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F 520	Continued From page 88 problems in Infection Control(R1). Findings include: 1. On 9/14/10 at 9:35am E1, Administrator was interviewed about the QAA committee. When asked if the QAA committee had identified the deficient practice in the area of infection control, E1 stated the committee did not identify the problems with infection control. E1 stated the committee reviewed the cleaning process, and the type of spray being used but did not identify the problem of the disinfectant not being effective for Clostridium Difficile. E1 stated no action plan was developed or implemented by the QAA committee relating to infection control. On 9/14/10 at 9:35am E2, Director of Nurses, stated the QAA committee identifies problems based on information the Department Heads bring to the committee. E2 stated they talked about UTI's(urinary tract infection) or the high rate of respiratory infections and talked with E17, Housekeeping/Maintenance Supervisor about increasing cleaning of those area. E2 stated the QAA committee had not developed an action plan relating to infection control. 2. The facility failed to notify the Physician of R1's loose stools in a timely manner on more than 1 occasion. The facility failed to get stool cultures and followup on a stool culture report in a timely manner, which resulted in a delay in treatment and implementation of isolation precautions for R1. The isolation precautions were not implemented as specified in the infection control policy. R1 continued to reside in a room with another resident. The facility failed to effectively disinfect the shower chair and shower room floor	F 520		

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F 520	Continued From page 89 after a bowel incontinence by R1 who was actively infected with Clostridium difficile. All of these failures placed all the susceptible residents who used the same bathing facility at risk for infection. The QAA committee did not identify any of these deficient practices in infection control.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.696a) 300.696b) 300.1210a) Section 300.696 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. b) A group, i.e., an infection control committee, quality assurance committee, or other facility entity, shall periodically review the results of investigations and activities to control infections. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	F9999		

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F9999	Continued From page 90 well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. These requirements are not met as evidenced by: A) Based on observation, record review, and interview, the facility failed to have an effective Infection Control Program in place to ensure surveillance of infections and to prevent the spread of infections within the facility. The facility failed to clean and disinfect environmental and resident equipment surface to control and prevent the spread of infections. The facility failed to analyze data related to infections, to identify trends and implement corrective actions. Staff failed to notify the Physician of loose stools for 2 of 2 sampled residents with loose stools (R1, R18) in the sample of 18. The facility failed to obtain a stool culture and followup on the result of the culture, delaying treatment and the implementation of isolation precautions to prevent cross contamination (R1). Staff failed to carry out isolation precautions by not placing R1 in a private room. The facility failed to use an effective disinfectant to clean the shower chair and floor of the shower following bowel incontinence of a resident with an active Clostridium difficile infection (R1). These collective failures put all susceptible residents that use this bathing location at risk for infection (R1, R11, R26, R27, R28, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, and R43).	F9999		

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F9999	Continued From page 91 B) In addition, the facility failed to disinfect the glucometer (blood glucose monitoring device) after use for 1 supplemental resident observed for blood glucose monitoring to prevent cross contamination (R61). This practice affects 6 of 18 sampled residents (R12,5,10,14,18,20) and 21 supplemental residents(R30, 32, 35, 37-40, 43, 44, 45, 47, 52, 53, 54-60). The facility failed to use aseptic technique when administering Intravenous (IV) medication for 1 of 1 supplemental resident observed receiving IV medication (R23). The facility failed to ensure that personal hygiene supplies were stored to prevent cross contamination for 2 of 18 sampled residents (R9, R14); failed to maintain the laundry processing area and linens for residents in a sanitary condition so as to prevent cross contamination; and failed to ensure that the A wing whirlpool tub unit was properly decontaminated between uses so as to prevent potential spread of infection. Findings include: A) 1) R1's Physician's Order Sheet (POS) dated 8/10 lists multiple diagnoses to include Clostridium difficile (Cdiff). The most recent Minimum Data Set (MDS) for R1 dated 8/18/10 indicates R1 is incontinent of bowel and bladder and dependent on staff for care. R1's BM (Bowel Movement) Record for July 2010 indicates she began having loose stools on 7/22/10. On 7/22/10 the record indicates R1 had a total of 6 loose stools, on 7/23/10 one episode of diarrhea was recorded, and on 7/25/10 one episode of diarrhea. Nurses Notes dated 7/26/10 at 12:45 PM state physician "noted fax regarding	F9999		

