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NEW ATHENS HOME FOR THE AGED	203 SOUTH JOHNSON STREET NEW ATHENS, IL 62264

(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 000	INITIAL COMMENTS	F 000		
F 221 SS=D	Annual Certification Survey 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 observation, interview, and record review, the facility failed to assess and document the risk versus benefits for the use of restraints for 1 of 3 residents (R2) reviewed for restraints in the sample of 11. Findings Include: R2's June 2016 Physician Order Sheet (POS) documents R2 has diagnoses of Arthritis, Abnormal Gait, and Degenerative Joint Disease. R2's Bed Rail/ Assist Bar Evaluation, dated 05/16/16, documents R2 has 2 upper side rails to help promote independence with bed mobility and positioning. R2's Bed Rail/Assist Bar Evaluation also documents R2 has decreased trunk strength and poor gait. R2's Bed Rail/Assist Bar Evaluation form does not document the risk versus benefits for the use of side rails. On 06/14/16 at 1:30 PM, R2 was in her bed lying on her back with full side rails up with padding. R2 also had bolsters on her bed.	F 221		

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

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F 221	Continued From page 1 On 06/16/16 at 1:30 PM, during passive and active range of motion, R2 was able to raise both arms and raise both of her legs. R2's Investigative Report, dated 11/10/15, documents (in part) R2 is combative during care, and she could have hit her nose on the side rail. R2 was found with a 1.2 x 4.0 centimeter bruise to her nose. In an interview, on 06/16/16 at 1:15 PM, E14, Assistant Director of Nursing (ADON), stated "(R2) was in another room on a low air loss mattress. When she was moved to this room without the low air loss mattress, her side rails were not removed, but we will remove them now." The undated Facility Policy entitled Restraint Policy /Physical documents "the type of restraint in use must be the least restrictive device and be the result of documented alternatives tried prior to application. Documentation must also include the consideration of risks of use versus the benefit of use."	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry	F 225		

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F 225	Continued From page 2	F 225		

or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the Facility failed to ensure the administrator is notified immediately of all allegations of abuse and immediately start the initial investigation for 1 of 1 residents (R1) in the sample of 11 and 2 residents (R15, R16) in the supplemental sample reviewed for abuse.

Findings include:

1. A" Report of Alleged Abuse" documents in part,

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Alleged Abuse date of 04/30/2016 with the report date of 05/02/2016. "During the afternoon on 04/30/2016, (E4, Certified Nursing Assistant, CNA) witnessed (R1) walking out of her room towards another resident's, and toss a pillow at (R15). (R15) stated 'Shut up' as (R1) continued walking down the hall. (E4) immediately notified (E5, Licensed Practical Nurse, LPN). The above incident was not reported to (E1, Abuse Coordinator/Administrator), until the morning of 05/02/2016 by (E6, Social Service Director) who was asked about the incident while working on 05/01/2016."

On 06/16/2016 at 4:12 PM, E2, Director of Nursing stated "(E4),(E5) and(E6) were written up on 05/02/2016 for not properly reporting possible resident to resident abuse in a timely manner."

2. The Nurses Notes for R16 dated 02/24/2016 9:05 PM document in part, resident very upset this evening stating that on Monday a tall therapist came into her room for therapy and resident told her she had to go to the bathroom. (E12) therapist identified stated "you can go on the bedpan." Resident stated it hurts her back and she was here to learn how to strengthen her back to use the commode. Therapist stated "No you are going to use the bedpan. I do not have time for that". Resident stated that this is why she is here and the bedpan hurts her back. Therapist still put resident on bedpan and resident stated her back was hurting and therapist gave (R16) her an emolism reduction hose and told her to put them on and (R16) stated this is why I am here so I can learn to do these things and (E12) stated "I do not have time for therapy now, spent too much time getting you

