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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING ______ B. WING ______	08/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE CENTER	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 520	Continued From page 183 Monday August 2, 2010. A face-to-face interview was conducted with Employee #7 on August 3, 2010 at approximately 2:00 PM after reviewing Resident #10 ' s left AV site he/she acknowledged that the tape should have been removed. The observation was made on August 3, 2010. 5. Resident #13 ' s clinical record revealed facility staff failed to administer pain medication and perform weekly blood pressure assessments per physician ' s orders. According to the history and physical examination dated Sept 19, 2009, Resident #13 ' s diagnoses included hypertensive cardiovascular disease, diabetes mellitus, atherosclerotic cardiovascular disease, congestive heart failure emphysema and chronic obstructive pulmonary disorder. The resident ' s medication regimen included Lisinopril 20mg daily for hypertension. a.) Physician ' s orders dated July 2, 2010 [originated March 22, 2006] directed, " [assess] blood pressure every Tuesday. " A review of the Medication Administration Records [MAR] for June and July 2010 lacked evidence of blood pressure assessments. b.) Physician ' s orders dated July 2, 2010 [originated September 22, 2009] directed " Bengay Ultra regular strength 5% patch, apply one patch to skin of right shoulder every morning at 9AM and remove at 9PM for pain. " A review of the Medication Administration Record [MAR] for July 2010 revealed the resident ' s pain	F 520	Continued From page 183 1. Resident #13, we are unable to correct the cited deficiency for pain medication. Staff was remediated at the time of the survey. 2. Review of residents with scheduled pain medication and those receiving scheduled pain medication prior to wound care has been completed. 3. An in-service for staff has been completed by the educator on pain management. 4. An audit of this process will be conducted monthly by the Director of Nursing/designee. The results of the above audit will be reported to the CQI committee monthly for three months, then quarterly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and the frequency of further audits.	8/4/10 10/19/10 10/19/10 10/28/10

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medication, Bengay was not administered July 1st thru 4th, 6th and 7th. The record lacked evidence of a reason why the medication was omitted.

The findings were reviewed and confirmed during a face-to-face interview with Employee #7 on August 4, 2010 at approximately 12:30 PM. The record was reviewed August 4, 2010.

6. Facility staff failed to administer oxygen continuously to Resident #16 according to physician ' s order, subsequently resident was transferred to hospital with respiratory distress.

According to the physician ' s admitting evaluation history dated April 28, 2010, revealed chief complaint of shortness of breath. Diagnosis: hypertension, chronic obstructive pulmonary disease, atrial fibrillation, coronary artery disease, and cardiomyopathy.

According to resident ' s clinical record, resident was admitted on April 27, 2010 to the facility. Resident was admitted to [hospital] on April 28, 2010 with chief complaint of worsening shortness of breath and lethargy/altered mental status. Resident was discharged back to skilled nursing facility on May 11, 2010. On May 15, 2010, resident was admitted with chief complaint of shortness of breath, cough and chest tightness and discharged back to the facility on May 26, 2010.

Physician ' s order sheet and plan of care signed and dated April 27, 2010, directed [Oxygen at 2 liters via [nasal cannula] continuous for shortness of breath.

Physician ' s order sheet and plan of care signed

Provider's Plan of Correction:

1. **Resident #16** was transferred to hospital at the time of survey. Staff was remediated at the time of survey. — 8/3/10

2. An audit has been completed on residents receiving oxygen therapy by the unit managers. Corrective actions have been implemented as needed. — 10/19/10

3. Staff education has been completed on respiratory assessment and the use of oxygen by the educator. — 10/19/10

4. A monthly audit of respiratory care and services will be completed by the unit manager/ designee monthly for three months then quarterly and a report provided to the DON. The results of the above audit will be reported to the CQI committee monthly for three months then quarterly by the DON/ designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need for frequency of further audits. — 10/28/10

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F 520	Continued From page 185 May 26, 2010, directed oxygen- 2 liters via nasal cannula every shift for shortness of breath. According to the admission Minimum data Sets [MDS] dated June 8, 2010, Section I, Disease Diagnoses included Arteriosclerotic Heart Disease, Congestive Heart Failure, Hypertension, Peripheral Vascular Disease, and Emphysema/Chronic Obstructive Lung Disease. Section P revealed the resident required oxygen therapy. According to the oxygen nursing care plan initiated April 26, 2010 and updated June 9, 2010 revealed, " resident oxygen dependent 2L [oxygen] via nasal cannula with humidity. Saturation 95% on oxygen. Continue plan of care. " Physician ' s orders signed July 2, 2010 prescribed [Oxygen} at 2L/min via nasal cannula every shift. Resident observed on August 3, 2010 in the dayroom at approximately 1:20 PM sitting in wheelchair next to the window. Resident was not wearing his/her oxygen. A face-to-face interview was conducted with Employee #5 regarding resident ' s mental status. He/she stated, " he/she is alert and oriented times three, however, he/she can get confused when he/she is not on his oxygen, he can get hypoxic. " Informed Employee #5 he/she was not wearing oxygen. Employee #5 proceeded to dayroom and assisted resident back to his/her room to obtain a pulse ox. Resident ' s oxygen concentrator was in the dayroom by the door to the left. Oxygen concentrator was taken to resident ' s room. Employee #5 was unable to obtain a pulse	F 520		

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F 520	Continued From page 186 oximetry times two when placed on index finger of both hands. Oxygen was initiated. Employee #5 obtained a reading of 70% to 78% when placed on the left great toe. Oxygen titrated from 2-4L by Employee #5. Resident ' s vital signs were: Temperature 98.2, Pulse 63, Respirations 28, and Blood Pressure130/70. Resident was transferred to the hospital at approximately 5:15 PM. Vital signs at the time of transport were, Blood Pressure 130/70-130/78, Pulse 63, Respirations 18, Pulse Ox-99% on 12 liters oxygen via rebreathing mask. Facility staff failed to administer oxygen continuously to ensure the resident ' s oxygen saturation was maintained according to physician ' s order; subsequently resident was transferred to hospital with respiratory distress. The record was reviewed August 3, 2010. 7. Resident #18 ' s clinical record revealed facility staff failed to consistently assess the resident ' s blood pressure prior to the administration of an antihypertensive medication and failed to administer pre-treatment pain medication prior to performing wound care. According to the history and physical examination dated October 8, 2009, Resident #18 ' s diagnoses included psychotic disorder, diabetes mellitus, heart failure, atherosclerotic cardiovascular disease, schizophrenia and sepsis. a.) Physician ' s orders dated July 2, 2010 [originated October 5, 2009] directed, " Atenolol 25mg by mouth every day for hypertension, hold if systolic blood pressure is less than 110. "	F 520	#7 1. **Resident #18's** Blood pressures are being monitored as ordered. 2. All residents have the potential to be affected by this practice. Residents receiving hypertension medications had a review of their MAR. 3. The systematic change/measures taken to correct this practice entails: staff education on the importance of documentation on the MAR/TAR and revised shift report, which includes the review of MARs/TARs. 4. Unit Managers will complete audits monthly and a report will be provided to the DON. The results of this audit will be reported to the CQI committee monthly for three months then	10/19/10 10/19/10 10/19/10 10/28/10

