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F 000	INITIAL COMMENTS Annual Licensure and Certification Complaint # 1263594- IL. 59877 - F315 Complaint # 1263789-IL. 60080 - No deficiencies	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to timely release self releasing devices and provide a medical diagnoses for 2 of 3 residents (R7, R10) reviewed for restraints in the sample of 24. Findings include: 1. R7's Minimum Data Set (MDS), dated 8-1-12, documented, in part, that R7 was totally dependent on one person physical assistance for mobility and transfer. R7's physician's order, dated 6-20-12, documented R7 had a self releasing seat belt to his wheelchair. It was also noted his self release seat belt was to be removed every 2 hours for 10 minutes for meals. During observation of R7's meals, on 10-23-12 and 10-24-12, E4, Certified Nursing Assistant CNA), did not release R7's self releasing seat belt while feeding R7.	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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During interviews with R7, on 10-23-12 at 11:00a.m. and on 10-24-12 at 9:00a.m., R7 stated he could not release his self releasing seat belt. It was also noted R7 attempted during both interviews to release his self releasing self belt was unable to release the belt.

The facility's Physical Restraints policy, revision date 12-8-11, documented, in part, "4. Loosen or remove restraints several times each shift (e.g. every two hours and as needed)." and "5. Medical symptoms that warrant the use of restraints and/or other devices will be documented in the resident's medical record, ongoing assessments, and care plans."

2. Record review of R10's Physician Order Sheet (POS) documents an order on 7-17-12 for a lap top cushion while up in the wheel chair (w/c) for resident safety, due to (d/t) poor standing balance, unsteady gait, weakness, poor safety awareness, release every 2 hours and at meals and during toileting.

R10's Care Plan of 8-13-12 documents R10 requires a lap top cushion while up in w/c prn (as needed) due to poor standing balance, unsteady gait , weakness and poor safety awareness. Care Plan approach includes ensure that restraint will only be used to treat medical symptoms; reevaluate the use and need for the lap top every 90 days and prn; use lap top cushion prn when unable to comprehend safety instructions. CNA release at least 10 minutes every 2 hours for toileting and repositioning and meals.

R10 was observed through out the day on

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F 221	Continued From page 2 10-23-12 and 10-24-12 to have a lap top cushion on her wheel chair. During lunch on 10-23-12, R10 was observed to have her lap top cushion on her w/c even though staff were next to her feeding her. On 10-24-12, R10 had her lap top cushion on during the entire meal at breakfast and lunch with E24 and E23 feeding resident. There is nothing in R10's Pre-Restraining Assessment of 5-24-11 or Physical Restraint Elimination Assessment of 8-1-12 documenting a medical diagnosis/symptom that would warrant the use of the restraint.	F 221		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide timely responses to answering call lights for 1 of 14 residents (R18) reviewed for call lights in the sample of 24, and 4 residents (R26, R27, R28 & R29) in the supplemental sample. Findings include: 1. On 10/24/12 at 10:00 AM during the group interview, R26, R27, R28 and R29 all stated that	F 246		

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F 246	Continued From page 3 they have to wait often times over 30 minutes or more for call lights to be answered. All stated that staff will often come into the room and turn the call light off and tell the residents they will be right back, and do not come back at all. All stated that they have on numerous occasions had to ring the call light again. The Resident Council Minutes were reviewed for the past year. The Council Minutes for June 11, 2012 documented "some of the Certified Nursing Assistant's (CNA's) are answering their call light and then shutting it off and saying they will be back and then it is quite a while before they return. Also, a resident waited in the bathroom quite a while before someone came and got her off." The Council Minutes for August 13, 2012 documented "the residents feel that the call lights could be answered in a more timely manner." The Council Minutes for September 28, 2012 documented "Residents state that call lights being answered timely is still a concern often." After each entry regarding concern for call lights being answered timely, the Council Minutes documented "This will be sent to the Nursing Department." 2. On 10/25/12 at 9:30am, Z1, friend of R18, stated in interview that she has turned the call light on for R18 only to have staff come in and shut it off and leave the room stating they will return in a few minutes. Z1 stated they may not return for up to 30 minutes.	F 246		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities	F 311		

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F 311		F 311		

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specified in paragraph (a)(1) of this section.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to provide restorative services for eating for 3 of 9 residents (R7, R10, R11) of 9 reviewed for restorative services in a sample of 24.