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F 225	Continued From page 4 dressed; resident then stated just give me my hose and shoes and I will do it myself. (R16) then stated she was then in her bed crying and was so upset at how rude and mean the therapist was to her." The Report of Alleged Abuse documents, in part, the alleged abuse date of 02/25/2016 and the report date of 03/02/2016. The allegation was unsubstantiated by the investigation. On 06/16/2016 at 4:54 PM, E2 stated "A note was left on my door rather than calling me or the administrator immediately regarding (R16). As soon as I got the note and became aware of the allegation we started an investigation immediately. I am not sure why I was not contacted immediately, I should have been contacted. That was not the protocol and a note should never be left at the door."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Facility failed to follow their written policy to ensure the administrator is notified immediately of all allegations of abuse for 1 of 1 residents (R1) in the sample of 11 and 2 residents (R15, R16) supplemental sample.	F 226		

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Findings include:

1. The Facility Policy and Procedures Manual, revised date of 05/15/2013, documents in part, "It is the every ones responsibility to report suspicions of neglect or abuse to the Abuse Prevention Coordinator immediately."

2. A" Report of Alleged Abuse" documents in part, Alleged Abuse date of 04/30/2016 with the report date of 05/02/2016. "During the afternoon on 04/30/2016, (E4, Certified Nursing Assistant, CNA) witnessed (R1) walking out of her room towards another resident's, and toss a pillow at (R15). (R15) stated 'Shut up' as (R1) continued walking down the hall. (E4) immediately notified (E5, Licensed Practical Nurse, LPN). The above incident was not reported to (E1, Abuse Coordinator/Administrator), until the morning of 05/02/2016 by (E6, Social Service Director) who was asked about the incident while working on 05/01/2016."

On 06/16/2016 at 4:12 PM, E2, Director of Nursing stated (E4), (E5) and (E6) were all written up on 05/02/2016 for not properly reporting suspected resident to resident abuse in a timely manner to the administrator.

3. The Nurses Notes for R16 dated 02/24/2016 9:05 PM document in part, resident very upset this evening stating that on Monday a tall therapist came into her room for therapy and resident told her she had to go to the bathroom. (E12) therapist identified stated "you can go on the bedpan." Resident stated it hurts her back and she was here to learn how to strengthen her back to use the commode. Therapist stated "No

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F 226	Continued From page 6 you are going to use the bedpan. I do not have time for that". Resident stated that this is why she is here and the bedpan hurts her back. Therapist still put resident on bedpan and resident stated her back was hurting and therapist gave (R16) her an emolism reduction hose and told her to put them on and (R16) stated this is why I am here so I can learn to do these things and (E12) stated "I do not have time for therapy now, spent too much time getting you dressed; resident then stated just give me my hose and shoes and I will do it myself. (R16) then stated she was then in her bed crying and was so upset at how rude and mean the therapist was to her." The Report of Alleged Abuse documents, in part, the alleged abuse date for the incident was 02/25/2016 and it was not reported until 03/02/2016. The alleged abuse was unsubstantiated by the investigation. On 06/16/2016 at 4:54 PM, E2 stated "A note was left on my door rather than calling me or the administrator immediately regarding (R16). As soon as I got the note and became aware of the allegation we started an investigation immediately. I am not sure why I was not contacted immediately, I should have been contacted. That was not the protocol and a note should never be left at the door."	F 226		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		

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accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to provide timely assessment and treatment for one of 5 residents (R4) reviewed for pain in the sample of 11. This failure resulted in a delay in diagnosis of R4's fractured patella.

Findings include:

R4's Minimum Data Set, (MDS), dated 5/16/2016, documents a moderately impaired cognitive level.

R4's Fall incident Report, dated 8/24/2015 at 7:30 AM, documents in part, "Resident was on the ground, leaning with her back against the bed. (E3, Certified Nursing Assistant, CNA) that answered her call light called for nurse and other CNA down to resident's room. Resident had blood on her and the floor."

The facilities Investigative Report for Fall for R4, date of incident 8/24/2015 at 3:30 AM, documents, that E3 found R4 on the floor.