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	A review of the Medication Administration Records [MAR] for May and June, 2010 revealed the resident ' s blood pressure was inconsistently assessed. Parameters of administration [hold for systolic less than 110] were not followed in the absence of blood pressure assessments.		**Ftag 309 7a – Resident#18**	
			1. Resident #18, we are unable to correct the cited deficiency for pain medication. Staff was remediated at the time of the survey.	8/6/10
	b.) Physician ' s orders dated July 2, 2010 [originated October 5, 2009] directed " Tylenol 650 mg by mouth every day 30 minutes before dressing change. "		2. Review of residents with scheduled pain medication and those receiving scheduled pain medication prior to wound care has been completed.	10/19/10
	A review of the Medication Administration Record [MAR] for May and June, 2010 revealed Resident #18 ' s pre-treatment pain medication, was inconsistently administered in synchronization with wound care. The record lacked evidence of reasons why the medication was omitted.		3. An in-service for staff has been completed by the educator on pain management.	10/19/10
	The findings were reviewed and confirmed during a face-to-face interview with Employee #5 on August 6, 2010 at approximately 4:30 PM. The record was reviewed August 6, 2010.		4. An audit of this process will be conducted monthly by the Director of Nursing/designee. The results of the above audit will be reported to the CQI committee monthly for three months, then quarterly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need for frequency of further audits.	10/28/10
	8. Facility staff failed to follow up on a dental consult as per the physicians order for Resident #25.		#8 1. **Resident #25** no longer resides in the facility.	10/19/10
	The Interim Order Form dated July 22, 2010 directed, "Dental Consult for cleaning teeth ."		2. An audit of appointments and follow-up has been conducted by the unit secretaries.. Corrective actions and physician notifications have been completed as needed for the past 30 days..	10/19/10
	A review of the current clinical was conducted and there was no evidence that Resident #25 was seen by a dentist during his/her stay at the facility.			
	A face-to-face interview was conducted with Employee #5 at approximately August 9, 2010 at		3. Staff education has been completed by the DON regarding the process for appointment scheduling and follow-up. The unit secretaries will complete weekly audits of appointments and provide a report to the DON.	10/19/10

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F 520	Continued From page 188 approximately 4:17 PM. He/she acknowledged that the dental consult was not done as ordered/directed by the physician. The record was reviewed on August 9, 2010. 9. Facility staff failed to fully assess Resident #CBL3 after sustaining an injury to the eye. According to the history and physical examination dated May 29, 2010, the resident ' s diagnoses included schizophrenia, anemia, peripheral vascular disease and frostbite with bilateral lower extremity amputations. A review of the clinical record for Resident #CBL3 revealed the resident sustained an injury to the left eye on August 1, 2010. According to documentation accompanied with the incident report dated August 1, 2010, " [employee name] had a cigarette and some of the ashes got in [his/her] left eye, assessment done, no sign of injury, [he/she] denies pain but says irritation to left eye gone at this time, left eye clear no redness ... " Resident #CBL3 was observed on August 6, 2010 at approximately 5:30 PM with medical tape adhered to the left eyelid rendering it shut. The observation was made in the presence of Employee #5, who stated the resident applied the tape to his/her eye. The resident stated " my eye is irritated and my vision is blurred since [employee named] hit me in the eye with ashes from a cigarette. " A review of the clinical record on August 6, 2010, lacked evidence of an assessment of the resident ' s eye subsequent to August 1, 2010. Facility staff acknowledged observing the resident with	F 520	4. The results of the above audit will be reported to the CQI committee monthly by the DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for further interventions and need and frequency of further audits	10/28/10
			#9	
			1. **CBL #3** was examined by an Opthalmologist on 8/12/10.	8/12/10
			2. A review of the Incident Report for the past 7 days has been completed to assure residents have follow-up documentation on the record Incident Reports. An audit has been completed on assessments post injury.	10/19/10
			3. Staff education has been completed by the educator on generalized assessment and documentation of post injury.	10/19/10
			4. The results of the above audit will be reported to the CQI committee monthly by the DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for further interventions and need and frequency of further audits. A random audit of Incident Reports will be completed monthly by the Medical Records Coordinator to assure that flu documentation is present and problems identified will be reported to the DON	10/28/10

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F 520	Continued From page 189 tape applied to the left eye subsequent to the incident. He/she verbalized irritation and blurred vision of the affected eye. A subsequent interview was held with the resident on August 9, 2010 at approximately 2:30 PM. He/she stated the left eye had continued irritation and that visually, he/she couldn't ' t see as well as before the incident. " They [facility staff] told me to keep the tape off of my eye, I put it there because it made it feel better, they are going to let me see an eye doctor. " Facility staff failed to fully assess Resident #CBL3 after sustaining and injury to the eye. The resident applied tape to his/her eye subsequent to the incident and complained of eye irritation and blurred vision. There was no evidence that the medical team evaluated the resident ' s eye. A face-to-face interview was conducted with Employee #5 on August 10, 2010 at approximately 4:00 PM. S/he stated that the physician ordered an ophthalmology consultation on August 8, 2010 and the appointment was pending. The record was reviewed August 6, 2010. 10. Facility staff failed to assess a sudden change in one (1) resident's respiratory condition Resident #CBL8. On August 3, 2010 during med pass the CNA reported to nurse that resident was in distress. The nurse immediately went to the medication cart and checks the resident medication in Medication Administration Record. He/she poured resident morning medication, he/she knocked the resident room door, on entering the room he/she put on a mask and a	F 520	**#10** 1. **CBL #8** was transferred to hospital at the time of survey. Staff was remediated at the time of survey. 2. An audit has been completed on residents receiving oxygen therapy by the unit managers. Corrective measures have been implemented as needed. 3. Staff education has been completed on respiratory assessment and the use of oxygen by the educator. 4. A monthly audit of respiratory care and services and documentation will be completed by the unit manager and submitted to the DON/designee. The results of the above audit will be reported to the CQI committee for three months and then quarterly by the DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for further interventions and need and frequency of further audits	8/3/10 10/19/10 10/19/10 10/28/10