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F9999	Continued From page 92 mucous in stools. No new orders at this time." On 7/31/10 at 10:58 AM, Nurses Notes indicate that the physician was notified again of mucous in R1's stools. A fax sheet from the facility to the physician's office indicated the physician's office was notified by fax on 7/31/10 of R1's "mucousy anal discharge" and the response to the facility was stamped as received 8/2/10, and has a handwritten note at the bottom "Appointment 8/3/10 10:15 (Illinois)." The POS has an order on 8/3/10 for R1 to have stool studies to include a check for Ova and Parasites, C difficile and a stool culture. R1's Bowel Movement record indicates she had daily BMs from the time this order was written. Nurses Notes from 8/6/10 at 4:35 AM indicated that a stool specimen was collected from R1 that day. Lab results dated 8/6/10 at 6:29 PM indicate the stool specimen was positive for C diff. This result sheet has a stamp indicating it was received by the facility on 8/10/10. On 8/9/10 at 9:28 AM, Nurses Notes indicate that R1 was to be put on contact isolation and a new order had been received for Flagyl. The POS contains a Telephone Order (T.O.) dated 8/9/10 for Flagyl 500mg (milligrams) BID (twice a day) for 7 days. R1's Medication Administration Record (MAR) dated 8/10 indicates the Flagyl was started on 8/9/10 with the PM dose and completed on 8/16/10 with the AM dose. On 8/24/10 at 12:40 PM Nurses Notes state "D/C (discontinue) isolation -DON (Director of Nurses) notified - housekeeping cleaning room." R1's BM Record for August 2010 indicates on 8/24/10 R1 had four BMs with mucous, on 8/25/10 one BM	F9999		

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with mucous, on 8/26/10 R1 had one loose BM and one BM with mucous.

On 8/26/10 at 10:40 AM, Nurse's Notes state "T.O. Flagyl 500mg BID X 7 days r/t (related to) C diff." This order is also on the POS. R1's MAR indicates the Flagyl was started with the 8/26/10 PM dose and completed on 9/2/10 with the AM dose.

R1's BM Record for 9/3/10 indicates she had one episode of diarrhea, with Nurse's Notes at 10:45 AM that day indicating R1 had "loose foul smelling stool but no mucous noted," and on 9/6/10 at 3:12 AM notes state R1 had "2 episodes of mucousy loose incont. (incontinent) stools."

On 9/7/10 at 4:00 PM, E14, Registered Nurse, stated that R1 had completed the Flagyl on 9/3/10 and that the "protocol" is to follow-up on day 3 after completion of the medication if the resident is still having symptoms. She confirmed that the physician had not been notified of R1's continued loose, mucousy stools.

On 9/9/10 there is a T.O. on the POS to check R1's stool for C diff. Nurse's Notes on 9/13/10 at 4:10 AM indicate a stool specimen was collected from R1 that day. There was no result on the chart as of 9/14/10 at 9:05 AM. R1's Care Plan last updated on 6/9/10 does not list any interventions related to C diff.

On 9-16-10 the facility provided a copy of R1's lab report dated 9/13/10 which indicates the stool specimen was positive for C diff.

On 9/9/10 at 3:25 PM E2 stated that R1 was not

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in a private room or cohorted with another resident with C diff per facility policy because there were no private rooms available and no other residents had C diff. R1 was sharing a room with R31. According to R31's September 2010 Physician Order Sheet she has diagnoses including Alzheimer's Disease, Parkinson's, Anxiety, Depression and has no current infection. R31's minimum data set dated 8-24-10 assesses her as having long term memory problems, moderate impairment of cognitive decision making ability, impaired vision, and requires limited to extensive assistance for ambulation in her room, toilet use, and personal hygiene.