Findings include:

1. R10's MDS of 8-2-12 documents R10 is totally dependent on staff for eating.
R10's Care Plan of 8-13-12 documents R10 has an eating self care performance deficit related to Alzheimer's, Dementia with behavior disturbances Depression, agitation, short and long term memory impairments. Care Plan documents R10 is on an eating program. Care Plan approach includes, in part, "Eating Restorative Program. CNA will 1. start with a drink. 2..May use drink to try to wake R10, but if does not wake up after two drinks, wait until she wakes up then attempt to have her take another drink. 3. use small nosey cups with all drinks. 4. assist R10 with eating as needed. 5. If R10 is never awake during meal, recommend trying with sandwich and fruit when she is awake.

On 10-24-12 at breakfast meal, R10 was fed by E24, CNA and noon meal by E23 CNA. R10 was not encouraged or given the opportunity to feed herself.

2. The data sheet identifies R11 to be an 88 year old female admitted to the facility on 3/31/10 with

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diagnoses of abnormal gait and depression. According to the MDS dated 9/5/12, R11 requires total assistance for all aspects of activities of daily living including eating and has severe cognitive impairment. According to the Restorative Program Tracking Log, R11 is currently on an eating restorative. The restorative section of the care plan dated 9/5/12, includes a goal to "safely eat all meals with staff assist." Interventions include: give all liquids by cup, no straws, start all meals with a drink, alternate 2 bites/1 drink throughout entire meal and end all meals with a drink."

At the lunch meal on 10/23/12 and 10/24/12, R11 was observed to be totally fed per staff and not observed to participate in feeding herself.

On 10/25/12 at 4pm, E16 Licensed Practical Nurse (LPN)/Restorative Nurse was asked for an eating assessment and was unable to provide any for R11. E16 stated she has no assessments for restoratives or any other documentation including quarterly notes unless information is available from therapy. On 10/26/12 at 12:15pm, E1 Administrator confirmed that no assessment and/or documentation is available on the restoratives.

3. R7's Minimum Data Set (MDS), dated 5-12-12, documented R7's eating functional status as limited assistance of one person physical assist. The facility's Restorative Program Log, not dated, documented R7 was in a restorative eating program. R7's Care Plan, target date 1-20-13, documented, in part, "1. Set up all food so can easily be eaten. 2. encourage res (resident) to feed self 3. assist as needed but

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F 311	Continued From page 6 allow him to do as much on own as possible." During R7's meal observations, on 10-23-12 at 12:30p.m. and on 10-24-12 at 8:45a.m., E4, Certified Nursing Assistant (CNA), fed R7 his meals without encouraging R7 to feed himself. R7 was observed attempting to feed himself. E17 (CNA) was also observed, on 10-23-12, feeding R7 his afternoon snack without encouraging R7 to feed himself or setting his snack up so that R7 could feed himself. R7's MDS, dated 8-1-11, documented R7's eating functional status had declined to extensive assistance of one person physical assistance. R7's Occupational Therapy Evaluation, dated 12-2-11, documented "Pt (patient) achieved max (maximum) rehab potential at this time...Pt trained on proper positioning at w/c (wheelchair) level; self-feeding with hand to mouth approximation. Pt. needed mod/max (moderate/maximum) verbal cues to participate in tasks."	F 311		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		