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pair of gloves per isolation policy.
The nurse offered the resident his/her morning medication and water to drink.
The resident refused his/her medication but did take his/her bronchodilator puff.
Nurse continue to encourage resident to take him/her medication when resident stated he/she will try that ' s when resident reached in to the medication cup picked up two (2) small pills one brown and the other white place in his/her mouth and followed it with drinking more water.
Resident was able to verbalize refusal of the rest of medication. Resident was observed to be short of breath and very fatigued as he/she communicated his/her needs to the nurse. The nurse pulled resident up in bed elevate his/her head and voiced while leaving room that he/she will try later to offer resident his/her medication.
A review of MAR on August 3, 2010 revealed that resident morning medication was as followed:
Ascorbic Acid 500mg twice a day for wound healing
Aspirin chewable 81mg everyday for prophylaxis
Calcium Carbonate 648mg tablet twice daily for supplement
Digoxin 250mcg tablet every day for Congestive heart failure
Diltiazem HCL 120mg every day for Chronic Hypertension Disease
Furosemide 20mg tablet every day for diuretic
Isosorbide Monoonitrate 30mg every day for Cardiovascular Disease
Prednisone 20mg tablet twice daily for prophylaxis
Ranitidine HCL 300mg tablet every day for Gastroenteritis Reflux Disease
Singular 10mg tablet every day for COPD
Tab-A-Vite multivitamin tablet every day for supplement

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F 520	Continued From page 191 Vitamin B-1 100mg On August 3, 2010 at 10:15AM another visit to resident room, the resident was observed to be in respiratory distress and the nurse was observed at the medication cart signing off medication. Review of resident clinical records revealed the following: Physician order sheet and plan of care dated July 26, 2010 reads Oxygen with 3 liters continuing every shift via Nasal cannula. Telephone order dated July 27, 2010 at 10:15AM reads Maintain pulse OX above 90 if less than 90 increase oxygen to 4 liters per nasal canula. On August 3, 2010 at 10:20AM an interview immediately with employee # 16 revealed that the only intervention offered to resident was the medications he/she refused at 9:30AM. An immediate interview with Employee #2 and Employee #6 revealed that they were not notified that the Resident ' s was experiencing a change in his/her respiratory status, resident pulse Ox was 88 when taken by Employee #2. A face-to-face interview was conducted post incident with Employee #2 and Employee #3 on August 3, 2010, 10:50AM. He/she acknowledged that an assessment and description of the resident's condition and interventions should have been done. There was no explanation as to why the staff failed to assess the resident. The record was reviewed August 3, 2010. 12. The facility staff failed to have medication available for Resident CBL10 for three (3) days. A review of medication administration record was conducted on August 6, 2010 at 10:00AM revealed that the missed medication dosage was as follows: Baclofen 10mg tab give one (1) tab by mouth three (3) times daily for spasms, was missed six (6) times during the month of July 2010	F 520	**#12** 1. **CBL #8** was transferred to hospital at the time of survey. Staff was remediated at the time of survey.	8/3/10
			2. An audit has been completed on residents receiving oxygen therapy by the unit managers. Corrective measures have been implemented as needed.	10/19/10
			3. Staff education has been completed on respiratory assessment and the use of oxygen by the educator.	10/19/10
			4. A monthly audit of respiratory care and services and documentation will be completed by the unit manager and submitted to the DON/designee. The results of the above audit will be reported to the CQI committee for three months and then quarterly by the DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for further interventions and need and frequency of further audits	10/28/10

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F 520	Continued From page 192 Lyrica 200mg capsule give one (1) capsule by mouth three (3) times daily neuropathic pain, was missed eight(8) times during the month of April 2010 Tramadol 50mg tablet give one (1) Tablet by mouth three (3) times daily for pain, was missed 11 times during the month of July 2010 An interview was conducted with resident CBL10 on August 6, 2010 at 10:15AM and he revealed that because he/she missed those dosages of medication he/she suffered from a burning pain in his/her right arm, diarrhea, no feelings in his/her finger tips and depression. " I now take cymbalta for my depression; I do not want to go through the pain I felt when I missed those medications because the pain was so bad I could not eat. A face-to-face interviewed was conducted with Employee #7 on August 6, 2010 at 10:30AM. He/she acknowledge that the medication was ordered and pharmacy called each of the three days the resident was without medication. The record was review August 6, 2010. 13. The facility staff failed to clarify order for type of isolation for Resident #CBL 14. Physician Order Sheet and Plan of Care dated and signed July 7, 2010 directed, " Contact Isolation for MRSA [methicillin resistant staphylococcus aureus] in sputum. " According to the July 2010 MAR [Medication Administration Record]; MRSA of sputum was included as one of the diagnoses. The clinical record lacked documented evidence that the resident had MRSA of the sputum A Nurse Practitioner progress note dated April 28, 2010 revealed, " [positive] MRSA [methicillin	F 520	#13 1. **CBL #14** was seen by the physician and the isolation order was clarified on 8/23/10. 2. Review of residents requiring isolation has been conducted by the ADON. Corrective actions implemented and physician notified as needed. 3. The ADON has completed staff education on isolation implementation and discontinuation. A review of the facility policy on Isolation has been completed and corrections made as needed 4. An audit of residents on isolation will be completed monthly and a report provided to the DON. The results of the above audit will be reported to the CQI committee monthly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	08/23/10 10/19/10 10/19/10 10/28/10

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F 520	Continued From page 193 resistant staphylococcus aureus] of left big toe wound. Plan: Contact isolation for [positive] MRSA wound. Nurses note dated June 1, 2010 revealed, " Continue on isolation for MRSA to great toe. " According to the MDS [Minimum Data Set] completed June 4, 2010, resident was coded under Section I (12a Infections) as Antibiotic resistant infection and Section M (6b) infection of the foot. A face-to-face interview was conducted with Employees #4 and Employee #5 on August 10, 2010 at 12:45 PM. Both acknowledged that the resident " was on contact isolation for MRSA of the right big toe. " Facility staff failed to clarify Physician's order for type of isolation. The record was reviewed on August 10, 2010. 3. The Quality Assurance Committee failed to control and prevent infections within the facility. Cross reference CFR 483.65, Infection Control F441. A. Based on observations, record reviews, staff and residents interviews for three (3) of 26 sampled residents and three (3) Supplemental residents, two (2) observations it was determined that facility staff failed to: provide an infection control program that identified control and prevention procedures to prevent the spread of infections, failed to develop and implement an effective TB Infection Control Program to prevent	F 520		

