedule. He was tested for a UTI on 03/03/10 and it was negative. Sometimes he has more incontinence when he isn't feeling well. Resident #9 has had his care plan updated with a toileting schedule. 2. All residents have the potential to be affected by this deficient practice. All residents will be assessed yearly and with any significant changes for incontinence. Residents who are incontinent on admission and existing residents who exhibit new incontinence or a decline in continence will have an assessment done. The MDS or IC nurse will update the care plan regarding incontinence and a toileting schedule completed. The QA nurse or DON will review incontinent assessments upon completion to verify accuracy and interventions appropriate to enabling each resident to maintain or improve to their highest level of care. 3. The DON or designee will monitor ADL documentation for evidence of increased/decreased incontinence on all residents monthly. Any resident with new episodes of 5 or more incon--tinence in the preceding month will have a 3 day incontinence assessment form initiated by the DON or charge nurse. The QA nurse or DON will review the 3 day incontinence form upon completion. Patterns will be identified and interventions/changes in toileting times will be made as applicable .Documentation of incontinence and a toileting schedule will be placed on the care plan by the QA nurse and/or the MDS nurse. The MDS nurse will notify the CNA staff and note on the residents ADL sheets if a toileting schedule is initiated. The QA nurse will develop a toileting schedule master list to be used by the CNA and the Nursing staff. Quarterly the care plan will be evaluated by the MDS coord-	

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F 315	Continued From page 5 Resident #9's record lacked evidence of an assessment of the resident's bladder incontinence, including an assessment of Resident #9's voiding habits/patterns. The lack of adequate assessment failed to determine if Resident #9 could benefit from a scheduled toileting plan developed in response to his identified individual needs. Review of Resident #9's physician orders showed the resident on Hydrodiuril 12.5 milligrams daily. The use of a diuretic has the potential to increase Resident #9's bladder incontinence. Review of the certified nurse aide (CNA) charting indicated a decline in bladder continence over the past six months: September 2009 - incontinent 2 of 30 days. October 2009 - incontinent 1 of 31 days. November 2009 - incontinent 5 of 30 days. December 2009 - incontinent 15 of 31 days. January 2010 - incontinent 15 of 31 days. February 1-9, 2010 - incontinent 6 of 9 days. On 02/09/10 at 1:00 p.m., a CNA (#6) indicated she assisted Resident #9 to the bathroom before lunch and he voided. The CNA stated, [Resident #9's name] calls or comes to his door when he needs to use the bathroom and he wears a pull-up [brief], as once in awhile he has a little accident, but not often." On 02/09/10 at 1:10 p.m., observation showed a CNA (#6) asked Resident #9 if he would like to go to the bathroom now, and the resident stated he didn't have to go. The CNA reminded the resident to call when he needed to go [to the bathroom]. On 02/09/10 at 3:19 p.m., observation showed	F 315	inator for the presence of a toileting schedule, as applicable. 4. Monthly, all residents will be monitored for increase/decrease in incontinence. Any incontinence episodes of 5 or more in a month will have an incontinence assessment initiated and a toileting schedule established as needed. Monitoring of times of incontinence will be presented to the MDS nurse by the 10th of each month and monthly X 6 months for the presence of a toileting schedule on the ADL documentation sheets and the residents care plans. The QA coordinator will check monthly for the presence of a toileting schedule on the ADL documentation sheets and the residents care plans. 5. An incontinence assessment for Resident #9 was completed 3/5/10. A toileting schedule will be on the ADL documentation as of 3/5/10. The need for a toileting schedule is on the residents care plan as of 3/5/10. All other residents with 5 or more episodes of incontinence and who are not already on a toileting schedule will be assessed for incontinence and placed on a schedule, as appropriate by March 17th. All care plans will be reviewed for appropriateness of toileting schedules by March 17th. The initial QA monitors will be completed by March 17th. a CNA meeting and inservice regarding toileting and incontinence will be held on March 16th. Discussions regarding care planning and toileting schedules will take place on March 6th. QA monitoring will be done monthly for 6 months and then quarterly for six months.	