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F 315	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record record, interview and observation, the facility failed to provide thorough incontinent care for 3 of 5 residents (R10, R11, R17) reviewed for incontinent care in the sample of 24. Findings include: 1. R17's Minimum Data Set (MDS), dated 8-22-12, documented cognitive impairment, incontinent of bowel and bladder and extensive assistance of one person physical assistance with mobility and toileting. R17's Care Plan, target date 11-18-12, documented R17 was incontinent of bowel and bladder related to active infection with symptom of UTI (Urinary Tract Infection). It was also noted to "wash, rinse and dry perineum" after incontinence. During observation of R17's transfer and incontinent care, on 10-24-12, E4, Certified Nursing Assistant (CNA), transferred R17 from chair to bed. E4 removed R17's urine soiled adult diaper. E4 wiped fecal matter from R17's anal area. E4 did not completely cleanse R17's buttock and or clean R17's perineal area before E4 placed another adult diaper on R17. 2. R10's MDS of 8-2-12 documents R10 is totally dependent on staff for toilet use and hygiene and is frequently incontinent of bowel and bladder. R10's Physician Order Sheet (POS) of October 2012 documents a diagnosis, in part, UTI.	F 315		

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On 10-23-12 at 11:40AM, E23, CNA was observed to take R10 to her room and put her on the toilet per mechanical stand lift. R10's incontinent brief was saturated with urine and she had a large bowel movement. E23 stood over the toilet using the standing lift and wiped between her buttocks and on the buttocks. E23 did not do any front perineal care or wash R10's abdomen that had been soiled with urine.

3. The data sheet identifies R11 to be an 88 year old female admitted to the facility on 3/31/10 with diagnoses of abnormal gait and depression. According to the MDS dated 9/5/12, R11 requires total assistance for all aspects of activities of daily living and has severe cognitive impairment. The MDS also identifies her to be always incontinent of bowel and bladder. The restorative section of the care plan dated 9/5/12, includes a goal to have no complications for her incontinence with an intervention for a scheduled toileting plan, check/change protocol upon awakening, before meals, during morning/evening care, at regular intervals while in bed and as needed (PRN.) In addition, it includes checking and changing resident hourly and as needed. The care plan identifies R11 to be at risk for a urinary tract infection.

On 10/24/12 at 9:30am, R11 was observed up in her wheelchair. She was noted to remain in her wheelchair with observations noted every 10-15 minute intervals. R11 was transferred to bed at 1:50pm by E12 and E13, Certified Nurses Aide (CNA's). R11's incontinent brief was saturated with urine and while E12 provided incontinent care, smears of bowel movements were wiped

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F 315	Continued From page 9 from her rectal/perineal area. Areas wet with urine not cleansed included outer buttocks, left hip. In addition, no toileting and/or check/change was provided as indicated in the care plan for hourly, before meals. On 10/25/12 during the daily meeting, E1 indicated that both E12 and E13 stated they had laid R11 down between 10:30 and 10:45 to check/change. This was not observed. However, no other opportunities were provided in the the three hours between 10:45am and 1:50pm.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record review, the facility failed to ensure that 2 of 15 residents (R11, 16) of 15 reviewed for range of motion on a sample of 24. Findings include: 1. The data sheet identifies R11 to be an 88 year old female admitted to the facility on 3/31/10 with diagnoses of abnormal gait and depression. According to the MDS dated 9/5/12, R11 requires total assistance for all aspects of mobility and	F 318		

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F 318	Continued From page 10 has severe cognitive impairment. The MDS also identifies her to have no limitations of range of motion with no range of motion provided to prevent contracture development. The restorative section of the care plan dated 9/5/12 under "Focus", however, documents R11 "requires total assist for all ADL's (activities of daily living) and transfers(mechanical lift) with 2 staff. She has R (right) arm and R leg contractures." The care plan fails to identify any services addressing R11's right sided contractures. On 10/25/12 at 4pm, E16 Licensed Practical Nurse (LPN)/Restorative Nurse was asked for range of motion assessments and was unable to provide any for R11. In addition, the passive range of motion (PROM) list E16 provided does not identify R11 as a resident who receives services for contracture treatment or prevention. On 10/26/12 at 10:am, E18 Registered Nurse stated that the only assessments she is aware of for range of motion purposes is the MDS. On 10/23/12 at 1:50pm, R11 was transferred via a mechanical lift to bed. She did not participate in the transfer at all nor did she assist in bed mobility as care was provided. She was noted to keep her right arm across her chest at all times. On 10/26/12 at 1:15pm, E1 Administrator provided a physical therapy Evaluation completed by E22 Physical Therapist (PT) dated 4/23/12 that documented R11 was referred to therapy due to have poor positioning. The eval documents R11 "has poor balance, is dependent c (with) transfers, & has B (bilateral) LE (Lower Extremety) ROM (Range of Motion.)	F 318		