On 9/14/10 at 10:20 AM, E2, Director of Nurses, stated she could not explain the delay in the response from the physician's office when they were notified by fax on 7/31/10. She stated it may have been over a weekend. E2 also stated she could not explain the three day delay in collecting R1's initial stool specimen. She stated that information on the need for collection of specimens is usually passed from shift to shift in daily report. E2 also stated she could not explain the delay in communication of the positive C diff results and subsequent treatment and stated the lab only calls with "panic values." E2 could not explain why R1's physician was not notified until 9/9/10 that R1 was continuing to have loose, mucousy stools and could not explain why the stool specimen that was ordered on 9-9-10 was not collected until 9/13/10.

On 9/7/10 at 3:45 PM, E15, Certified Nurses Assistant (CNA) and E16, CNA transferred R1 from her wheelchair and positioned her on the bed to provide incontinence care. R1's incontinence brief was removed and revealed a

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large amount of liquid stool that had saturated the brief. There was visible stool on R1's entire groin area towards the front of the brief. E16 proceeded to wash R1's groin and urinary meatus with a washcloth that she was turning and repositioning as she washed the area. E16 continued to use the washcloth even though it had become visibly contaminated with stool. E15 repeatedly stated to E16 that she had brought "plenty" of washcloths, prompting E16 to begin using a clean washcloth. Even though she switched to a clean washcloth, E16 continued to use the same technique with subsequent washcloths and continued to contact R1's skin with contaminated washcloths. R1 was then positioned on her right side for E16 to clean her buttocks. E16 completed cleaning R1's rectal area and buttocks using the same technique as before and then required prompting from E15 to rinse and dry the area. After incontinence care was completed, E15 and E16 applied a clean incontinence brief and redressed R1, then took the wash basin into the bathroom and emptied it and washed their hands. E16 returned to the room and began placing the soap and other care supplies from the over the bed table into the basin and set it on the bedside table. E15 and E16 then transferred R1 from the bed into the wheelchair and wheeled R1 out of the room without washing their hands prior to assisting R1's roommate, who was waiting in the hallway, with care.

On 9/7/10 at 4:15 PM, E16 stated she probably should have used more washcloths when providing care to R1. She also stated she had been "taught" (incontinence care) differently than E15.

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F9999	Continued From page 96 On 9/8/10 at 8:55 AM, E30, Housekeeper, stated that she was responsible for cleaning R1's room that day. E30 stated that she used the same products, Bowl X for the toilet and Sanifect for the floor and surfaces, that she used in all the other rooms. Neither chemical agent is formulated to be effective as a disinfectant, against Clostridium difficile, according to product labeling. 2) E19, CNA on 9-9-10 at 9:20 A.M. stated she sprayed the "Sanifect" on the surface of the whirlpool tub and the shower chairs. E19 said she let the disinfectant remain on the surface for 2 to 3 minutes. E19 was asked about R1's showers. E19 stated R1 would have loose bowel movements during showers. E19 stated she cleans it up with a wipe and sprays the area with "Sanifect." E20, CNA on 9-14-10 at 2:30 P.M., stated she had been spraying the disinfectant, "Sanifect" on the surface and allowing it to remain on the surface for a few minutes. E20 was asked about which residents used the shower that R1 uses. E20 stated R1 was the last shower of the day and the housekeeping staff cleans the shower at the end of the day. E20 provided a list of the current residents that are showered in the F wing shower with a shower chair: R1, R11, R26, R27, R28, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, and R43. E21, Housekeeper was interviewed about the cleaning procedure of the shower and the shower chair. E21 stated that she rinses the shower area and shower chair with clear water. Then she sprays "Sanifect" on the surfaces. E21 stated she would let the chemical stay on the surface for 10 minutes. E21 said she would	F9999		

