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F 520	Continued From page 132 discusses one quality of care and one quality of life issue. The facility has two sub-committees that meet separately prior to the quarterly QA meeting and then bring identified issues to QA. The QA met April 1st and the topic discussed for quality of care issue was the 30 day re-admission tracking related to congestive heart failure, the quality of life issue was advanced directives. The QA routinely discusses issues concerning skin integrity, infection control, falls, and other items identified by the QA committee or department heads. QA has not identified a clustering of infection over the past year, only scattered infections. QA has not identified any concerns or a specific individual that has had an issue with falls or safety. E1 stated the concerns were "discussed" in QA meetings. E1 verified the facility did not have a Quality Assurance action plan to address the ongoing identified issues of falls and infection control. On the prior Annual Survey dated 4/14/10, citations for infection control had been cited on their annual survey. Interview with Z1(medical director) and Z2 (pharmacist) on 5/20/11, both confirmed they attend the facility's QA and there has not been a concern discussed relating to falls or infection control	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a)5) 300.1210b)3)6)	F9999		

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Continued From page 133
300.1220b)3)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder.

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 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. Restorative measures shall include at a minimum the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

b) General nursing care shall include at a

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minimum the following and shall be practiced on a 24-hour, seven day a week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

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Continued From page 135

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidenced by:

Based on observations, interviews and record reviews, the facility failed to:
-Identify and analyze all the risk factors and causes of residents' falls, and ensure interventions used were effective.
-Monitor for the effectiveness of the interventions and change/modify the interventions as necessary to prevent recurrence for residents assessed as high risk for falls.
This is for 2 of 24 sampled residents (R11 and R21) and 5 residents out of the sample (R39, R43, R89, R91 and R124) who were assessed as high risk for falls with decreased cognition.
These failures resulted in R11 experiencing 17 avoidable falls in the facility from 4/3/10 through 4/20/11. The fall on 4/20/11 resulted in R11 sustaining a fracture of the right Humorous.

Findings include:

1) Review of the most recent Minimum Data Set (MDS) dated 4/21/11 shows that R11 is 83 years old and was admitted to the facility on 4/30/09 with diagnosis including Dementia and Parkinson's disease. This MDS shows R11 is interviewable and able to make his needs known. R11's 4/29/11 MDS and Care Area Assessment (CAA) identified the resident requiring extensive assistance with transfers, ambulation, toileting, hygiene, dressing and activities, and utilizes a

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F9999	Continued From page 136 walker/wheelchair for ambulation. R11's 4/29/11 fall assessment and CAA's identified him as high risk for falls, increase in cognitive impairment, and decline in activities of daily living (ADL) and mobility. Observations on 5/10/11 at 11:30 A.M., R11 was in his wheelchair using his left arm to wheel himself into the 300 dining room, R11's right arm was in a blue sling that was not applied properly. E49 (CNA) stated R11 had fallen and broken his right arm and the sling is to be worn all times. On 5/11/11 at 12:30 P.M., R11 was leaving the 300 dining room using his left arm to wheel himself out of the 300 dining room, right arm sling not applied correctly, only top half of the arm. On 5/19/11, R11 was observed attempting to transfer himself to his bed, chair alarm sounding, no staff responding. Interview with E1 (Administrator) on 5/12/11 at 9:35 A.M., E1 stated the Quality Assurance (QA) Committee meets quarterly, last meeting was held April 1st. At the April 1st meeting the QA concerns identified were 1) 30 day turn around from the hospital and 2) advanced directives. The QA discussed falls and the number of incidents but no particular resident was identified as a concern. Interview with Z1 (Medical Director) on 5/20/11 at 1:30 P.M., Z1 said he attends QA every three months but he has not discussed or identified a concern with falls. Interview with Z2 (Pharmacist) on 5/20/11 at 1:50 P.M., Z2 said she does look at the residents medication to evaluate if any of the medications	F9999		