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F 315	Continued From page 6 two CNAs (#9 and #13) entered Resident #9's room, placed a gait belt around the resident's waist, assisted him up from the bed, and walked with him to the toilet. One CNA (#13) removed and discarded the resident's pull-up, and stated the pull-up was wet with urine and smear of stool. The resident voided in the toilet. The CNA (#13) stated, "He [Resident #9] is usually continent in the afternoon, but incontinent of small amount urine after supper." In an interview on 02/09/10 at 3:45 p.m., an administrative nursing staff member (#2) stated, "[Resident #9's name] hasn't been assessed for a toilet plan and probably should be." An administrative nursing staff member (#10) stated, "I haven't had a chance to do another bowel and bladder assessment on Resident #9 yet."	F 315		
F 371 SS=C	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 and staff interview, the facility failed to store, prepare, and serve food under sanitary conditions in 1 of 1 kitchen. These practices have the potential to increase the risk of food borne illness and can affect all residents who	F 371	F 371: 1. No current residents were identified to have been affected by this concern. 2. All residents have the potential to be affected. 3. New policy has been written on the cleaning of the hood above the stove. Meeting is scheduled for 03/10/10 to educate staff on the policy. 4. Dietary manager will do a sanitation audit quarterly or as often as needed with variances addressed immediately.The audit will be maintained in the dietary dept. and reported to the QA committee quarterly. 5. 03/10/10	

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F 441	Continued From page 9 and infections to, and between, residents, facility staff, and visitors. Findings include: Review of the facility policy titled "HANDWASHING" occurred on 02/09/10. This policy, dated 2003, stated, "A. PURPOSE: 1. Handwashing decreases contamination of the hands and prevents the spread of pathogens to noncontaminated areas, including medical personnel. 2. It is a safety skill that protects patients, healthcare personnel, family and visitors. . . . C. WHEN SHOULD YOUR HANDS BE WASHED? . . . 2. Before entering and leaving the patient/resident unit. 3. Before, between, and after all physical contacts with the patient. . . . D. HANDWASHING TECHNIQUE: . . . 7. Lather hands. a. This step will take 15 seconds. . . ." Review of a facility policy titled "UNIVERSAL PRECAUTIONS" occurred on 02/09/10. This policy, revised 01/2010, stated, ". . . GLOVES: . . . 3. Put on gloves prior to contact and remove after task is completed. 4. Wash hands after removing gloves. . . ." Review of a facility policy titled "ROUTINE CLEANING OF PATIENT/RESIDENT ROOMS" occurred on 02/08/10. This undated policy stated, "POLICY: All patients/residents rooms will be kept clean regardless of an infectious disease. GUIDELINES: . . . 2. Rooms of patient's/resident's with precautions in addition to Standard Precautions will be cleaned last. Dedicated mop heads will be used to clean these rooms. 3. Housekeeping personnel shall be alerted to the potential hazards and instructed as to the proper precautions and protective clothing	F 441	F441: 1. & 2:All residents have the potential to be affected by this deficient practice. As there was no listing of facility to identify specific caregivers who demonstrated this deficient practice, the IC Nurse will initially monitor the assigned caregivers of Residents #1,#2, #6, #8, and #9 for hand hygiene, glove use, utilization of specific disease related IC precautions, as applicable, and knowledge of the IC status of residents they care for, how to access any information related to the IC status of any resident, and the necessary precautions required for those residents . All nursing care staff will be required to read and implement the policies and procedures for hand hygiene, universal precautions, disease specific implementation of additional IC precaution standards, glove use, and the MDRO policy. The IC nurse or assigned designee will complete a skills test on all nursing care staff re: glove use and handwashing to verify compliance. As noted above, the initial priority staff observations will be for the care providers assigned to the residents noted above to verify initial compliance. However, skills monitoring of appropriate glove use and handwashing will be completed on all nursing staff by the IC nurse and or designee with nursing staff observed every quarter	