R4's Progress Note, dated 8/24/2015 at 11:42 AM, documents that R4 complained of pain and refused Skilled Occupational Therapy.

R4's Progress Note, dated 8/25/2015 at 9:35 AM, documents that R4 refused Physical Therapy and reported "I don't feel good, I hurt all over."

R4's Progress Note, dated 8/26/2015 at 3:00 AM,

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documents in part, "complains of pain to legs PRN (as needed)."

R4's Progress Note, dated 8/27/2015 at 11:19 AM, documents in part, "continues to complain of pain."

R4's Progress Note, dated 8/29/2015 at 9:43 AM, documents in part, " c/o (complaint of) B (both) knee pain."

R4's Progress Note, dated 9/1/2015 at 2:00 PM, documents in part, "Patient voices same c/o pain in knees."

R4's Progress Note, dated 9/2/2015 at 2:30 PM, documents in part, "Resident complaining of pain to the LT (left) knee, given Norco 5/325 mg (milligrams)."

R4's Progress Note, dated 9/3/2015 at 2:45 PM, documents in part, "complained of increased pain to L (left) knee. PRN Norco given."

R4's Progress Note, dated 9/4/2015 at 10:45 AM, documents in part, "presents with SOB (shortness of breath), coupled with CO (complaint) of pain in L knee. Nurse reports that x-ray was ordered of L knee."

R4's Progress Note undated and no time documents in part, "xray of Left knee D/T (due to) c/o pain and discomfort with no relief from analgesic cream and swelling."

R4's Patient Report x-ray of left knee, dated 9/4/2015 at 5:02 PM, documents in part, "mildly comminuted transverse patellar fracture seen with mild diatases measuring 3 mm (millimeters).

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Follow up recommended."

There is no documentation in R4's clinical record of an assessment of R4's left leg /knee from 8/26/2015 until 9/4/2015.

R4's Physicians Orders, dated 9/4/2015, document weight bearing as tolerated, refer for Orthopedic consult, care pain meds and Physical Therapy as tolerated.

R4's Physicians Orders, dated 9/8/2015, documents in part, "please ice and elevate left knee when laying in bed."

On 6/15/2016 at 1:57 PM, E2, Director of Nurses (DON), said, "I would expect the nurses to do an assessment each shift with complaints of pain to a resident's knees." E2 also said that she would expect the nurses to contact the physician within 48 hours if pain persists. E2 could not provide documentation when the physician was contacted with R4's complaint of leg pain.

On 6/16/2016 at 10:11 AM, E3 said that she did not recall R4 falling on 8/24/2015. E3 also said that she could not recall if R4 has pain.

The facility's Resident Accident and Incident Evaluation & Investigation, Tracking and Monitoring policy documents in part, "Standard: Residents experiencing a fall or other incident will be promptly assesses for injury and investigation for causative factors. Policy: The medical record will reflect the occurrence, findings, actions, and outcome as appropriate. A multi-level review will be conducted to insure optimum response and minimize repeat occurrences. 1. Nurse on duty assess for injury, medical and nursing

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F 309	Continued From page 10 interventions, taking actions accordingly."	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure accurate amounts of gastrostomy tube feedings were infusing as ordered for one of one resident (R6) reviewed for gastrostomy feedings in the sample of 11. Findings Include: R6's Physician Order Sheet (POS), dated	F 322		

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06/01/16, documents R6 has a diagnosis of Quadriplegia C1-C4 complete, and is to receive nothing by mouth due to this. R6's POS documents R6's gastrostomy tube water flush is 400 cubic centimeters (cc) every four hours.

R6's Nutritional Assessment, dated 06/02/16, documents R2's gastrostomy tube feeding is Vital 1.5 at 50 (cc)/hour (hr) x 23 hr, and R6 should receive 1818 calories/per day. The Nutritional Assessment also documents R6 has a history of volume intolerance, and recommend continue tube feeding, but decrease the flush to 200 cc every four hours.