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	095015	A. BUILDING ____ B. WING ____	08/11/2010

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F 520	Continued From page 194 the spread communicable disease, wash hands between residents' care, wash after disposing of red bag, post isolation signage, handle soiled linen appropriately and maintain clean technique during wound treatments. Residents # 5, 6, 12, 19, CBL5, CBL8, CBL13 and CBL14. The findings include: 1. The facility's "Infection Control Policy", Policy and Procedure No. 1018; Revised August 3, 2007 stipulated, " Purpose: The primary purpose of infection control monitoring procedure is to establish guidelines to follow in reporting nosocomial infections and communicable diseases in the facility." Included in the "Infection Control Policy" on pages 1 and 2 were specific directions on reporting an infection to the infection control practitioner, documenting action taken in the resident's record and monthly reporting of information contained in the "Infection Control Workbook." On page 2, "Tabulation of the Facility's Nosocomial Rate" discussed the tabulation and calculation of the nosocomial rate of infections in the facility. On page 3, "Resident Infection Surveillance and Monitoring" discussed analysis and trends of nosocomial rates greater than 5% and the reporting of communicable disease breakouts. Although the facility investigated causes of infections and the treatment of residents, there was no evidence that the facility had developed policies that addressed the control or prevention of infections throughout the facility.	F 520	**#1.** 1. Infection Control Plan has been reviewed and revised to reflect CDC Standards for Long Term Care. 2. No resident was identified. The current data collected has been used to initiate interventions and to prevent the spread of infection. 3. The infection control policy and program has been reviewed, re-evaluated, and revised. Policies have been developed that address the control and prevention of infection throughout the facility. The review of the program has been completed and signed off by the medical director. The current program will be used to identify, prevent, and control the spread of infection throughout the facility. Staff has received education on policies. 4. Data collected will be analyzed and corrections have been implemented into staff practices presented to the CQI committee monthly by the ADON/IC Coordinator. The CQI committee will determine the need for other interventions and need and frequency of further audits. Report results to scheduled Board meetings.	10/19/10 10/19/10 10/19/10 10/28/10

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F 520	Continued From page 195 Data was collected by the facility on a monthly basis regarding nosocomial and community acquired infections and was reviewed to include January through July 2010. There was no evidence at the time of this review that facility staff utilized the collected data to initiate interventions for control and prevention of infections. There was no evidence that on-going in-services regarding infection disease prevention had been conducted. A face-to-face interview was conducted with Employee #3 on August 4, 2010 at 11:30 AM. At this time the Infection Control Program was reviewed and he/she acknowledged the program did not utilize the collected data to develop a control or prevention component.	F 520		
			#2	
	2. Facility staff failed to minimize exposure to a potential source of infection for Resident #5 during a wound treatment.		1. Staff was re-educated at the time of survey on proper technique dressing/ wound treatment.	10/19/10
	A wound care treatment observation was conducted on August 3, 2010 at approximately 11:10 AM with Resident #5 who had bilateral lower extremity venous stasis ulcers. Employee #16 failed to minimize exposure to a potential source of infection as evidenced by failing to ensure that saline soaked gauze remained free of potential contaminants and failed to create a barrier between the wound site and bed linens.		2. All residents have the potential to be affected by this practice. Wound competency has been completed on the licensed staff by the educator. Remediation has been made as needed. Infection control in the environment has also been addressed by the Infection Control Coordinator. Handwashing observations have been completed by educator and unit managers	10/19/10

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F 520	Continued From page 196 The resident ' s bedside table was used as the treatment work surface area. Employee #16 placed disposable washcloths atop the bedside table prior to the treatment observation. The employee opened packages containing sterile 4X4 gauze sponges and dropped them onto the covered bedside table. The employee saturated the gauze sponges with normal saline. The saline soaked sponges penetrated through the washcloths atop the table and made contact with the table surface. The employee proceeded with the wound treatment and utilized the saline sponges to cleanse the wound sites. The resident ' s legs rested atop the bed linens and there was no barrier placed between the resident ' s legs and the bed linens. The cleansing of the wounds, in the absence of a barrier, afforded an opportunity for the saline solution to drain onto the bed linen. Employee #16 failed to ensure the integrity of the gauze sponges; as they were exposed to potential contaminants atop the bedside table. Additionally, a barrier was not placed between the wound site and the bed linen, potentially exposing the wounds and/or linens to potential contaminants. A face-to-face interview was conducted with Employee #16 subsequent to the wound observation. He/she stated that the washcloths utilized to line the work surface area were disposable cloths stored on linen carts. A face-to-face interview with Employee #6 on August 6, at approximately 2:00 PM revealed that it was customary to utilize a barrier beneath the wound site during treatment.	F 520	3 Wound education, staging, isolation techniques, clean dressing technique Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the Director of Nursing. Environmental rounds will be completed bi-weekly by the infection control coordinator and the environmental team. Dining and meal service education has been completed by the dining services director. Meal pass observations will be conducted by the Infection Control Coordinator monthly. 4. The results of the above audit will be reported to the CQI committee monthly by the DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for further interventions and need and frequency of further audits. A random audit of Incident Reports will be completed monthly by the Medical Records Coordinator to assure that flu documentation is present and problems identified will be reported to the DON	10/19/10 10/28/10

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F 520	Continued From page 197 3. Facility staff failed to maintain appropriate infection control practices during wound care treatment. Resident #6 A review Resident ' s 6 ' s record revealed a physician ' s order dated and signed July 2, 2010 directed " right leg - cleanse W/NS (with/normal saline) apply Neosporin every shift and leave open to air until healed. " A wound treatment observation was conducted on August 4, 2010 at approximately 9:15 AM with Employee #32. Employee #32 failed to maintain clean technique during the wound treatment process: The resident was sitting in an upright position on his/her bed. The following was not maintained during the wound treatment observation. Employee #32 failed to wash hands greater than 15 seconds (upon entering the room, after placing supplies on table, after cleaning the wound and removing the dirty gloves, after leaving and reentering the room to address a second wound, and after completing the process), failed to place a barrier under the resident ' s right leg prior to cleaning the wound. Placed a small size red bag marked biohazard directly on the table with the clean supplies. Removed an ink pen from his/her pocket to label the dressing with same gloved hand after cleaning the second wound, and failed to clean over bed table after removing used supplies and completion of the process. A face-to-face interview was conducted with Employee #5 at 8:50 AM after review of the	F 520	1. Staff was re-educated at the time of survey on proper technique dressing/wound treatment. Resident #6 2. All residents have the potential to be affected by this practice. Wound competency has been completed on the licensed staff by the educator. Remediation has been made as needed. Infection control in the environment has also been addressed by the Infection Control Coordinator. Handwashing observations have been completed by Educator and unit managers. 3 Wound education, staging, isolation techniques, clean dressing technique Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the director of nursing. Environmental rounds will be completed bi-weekly by the infection control coordinator and the environmental team. Dining and meal service education has been completed by the Dining Services Director. Meal pass observations will be conducted by the Infection Control Coordinator monthly. 4. The results of the above audit will be reported to the CQI committee monthly by the ADON/Infection Control Coordinator . A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. Feb., May, Aug., Nov.	8/4/10 10/19/10 10/19/10 10/28/10