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F 441	Continued From page 10 to be used, if any, while performing functions within the rooms. 4. Cleaning cloths and mop heads that are contaminated with infective material or blood will be bagged in a clear bag and labeled for laundry to indicate its contents." Review of the facility policy titled "CONTACT PRECAUTIONS" occurred on 02/09/10. This policy, dated 02/2000, stated, "POLICY: Contact precautions are used in addition to standard precautions when patients/residents are infected with an organism that is transferable by contact. . . .INFECTIONS OR CONDITIONS REQUIRING CONTACT ISOLATION: . . . 14. Multi-drug Resistant Organisms 15. MRSA (methicillin resistant staph aureus) . . . 29. VRE (Vancomycin-resistant Enterococcus) . . ." Review of the facility policy titled ". . . INFECTION CONTROL POLICY AND PROCEDURE MULTIDRUG-RESISTANT ORGANISMS" occurred on 02/10/10. This policy, dated 03/2009, stated, ". . . Upon receipt of information . . . the staff and medical provider will evaluate each individual known or suspected infection and/or colonization with a MDRO for room placement and initiation of Contact Precautions on a case-by-case basis. . . . Notifications, as appropriate, will be provided to any other department/staff who provide care and/or services to the resident colonized/infected with a MDRO . . ." - An interview with a housekeeping staff member (#11) regarding the facility's infection control policies and procedures related to MDROs occurred on 02/08/10 at 1:00 p.m. This staff member stated all resident rooms are cleaned the same and gloves are always worn. She stated	F 441	to ensure all nursing staff comply with IC policies/procedures on at least an annual observation basis, or as often as needed to verify continued compliance. The IC nurse will include this task in her monthly IC/QA report, and notify the DON of any identified concerns. 3. & 4. Education of the nursing staff re: the facilities hand hygiene, glove use, MDRO universal precaution, disease specific IC precautions and identification and awareness of the infective status of any resident requiring precautions other than Standard precautions as noted in the facilities policies and procedures will be documented by their signature indicating their review and understanding of these facility policies and procedures. All employees have the opportunity to discuss any questions/concerns related to IC and facility policies/procedures at anytime with the facilities IC nurse, charge Nurse and /or DON as applicable. Completion of this educational review and documentation will reported to the DON by the IC nurse after verifying all nursing care staff have complied and included in the next monthly IC and QA report. The signature sheets will be maintained by the IC nurse. Additional IC courses have been added to the annual inservice requirements through the online education system utilized by NCHS to ensure, minimally, annual reviews and successful completion	

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F 441	Continued From page 11 she tries to clean the rooms while residents are at a meal or activity and the rooms are not cleaned in a particular manner or order. The staff member (#11) stated housekeeping staff are not informed of the residents infected with a MDRO. During an interview on 02/09/10 at 3:45 p.m., an administrative nurse (#2) stated facility staff follow universal precautions for all residents. To protect the confidentiality of the residents, names of residents infected with a MDRO are not posted in housekeeping and no precaution signs are used on the residents' doors. - Review of Resident #2's medical record occurred on all days of survey. Medical diagnoses included a urinary tract infection (UTI) identified as VRE. Resident #2's most current Minimum Data Set (MDS), dated 01/29/10, identified this resident as occasionally incontinent of bowel and bladder. The MDSs, dated 10/30/09, 07/31/09, 05/07/09, and 04/30/09, all identified an antibiotic resistant infection in the past seven days. Review of Resident #2's care plan, dated 10/27/08, failed to identify a problem of VRE or any isolation precautions. Review of Resident #2's nurses notes revealed the following: * 04/24/09 at 11:00 a.m., "Received orders from [name of hospital] Res [resident] is VRE positive in urine * 04/24/09 at 4:15 p.m., "Res returned to care center . . . urinary catheter secure with leg bag . . ." * 04/27/09 at 2:00 p.m., "Spoke with [physician name] re: retaining foley catheter, VRE precautions and next appt . . ." * 04/27/09 at 2:15 p.m., "T.C. [telephone call] to	F 441	of these inservices by all staff on all topics. Completion of these requirements is accessible to all applicable Department Managers and will be reviewed by them and included in each employees annual evaluation. Failure to complete this inservice will result in an unsatisfactory job performance with the expectations to complete and be re-evaluated within 30 days of their annual employment date. The IC nurse will provide an inservice for CC staff related specifically to MDRO's. Each DM will include a monitor in their QA report of any noncompliance and notify administration of same. A pre and post test, along with a sign in sheet will be utilized to verify completion of same by all attendees.. The DON will be informed by the IC nurse of the completion of this task and compliance by all applicable staff members. Documentation of same will be maintained by the IC nurse. MDRO IC and prevention posters will be posted in staff bathrooms, the chart room, and the staff dining room by the IC nurse. All MDRO residents will be assessed and reviewed by the medical provider to determine the appropriate level of precautions per their current status. All admission inquiries will be reviewed by the DON and SWD/LPN for any active infections. This information will be provided to the admitting provider to review and determine	