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F9999	Continued From page 137 are contributing to their falls. Z2 said she has not identified any one specific resident with a concern. A review of the facility's incident reports showed R11 fell in the facility 16 times with minor injuries from 4/3/10 through 4/20/11. The fall on 4/20/11 resulted in R11 sustaining a fracture of the right Humerus. - R11 was found on the floor 10 times, unwitnessed falls on the following dates: 4/3/10, 4/8/10, 4/21/10, 12/18/10, 2/11/11, 2/12/11, 2/24/11, 3/20/11, 4/7/11, and 4/20/11. The fall on 4/20/11 resulted in R11 sustaining a fracture to the right humerus. -5/25/10 -witnessed fall in dining room pushing himself off the wheelchair and wheelchair moved back because wheelchair brakes were unlocked. -7/22/10- witnessed fall, R11 observed to stand up in wheelchair and tried to sit back but the wheelchair moved back and he missed it. -12/18/10- witnessed fall at nurses station- standing up in wheelchair, went to sit back down and wheelchair moved-resident fell to floor. -2/14/11- witnessed fall, staff transferring resident to bed from wheelchair and he slipped, falling to floor. -2/28/11- witnessed fall to floor- attempting to transfer self from bed to wheelchair -3/8/11-witnessed fall- slipped out of wheelchair -3/29/11- witnessed fall- resident attempting to transfer himself from chair to wheelchair. On 5/13/11 E2 said the fall committee meets monthly and looks at the number of falls in the facility but no particular resident has been a concern. E2 said the pharmacist reviewed R11's	F9999		

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F9999	Continued From page 138 medications in March but did not have a concern. R11's POA was making an appointment with the neurologist related to his Parkinson's disease but then the POA went on vacation and R11 has not been to the appointment. R11's falls occurred mainly when he attempted to transfer without assistance and not lock the wheelchair brakes. On 4/11/11, R11's care plan was updated to include to "re-educate resident to lock wheelchair brake," but this is unrealistic because of his cognitive status, he cannot remember to lock the wheelchair brakes. R11's fall care plan did not include updated interventions after each fall nor were the falls analyzed to find the root cause in an attempt to prevent further falls. During a 5/17/11 interview with E50 (nurse), E50 said R11 is high risk for falling and he should be on a one to one. When his alarm goes off we can't get to him fast enough before he falls, it is to late, he has already fallen. Interview with E41 (CNA) on 5/16/11, E41 said she is R11's primary care taker during the A.M. shift and R11 does not usually fall when she is on duty. R11 needs assistance with transfers and toileting, he has a bed and chair alarm. Review of the facility's Accident Prevention and Resident Supervision policy and procedure dated 9/7/09 documents the following: Facility ensures to provide an environment that is free from hazards over which the facility has control and provides appropriate supervision and assistance devices to each resident to prevent avoidable accident. This includes systems and processes	F9999		

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designed to:
1. Identify hazards and risks;
2. Evaluated and analyze hazards and risks;
3. Implement interventions to reduce hazards and risks;and
4. Monitor for effectiveness and modify approaches as indicated;
5. Residents receive supervision and assistive devices to prevent avoidable accidents.

In review of the facility's list of residents that are high risk for falls and accidents that was provided to surveyors, resident's fall care plans, facility's incident reports, and observations shows the facility has not implemented or followed their policy and procedure for falls and accidents.

2) R21 was admitted to facility 3/10/11 after a recent cerebral vascular accident resulting in left sided weakness and unsteady balance. R21 also developed a urinary tract infection (UTI) requiring isolation precautions 4/07/11 - 4/25/11.

R21's 3/27/11 Minimum Data Set assessment (MDS) and Care Area Assessment (CAA) identified the resident as requiring extensive assist with transfers, ambulation, toileting, hygiene and dressing activities. R21's 3/20/11 fall assessment and 3/27/11 Care Area Assessment (CAA) identify the resident as a high risk for falls, has poor judgement and insight and left sided weakness.