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F 520	Continued From page 198 above, he/she acknowledged the findings. The observation was made August 4, 2010 4. Facility staff failed to maintain clean technique during wound care for Resident #12. On August 4, 2010 at approximately 2:20 PM, Employee # 32 was observed during wound care treatment for Resident #12. The employee used a pair of scissors to remove the soiled bandage from the resident ' s right heel. The bandage was placed in a red bag. The employee placed the scissors on the field which she/he had set up on the resident ' s over the bed table. She/he completed the dressing change and discarded the field and proceeded to wash the scissors with soap and water. The employee did not clean the over bed table after the wound treatment. A face-to-face interview was conducted with Employee #5 on August 4, 2010 at approximately 3:15 PM. He/she stated that the over bed table should have been cleaned after the wound treatment and the scissors should have been cleaned with a germicide. The chart was reviewed August 4, 2010. 5. A. On August 10, 2010 at approximately 10:55 AM, Employee #18 was observed during wound care to umbilicus abdomen treatment for Resident #19. Employee failed to apply barrier prior to wound care. Also, during wound care, observed hamper in resident ' s room was full with soiled clothing with no cover. A face-to-face interview was conducted on August 10, 2010 at 12:30 PM with Employee #5. He/she stated that a barrier should have been	F 520	1. Staff was re-educated at the time of survey on proper technique dressing/wound treatment. Resident #12. 2. All residents have the potential to be affected by this practice. Wound competency has been completed on the licensed staff by the educator. Remediation has been made as needed. Infection Control in the environment has also been addressed by the Infection Control Coordinator. Handwashing observations have been completed by educator and unit managers. 3 Wound education, staging, isolation techniques, clean dressing technique Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the director of nursing. Environmental rounds will be completed bi-weekly by the Infection Control Coordinator and the environmental team. Dining and meal service education has been completed by the Dining Services Director. Meal pass observations will be conducted by the Infection Control Coordinator monthly. 4. The results of the above audit will be reported to the CQI committee monthly by the ADON/Infection Control Coordinator . A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. Feb., May, Aug., Nov	8/4/10 10/19/10 10/19/10 10/28/10

1. Staff was re-educated at the time of survey on proper technique dressing/wound treatment. The hamper in Resident #19's room was replaced.	8/10/10
2. All residents have the potential to be affected by this practice. Wound competency has been completed for the licensed staff by the educator. Remediation has been made as needed. Infection Control in the environment has also been addressed by the Infection Control Coordinator. Handwashing observations have been completed by Educator and unit managers.	10/19/10
3 Wound education, staging, isolation techniques, clean dressing technique Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the Director of Nursing. Environmental rounds will be completed bi-weekly by the Infection Control Coordinator and the environmental team. Dining and meal service education has been completed by the Dining Services Director. Meal pass observations will be conducted by the infection control coordinator monthly.	10/19/10
4. The results of the above audit will be reported to the CQI committee monthly by the ADON/Infection Control Coordinator . A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. Feb., May, Aug., Nov.	10/28/10

1. Staff was re-educated at the time of survey on proper technique dressing/wound treatment. Resident #CBL5. 8/5/10

2. All residents have the potential to be affected by this practice. Wound competency has been completed on the licensed staff by the Educator. Remediation has been made as needed. Infection Control in the environment has also been addressed by the Infection Control Coordinator. Handwashing observations have been completed by Educator and unit managers. 10/19/10

3 Wound education, staging, isolation techniques, clean dressing technique Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the Director of Nursing. Environmental rounds will be completed bi-weekly by the Infection Control Coordinator and the environmental team. Dining and meal service education has been completed by the Dining Services Director. Meal pass observations will be conducted by the infection control coordinator monthly. 10/19/10

4. The results of the above audit will be reported to the CQI committee monthly by the ADON/Infection Control Coordinator . A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. Feb., May, Aug., Nov. 10/28/10

1. Staff was re-educated at the time of survey on proper technique dressing/wound treatment. Resident #CBL8 — 8/3/10

2. All residents have the potential to be affected by this practice. Wound competency has been completed on the licensed staff by the Educator. Remediation has been made as needed. Infection Control in the environment has also been addressed by the Infection Control Coordinator. Handwashing observations have been completed by Educator and unit managers. — 10/19/10

3 Wound education, staging, isolation techniques, clean dressing technique Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the Director of Nursing. Environmental rounds will be completed bi-weekly by the Infection Control Coordinator and the environmental team. Dining and meal service education has been completed by the Dining Services Director. Meal pass observations will be conducted by the Infection Control Coordinator monthly. — 10/19/10

4. The results of the above audit will be reported to the CQI committee monthly by the ADON/Infection Control Coordinator . A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. Feb., May, Aug., Nov. — 10/28/10

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F 520	Continued From page 199 placed prior to wound care. The chart was reviewed on August 10, 2010. B. Employee # 18 was observed on August 5, 2010 at approximately 1:50 PM provide wound treatment to Resident CBL5. After the completion of the treatment, Employee #18 failed to wash his/her hands after discarding the red trash bag in the soiled utility room. A face-to-face interview was conducted with Employee #18 on August 5, 20010 at approximately 2:00 PM. He/she acknowledged the observation. 6. Facility failed to post isolation signage on resident in isolation room door. Resident CBL8 On August 3, 2010 at 9:30AM the nurse walks in to resident room and immediately put her face mask on. When query about her wearing a mask she replied that resident was on isolation for positive MRSA in nares and VRE in urine A review of admission physician order sheet and Plan of care notes dated July 26, 2010 in the section mark treatments reads, " monitor isolation precaution every shift " . A face-to-face interview was conducted on August 3, 2010 at 9:40 AM with employee # 16. He/she acknowledged stated I was so busy she did not check or looked up to see if isolation sign was on the door. The record was reviewed on August 3, 2010. 7. Facility staff failed to develop and implement an effective TB Infection Control Program to prevent the spread Communicable disease and subsequently one resident was not identified with TB [Resident 13], one resident was exposed and converted to a positive PPD [Resident 14] and three (3) staff members converted.	F 520	1. Preventive measures were put in place at the time of discovery. For the residents CBL14. 2. All residents have the potential to be affected by this practice. Review of residents requiring isolation has been conducted by the ADON corrective actions implemented and physician notified as needed. 3. The facility has reviewed and revised its policies. A TB Exposure Control Plan has been reviewed and approved by the medical director. The DC Bureau of TB Control Clinical nurse supervisor has provided staff education in recognizing the signs and symptoms of TB, administering the PPD, reading the PPD, and documenting results. The ADON has completed staff education on isolation implementation and discontinuation. A review of the facility policy on isolation has been completed and corrections made as needed. An audit of residents on isolation will be completed monthly and a report provided to the DON. 4. The results of the above audit will be reported to the CQI committee quarterly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits Feb., May, Aug., Nov	 10/19/10 10/19/10 10/28/10

