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F 441	Continued From page 18 schedule will be given. The Program Coordinator will assess and the CNA(Certified Nursing Assistant) supervisor will monitor through the use of Q. A. form. Treatment Nurse E8 was re-educated on proper sterile techniques and isolation techniques with return demonstration by both the Director of Nursing and the wound care physician. All nurses were in-serviced on infection control procedures by both the Assistant Director of Nursing and Housekeeping Supervisor. The Director of Nursing will monitor for overall compliance. All staff will be-inserviced on hand washing techniques and isolation procedures. This change in procedure will be effective April 13, 2012. By April 13, 2012(or next work day for staff members not at work on that day), all staff will be-inserviced on the changes. Any staff members on vacation or leave of absence will be in-serviced immediately on return to work. Additionally, these policies and procedures that are being implemented will also be a part of the orientation process for new employees, as well as a part of the employee in-service program. Overall compliance with this policy and procedures will be the responsibility of the Director of Nursing and on a daily basis his/her designee will monitor and QA the process. Total compliance will be completed by April 13, 2012 and monitored by the Administrator.	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.696a) 300.696b)	F9999		

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F9999	Continued From page 19 300.696c)2)6) 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. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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.	F9999		

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F9999	Continued From page 20 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): 2) Guideline for Hand Hygiene in Health-Care Settings 6) Guideline for Isolation Precautions in Hospitals 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, interview and record review the facility failed to implement aspects of their infection control program for 3 of 7 sampled residents (R3, R5 and R6) and 5 residents (R8, R9, R10, R11, R12) in the supplemental sample on contact isolation. The facility failed to place these residents in private rooms or cohort residents with the same infection in the same room. The facility failed to clean and disinfect environmental surfaces and resident equipment per disinfectant manufacturer's instructions. Facility staff failed to wash hands and wear protective equipment during direct care (R5,R6). Failed to educate a resident on contact precautions (R12). Failed to analyze infection	F9999		

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F9999	Continued From page 21 control data. Findings Include: 1. On 4-10-2012 at 11:30AM during tour with E2 (Director of Nursing), three (3) residents were observed in a four bed room. E2 stated, "...This is one of our infection control rooms...R5 has ESBL (Extended-Spectrum Beta Lactamase) of urine...R8 has MRSA (Methicillin Resistant Staphylococcus Aureus) of wound...R9 has MRSA of urine and VRE(Vancomycin Resistant Enterococcus) in the rectum...and R10 has MRSA of wound..." R5 was in bed with a Gastrotomy tube feeding and a urinary drainage system in place. R9 was in bed and did not verbalize. R10 was sitting in a wheelchair next to R9's bed but did not verbalize anything. R5 has diagnoses to include urinary tract infection secondary to infected bladder stone, Myositic Abscess potential for sepsis syndrome, anorexic encephalopathy, and diabetes mellitus. The Physician Order Sheet (POS) for R5 dated 3-1-2012 through 3-21-2012 documents, "...Contact Isolation for MRSA of nares.." The current POS for R5 dated 3-28-2012 states, ...'Contact Isolation for ESBL urine...". A lab report for R5 dated 3-26-2012 documents, "...Positive for Acinetobacter Baumannii in the urine...". R8 has diagnoses to include right ischial pressure ulcer stage 4, osteomyelitis and chronic sacral wounds. A lab report for R8 dated 11-15-2011	F9999		

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documents, "...Positive for Proteus Mirabilis and positive for MRSA in the wound..." A lab report dated 3-19-2012 documents, "... positive ESBL in the urine..."

R9 has diagnoses to include dementia and neurogenic bladder benign prostatic hypertropy. Lab reports for R9 collected 2-7-2012 and 3-18-2012 document being positive for VRE in the stool.

R10 has diagnoses to include urinary incontinence and diabetes mellitus. A Lab report for R10 collected 10-23-2011 documents Morganella Morganii and MRSA in the wound. A POS dated 4-1-2012 through 4-20-2012 documents, "...Contact Isolation for MRSA of wound...." R10 had one negative culture for MRSA dated 1-28-2012. On 4-13-2012 at 10:24AM, E 2 stated, "...There are no further lab reports...that is all we have..." E2 had no response to the reason why only one culture for MRSA was drawn.

R5, R8 , R9 and R10 are cohorts in the same room for contact isolation.

2. On 4-10-2012 at 11:33AM in the next isolation room, R12 was sitting in a wheelchair. R6 was sitting covered in a shower chair in the hallway. E2 stated, "...This is the other isolation room...R3 is in the hospital...R6 has MRSA in the wound...R11 has ESBL in the urine... and E12 has MRSA of nares..." R11 was not in the room at the time.