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F9999	Continued From page 97 clean shower after the resident showers were completed. E21 stated that she also may use a spray foam disinfectant on the shower chair. E17, Housekeeping/Maintenance Supervisor, was asked for the product information for the facility's disinfectant, "Sanifect." E17 provided the product information on 9-9-10 at 8:00 A.M. According to the chemical manufacturer's information, the disinfectant is a one step quaternary ammonium compound. The chemical lists the organisms it was effective against. C. difficile was not listed. The chemical is to remain on the surface for a minimum of 10 minutes to be effective as a disinfectant against other pathogens. E17 stated that the quaternary ammonia compound is the primary disinfectant used in the facility. E17 stated the housekeepers and CNAs also may use a spray foam disinfectant that is quaternary ammonia-based. E17 stated housekeepers use a bleach solution to wipe down the corridor handrails. E17 stated on 9/14/10 at 9:55 A.M. the housekeepers are to use a bleach solution to clean the surfaces of furniture in the room where a resident with Clostridium Difficile resides, as well as the hall. E17 stated the housekeepers should also be wiping the handrails throughout the building with a bleach solution. When asked what the concentration of the bleach to water ratio was, E17 stated he did not know. Undated facility policy titled Policy for Cleaning an Isolation Room of Resident with Clostridium Difficile dated states "...it shall be the policy of Burnsides Community Health Center to implement the following procedure to decrease the possibility of transmission of the infection to	F9999		

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F9999	Continued From page 98 other residents...5. bleach is to be used as the disinfectant...housekeeping is to clean surfaces in contact with the resident in isolation twice a day...." The policy fails to specify the strength/concentration of bleach to be used, the ratio of bleach to water (i.e. 1:10), how to prepare the solution, and the minimum required contact time for effective disinfection (i.e. 10 minutes). E31, Housekeeper, stated on 9/14/10 at 10:05 A.M. that when cleaning a room which has a resident with Clostridium difficile or the hall handrails she uses a bleach solution. E31 stated she uses about a 1/2 ounce of bleach in a bucket of water. E31 stated she will clean the handrails weekly. E21, Housekeeper, stated on 9/14/10 at 10:15 A.M. that she cleans the isolation room (Clostridium difficile) with bleach. E21 stated she adds about 1 tablespoon of bleach to a bucket of water and wipes the bed, furniture and hall handrails. E21 stated she uses Sanifect and water on the floors in the room and hall. 3) The Admission Face Sheet states R18 was admitted to the facility on 8/25/10. The hospital Discharge Summary dated 8/25/10 states R18 has diagnoses of Anemia, Diabetes, Osteoarthritis and Depression. The ADL (Activities Daily Living) Functional/Restorative Assessment and Progress dated 8/26/10 states R18 is orientated times 3 (person, place, time), requires 1 assist with hygiene/grooming, requires 2 assist with bed mobility/transfers and limited assist with toileting. The assessment states R18 is continent of bowel/bladder and uses the urinal/bedpan. The	F9999		

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F9999	Continued From page 99 Interim Care Plan dated 8/26/10 states that R18 uses the urinal/ bedpan, is orientated and requires assist with hygiene, transfers and uses a wheelchair for locomotion. The Nurse's Notes dated 8/28/10 at 12:25 P.M. state the Physician was notified that R18 was having "diarrhea." The Physician's Order dated 8/28/10 states, "......Collect stool sample Monday, Start Flagyl 500 mg (milligrams) tid (3 times day)....." The facility Infection Control Reporting Form dated 8/28/10 lists a possible diagnosis for R18 as "C-diff (Clostridium Difficile)," stool culture to be done 8/30/10 and Flagyl 500mg tid. The form states "Was resident (R18) placed on precautions?" The response to the question is "No." E2, Director of Nurses (DON) stated on 9/9/10 at 3:25 P.M. that the nurses fill out the Infection Control Reporting Form when they get an order for a culture/medication. E2 stated she uses the form to monitor and log infections. The Nurse's Notes dated 8/29/10 at 6:30 A.M. state R18 was sent to the hospital. The hospital History and Physical dated 8/29/10 states R18 was having "respiratory problems," low blood sugars, vomiting and "significant diarrhea." The note states that R18 was found to "have evidence of underlying urinary tract infection, pneumonia....." The hospital Physician's Order sheet dated 8/29/10 also documents Gastroenteritis. The Nurse's Notes dated 9/1/10 document that R18 was readmitted to the facility from the hospital.	F9999		