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F 441	Continued From page 12 infection control at [name of hospital] - message left . . .VRE precautions" * 04/27/09 at 3:00 p.m., [name] at [name of hospital], who states [name of hospital] has no special procedures for laundry and does not recommend any triple rinsing used for skin rash . . ." * 04/28/09 at 11:00 a.m., "late entry for 4/27/09, 3:45p. Foley catheter removed [after] incident urine" Observations of cares provided for Resident #2 showed the following: * On 02/08/10 at 10:32 a.m., a certified nursing assistant (CNA) (#4) assisted Resident #2 to the bathroom, pulled her brief down and positioned her on the toilet. As another CNA (#5) entered Resident #2's room, the CNA (#4) left the room without washing her hands. The CNA (#5) utilized a wash basin and washcloths and assisted the resident with morning cares. Observation showed the CNA used the same washcloth several times during perineal cares. * On 02/09/10 at 9:50 a.m., a CNA (#6) applied gloves and assisted Resident #2 with perineal cares. After completion, the CNA removed her gloves and assisted the resident with her brief and pants. The CNA walked Resident #2 to the recliner and assisted the resident with her glasses. The CNA (#6) washed her hands with soap and water for an insufficient amount of time and left the room. The CNA failed to wash her hands according to facility policy after perineal cares and before she touched other items in the room. * On 02/09/10 at 12:30 p.m., a CNA (#6) applied	F 441	if the potential resident's cares can be provided by our facility in a safe environment. The medical provider will document monthly in the physicians progress notes the need to continue additional precautions and/or any change in precautions to be utilized for all residents currently assigned any IC precaution level other than Standard Precautions. The MDS nurse or DON assigned designee will be responsible for providing the Medical Provider with a listing of residents monthly during rounds to review complete this documentation. The IC nurse will monitor monthly or as often as needed to verify compliance and include on her IC/QA report. any variations will be reported by the IC nurse to the DON. A MDRO nursing assessment form will be developed by the IC nurse to be used by the admitting nurse for any resident that is newly diagnosed or is a new facility admission with an MDRO. The MDRO nursing assessment form will be reviewed & approved by the DON & Medical Director prior to implementation. Once again, completion of this assessment will be done monthly by the IC nurse, with notification to the DON of any identified concerns. This monitor will be included on the IC nurses monthly IC/QA report. Notification of other service departments is included as one of the steps in the assessment process. The medical provider will be notified of any change in resident status, as required,	

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F 441	Continued From page 13 gloves and assisted Resident #2 with perineal cares. After completion, the CNA removed her gloves, assisted the resident to the bed, removed the resident's glasses and shoes, adjusted the pillow and blanket, and closed the shades. The CNA (#6) washed her hands with soap and water for an insufficient amount of time and left the room. The CNA failed to wash her hands according to facility policy after perineal cares and before she touched other items in the room. - Observations of cares provided for Resident #6 revealed the following: * On 02/08/10 at 4:35 p.m., a CNA (#7) applied gloves and assisted Resident #6 with perineal cares. After completion, the CNA removed her gloves and washed her hands with soap and water for an insufficient amount of time, not as stated in the facility policy. * On 02/09/10 at 8:35 a.m., a CNA (#6) applied gloves and assisted Resident #6 with perineal cares. When finished, the CNA removed her gloves, used a hand sanitizer, and left the room. The CNA failed to wash her hands with soap and water after performing perineal cares. - Review of Resident #8's medical record occurred on 02/09/10. Medical diagnoses included MRSA. A urine culture report, dated 11/21/09, identified MDROs. The most current MDS, dated 12/09/09, identified Resident #8 required total assistance by facility staff for all activities of daily living (ADLs) and had an antibiotic resistant infection in the past seven days. The MDSs dated 09/09/09 and 06/10/09 also identified an antibiotic resistant infection in the past seven days.	F 441	and will include documentation regarding IC and precautions to be taken based on their individual assessment. The Medical Provider may consult with the transferring facilities IC Practitioner to acquire additional information and/or arrive at the diagnosis and determination of an active/colonized/appropriate precautions, as well as interventions required, such as cultures, etc. to enable standard based medical treatments as applicable. A doorknob hanger/ sign will be implemented with a laboratory diagnosis and physician orders for implementing additional IC precautions to notify family and visitors, as well as remind staff of this residents status. Upon admission and the initial care conference for new residents, the resident and family members will be educated re: any additional precautions that will be initiated for their family member, and the need for their adherence to the same precautions, as applicable when visiting. Visitors will be instructed on the correct procedures and use of PPE, as applicable. All residents with an applicable MDRO will have contact isolation supplies available in their rooms or location as required to protect any spread/cross contamination of active infections in the facility. Daily information related to current infections and specific isolation precautions other than Standard Precautions which are to be implemented by all applicable facility staff will be initiated by written communication from the night nurse of the applicable resident and include any additional required isolation practices, as assessed,	