R21's care plan and incident reports document 4 separate fall incidents between 3/29/11 and 5/09/11 (3/29/11, 4/04/11, 4/08/11 and 5/09/11).
- 3/29/11 at 11:25AM while being assisted by

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F9999	Continued From page 140 E36 (CNA), in the toilet room, R21's knees became weak and sustained a fall. - 4/04/11 at 2:45PM R21 was left alone on the toilet by her CNA (E39) and fell to the floor. - 4/08/11 at 7:30PM R21 sustained a fall while being assisted by E40 (CNA) with a transfer from bed to wheelchair. - 5/09/11 at 6:30AM R21 fell while attempting to get to the toilet by herself. R21's fall care plan did not include updated interventions between 3/30 and 5/09/11 in an attempt to prevent further falls. R21's fall care plan failed to address the current UTI and urgent sensation to void. During a 5/13/11 interview with E38 (nurse), and a 5/18/11 interview with E41 (CNA), surveyor was told that R21 requires assistance with ambulation and toileting. R21's 5/13/11 fall assessment states the resident has unsteady balance with sitting, standing and ambulating and decreased coordination and strength. R21's 5/09, 5/10 and 5/11/11 nursing progress notes include that the resident requires assistance with transfers and activities of daily living. R21 was observed 5/13/11 at 9:28AM and again 5/20/11 at approximately 11:15AM independently ambulating in her room without any assistance or assistive devices. 3) On 5/13/11 surveyor observed 13 unsupervised residents in the first floor television room from 9:37AM - 10:00AM, including R3, R39, R43, R89, R91 and R124. At 10:00AM, E37 (CNA) arrived to monitor the television room. E37	F9999		

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F9999	Continued From page 141 stated that her assignment today was to feed residents and then to monitor the television room between meals. E37 said that at 9:45AM she went downstairs to break until 10:00AM after feeding residents. Record review of R3, R39, R43, R89, R91 and R124's current care plan and fall risk assessments, and 5/14/11 interview of E2 and 5/13/11 interview of E37, validated that these residents are cognitively impaired, require extensive assist with 1 or 2 staff for all activities of daily living, and require supervision related to being a fall risks. 4) During the survey E2 (DON) was asked multiple times for a complete list of residents identified as being high risk for falls. On 5/19/11 E2 provided surveyors with a list that identified 132 of facility's 137 in house residents as being high risk for falls. E2 said that almost every in house resident is a high risk for falls related to decreased cognition, age and medical conditions. The "Fall Risk Assessment" used by facility through 5/10/11 was generic, un-individualized and number coded 8 questions. The total sum at the end determined if a fall risk but no analysis of possible causes or recommendations to prevent further falls are included. (A) 300.696a) 300.696b) 300.696c) 300.1210a) 300.3240a)	F9999		

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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.

c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340):
1) Guideline for Prevention of Catheter-Associated Urinary Tract Infections
2) Guideline for Hand Hygiene in Health-Care Settings
3) Guidelines for Prevention of Intravascular Catheter-Related Infections
4) Guideline for Prevention of Surgical Site Infection
5) Guideline for Prevention of Nosocomial Pneumonia
6) Guideline for Isolation Precautions in Hospitals
7) Guidelines for Infection Control in Health Care Personnel

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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 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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidenced by:

Based on observation, record review, and interview the facility failed to maintain an infection control system which:

1. Ensured residents at the facility did not acquire a high rate of infections at the facility, specifically C-Diff (clostridium difficile) and ESBL (extended spectrum beta lactamase) infections.
2. Developed an Infection Control Committee which identified, analyzed, and implemented interventions to decrease/eliminate facility acquired infections.
3. Ensured the infection control tracking log was accurate and complete.
4. Ensured contact isolation protocol was followed regarding isolating residents and

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discontinuing isolations.
5. Ensured contact isolation rooms and community bathrooms were cleaned/disinfected with the appropriate chemical agents to kill the infective C-Diff organisms.
6. Ensured facility staff was educated on the infective organisms of residents in isolation.
7. Ensured linens were not contaminated when being handled in the Laundry Dept.
8. Ensured residents with infections who needed isolation were cohorted with residents with the same infections.
9. Ensured facility staff washed their hands when needed.
10. Ensured glucose monitoring machines were disinfected after being used on residents who required blood glucose monitoring.