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On 10/26/12 at 1:20pm, E22 confirmed that R11 has limitations bilateral lower extremeties and would be a candidate for PROM. E22 stated he did not assess her for PROM at the time. E22 also stated that an assessment for PROM should be done in order to be able to determine if services provided are effective.

2. R16's Care Plan, target date 12-4-12, documented self care deficit related to, in part, decreased physical mobility, weakness and impaired cognition. It was also noted that R16 was on a PROM (passive range of motion) Restorative Program with 3-5 repetitive motions to be done in all extremities.

During observation of R16's PROM, on 10-25-12 at 8:40a.m., E5, Certified Nursing Assistant (CNA), only provided bilateral PROM's for R16's shoulder joint (flexion and extension and abduction and adduction), finger joint (flexion and extension) and hip joint (flexion and extension). E5 did not provide 3-5 repetitives motions to all extremities.

The facility's Range of Motion Exercises policy, revision date 12-7-11, documented how to physically support the shoulder, elbow, wrist, thumb and finger, hip and feet and toes with range of motion of exercisers. The policy did not document planes.

Interview of E2, Director of Nursing (DON), on 10-26-12 during refutation, E2 stated she would look for further policy(s). No additional policies were provided.

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F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on interview, observation and record review, the facility failed to ensure that adequate supervision and assistance to prevent falls was provided for 1 of 11 resident (R1) reviewed for falls in a sample of 24. This failure resulted in R1 falling which resulted in multiple fractures requiring surgical interventions.

Findings include:

1. According to the falls log, R1 fell and sustained a fractured distal right humerus, a spiral fracture of the distal tibia, and a comminuted fracture of the right distal femoral shaft on 5/4/12. The Minimum Data Set (MDS) dated 3/8/12 identifies R1 to have no cognitive impairment and no memory deficits. The MDS indicates R1 required limited assist of one staff for transfers, walking in room, and toilet use. The MDS also indicates R1 was not steady, "only able to stabilize with human assistance" for walking and moving on/off the toilet.

The Incident/Accident Report dated 5/4/12 indicates R1 had a witnessed fall and

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR HAVENS CHRISTIAN HOME	1790 SOUTH FAIRVIEW AVENUE DECATUR, IL 62521

(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 323	Continued From page 13 documented "res (resident) states she was walking back to recliner from commode et (and) slipped. Stated "Must have peed on the way to the bathroom because the floor was wet." The summary of comprehensive Investigation concluded that R1 was being assisted back to the bed and R1 slipped on dribbled urine. The report documents the "CNA (Certified Nurses Aide) was unable to prevent resident from falling." Information obtained following the fall, documents that E11, CNA, failed to use a gait belt. Interview with E11, CNA, on 10/26/12 at 9:45am confirmed that R1 did not have a gait belt on when she ambulated her from the recliner to the commode. E1 stated she turned to get toilet paper and barrier cream and when she turned back around, R1 had started to ambulate by herself. E11 stated R1 fell to the floor. E11 stated there may have been urine on the floor but wasn't sure. E11 acknowledged that she should have had a gait belt on R1 at the time of the transfer. Interview with E1, Administrator, on 10/25/12 at 1:45pm confirmed that the CNA did not use a gait belt and acknowledged that gait belt use is a facility policy. The facility policy entitled "Gait Belt" dated 5/26/09 documents that it is the policy of the facility that gait belts are utilized on all residents requiring physical assistance with transfer unless contraindicated. Under section 2, it documents "Direct care staff will utilize the gait belt for all transfers requiring "hands-on" assistance with a pivot or manual transfer.	F 323		

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F 323

Continued From page 14

On 10/23/12 at 4pm, R1 was in her wheelchair at bedside. She had a hoyer sling under her and stated she has been a total mechanical lift since her fall and is not walking yet. R1 stated she is hopeful to return home. R1 recalled the fall and stated she still has a wound from surgery on her fractured arm. R1 stated she is still recovering from the fall with therapy as well.