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F9999	Continued From page 100 The facility "BM (bowel movement) Record" dated September 2010 documents R18 having stools on the following days: 9/3 second shift-extra large "DI (diarrhea);" 9/4 first shift-extra large "loose;" third shift-extra large "DI;" 9/5 first shift-small, second shift-medium; 9/6 first shift-large, second shift-large loose; 9/7 first shift-large loose and 2 moderate loose; 9/8 second shift-large DI and third shift-extra large DI. The Nurse's Notes from 9/1-9/8/10 do not document R18 having loose stools. E13, LPN (Licensed Practical Nurse) stated on 9/9/10 at 8:55 A.M. that she was not aware of R18 having any loose stools or issues with Clostridium difficile. At 9:35 A.M., E13 stated she checked and Z1, R18's Physician was notified by fax of R18's loose stools last night (9/8), but they had not heard back from him yet. E13 stated R18 told her his stools are liquid, with no mucus. There is no documentation in the record of the Physician being notified of R18's diarrhea stools from 9/3-9/9. R18 stated on 9/10/10 at 10:50 A.M. "What bothers me, I've been having diarrhea for 8 days." R18 stated he had asked the nurses to call his doctor about the diarrhea. R18 stated he's having to wear disposable briefs because "it (diarrhea) comes on me so quick." R18 stated, "the staff can be in the room, I'll be okay, then 2 minutes later I get the urge to go, can't make it to the bathroom and have an accident." R18 stated, "I'm exaggerating but the diarrhea is killing me!"	F9999		

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	146046	A. BUILDING _____ B. WING _____	09/23/2010

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F9999	Continued From page 101 E2, DON, stated 9/10/10 at 11:00 A.M. that she had called Z1 about the stool culture and diarrhea that morning. At 2:00 P.M. E2 stated that the stool culture for R18 ordered to be done on 8/30/10 was not collected because R18 was in the hospital. E2 stated she checked with R18's Physician's (Z1) office and a stool culture was not collected while R18 was in the hospital. E2 stated Z1's office nurse called at 11:00 A.M. and relayed to her that Z1 stated, "There was no reason to continue that order (stool culture) in the hospital because that was not the problem." 4) The facility policy "Infection Control Program," which is not dated, states its goals are to investigate causes of infections, develop measures to prevent spread of infections and the prevention of infections. The investigation aspect of this goal involves the facility collecting data about each resident with an infection to include the type of infection, the date of infection, the origin or site of infection and causative agent if known. As part of its goal to prevent spread of infections the program states it will analyze infection data, conduct surveillance rounds to develop strategies to prevent infections, place isolation precautions when needed and "the infection control committee will review all infections monthly and provide information for the Quality Assurance Program." The goal related to prevention of infections states standard precautions will be used for all residents and "the facility will provide an aggressive on-going educational program for staff which will include formal in-servicing programs and on-the-spot training when indicated." The program further addresses initiation of isolation precautions and states they should be started when "there is reason to believe that a resident has an	F9999		

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infectious or communicable disease." The isolation precautions are further broken down into types to include airborne, contact and droplet. Examples of infections requiring contact precautions include Clostridium difficile. The program states residents on contact precautions should be in a private room if available or placed in a room with residents infected with the same microorganism. Other contact precautions to be used include not touching potentially contaminated surfaces with ungloved hands and dedicating patient care equipment to infected residents or if sharing of equipment cannot be avoided they must be cleaned and disinfected before use by other residents.