This impacted 8 residents in the sample of 24 (R3, R14, R16, R10, R17, R21, R24, R4) and 13 supplemental residents outside of the supplemental sample (R141, R142, R47, R135, R92, R60, R41, R71, R26, R91, R125, R116, R97). This failure has the potential to affect every resident in the facility.

The findings include:

1. Review of the facility's infection control logs for February, March and April, 2011 showed from 2/22/11 to 4/28/11 eleven residents (R141, R142, R47, R135, R24, R92, R3, R60, R14, R41, and R16) had C-Diff at the facility. Nine of the above eleven residents (R141, R135, R24, R92, R3, R60, R14, R41, and R16) acquired the C-Diff infections at the facility. This showed the facility had a 72% rate of C-Diff acquired infections from 2/22/11 to 5/16/11. Review of the infection

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control logs showed of the 8 acquired C-Diff infections, 1 was acquired in Feb. 2011, 3 were acquired in Mar. 2011, and 4 were acquired in Apr. 2011.

Review of the infection control logs from 2/01/11 to 5/17/11 showed 8 residents with ESBL infections of the urine. Two of the ESBL infections (R21 and R60) were community acquired and 6 of the ESBL infections (R71, R26, R91, R21 (second infection), R17, R125, and R60) were facility acquired. Of the 6 facility acquired ESBL's of the urine 3 of the infections were acquired in Feb. 2011, 1 was acquired in Mar. 2011, and 2 were acquired in Apr. 2011.

Interview with E3 (Assistant Director of Nurses) on 5/18/11 at 1:30 p.m. noted E3 to say all of the residents who acquired C-Diff and ESBL at the facility had no signs and symptoms of C-Diff or ESBL before they acquired the infections. When E3 was asked why residents were acquiring infections at the facility, E3 stated, "I don't know."

2. Further interview with E3 noted E3 to say the facility had no Infection Control Committee at the facility which identified, analyzed, and developed interventions to decrease and/or eliminate facility acquired infections.

3. Review of the Infection Control Tracking Log showed the log to be inaccurate and incomplete.

Review of the Infection Control Tracking Log dated 5/10 to 5/16/11 showed 9 resident in contact isolation. Five of the 9 residents (R135, R3, R47, R4, R14, R41, and R16) were identified occupying the wrong rooms. This log also

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showed R47 had been removed from isolation on 5/06/10. R47 was observed in contact isolation on 5/10/11. Review of the Infection Control Log dated 5/03/11 to 5/09/11 showed one resident (R10) was not listed on the log as being in contact isolation. R10 was observed in contact isolation for VRE (vancomycin resistant enterococcus) on 5/10/11 during the initial tour of the facility. Interview with E3 (Assistant Director of Nurses/Infection Control Nurse) on 5/18/11 at 1:30 p.m. noted E3 to say R10 had been placed in contact isolation on 5/04/11 for VRE of a coccyx wound.

4. Review of R16's nurses notes showed R16 was having LBM's (loose bowel movements) and showing signs and symptoms of C-Diff on 4/26/11. Nursing documentation showed R16 had 8 LBM's on 4/26/11 which 4 LBM's were documented as being watery and foul smelling. Stool collection for C-Diff and antibiotic therapy was ordered. There was no documentation that R16 was placed into contact isolation for possible C-Diff on 4/26/11. R16 was exhibiting signs and symptoms of C-Diff on 4/26/11 but according to the Infection Control Log R16 was not placed into contact isolation until 4/28/11 (2 days later).