R3 was admitted 10/22/10. Lab Reports for R3 are as follows: Reports for 8-17-2011 and

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9-2-2011 were positive for ESBL of urine. Report for 12-14-2011 was positive for VRE in the urine. R3 was hospitalized from 3-11-2012 until 3-26-2012 and was diagnosed with Sepsis secondary to endocarditis according to the hospital records. As a result of this hospitalization, R3 was treated with intravenous antibiotics and had a spleen drain placed. On 4-10-2012 at 1:50PM, E6 (Nurse) stated R3 had a stage two sacral sore prior to hospital admission on 3-11-2012 and when R3 returned from the hospital no longer had a sacral sore. On the morning of 4-10-2012, R3 went out via emergency due to breathing difficulty. .

On 4-11-2012 at 2:52PM, E2 stated,"...I do not know how R3 could have developed sepsis...I did not analyze that trend..I will call the doctor today and speak with him about it..." The current Surveillance Program does not analyze trends or possible reasons for attaining infections.

On 4-12-2012 at 11:16 AM Z1(Attending Physician) stated, "...The most likely source of Sepsis for R3...was urine and the organism is enterococcus...she is functionally immobile..... even with the best incontinent care it could have developed..."

R6 has diagnoses to include multiple ulcers, intraspinal abscess, and diabetes mellitus. A Consultation Report for R6 dated 3-13-2012 documents, "...MRSA in wound..." A Physician Order Sheet (POS) dated 3-26-2012 documents, "...Contact Isolation for MRSA sacral wound...."

R11 has diagnoses to include stroke, diabetes mellitus and acute bronchitis. The April, 2012,

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F9999	Continued From page 24 POS for R11 documents, "...Contact Isolation ESBL in urine...." A lab report dated 4-3-2012 documents Escherichia Coli and Klebsiella Pneumoniae in the urine. R12 has diagnoses to include hypertension and cholecystectomy. A report for R12 dated 3-21-2012 documents positive for MRSA of nares. R3, R6, R11 and R12 are cohorts in the same room on contact isolation. 3. On 4-11-2012 at 2:52PM, E2 stated, "...We do not have too many rooms so if someone is on isolation precautions we put them all-together...I am aware of our policy on isolation...what can we do...we do not have the space..." On 4-11-2012 at 2:52PM, E2, "...I do not know how R3 developed sepsis. I did not analyze that trend. I will call the doctor to day and speak with him about it." The current Surveillance Program does not analyze trends or possible reasons for attaining infections. 4. After being informed of observations of cohort residents R5 and R6 treatment procedures which took place on 4-11-2012, Z1 stated, "...We need to follow isolation precautions, infectious disease protocol and standard precautions...that needs to be investigated... that could cause the sepsis from the enterococcus growth..." 5. On 4-12-2012 at 2:20PM, Z2 (Medical Director) stated , "...The effects of cohorting residents depends on the organism...on colonization and	F9999		

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F9999	Continued From page 25 on the site...I can not answer what would be some of the effects that is has on residents...None of the residents on isolation are my patients.." After being informed of observations made during resident treatment procedures for co-horted residents R5 and R6 on 4-11-2012, Z2 stated," ...I am not there everyday...you were there you made the observations...it is your judgement on what effects of co-horting multiple residents with different MDRO's can have on those residents..." 6. The facility's policy "Fundamentals of Isolation Precautions" (updated 11-5-2009) states, " ...A variety of infection control measures are used for decreasing the risk of transmission of microorganism. These measures make up the fundamentals of isolation precautions. Appropriate placement is a significant component of isolation precautions. A private room is important to prevent direct or indirect contact transmission when the source resident has poor hygiene habits, contaminates the environment or cannot be expected to assist in maintaining infection control precautions. When possible a resident with a highly transmissible or epidemiologically important microorganism is placed in a private room. When a private room is not available, an infected resident is placed with an appropriate roommate. Residents infected with the same microorganism usually can share a room, provided they are not infected with other potentially transmissible microorganisms. Such sharing of rooms, also referred to as co-horting is useful during an outbreak..." 7. On 4-11-2012 at 10:00 AM, E8 (Treatment Nurse) began pressure sore treatment for R6. E8	F9999		

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began by placing clean materials: cotton tip applicators, Mepilex (R) gauze, Aquacel AG (R), Xtrasorb (R), plastic tape measures, and Santyl (R) [squeezed into a medicine cup] on a tray covered with a black substance. E8 did not clean the tray before placing the clean material on it. At 10:18AM, E8 went into an isolation room. R6 was lying in bed without dressings on any of R6's four (4) wounds. E9(Certified Nursing Assistant, CNA) was inside the room to help E8. E8 placed the tray on R11's cluttered, soiled bedside table; R11 is roommate to R6. On the bedside table was a flower pot, books and other personal items that E9 said belonged to R11. R6's bedside table was soiled and cluttered with a purse with contents falling out of it,a computer and cups containing a clear fluid. E8 placed the gauze and wound cleanser on the bedside table. On several occasions during R6's treatment, E8 removed gloves, did not wash hands and opened the door using the door knob to get supplies from a treatment cart in the hallway. Then E8 would come back in room, closed the door using the door knob and placed the supplies on the bedside table. After cleaning the wounds, E8 measured each of R6's four (4) wounds with the tape measures from the soiled tray. E8 applied Santyl (R) to the right shin and the right heel pressure area. The Santyl (R) was taken from the medicine cup with contaminated cotton tip applicators which were on the soiled tray. Before E8 treated R6's largest wound, R6 was incontinent of stool. E8 cleaned stool from R6, removed gloves, donned a new pair of gloves without washing hands, then cleaned R6's large wound with full thickness skin loss with green and yellow slough. E8 stated, " ...This is the infected site MRSA in the wound..." E8 measured the wound using a