F 363 SS=E

483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED

Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure menus and recipes were followed for 7 of 14 residents (R6, R9, R10, R11, R16, R20 and R21) reviewed for diets in the sample of 24 and 14 residents (R32 and R35 thru R46) in the supplemental sample. Findings include:

1. Record review of Resident Council Meeting notes of 9-28-12 document the October 2012 meal of the month included Ham and Beans, Cornbread, Coleslaw (without carrots), green beans and a choice of either pumpkin or apple pie.

The menu for noon meal on 10-23-12 documents residents on a pureed diet were to receive pureed

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FAIR HAVENS CHRISTIAN HOME	1790 SOUTH FAIRVIEW AVENUE DECATUR, IL 62521

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F 363	Continued From page 15 pizza, pureed tossed salad, pureed capri vegetable blend pureed garlic toast and pureed cranberry chill. The alternate menu for the pizza was pureed meatloaf and mashed potatoes. During the noon meal on 10-23-12, R6, R11, R16, R20 and R21 were observed to get the alternative menu of meat loaf and confetti potatoes and got pie for dessert. That is all the only food they received at the noon meal. They did not get the corn bread, coleslaw or green beans. Observation of the tray line showed there was no pureed slaw, cornbread, or green beans. Other residents on a pureed diet include R32, and R35 thru R46. Interview with E20, Dietary Manager, on 10-23-12 during noon meal, E20 stated that residents were getting the meal of the month. E20 was asked why residents on pureed diets did not get ham and beans and she stated they got the alternate menu. Interview with Z2, Dietitian, on 10-26-12 at 11:45AM, Z2 stated if the facility was using the alternate menu for the pureed diets she would have expected them to get also have gotten the pureed tossed salad and pureed garlic bread. Also during the noon meal residents on regular and/or mechanical soft consistency, R9, R10, R30, R31, R33 and R34 were observed to get meat loaf and confetti potatoes and pie, they did not receive any vegetables or corn bread. The menu for noon meal on 10-24-12 documents residents on a pureed diet were to receive pureed creamy beef pasta, pureed baby carrots, pureed bread, raspberry whip, and margarine. The alternate to the creamy beef pasta was pureed breaded chicken with broccoli patty and pureed red bliss potatoes. During noon meal on 10-24-12, R6, R11, R16, R21, R32, R35, R36, R38, R41, R43, R44, and R46 were observed to	F 363		

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FAIR HAVENS CHRISTIAN HOME	**1790 SOUTH FAIRVIEW AVENUE** **DECATUR, IL 62521**

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F 363	Continued From page 16 get 1/2 cup of pureed Chicken Breaded with Broccoli and cheese, 1/2 cup of pureed potatoes and 1/2 cup raspberry whip. That is the only food items residents on pureed diets received. The pureed potatoes were the consistency of gravy and ran all over the plate when served. Observation of the tray line showed there was no pureed carrots or pureed bread and residents did not receive margarine. Interview with E21, the cook, at 11:35AM, E21 stated she had prepared the pureed food. E21 was asked how many residents were on pureed diets and she stated she didn't know, "I know there are more than 10." E21 stated the only food she prepared for the pureed diets was the chicken/broccoli patty and the potatoes. Interview with Z2 on 10-26-12 at 11:45AM, Z2 stated residents on the pureed diet should have also received pureed bread and margarine. Z2 stated the potato substituted for the carrots. 2. Interview with R43 on 10-25-12 at 3:45PM, R43 stated the pureed food is not hardly flavored at all and she would like to see the food have a little more feeling to it. "It' s too runny and hard to even keep on a spoon at times." 3. During observation of the noon meal, on 10-23-12, R9, R31, R20, R30, R32, R33 and R34 the following residents were not served a vegetable with their meals.	F 363		
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.	F 366		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR HAVENS CHRISTIAN HOME	**1790 SOUTH FAIRVIEW AVENUE DECATUR, IL 62521**