On 06/14/16 at 10:10 AM, R6's Vital 1.2 900 cc tube feeding bag was labeled as hung at 9:00 PM on 6/13/16 and the tube feeding pump was not running. On 06/14/16 at 10:30 AM, R6's tube feeding pump was not running and there was 700 cc left in the tube feeding bag.

R6's POS, dated 06/01/06, documents that if R6 has an emesis, the tube feeding is to be stopped for four hours.

R6's Nurses Note, dated 06/14/16 at 0500 AM, documents R6 had a small tan emesis and his feeding pump was turned off per doctors order. Based on this according to the POS, R6's feeding pump should have been turned back on at 9:00 AM.

On 06/16/16 at 7:50 AM, R6's Vital 1.2 tube feeding bag was labeled as hung at 10:10 PM on 06/15/16. At 7:50 AM on 06/16/16, 650 cc was remained in the bag. There should only be 400 cc remaining if the tube feeding was administered as ordered.

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F 322	Continued From page 12 R6's Nurses Notes for 06/15/16 and 06/16/16 have no documentation of emesis. The facility Gastric Feeding Monitoring for and Prevention of Complications policy, dated 08/20/90 documents (in part) "a resident who is fed by gastrostomy tube receives appropriate treatment and services to prevent complications."	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 and record review, the Facility failed to ensure the proper functioning of alarms to alert staff for the prevention of falls for 1 of 3 residents (R5) reviewed for falls in the sample of 11. This failure resulted in R5's fall with fracture of her left upper arm. Findings include: R5's December 2015 Physician Order Sheet (POS) documents in part, a diagnosis of syncope and collapse, transient cerebral attack, unsteady gait and poor balance. The POS also documents the order for furosemide (a diuretic for the	F 323		

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swelling in her legs). R5's Minimum Data Set, dated 12/17/2015, documents R5's balance was not steady, only able to stabilize with staff assistance, and is on Hospice.

The Care Plan, with a target date of 06/15/2016, documents under Black Box Warning: Diuretic drug can cause severe diuresis with water and electrolyte depletion monitor patient closely. Focus Section, undated documents (R5) is unable to transfer safely and /or independently related to unsteady gait. History of Transient Ischemic Attack and history of syncope with collapse. Transfers Pressure Sensitive Alarm applied to bed and wheelchair. It also documents R5's fall with a fractured humerus on 12/16/15 with interventions to implement toileting schedule.

Nurses Notes for R5, dated 12/16/2015 8:07 PM, document in part, "resident not wanting to go to bed, (E18, Certified Nursing Assistant, CNA) attempted to put resident to bed but resident stated 'I get nervous when I lay down in bed.' Gave resident scheduled Ativan, sat and talked with resident for 15 minutes. Resident in recliner with pressure alarm in place and working, Call light in reach."

Nurses Note, dated 12/16/2016 at 11:15 PM, document in part, "Late Entry. This nurse (E18, Licensed Practical Nurse, LPN) was at north hall station getting a report when I heard yelling, 'Help, Help,' as I came to (R5's) room noted resident laying face down to the floor with left arm extended out under her, Resident stated 'was in her recliner trying to go to the bathroom' resident had a pressure pad alarm in her recliner but did not sound."

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F 323	Continued From page 14 The Incident Report, dated 12/16/2015, documents in part, (R5) was attempting to ambulate to bathroom and was found lying face down, alarm not sounding. The Fall Incident Report, dated 12/17/2015, document in part, alarm applied and the box "no" was checked for section 4. Independent with Toileting. Prior Toileting date and time 12/16/2015 8:07 PM. On 06/15/2016 at 2:30 PM, E2, Director of Nursing stated "(R5) had a fall at home and has a history of a fracture. She had not been here long when she was ambulating without assistance and sustained a fall, x-rays were taken and revealed a nondisplaced fracture of the left arm (humerus)." The Facility's Fall Risk Guidelines, dated 01/20/2016, document in part, "Staff education in regards to falls (equipment, gait, personalized factors, toileting, etc.)" There was nothing that directly addressed alarms in the guidelines.	F 323		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily	F 354		