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F9999	Continued From page 27 contaminated tape.(11.3 cm by 12 cm). On 4-11-2012 at 10:40AM E10(Nurse) donned a Personal Protective Equipment (PPE)gown in the hallway. E10 came into the isolation room (without washing hands or wearing gloves), leaned over the bedrail with gown touching the railing, raised the head of R6's bed with bare hands, R6 medicine in a cup, lowered the head of the bed, then left the room without washing hands. E10 removed the PPE gown in the hallway. E8, already inside the room, closed the door. During R6's treatment time, on 4-11-2012 at 10:59AM, R12 was in the room. R12 with (MRSA) of nares, while sitting in a wheelchair, began coughing into R12's hands, then without washing hands, rolled self over to the bedside table and touched all of the supplies on the bedside table that were being used for dressing changes for R6. E8 told R12 to "stop" but did not change any of the supplies. R12 stated later in the day that R12 touches everything in this room. R12 had positive lab work for MRSA of nares dated 3-21-2012. Later that day at 2:20pm, R12, (alert and oriented) stated, "...oh I touch everything in this room...I do not know why I am in this room...I do not wash my hands...why do I need to?..." E8 cleaned R6's ischial wound last. E8 measured the area with a contaminated tape measure that was on the soiled tray, applied Santyl (R) with a contaminated cotton tip applicator from the soiled tray (2 cm in length by 4 cm in width partial thickness skin loss). Treatment to R6's pressure sores ended at	F9999		

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F9999	Continued From page 28 11:17AM on 4-11-2012. E8 removed the PPE, washed hands, went outside of the room and wiped the soiled tray with Micro-Kill (TM) for 10 seconds, then proceeded to do R5's treatment in the other isolation room. 8. On 4/11/12, in the hallway E8 placed treatment supplies(Mepilex (R), cotton tip applicators, Skintegrity (R) , plastic tape measure , and Santyl (R) in a medicine cup) on the same tray used for R6. Then E8 and E3(Certified Nursing Assistant) donned PPE and entered R5's room. E8 placed the tray on R5's night stand. The night stand was cluttered with personal items including soiled socks. E8 did not clean the night stand. The supplies were falling off the tray onto the night stand. E8 cleaned R5's sacral wound, measured the would, then applied Santyl (R) with a contaminated cotton tip applicator from the tray. 9. On 4-11-2012 at 11:50AM, after completion of treatments for R5 and R6, E8 was able to scrub/clean all of the black substance from the tray used for the residents treatments. E8 stated, "...I did not clean the tray... Micro-Kill (R) instruction for MDRO kill time 2 minutes according to the package... I did not do that...the tray was dirty...I thought it was ink but I was able to remove the dirty black pieces...I should have washed my hands after removing the gloves and cleaning R6's stool...I did not provide a sanitized surface (bedside table and night stand) to do the treatments on... I should have cleaned the tables prior to placing the supplies on it...that can cause cross-contamination..." Micro-Kill trademark document states, "...Contact	F9999		

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time for a disinfectant is the amount of time a surface must remain wet with the product to achieve disinfection. Overall Kill time needed is 2 minutes...."

10. On 4-13-2012 at 9:17AM, E10 stated, "...I did not have to wash my hands...I did not think I would touch anything...I only came in the room to give R6 pain medicine...I do not remember raising or lowering the head of the bed or taking off PPE in the hallway..."

11. The facility's policy titled, " Fundamentals of Isolation Precautions" (updated 11-5-2009) states, "...Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn. Wash hands immediately after gloves were removed, between contacts and when otherwise indicated. It may be necessary to wash hands between tasks on the same resident to prevent cross-contamination of different body sites..." This same policy states, "... MRSA(Methicillin Resistant Staphylococcus Aureus Prevention: 1. Practice Good Hygiene. Handwashing or use alcohol based hand sanitizer. 2. Compromised skin integrity. Keep cuts scrapes clean and covered with bandage. 3. Contact Isolation. 4. Avoid sharing personal items and 5. Maintaining a clean environment..."

12. On 4-11-2012 at 3:30PM during a meeting with E1(Administrator) and E2, observations of R5 and R6 treatment procedures were discussed. E2 had no response for how the facility monitors staff and residents for compliance with infection control. The Infection Control Policy, updated 11-2-2009, and the last six months of surveillance

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F9999	Continued From page 30 for infection control does not address monitoring for compliance. (A)	F9999		