On 9/9/10 at 3:25 PM, E2, the facility infection control monitor, stated that the document labeled "Infection Control Program" is the facility infection control policy. She states she is not sure of when it was written but believes it was in 2007 because she wrote it based on the 2007 CDC (Centers for Disease Control) guidelines that are in the same binder. E2 stated that the facility uses an Infection Control Reporting Form that is filled out by the nurses when a resident has been identified with an infection. She states she then enters the information into a monthly log to track infections. E2 then stated she uses this information to complete the Monthly Facility Infection Control Report.

The Monthly Facility Infection Control Report shows a section marked "Infection Control Summary for the Reporting Period" that is divided into Nosocomial or Community Acquired infections and gives an infection rate for both based on the number of new infections, the average census, the number of days in the

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reporting period and the number of resident days per reporting period. This data is further broken down into percent by infection site such as urinary tract or gastrointestinal tract. Lastly, the data is broken down into resident care areas, or hallways where the residents live. There is no indication from this report that data is analyzed or what is done with the information.

On 9/9/10 at 3:25 PM, E2 stated that she uses this data for a final report that she presents to the Quality Assurance Committee. E2 did not produce a copy of the report.

On 9/14/10 at 1:30 PM, the facility provided a copy of their 8/26/10 Quality Assurance Meeting minutes with a discussion of infection control. There is information regarding numbers and types of infections but no analysis of the data or how the information would be used.

On 9/10/10 at 1:20 PM, E1 and E2 stated there was no infection control committee and no policy on when to do cultures.

On 9/14/10 at 1:20 PM, E2 stated there is no specific written policy on employee illness, they are sent home if they have a fever or something "contagious."

On 9/14/10 at 2:50 PM, E2 provided a copy of the facility New Employee Orientation Program that listed the topic Infection Control in a 50 minute time period with 16 other topics. E2 stated that many of these areas are only briefly discussed so that they can discuss in detail topics like infection control. She stated there is no written script, powerpoints or employee handouts related to this instruction. E2 provided copies of the

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F9999	Continued From page 104 "Incontinence Care Transfer Inspection" forms which includes columns labeled Employee, Date, Incontinent Care, and Done Properly. The facility has no methodology regarding which employee is selected for review and how often review is done. E2 provided no other information related to inservices on infection control. B) 1) On 9/7/10 at 4:00pm E46, RN (Registered Nurse), checked R61's blood glucose level. E46 cleaned the glucometer with a Sanihands ALC wipe and an alcohol swab prior to doing R61's blood glucose test. When finished checking R61's blood glucose level, E46 cleaned the glucometer with a Sanihand ALC wipe and put it away. E46 confirmed at the time of the observation that the glucometer is used for more than 1 resident. The label of the Sanihands ALC container stated it was an "antiseptic handwash." The product label made no claim as a disinfectant. The facility "Policy For Cleaning Glucometer " dated 5/25/10 states "Clean glucometer surface when visible blood or body fluids are present by wiping with a cloth dampened with soap and water to remove debris, then wipe glucometer surfaces with a 70% alcohol wipe. If no visible blood or body fluids are present, wipe off exterior surfaces with a 70% alcohol wipe. Clean glucometer after each use." On 9/9/10 at 9:30am E2, DON (Director of Nurses), stated after writing the policy she sent it out as a memo to the staff.	F9999		