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F 520	Continued From page 200 Resident CBL 13. A review of the resident's clinical record revealed the followings: Facility Policy #200 titled " Admissions Policy ", Effective: 09/19/00[September 19, 2000], revised: 08/03/2007, 07/29/2010 indicates: an individual meeting any of the following conditions may be refused admission: 1. Those with communicable diseases. 2. Those currently addicted to alcohol, narcotics, or other controlled drugs or whose condition presents a probability of causing significant risk to themselves or others Facility Policy # 1018 " Infection Control Policy " Effective 09/19/00 [September 19, 2000], Revised 08/07/07 [August 3, 2007], indicates; ...The primary purpose of infection control monitoring procedure is to establish guidelines to follow in reporting nosocomial infections and communicable disease in the facility. ...Communicable disease: a disease capable of being transmitted from one person to another ...The infection control Practioner is notified of any resident admitted with a communicable disease and or any resident admitted with and infection requiring isolation precautions ... A review of the resident's clinical record revealed the followings: A report from the discharging community based residence dated 6/19/2009 [June 19, 2009] provided the following information: Diagnoses included Dementia, Anemia, HepA+/HepC+ and Chronic Diarrhea.	F 520	1. Preventive measures were put in place at the time of discovery. For the residents identified.	
			2. All residents have the potential to be affected by this practice. Review of residents requiring isolation has been conducted by the ADON corrective actions implemented and physician notified as needed.	10/19/10
			3. The facility has reviewed and revised its policies. A TB Exposure Control Plan has been reviewed and approved by the medical director. The DC Bureau of TB Control Clinical nurse supervisor has provided staff education in recognizing the signs and symptoms of TB, administering the PPD, reading the PPD, and documenting results. The ADON has completed staff education on isolation implementation and discontinuation. A review of the facility policy on isolation has been completed and corrections made as needed. An audit of residents on isolation will be completed monthly and a report provided to the DON.	10/19/10
			4. The results of the above audit will be reported to the CQI committee quarterly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits	10/28/10

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F 520	Continued From page 201 Multiple reports of lab test. A chest X-ray dated June 2, 2009 was included in this packet. The findings included: " Chest PA and Lateral 06/02/2009 at 12:19 hours: No Priors. There is deformity of the right distal clavicle, which is displaced superiorly, consistent with old trauma, and ossification of the coracoclavicular ligament. Nodule at the left posterior lung base, probably calcified granuloma. CT scan would be necessary to be certain. Lungs otherwise clear. Vascularity normal. There is mild ectasia and unfolding of the thoracic aorta consistent with but not diagnostic of hypertension. No pleural fluid or pneumothorax. IMPRESSION: Probable calcified granuloma at the left posterior lung base. CT scan could be performed to be certain. " The report from the discharging community based residence dated 6/19/2009 [June 19, 2009] lacked information regarding a Tuberculin skin test with a positive result. The a discharge summary that accompanied the resident on June 22, 2009 indicated that his/her active problems included dementia, anemia, Hepatitis A +, Hepatitis C+, positive PPD on June 14, 2009 with a 20mm indurations for PPD screen on June 14, 2009. The discharge summary further stated that the resident's chest X-ray showed no infectious process but recommended a chest CT to further evaluate a granuloma found on the chest X-ray. Also, the discharge summary indicated that the discharging facility was unable to initiate treatment for latent TB infection because of the inability to follow through the full course of treatment and is leaving the decision to initiate treatment at the discretion	F 520		

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F 520	Continued From page 202 of the admitting facility. The Resident was admitted to the Long Term Care facility on June 22, 2009. His/her admission Minimum Data Set MDS completed on June 30, 2009 coded him/her for: depression, anemia, organic brain syndrome, and hepatitis C carrier. On the date of Admission a consent form was obtained for Tuberculin Skin Test and the test was administered on June 22, 2009. The results were documented as negative on June 24, 2009. An "Interim Order Form" date June 23, 2009 contained orders including CT chest scan without contrast: Dx abnormal CXR " Documentation in the record indicates this CT scan of the chest was obtained on July 6, 2009 but no results for this CT scan were available in the clinical record. Facility staff could not provide results when requested. The clinical record lacked documentation that the resident was placed on any type of isolation upon admission until his/her communicable disease status could be determined. Nursing notes dated March 17, 2010 at 3:00PM and 6:00PM indicated the following: resident presented with coughing, an order for a chest X-ray that revealed ' Rt. Upper Lung field pneumonia infiltrate ', a physician's order to transfer the resident to the nearest emergency room and the resident was subsequently admitted to the hospital .	F 520		

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A chest x-ray report with an exam date of 3.17.2010 indicated the following:
" Impression: Right Upper Lobe Parenchymal Changes which Could Be Secondary to TB, Correlate Clinically. "

A CT of the Chest report, exam date 3/17/2010 with an indication of Respiratory distress, rule out TB indicated: " Impression: Nodular infiltrates in the right upper lobe. Changes of previous granulomatous infection. This could represent tuberculosis however; activity of disease must be established clinically. "

On 3/26/2010 [March 26, 2010] a Flexible fiberoptic bronschoscopy with bronchoalveolar lavage was performed by a surgeon at the acute care hospital. Samples were obtained and sent for AFB smears, culture and sensitivity, fungal stains and cytology.

A physician progress note dated March 30, 2010 by the pulmonary physician during the above procedure indicates; " AFB smear negative, C&S no growth after 29 hours; RUL infiltrate- TB ruled out; Discontinue respiratory isolation ...