Review of the facility's policy on Clostridium Difficile Associated Disease (CDAD) showed, "Contact precautions should be used for CDAD residents with diarrhea." The policy also notes, "A resident is considered to have symptomatic CDAD when:
1. Resident exhibits clinical symptoms, eg., diarrhea, watery or unformed stools occurring more than 3 times per day above the norm for that resident.

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F9999	Continued From page 147 2. Resident usually tests positive for both the C. difficile organism and its toxin. On 5/10/11 during the initial tour of the facility 6 residents were observed in contact isolation for C-Diff (R135, R3, R47, R14, R41, and R16). Review of documentation on R16's CNA Documentation Record for May 2011 showed R16 only had 4 BM's (bowel movements) from 5/1 to 5/12/11. Interview with Z4 (Hospice CNA) on 5/10/11, Z3 (Hospice CNA) on 5/13/11, and E12 (CNA) on 5/12/11 noted all to say R16 was not having LBM's. All interviewed could not remember when R16 had a LBM. R16 remained in contact isolation until 5/13/11. After review of the facility's Infection Control Log, observing residents in isolation for C-Diff without signs and symptoms, and questioning why residents remained in isolation for C-Diff, the other 5 residents were removed out of contact isolation. R10 was removed out of isolation on 5/10/11. R14 was sent to a nearby hospital on 5/12/11. R41 was removed out of isolation on 5/13/11. R3 was removed out of isolation on 5/17/11. R135 was removed out of isolation on 5/18/11. Review of CNA documentation and nurses notes showed all of these residents were asymptomatic of C-Diff and had gone more than 72 hours with formed stools. The facility's CDAD policy regarding discontinuation of isolation noted, "Contact precautions should continue until diarrhea ceases." It also noted, "If no episodes of diarrhea are noted x 48 hours, consult with Infection Control Coordinator and resident physician to discontinue... If no episodes of	F9999		

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resident, physician to discontinue isolation."

Telephone interview with Z1 on 5/19/11 at 1:35 p.m. noted Z1 to say, "Isolation for C-Diff should be discontinued when the resident has not had diarrhea for 3 days per isolation protocol."

5. On 5/11/11 E19 (Housekeeper) was observed cleaning/disinfecting R16's room. R16 was in contact isolation for C-Diff. E19 used a spray glass cleaner to wipe down R16's over bed table, dresser, bedside table, window sill and vent. E19 did not wipe down R16's bedrolls. E19 used a disinfectant bathroom cleaner to clean R16's toilet and a glass cleaner to clean the mirror and sink. After E19 cleaned R16's room and bathroom E19 mopped R16's floor with water which contained a disinfecting floor cleaner. Review of the cleaning/disinfectant product labels and product literature showed none of the cleaning/disinfectant products were effective at killing C-Diff.

Interview with E 24 (Housekeeping Supervisor) on 5/12/11 noted E 24 to say she did not know the cleaners/disinfectants the staff were using to clean/disinfect the residents' rooms did not kill the C-Diff organism.

On 5/12/11 E21 (Housekeeper) was observed cleaning/disinfecting a community shower room in which R141 had just been given a shower. R141 is a resident who has C-Diff infection. E21 sprayed glass cleaner on the lower wall tiles and shower chair, then sprayed the lower wall tiles with a disinfectant bathroom cleaner. E21 mopped the floor with a disinfectant floor cleaner solution. Review of product literature showed the

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glass cleaner, the disinfectant bathroom cleaner, nor the disinfectant floor cleaner solution was effective at killing C-Doff. E21 did not wipe both grab bars, the shower faucet, the shower head, nor the shower room door knob. E21 did go back and use a hospital cleaner disinfectant with bleach (which kills C-Doff after 5 minute contact) on the shower chair, 1 grab bar, the door knob, and light switch, but did not use the product as directed. E21 sprayed the hospital cleaner disinfectant with bleach on the above mentioned items and immediately wiped the items with a dry cloth. This product required a 5 minute contact time to kill C-Diff.