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F9999	Continued From page 105 Information provided on 9/8/10 by the facility from the manufacturer of the glucometer states, "If a glucometer that has been used for one resident must be reused for another, the device must be cleaned and disinfected in between resident use with a surface disinfectant." 2) On 9/9/10 at 10:40am E44, Registered Nurse (RN), administered Vancomycin 500mg (milligrams) IV piggyback to R23. E44 placed the IV tubing in the IV pump and draped the tubing over the attached IV pole. There was no protective cap on the tip of the IV tubing which would be connected to R23's peripheral IV. The syringe with normal saline was lying on R23's bedside table without the protective cap on the end of the syringe. E44 picked up the syringe of normal saline, wiped the IV port with alcohol and flushed R23's peripheral IV. E44 then wiped the tip of the IV tubing with alcohol, wiped the IV port with alcohol and connected the IV tubing to R23's peripheral IV line. E44 then started the infusion of IV Vancomycin. On 9/9/10 at 10:45am E44 confirmed the protective caps were not on the syringe of normal saline and the tip of the IV tubing. When asked why the protective caps were not in place, E44 stated she threw the protective caps away in the medication room after getting the medication and syringe ready because she was going to be hooking up the tubing to R23's IV. E44 stated she carried the IV tubing and syringe of normal saline from the medication room to R23's room without protective caps on the ends of both items. The facility Peripheral IV Nursing Policy has the following information: "Universal precautions and facility infection control procedures are followed	F9999		

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F9999	Continued From page 106 when performing any peripheral IV therapy procedure;" "Aseptically attach infusion tubing or syringe with medication to the injection port...." and "Products will be inspected for integrity and sterility." 3) On 9/7/10 at 12:30 p.m. unidentified personal care/hygiene items including a denture cup filled with cleaning solution and a container of mouthwash were intermingled on the shared bathroom counter. It was not clear if these items belonged to R9 or occupants of the adjoining bedroom. R9's most recent Minimum Data Set (MDS) of 6/1/10 reflects that she is cognitively impaired, unable to communicate, and totally dependent on staff for all care. On 9/7/10 at 2:00 p.m. unidentified personal care/hygiene items including a denture cup filled with cleaning solution, a toothbrush, and a container of mouthwash were intermingled on the bedroom lavatory counter. It was not clear if these items belonged to R14 or his roommate. R14's 6-18-10 MDS assesses him as having memory problems, is cognitively impaired, requires assistance with personal hygiene, has impaired vision, and is independent with ambulation. Storage of personal care items in this manner puts them at risk for cross contamination. These residents are at risk for becoming ill due to use of potentially contaminated personal care/hygiene supplies 4) During the General Observation tour on 9/9/10 at 8:45 A.M., the laundry was observed. The ceiling air handler filter was caked with dust and lint. Dust and lint was present on the overhead	F9999		

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F9999	Continued From page 107 pipes and electrical service, on the tops of the washers and dryers, and behind the washers and dryers. Canvas linen hampers and cloth linen hampers on metal frames had torn and frayed edges exposing the metal frames. E33, laundry employee stated that the linen holding hampers are not cleaned and disinfected daily. The clean holding hampers are cleaned and disinfected "about every two weeks." The soiled and clean linen were not covered when processing was being done. The soiled linen containers were not covered when the soiled linen was not being sorted and handled. The soiled linen was not covered to contain the organisms and pathogens. 5) During General Observation Tour on 9-8-10 at 1:30 P.M. accompanied by E17, the Maintenance and Housekeeping Supervisor, the A wing tub room was observed. The A Wing tub room has a bathing tub with a whirlpool. A Certified Nurse Assistant (CNA), E18 was asked how the tub was cleaned and disinfected after use. E18 stated that she sprays on the cleaner, waits a few minutes, and sprays it off with clear water. E18 was asked if she did anything else to clean and disinfect the tub. E18's response was "no." E17 was asked about the chemical disinfectant. E17 stated the facility uses "Sanifect" for cleaning and disinfection of the tub. Following the interview with E18 , E17 was asked about the disinfecting process. E17 responded by stating "Looks like (the Director of Nurse, E2) needs to do inservices again." The disinfectant is to be sprayed into the whirlpool pump in the tub	F9999		