A hospital ' Transfer summary ' dictated by the primary physician on March 28, 2010 indicated that the " patient had had blood culture, urine culture, sputum colure, but was reported negative. The sputum for acid-fast bacillus will take a long time to get report back. It was noted by the time of this dictation they have got sputum acid -fast bacillus smear which was negative, and the bronchial lavage done by [physician name], though still pending and was reported from day of admission. Finally from the small PPD-positive which was reported reactive to 5mm perimeter."

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A nursing note dated March 30, 2010 at 3:30 PM that indicated that the resident was re-admitted to the facility post hospitalization with a diagnosis of " Right pneumonia"

A nursing note dated May 17, 2010 at 4:00 PM that indicated that the resident was transferred out of the facility and admitted to a hospital.

Another CT scan was done on May 17, 2010 a the admitting hospital reveals " ...a calcified granuloma measuring approximately 8mm, remains within the left lower lobe posterior segment without change with an adjacent area of scarring versus subsegmental atelectasis.

The state agency was notified on June 14, 2010, of the resident ' s positive test for TB , that the Resident's roommate Resident CBL 14 was exposed to tuberculosis and is currently on prophylaxis treatment for tuberculosis and that three (3) staff members converted post exposure.

A memorandum from DC Department of Health Bureau of TB Control dated May 27, 2010 indicated that the facility failed to comply with recommended infection control guidelines by failing to appropriately isolate the resident with undiagnosed pulmonary tuberculosis.

A face-to-face interview was conducted with Employee #2 on August 10, 2010 at approximately 10:00 AM. After reviewing the resident's clinical record, he/she acknowledged the above findings. The record was reviewed August 9, 2010.

8. Facility staff failed to implement appropriate

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interventions to prevent the spread of infection of a communicable disease subsequently resulted in resident having a Positive PPD and hospitalized for treatment of tuberculosis exposure. Resident CBL #14.

According to a history and physical dated June 2, 2010 revealed, " Past medical history: Chronic Obstructive Pulmonary Disease, Parkinson ' s disease, Debility, Peripheral Vascular Disease, Hypertension, and Degenerative Joint Disease. "

According to the Quarterly MDS [Minimum Data Set] completed March 3, 2010, Section I (Infections) revealed, " Antibiotic resistant infection. " There was no June 2010 Quarterly MDS on the clinical record.

A review of Resident CBL #14 ' s record revealed a PPD [Positive Purified Protein Derivative] tuberculin screening resident log sheet report that was conducted on October 27, 2008. " Results negative on October 30, 2008.

According to nurses ' progress notes dated:
May 28, 2010 at 7:00 PM revealed, " PPD placed on right forearm " .
May 29, 2010 at 2:00 PM ... " [status post] PPD right are. No reaction noted. "
May 30, 2010 at 3:00 PM ... " Post PPD on 5/29/10, no reaction noted. "
June 1, 2010 at 6:00 AM ... " Resident alert and verbally responsive. 2cm X 2cm reddish area noted on [right] arm PPD site. "
June 2, 2010 at 7:00 AM ... " Resident remains stable. PPD site right arm remain reddish. "
June 1, 2010 at 5:30 PM ... " [Medical Doctor] called and requests the following test for resident [as soon as possible] ... Cat Scan of chest with

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F 520	Continued From page 206 contrast to [rule out mass], to evaluate pleural effusion. " According to an attending note dated June 2, 2010 at 11:00 AM revealed, " This is an alert oriented X3 [times three] [male/female] with multiple medical conditions. Social history negative for tobacco or [alcohol] abuse. Resident is noncompliant with treatment and medications. [His/her] roommate was recently diagnosed with pulmonary tuberculosis. Resident is currently asymptomatic but has [chest x-ray] of last week positive for pleural effusion. Plan: After long conversation with resident at bedside; resident has agreed to admission at [hospital] for further investigation for tuberculosis and Cat Scan of Chest. " According to a History and Physical dated June 3, 2010 revealed, " Plan: Admission to the negative-pressure room. Pulmonary workup, pulmonologist consultation, [Infectious disease] consultation. " According to a CT [computerized] Scan of the chest dated June 2, 2010 revealed, " Impression: There are few scattered noncalcified subcentimeter nodules abutting the pleural surface of the middle lobe which may reflect early airway infection. A follow-up study is recommended, a correlation with previous exam, if available, is suggested. " Infectious Disease hospital consultation report dated June 4, 2010 revealed, " Reason for Consultation: The patient with TB exposure, positive PPD; evaluation and anti-TB recommendation. " " The patient stated, [he/she] had a roommate for a couple of months,	F 520		

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and the roommate too was just diagnosed with pulmonary tuberculosis. The patient underwent bronchoscopy with bronchoalvelolar lavage today, results are pending. The patient is on respiratory isolation. "

According to a nephrologist hospital consultation dated June 28, 2010 revealed, " Infectious disease recommended full treatment for tuberculosis with 4 [four] agents based on high risk for prolonged exposure. [He/She] was admitted on June 2, 2010, and after an initial workup, has been treated with isoniazid, pyrazinamide, ethambutol, and rifampin. Considering recent history of starting multiple antituberculosis medications, must also consider interstitial nephritis or rapidly progressive glomerulonephritis due to anti-TB medications, which have been associated with ethambutol, pyrazinamide, and rifampin; and rapidly progressive glomerulonephritis has been rarely reported with rifampin. Plan: Change ethambutol and pyrazinamide to every other dosing based on reduced glomerular filtration rate. "

According to a hospital transfer summary form dated July 7, 2010 revealed, " Hospital Course: At this point, the patient has adequately been treated with antituberculous medication for about a month, and [he/she] is considered not to be infectious. [He/She] has been removed from isolation, and he/she has been deemed stable for return back to the nursing home by the infectious disease doctor and pulmonologist doctor. [His/her] TB medications are ethambutol 400mg 4 tablets po [by mouth] every other day, isoniazid 300 mg po daily, pyrazinamide 500mg 3 [three] tablets po every other day, rifampin 300mg 2 [two] tablets daily. "

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A face-to-face interview was conducted with Resident CBL #14 on August 10, 2010 at approximately 12:30 PM. Resident stated, " I had a roommate, when he first came in, it was something wrong with [him/her] and I was exposed to it ... I was exposed to.... I can ' t think of the name of it. "

A face-to- face interview was conducted on August 10, 2010 at approximately 12:45 PM with Employees #2 and Employee #3. Both acknowledged appropriate interventions were not implemented to ensure resident was not exposed to a communicable disease. The record was reviewed on August 10, 2010.