On 5/13/10 E23 (p.m. Housekeeper) was observed ineffectively cleaning a C-Diff contact isolation room. E23 mopped the floor with a floor cleaner solution that was not effective with killing C-Diff.

On 5/17/11 E 23 was again cleaning/disinfecting a C-Diff contact isolation room. E24 (housekeeping supervisor) stood by to observe. E24 stated E23 was using a new product which was effective at killing C-Diff. Again E23 ineffectively cleaned the room. Product information did show the new product was effective at killing C-Diff but a 10 minute contact time was required. E23 was observed wiping the product right away after spraying. E23 also used a hospital germicide disinfectant to mop the floor. Product literature showed the germicide disinfectant did not kill C-Diff. There was also a resident's wheelchair with plastic cushion and bedside commode in the room. These items were not cleaned/disinfected when the room was cleaned.

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On 5/18/11 E19, E25, and E26 were observed terminally cleaning a contact isolation room in which a resident had been removed from isolation who had C-Diff. The terminal cleaning was ineffective due to the resident's bathroom not being cleaned and the hospital disinfectant solution used was not effective in killing C-Diff. Interview with E24 (housekeeping supervisor) noted E 24 to say, "We won't clean the bathroom because R 35 didn't use the bathroom, she used a bedside commode and the residents in the adjoining room used the bathroom." Nursing staff was observed in their PIPE (personal protective equipment) leaning against the bathroom sink to wash their hands and staff used the bathroom to empty R135's bedside commode. E24 was informed the bathroom had to be disinfected.

6. Interviews with Housekeeping staff E19 on 5/11/11 at 11:45 a.m., E21 on 5/12/11 at 10:40 a.m., and E23 on 5/13/11 at 3:30 p.m. noted all to say they did not know why residents in contact isolation were in contact isolation. Each of the housekeepers were observed ineffectively cleaning either resident rooms with C-Diff or community shower rooms after a resident with C-Diff had been showered. Each housekeeping staff admitted that they are not trained/informed of the specific infective organism for which the resident is isolated. Interview with E24 (Housekeeping Supervisor) also disclosed that the housekeeping staff is not trained or informed of infective organisms requiring resident isolation.

7. On 5/11/11 during the general observations of the facility the Laundry Dept. was observed.

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E18 (Laundry Aide) was observed folding clean linen to be prepared for use on the residents beds. E18 was observed folding comforters and blankets. While E18 was folding the comforters and blankets, E18 was letting the comforters and blankets touch and drag on the floor. When the surveyor intervened and told E18 that she was contaminating the linens, E18 first denied that the linens were touching/dragging on the floor. E14 (maintenance supervisor) witnessed the linen touching/dragging the floor and also informed E18 the linen was contaminated. E18's response was, "The housekeeper mopped the floor before she left so it's ok." E18 had to be informed that the linen was now contaminated and had to be washed again.

8. R17 was listed on the infection control log as having positive (+) ESBL (Extended Spectrum Bata Lactamase) in urine, that is health associated. The date of onset was 4/16/11, the date resolved was 4/30/11. The laboratory report of a urine culture collected on 4/14/11 and reported 4/16/11 showed Escherichia coli ESBL greater than 100,000 colonies/ml. with an antibiotic ordered for 7 days. E2 (director of nursing) was interviewed on 5/12/11 and review of facility policy: "Infection control, ESBL" revised 10/27/09 states that isolation contact precautions may be discontinued when the resident is no longer exhibiting signs and symptoms of active infection, or when re-culturing results are negative for ESBL. The policy also states that re-culturing is not routinely recommended, but if ordered, it should be done 72 hours after discontinuation of antibiotic therapy or when in the judgement of the physician the resident is no longer infected. A resident is considered clear

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after two negative cultures are obtained, each one week apart."