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F 366	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide/offer substitutes for 2 residents (R12, R19) of 22 residents reviewed for substitutes on a sample of 24 and one resident R48 on the supplemental sample. Findings include: 1. On 10/24/12 at 12:51pm, R48 was observed sitting at his table place in the dining room. He had eaten 100% of his meal except his carrots. R48 stated he "hated" carrots as he shook his head. No substitutes were observed being offered. At 12pm on 10/24/12, E20 Dietary manager stated she had no substitutes for carrots made but added "I can fix one if you want one." 2. On 10/23/12 at the noon meal, R19 received ham and beans. She stated she did not like the soup and sat for an extended time before picking at her cornbread. No staff offered substitutes at the time until the surveyor intervened. 3. The tray line in the kitchen and main dining room, no substitutions were present for the carrots. 4. R12 ate no carrots at the noon meal on 10/23/12 and no substitutes were offered.	F 366		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		

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F 441	Continued From page 18 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure staff remove gloves and	F 441		

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F 441	Continued From page 19 wash their hands after giving incontinent care and before touching clean items for 3 of 5 residents (R10, R11 and R17) reviewed for Urinary Tract Infection (UTI) in the sample of 24. Findings include: 1. R10's MDS of 8-2-12 documents R10 is totally dependent on staff for toilet use and hygiene and is frequently incontinent of bowel and bladder. R10's Physician Order Sheet (POS) of October 2012 documents a diagnosis, in part, UTI. On 10-23-12 at 11:40AM, R10 was observed to be incontinent of bowel and bladder. E23, Certified Nurse Aid, (CNA), was observed to do incontinent care and then touch R10's clean incontinent brief, pants, the mechanical standing lift, R10's call light and button to raise and lower the bed, while wearing the same soiled gloves. 2. On 10/24/12 at 9:30am, R11 transferred to bed at 1:50pm by E12 and E13, CNA's. R11's incontinent brief was saturated with urine. Both CNA's had gloves on as incontinent care was provided. Neither CNA removed their gloves following the care before handling clean linens, clothes and call light. 3. R17's Minimum Data Set (MDS), dated 8-22-12, documented cognitive impairment, incontinent of bowel and bladder and extensive assistance of one person physical assistance with mobility and toileting. R17's Care Plan, target date 11-18-12, documented R17 was incontinent of bowel and bladder related to active infection with symptom of UTI (Urinary Tract Infection). It	F 441		

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F 441	Continued From page 20 was also noted to "wash, rinse and dry perineum" after incontinence. During observation of R17's transfer and incontinent care, on 10-24-12, E4, Certified Nursing Assistant (CNA), transferred R17 from chair to bed. E4 removed R17's urine soiled adult diaper. E4 cleansed R17's anal area of a small fecal matter smear. E4 did not change her gloves. E4 touched R17's clean skin, linens, bed and clean adult diaper with soiled gloves. 4. On 10/23/12 at 1:50 PM, E19, CNA was observed to perform incontinent care for R25. R25 had been incontinent of bowel and bladder. After transferring R25 to the bed from the wheelchair, E19 removed R25's pants and noted that R25 had been incontinent of bowel and bladder. R25 was placed on a bedpan. E19 removed the bedpan, which had loose stool and urine, and moved it to the side of the bed. After cleansing R25, E19 removed the glove on the left hand and took the soiled bedpan into R25's bathroom and used the faucet from the sink to fill up the bedpan with water, swirled the water around in the bedpan and dumped the excrement into R25's toilet. E19 then used paper towels to dry the bedpan and placed it into a plastic bag and set it inside a nightstand drawer. E19 then removed the glove from the right hand. There was no use of a chemical-based cleanser to disinfect the bedpan. 5. The facility's policy entitled "Glove Usage/Peri-care" documents staff are to "remove gloves promptly after use, before touching non-contaminated/clean items and environmental surfaces."	F 441		