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F 354	Continued From page 15 occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the required Registered Nurse (RN) coverage. This failure has the potential to affect all 40 residents living in the facility. Findings include: 1. On 6/16/16 at 11:48 AM, E1, Administrator, stated, "We only have one RN employed here, not counting the DON (Director of Nursing). We had no RN working on June 1 and June 5." On 6/17/16 at 9:42 AM, E2, DON, stated, "The dates next to (E16, RN) that are blank on the schedule mean there was no RN working at all that day. " On 6/17/16 at 11:16 AM, E2 stated, "We don't have a policy on staffing. We go by the state minimum standards for staff." The facility's Nurses Schedule dated May 1 through May 31, 2016, documents on May 31, 2016 (E16, RN) was on Vacation and did not work. The facility's Nurses Schedule dated June 1 through June 30, 2016 documents no RN worked on June 1, June 2, June 3, June 4, June 5, June 7, June 11, June 12. 2. The Resident Census and Conditions of Residents, CMS 672, dated 6/14/16, documents that the facility has 40 residents living in the facility.	F 354		

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F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, and record review, the facility failed to ensure food is stored in a manner which prevents potential contamination by reusing single use containers for food storage. This has the potential to affect all 40 residents living in the facility.

Findings include:

On 6/14/16 at 8:10 AM in the back of the kitchen, Reach-In refrigerator contained 9 reused cottage cheese containers to store food.

On 6/14/16 at 8:15 AM, the Walk-In refrigerator contained a reused cottage cheese container labeled "Cod."

On 6/14/16 at 8:20 AM, the Reach-In refrigerator near the tray line contained a container with a mayonnaise label that was reused to store a red beverage with a hand written label that documents "Punch date 6-1," a reused cottage cheese container with a handwritten label that documents "Tomato Juice date 6/9," a reused

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F 371	Continued From page 17 cottage cheese container with a hand written label that documents "Pudding date 6/11," a reused cottage cheese container with a hand written label that documents "Applesauce date 6/9," and two glass gallon jars with Kosher pickle labels containing an unidentified brown liquid. On 6/14/16 at 11:50 AM, E17, Certified Dietary Manager (CDM) stated, "We use emptied food containers to store leftovers and other food in. Tea (The unidentified brown liquid) is in the two gallon jars with kosher pickle labels for residents meals." On 6/17/16 at 11:46 AM, E2, Director of Nursing (DON), stated, "We have no policy on food storage." 2. The Resident Census and Conditions of Residents, CMS 672, dated 6/14/16, documents that the facility has 40 residents living in the facility.	F 371		
F 441 SS=F	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 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	F 441		

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F 441	Continued From page 18 (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: A. Based on interviews and record reviews, the facility failed to adequately develop an ongoing infection control program that; adequately collects data to identify organisms causing infections and failed to operationalize infection control policies to adequately define infection control practice in the facility. This has the potential to affect all 40 residents living in the facility. Findings include: 1. The facility's January 2016 Infection Control Log documents the Infection Related diagnosis	F 441		

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UTI (urinary tract infection) for R24 with onset date 1/5/16, no organism identified.

2. The facility's March 2016 Infection Control Log documents R25 Infection Related diagnosis UTI, no organism identified, onset date 3/15/16. It also documents R21 Infection Related diagnosis UTI, no organism identified, onset date 3/15/16.

3. The facility's May 2016 Infection Control Log documents R20 Infection Related diagnosis UTI, no organism identified, onset date 5/24/16.

4. The facility's June 2016 Infection Control Log documents R3 Infection Related diagnosis UTI, no organism identified, onset date 6/5/16.