E2 said that the facility rule is to have 2 negative cultures to be removed from isolation. R17 had two urinalysis test done on 4/27/11- one at 06:00, and one at 13:30 both were negative and used to remove R17 from isolation. These tests were not done according to policy -one week apart.

Another part of this policy is that residents with ESBL will have their own room or be cohorted with a resident with the same infection. R17 had this infection 2 months in a row, and her roommate has not had this infection.

9. R24 was admitted to the facility on 10/20/10 with diagnoses which included Dementia. R24 had a indwelling catheter and colostomy, was assessed as experiencing short term and long term memory problems and was severely impaired in decision making. On 3/8/11 R24 was transferred to room 109. On 3/21/11 R24 was seen by physician for protrusion of tissue of colononostomy site (with colostomy) and stool specimen collected, stool output noted loose, slimy and greenish. On 3/23/11 stool specimen result was positive for C-diff, and R24 placed on Metronidazole. Metronidazole was discontinued and Vancor started four times a day for 14 days. R24 remained in room 109 and placed on isolation for C-diff. R 24's roommate (R117) was alert and oriented to person with periods of confusion. R24 and R117 remained roommates residing in the facility's cognitively impaired unit until R24 expired on 4/15/11.

Interview with E3 (Infection Control Nurse) on

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5/17/11 at 5:00pm, E3 said he assumed that since R24 had a colostomy the C-diff was contained. E3 said he did not consider that both residents were cognitively impaired, he should have placed R24 in a private room or with another resident with C-diff.

Review of the facility's Clostridium Difficile Associated Disease (CDAD) policy and procedure dated 10/27/09 documents for treatment of residents with suspected/identified CDAD: a private room is recommended, especially for residents who are fecally incontinent or who cannot practice good hand washing. Cohort symptomatic C-diff residents only with other symptomatic C-diff residents.

Review of the facility's isolation surveillance tracking log dated 5/18/11 shows R24 was positive for health associated (facility acquired) CDiff on 3/21/11.

10. During observation blood sugar testing on 5/14/11 at 6:30a.m., E35 performed testing for R116 at 6:30a.m. E35 wiped the blood glucose-testing machine with a Hospital Cleaner Disinfectant Towels with Bleach for less than 20 seconds. Manufacture's directions are to clean and disinfect the meter, wipe with towel until completely wet let stand for 2 minutes.

After completion of the test, E35 removed her gloves and placed the meter on the treatment cart, did not wash hands and went to R97 for glucose testing. E35 placed on gloves wiped, the meter for approximately 30 seconds performed the test removed the gloves placed the meter on the cart no hand washing done.

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E35 went to R4 who is in isolation for Methicillin Resistance Staph Aureus (MRSA) of the urine. E35 put on gloves, went into the isolation room, performed the glucose testing, removed the gloves, and placed the meter on the cart. E35 did not wash hands after the procedure. E35 went to R10 to perform the glucose testing, wiped the meter, waited approximately 40 seconds and went to R10 to perform the glucose testing. E35 performed the same process of not washing hands and placing the meter on the cart. E35 did not have alcohol base on the cart nor did she use soap and water after procedures.

Interview with E35 after the observations, E35 stated she knew she was suppose to wait 2 minutes for the cleaning and disinfecting of the glucose meter and stated she forgot to wash her hands. E35 was not aware of any special requirements for residents who are in isolation. The facility has identified 34 residents in the facility that receive blood sugar monitoring. Four of the 34 residents have infections for which the facility states require contact isolation: R4 (MRSA) of the urine, R10 Vancomycin Resistant Enterococci (VRE) of the wound, R21 Extended Spectrum Beta Lactamase (ESBL) of the urine and R41 with Clostridium Difficile (C-Diff).

11. The facility designates residents with coexisting chronic diseases such as diabetes, arthritis, cancer ,COPD and anemia, as high risk for developing infections.

A review of the facility's policy and procedure on blood Glucose monitoring dated 2/2011 documents hand hygiene and gloves point #2