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F 441	Continued From page 14 Review of Resident #8's current care plan, dated 03/17/08, stated, "Problem/Need: . . . 06/24/08 MRSA - urine . . . Approaches: 7). . . use universal precautions-MRSA . . ." Resident #8's care plan identified universal precautions, not contact precautions, and failed to identify the most current infection date of 11/21/09 or location of the MRSA. The care plan failed to identify any past dates of contact isolation for Resident #8. A document regarding infection control precautions, dated 03/15/09, stated, "The following residents have a MDRO diagnosis. As Medical Director, it is my clinical judgement the following precautions should be implemented for their care at [name of facility] . . . [name of Resident #8]: Standard precautions . . ." The medical record contained no documentation from the physician regarding Resident #8's diagnosis of MRSA on 11/21/09. Observations of cares provided for Resident #8 revealed the following: * On 02/09/10 at 1:45 p.m., two CNAs (#5 and #8) applied gloves and performed perineal cares for Resident #8. Observation showed the resident's brief soiled with feces. After completion, the CNAs removed their gloves. The CNA (#8) covered the resident with a blanket, utilized the bed control and raised the head of the bed, adjusted the bedside table, and opened the closet door and returned the perineal wipes. The CNA's (#5 and #8) washed their hands with soap and water for an insufficient amount of time and left the room. The CNA (#8) failed to wash her hands as stated in facility policy after performing perineal cares and before touching items in the	F 441	documented, and ordered by the medical provider. Daily notification will be monitored by the IC nurse X 1month to verify compliance and continued on a random quarterly basis, or as often as needed, to verify compliance. The IC nurse will report any concerns identified to the DON, and will include this information in the monthly IC/QA report when monitors are completed. It should be noted any staff nurse can implement any increased level IC PPE/precaution at any time without a physicians order to ensure safe practices. If this is implemented by nursing staff, notification of the medical provider is required, as for any other change in status. This communication form will be placed in each departmental mailbox located in the business office. It will be the responsibility of each department manager or their designee to pick this information up and provide it to their staff, while maintaining HIPAA compliance and confidentiality standards. CDC standards will be followed for IC control precautions except where federal regulations are different and require other actions not included in the CDC standards. Notifications of any changes in standards, CDC guidelines, and Federal or State regulatory requirements requiring changes will be the responsibility of the DON and/or assigned to the IC nurse for completion in an appropriate timeframe. On at least an annual basis, or as often as needed, the IC nurse will complete an annual review of the IC policies and procedures and QA program and document/report on her monthly IC/QA report	

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F 441	Continued From page 15 room. * On 02/09/10 at 4:15 p.m., two CNAs (#9 and #12) applied gloves and performed perineal cares for Resident #8. Observation showed the resident's brief soiled with feces. After completion, the CNAs removed their gloves, pulled up the resident's pants, and utilized a hoyer lift (a full body mechanical lift) and transferred her from the bed to the wheelchair. One CNA (#12) combed the resident's hair, while the other CNA (#9) straightened the bed. The CNA (#12) placed the comb back in the drawer and moved the hoyer lift to the hall. Both CNAs washed their hands with soap and water and left the room. The CNAs (#9 and #12) failed to wash their hands after performing perineal cares and before touching items in the room. - Review of Resident #7's record occurred on all days of survey. Medical diagnoses included VRE. The MDSs, dated 02/03/10, 11/04/09, and 04/27/09 indicated no current infections Review of Resident #7's current care plan, dated 10/27/08, stated, "Res [resident] has hx [history] of VRE exposure (husband). Goal: Res will not spread VRE in facility. . . . 6) Initiate contact precautions as appropriate." Care plan, dated 05/05/08, stated, "Res has hx of VRE. Goal: Res will not spread VRE in facility. Approaches: wear gloves, wash hands properly, disinfect supplies PRN [as needed]." Observation of Resident #7's room occurred at 1:10 p.m. on 02/09/10. The room did not contain signage indicating any precautions for staff or visitors.	F 44	upon completion. Any changes to any policies and procedures/practices will be reviewed by the DON or applicable Department Manager. Upon their approval, the DON or as assigned to the IC nurse, will be responsible for informing Medical Staff of the changes/proposed implementation for approval. Upon their approval, the policy/procedure will be provided to Administration for BOD review and approval. The Administrator will be responsible for notifying the DON/IC nurse of the BOD's action: 5.Initial compliance will be completed 03/17/2009. F441: Housekeeping 1.& 2. All residents have the potential to be affected by this deficient practice. No residents were identified related to this area of the deficiency. 3.All housekeeping staff were inserviced on cleaning residents rooms who have an active/potential infection/MDRO and proper use of PPE – putting it on, taking it off – including gloving and hand-washing was demonstrated with return demonstrations by all staff. Daily communication forms and their location will be sent to housekeeping re: any changes in resident status – including infections. Housekeeping staff were in-formed where these would be located & the importance of maintaining HIPAA compliance and confidentiality has NOT changed. This information was added to the new employee orientation check list for housekeeping and the departments	