On 6/17/16 at 11:18 AM, E14, Assistant Director of Nursing (ADON), stated "We don't always get orders for cultures of infections, that's a doctor thing, that's not up to me. I don't always get (the infectious organism) from the hospital, but I think the hospital would tell me if I needed to know (the infectious organism)."

The facility's undated, Infection Identification - High Risk Individuals policy documents in part, "(facility name) acknowledges that early recognition of infection in the nursing home resident is critical to a well-functioning infection control program as well as to the general well-being of the resident himself. 'high risk' individuals will receive additional monitoring for infection development."

5. The Resident Census and Conditions of Residents, CMS 672, dated 6/14/16, documents that the facility has 40 residents living in the facility.

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B. Based on observation, interview, and record review the facility failed to adequately clean multiple-use blood glucometers, failed to perform hand hygiene during medication administration and assistance with activities of daily living to prevent the spread of infection for 1 of 11 residents (R4) in the sample of 11 and 5 residents (R17, R18, R19, R20, R21) in the supplemental sample.

Findings include:

1. On 6/15/2016 at 11:31 AM, E8, License Practical Nurse (LPN), cleansed the glucometer with a bleach sanitizer pad for ten seconds. E8 used the glucometer for blood glucose monitoring of R20. On 6/15/2016 at 11:57 AM, E8 returned the blood glucometer to the top of the medication cart. When E8 was asked the protocol for cleaning the glucometer, E8 said that it is to be cleaned before each use.

2. On 6/15/2016 at 12:10 PM, E8 cleansed the glucometer with a bleach sanitizer pad for ten seconds. E8 moved R21 into the therapy room and performed the blood glucose monitoring. E8 returned the glucometer to the top of the medication cart.

On 6/16/2016 at 9:14 AM, E14, Assistant Director of Nurses (ADON), said that the nurse who trains the new nurse during orientation was responsible for training on the guidelines of cleaning the multiple-use glucometers according to guidelines from bleach sanitizer instructions. When asked the protocol for cleaning the blood glucose monitor, E14 said "Use wipes, let sit for two minutes on a paper towel between each use."

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On 6/17/2016 at 10:45 AM, E2, Director of Nurses (DON), was asked who is responsible for stocking the bleach sanitizer pads and checking them for the expiration date. E2 said, "I am." E2 confirmed that the expiration date on the bleach sanitizing pads were February 2015.

The box of bleach sanitizer pads with an expiration date of February 2015 documents the directions for use, in part, "Unfold a clean wipe and thoroughly wet surface. Treated surfaces must remain visible wet for a full four minutes (4). Use additional wipes if needed to assure 4 minute wet contact time. Let dry."

3. On 6/14/2016 at 2:54 PM, E9, License Practical Nurse (LPN), E11 Certified Nursing Assistant (CNA), and E15, CNA, toileted R4 on a bedside commode. Both E11 and E15 assisted R4 to a standing position and then onto the bedside commode. After R4's adult brief was removed E9 with gloved hands took the adult brief that was against R4's perineal area to confirm if the attends was soiled with urine. E9 then continued with contaminated gloves performing a skin assessment and holding a bottle of lotion with contaminated gloves and applying the lotion to R4's legs.
On 6/14/2016 at 3:00 PM, E15 wiped R4's buttocks with a cloth wipe. E15 took the bowl of the commode covered it with a towel and left the room without changing gloves or performing hand hygiene. On 6/14/2016 at 3:03 PM, E9 continued with skin assessment without changing gloves or hand hygiene, took the bottle of lotion and applied it to R4's arms, removed a cotton ball with tape from the antecubital area of R4's arm and rubbed lotion on this area with the same contaminated

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gloves. On 6/14/2016 at 3:06 PM, E9 without changing gloves or performing hand hygiene picked up R4's glass of water and put the straw from the glass into R4's mouth. On 6/14/2016 at 3:07 PM, E9 without changing gloves or performing hand hygiene picked up R4's hearing device and placed them into R4's ears.