Facility staff failed to implement appropriate interventions to prevent the spread of infection of a communicable disease to Resident CBL #14. The resident sustained a Positive PPD; subsequently resident was hospitalized for treatment of tuberculosis exposure.

9. On August 4, 2010 at approximately 10:30 AM, observed linen hamper in hallway corridor uncovered with red bag inside linen hamper. This observation was in the presence of Employee #5. He/she stated the linen hamper should have been covered. Also the red bag should have not been in the linen hamper.

10. Facility staff failed to maintain appropriate practices to prevent the spread of infection during a dinning observation by not washing hands in between feeding more than one resident at a time.

A dinning observation was conducted on August

Provider's Plan of Correction (F 520):

1. Uncovered hampers in the hallway were replaced at the time of the survey. — 8/4/10

2. All residents have the potential to be affected by this practice. Wound competency has been completed on the licensed staff by the Educator. Remediation has been made as needed. Infection Control in the environment has also been addressed by the Infection Control Coordinator. Handwashing observations have been completed by educator and unit managers. — 10/19/10

3 Wound education, staging, isolation techniques, clean dressing technique Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the Director of Nursing. Environmental rounds will be completed bi-weekly by the Infection Control Coordinator and the environmental team. Dining and meal service education has been completed by the Dining Services Director. Meal pass observations will be conducted by the Infection Control Coordinator monthly. — 10/19/10

4. The results of the above audit will be reported to the CQI committee monthly by the ADON/Infection Control Coordinator . A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. Feb., May, Aug., Nov. — 10/28/10

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F 520	Continued From page 209 3, 2010 at approximately 1:30 PM. Employee #27 entered the dining hall began to assist residents with opening their sugar packets and assisting with placing butter on several residents food items without washing his/her hands. After assisting other residents Employee #27 sat down and immediately began feeding a resident without washing his/her hands. Hand sanitizer was not observed in the dining hall at this time. A dinning observation was conducted on August 4, 2010 at approximately 1:10 PM. Employee #27 entered the dining hall, sat down and began immediately feeding a resident without washing his/her hands. Hand sanitizer was not observed in the room at this time. A face-to-face interview was conducted with Employee #7 on August 5, 2010 at approximately 9:00 AM. He/she acknowledged the above findings that hand washing should have taken place between feeding and assisting residents with their food. A face-to-face interview was conducted with Employee #7 on August 5, 2010 at approximately 9:00 AM. He/she acknowledged the above findings that hand washing should have taken place between feeding and assisting residents with their food. The observations were made on August 3, 2010 and August 4, 2010. 11. On August 4, 2010 at approximately 10:30 AM, observed linen hamper in hallway corridor uncovered with red bag inside linen hamper. This observation was in the presence of Employee #5. He/she stated the linen hamper should have been	F 520	1. Hand sanitizer dispensers have been placed in the dining room.	10/25/10
			2. All residents have the potential to be affected by this ractice. Wound competency has been completed on the licensed staff by the Educator. Remediation has been made as needed. Infection Control in the environment has also been addressed by the Infection Control Coordinator. Handwashing observations have been completed by Educator and unit managers.	10/19/10
			3 Wound education, staging, isolation techniques, clean dressing technique Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the Director of Nursing. Environmental rounds will be completed bi-weekly by the Infection Control Coordinator and the environmental team. Dining and meal service education has been completed by the Dining Services Director. Meal pass observations will be conducted by the Infection Control Coordinator monthly.	10/19/10
			4. The results of the above audit will be reported to the CQI committee monthly by the ADON/Infection Control Coordinator . A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. Feb., May, Aug., Nov.	10/28/10

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

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F 520	Continued From page 210 covered. Also the red bag should have not been in the linen hamper. B. Based on observations during the survey period it was determined that proper procedures were not followed to prevent the spread of infectious as evidenced by: diapers improperly stored on floors in residents rooms in three (3) of 20 observations, strong urine odors observed in a residents room In one (1) of one (1) observation, soiled covers on clean linen carts in one (1) of four observations, improper storage of a soiled toilet plunger in a residents room in none (1) of one (1) observation, ice scoops were improperly stored inside ice bins in water one (1) of three (3) observations, residents soiled linen holder lacked lids in four (4) of 20observations and a large electric fan was operating in the laundry room adjacent to clean linen in one (1) of one (1) observation. These findings were observed in the presence of employees # 13 and 31. The findings included: 1. Diapers and pads were improperly stored on closet floor surfaces outside of wrappers in residents ' rooms 135, 218, 308 in three (3) of 20 observations between 3:15 PM on August 2, 2010 and august 3, 2010. 2. A strong urine odor was observed in room 140, the resident placed a towel on the floor in the bathroom to avoid making contact with the urine in front of the toilet In one (1) of one (1) observation at 10:15 AM on August 2, 2010. 3. The top surfaces of clean linen cart stored in the hallway outside of room 109 and 146 was observed to be soiled with debris in one (1) of four observations at 10:45 AM on August 3, 2010. 4 A toilet soiled toilet plunger was observed on floor surfaces in room 225 in none (1) of one (1) observation at approximately 12:30 PM on August	F 520	1. Infection Control Plan has been reviewed and revised to reflect CDC Standards for Long Term Care. 2. No resident was identified. The current data collected has been used to initiate interventions and to prevent the spread of infection. 3. The infection control policy and program has been reviewed, re-evaluated, and revised. Policies have been developed that address the control and prevention of infection throughout the facility. The review of the program has been completed and signed off by the Medical Director. The current program will be used to identify, prevent, and control the spread of infection throughout the facility. Staff has received education on policies. 4. Data collected will be analyzed and corrections have been implemented into staff practices presented to the CQI committee monthly by the ADON/IC Coordinator. The CQI committee will determine the need for other interventions and need and frequency of further audits. Report results to scheduled Board meetings.	10/19/10 10/19/10 10/19/10 10/28/10

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F 520	Continued From page 211 3, 2010. 5. A ice scoop was observe stored on the interior of the of the ice chest in the Third floor Nourishment Room and the bin was ¼ full of water and the scoop was submerged in water one (1) of three (3) observations at 4:30 PM on August 3, 2010. 6. A large electric floor fan was observed operating on the clean side adjacent to clean linen potentially contaminating clean linen in one (1) of one (1) observation at 12:40 PM on August 4, 2010. 7. Residents soiled linen hampers lacked covers in rooms 214, 245, 321, and 324 in four (4) of 20 observations. There was no evidence that the facility implemented appropriate plans of actions for CFR 483.13, F226; CFR 483.25, F309; and CFR 483.65, F441.	F 520		