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F 441	Continued From page 16 Resident #7's medical record failed to identify the resident's current MDRO status and identify past dates for contact isolation. - On 02/08/10 at 9:02 a.m., observation showed Resident #1 wiped herself after voiding in the toilet. A CNA (#5) assisted the resident to stand and pull her pants up, then ambulated with her to the wheelchair. The CNA gave Resident #1 a personal hygiene cloth to wipe her hands and left the room. The CNA (#5) failed to perform hand hygiene after assisting Resident #1 and before leaving the room to assist another resident across the hall. - On 02/09/10 at 3:19 p.m., observation showed Resident #9 on the toilet. A CNA (#13) removed the resident's pull-up (incontinent brief) and pants, then washed her hands with soap and water. The CNA (#13) indicated the pull-up was wet with urine and a smear of stool. The CNA placed a pull-up and pants on Resident #9. A second CNA (#9) assisted Resident #9 with pericares, and the first CNA (#13) left the room, but failed to perform hand hygiene before leaving. - Review of Resident #3's medical record occurred on February 7-9, 2010. Diagnoses included progressive dementia and history of UTI. The care plan, dated 09/15/09, stated, "PROBLEM/NEED: . . . Continent of B&B [bowel and bladder]. Assist of 1 or 2. 11/25/09 Foley cath [catheter]." After this date, the facility deleted the Foley cath from the care plan and added, "Continent of bladder. (Hx [history] of UTI). Hx: VRE - urine. . . . Use incont [incontinence] pads in case of accident. APPROACHES: . . . 11/25: . . . 11) Universal precautions (VRE)."	F 441	policy manual. 4. The DM of housekeeping will monitor skills for all cleaning areas and staff at least yearly, or as often as needed, to verify compliance. Any concerns will be immediately addressed. All monitors and concerns will be noted and reported to Adminstration and included in the departments QA report. 5. Completion: 03/10/2010	

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F 441	Continued From page 17 Review of a urine culture report, dated 11/16/09, showed, "Enterococcus faecium Vancomycin Resistant." Review of a urine culture report, dated 12/19/09, showed, "Pseudomonas aeruginosa and Enterococcus faecium Vancomycin Resistant." Urinalysis reports, dated 12/28/09 and 01/12/10, of Resident #3's urine, showed positive for UTI. The physician treated the resident with antibiotics on all four occasions: 11/16/09, 12/19/09, 12/28/09, and 01/12/10. An active infection with VRE requires the use of contact precautions. Review of Resident #3's record and care plan failed to show the use of contact precautions with the urine culture identifying VRE on 11/16/09 and 12/19/09. The record also failed to show assessment for isolation precautions with the subsequent UTIs. During an interview on the afternoon of 02/09/10, an administrative nursing staff member (#2) stated, "There is PPE [personal protective equipment] in Resident #3's room for staff to use if they think there will be a splash or soiling. . . . We're just using universal precautions for MRSA/VRE, and staff wear a gown, gloves, or goggles if they think there is going to be a splash, such as urine." During an interview on 02/10/10 at 7:50 a.m., a licensed nursing staff member (#15) stated, "We only use PPE on residents with active infections, not once they are colonized. No resident currently has an active infection." This staff member indicated a plastic container containing PPE is kept in Resident #3's closet if needed. Observation showed a plastic tub labeled "PPE" on the top shelf of Resident #3's closet contained several gowns, masks, and red bags.	F 441		

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