4. On 6/15/2016 at 11:19 AM during medication administration, E8 performed hand hygiene and entered R3's room to administer medication. E8 administered medication and moved the medication cart without performing hand hygiene and at 11:22 on 6/15/2016 administered medication to R18.

On 6/15/2016 at 11:28 AM E8 moved the medication cart into R19's room and administered medication. No hand hygiene was performed before or after medication was administered.

On 6/17/2016 11:50 AM, E2 confirmed that she would expect her staff to perform hand hygiene prior to coming in contact with body fluids, handling supplies, and inserting hearing devices.

5. On 06/15/16 at 12:15 AM, E10 removed R17 from the dining room, and took her to the empty physical therapy room. E10 performed a blood glucose monitoring on R17. E10 rolled R17 back into the dining room to await her meal. E10 took the glucometer, and wiped it for 10 seconds. E10 then dried the machine with a tissue placing it into the medication cart in a drawer.

The facility's undated Disinfection of Glucometers policy, documents "Any blood glucose monitoring device used in this facility is to be disinfected before using it on a resident to prevent the

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potential transmission of infectious organisms. After each use the nurse will disinfect the Glucometers with a disinfectant wipe. There is to be at least 2 minutes dwell time for Glucometers disinfection between residents."

The facility's Infection Control Hand Hygiene policy, dated 6/3/2011, documents in part, "Purpose: Effective hand hygiene removes transient micro-organisms, dirt, and organic material from the hands and decreases the risk of cross contamination from residents, resident care equipment, and the environment. Hand hygiene is the single most important strategy for preventing the spread of infections in long term care facilities.
Policy: All staff will practice effective and appropriate hand hygiene. Whenever anticipating contact with any body fluid, feces, or contaminated item gloves should be worn. Handwashing and Hand Antisepsis should be used in the following instances:
1. Wash hands with non-antimicrobial soap and water. When visibly dirty or contaminated with proteinaceous material, or visible soiled with blood or other body fluids; before eating; or after using the bathroom.
2. If hands are not visibly soiled, use an alcohol based hand gel/rub for routinely decontaminating hands in other clinical situations such as the following:
a. Before having direct contact with residents.
b. before inserting devices such as urinary catheters, peripheral vascular catheters, or any other invasive device not requiring a surgical procedure.
c. After removing gloves.
d. After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound

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dressings if not visibly soiled.
e. If moving from a contaminated body site to a clean body site during resident care.
f. After contact with inanimate objects such as medical equipment in the immediate vicinity of the resident."

The facility's undated Infection Control policy, documents in part, "Purpose: Primary purpose of infection control policies and procedures is to establish guidelines to follow in the prevention and control of contagious, infectious, or communicable diseases.
Objectives: The objective of our infection control policies and procedures is to:
1. Provide a safe, sanitary and comfortable environment for our staff, residents, and visitors.
2. Prevent the development and transmission of infection.
3. Establish guidelines.
Subject: Standard/Universal Precautions Policy
I. Use Stand Precautions for the care of all patients.
A. Handwashing
1. Wash hands after any patient contact. Wash hands after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn. Wash hands immediately after gloves are removed between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments.
2. Use soap available in rooms for handwashing.
3. May use waterless antiseptic agent by applying a quarter size amount of liquid into palm of hand and applying friction by rubbing hands together as with normal handwashing and allow to air dry.
B. Gloves
1. Wear gloves (clean non-sterile gloves are

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F 441	Continued From page 25 adequate) when touching blood, body fluids, secretions, excretions and contaminated items. 2. Put on clean gloves just before touching mucous membranes and non-intact skin. Remove gloves promptly after use, before touching non=contaminated items and environmental surfaces, and before going to another patient, and wash hands immediately to avoid transfer of microorganisms. F. Patient Care Equipment 1. Handle used patient care equipment soiled with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and environment. Ensure that reusable equipment is not used for the care of another patient until it has been cleaned appropriately."	F 441		