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F 000	INITIAL COMMENTS Initial Complaint Investigations #1613671 / IL 86677 #1613725 / IL 86738 #1613849 / IL 86889 #1613945 / IL 86996	F 000		
F 441 SS=E	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 (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.	F 441		

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

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(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, interview and record review the facility failed to have an effective infection control program to identify, monitor and contain the spread of a communicable disease between residents and staff. This failure resulted in the spread of a communicable skin rash to 27 residents.

This applies to 3 of 3 residents (R1, R2, R3) reviewed for communicable disease and 24 residents in the supplemental sample (R4 - R16, R19, R21, R24, R25, R31, R34, R36, R40, R52, R54, R60, R61).

The findings include:

On July 1, 2016 at 5:00 PM, 13 residents were observed in the smaller dining room on the 2nd floor. The residents were observed with red rashes and notable itching while trying to eat the evening meal. In the larger dining room on the 2nd floor, R2 and R3 were seated at the circular table in the center of the dining room with 3 other residents. R2 and R3 were observed actively itching their scalp, face and arms. R4 was

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observed seated at a table near the far window and was vigorously scratching her head while being assisted to eat.

On July 1, 2016 at 3:50 PM, E2 (Care Plan Coordinator) stated the facility has had residents with rashes for some time. E2 stated they received a confirmed diagnosis of Norwegian scabies on June 30, 2016 for R1. E2 stated after they received the positive diagnosis, the facility decided to provide scabies lotion treatment to the other residents with a rash last evening/night.

On July 1, 2016 at 7:25 PM, E4 (DON) presented a resident roster of the residents that were treated the evening before (June 30/July 1). Two residents reside on the first floor and 19 on the second floor. E4 stated she talked to Z3 (Physician Assistant) about the confirmed diagnosis of scabies from R1 and it was decided to treat the other residents in the facility with a rash. E4 stated they thought they should also include the residents roommates as a precautionary measure and it would be done tomorrow night (July 2). E4 explained the list of residents with rashes came from the CNA shower checks. The nurses do not do routine resident skin checks; they rely on the CNA to identify and report unusual findings during the resident ' s weekly shower. If the CNA has not found a rash, they would not be on the list to be treated. E4 was uncertain if there were any unidentified cases in the facility as a house wide resident skin check had not been initiated. E4 stated the employees caring for these residents have not been treated.

On July 12, 2016 at 11:30 AM, E4 (DON) stated the first round of scabies lotion treatment was completed on June 30/July 1 for residents with a

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rash. The roommates were treated July 2. It was decided to treat all residents in the facility on July 7 and July 8th. Employees would also be treated during this time. The skin check log dated July 8 showed 27 residents were monitored for a rash on the second floor.

On July 19, 2016 at 3:10 PM, E4 reported that R6 and R8 developed rashes after June 30th. And R9 (resident on first floor) developed rash on July 7, and R10 (second floor resident) developed rash on July 8, 2016 at the time the house wide treatment was initiated.

On July 1, 2016 at 5:45 PM, E6 (Registered Nurse - RN) stated, " I first saw the rash on a resident last year, who has since passed. " E6 identified several residents with active rashes on the second floor. E6 stated skin checks are performed by the CNA (Certified Nursing Assistants) while providing care and they are to report changes to the nurse. The nurse will then do an assessment of the area and put a treatment in place if needed. E6 stated she did not have a list of residents with a rash on the floor, but thought the count was about 20 residents last week. E6 stated a couple staff members have been treated (by their personal doctor) for the rash, and a few did have confirmed cases of scabies.

On July 1, 2016 at 5:40 PM, E7 (RN) stated, " It has been a few weeks since I last worked. The rash has spread to a few more residents. E7 stated the skin checks are done with the resident ' s weekly shower by the (CNA-Certified Nursing Assistant) and if there is a reported concern, the nurse checks it out. " E7 identified R4 at the dining room table, as she was actively scratching

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her head while eating. E7 stated the CNA staff had not reported that she had a skin rash, and she was not on the list of residents being treated.

On July 12, 2016 at 12:25 PM, E10 (Licensed Practical Nurse - LPN) stated she developed a few small red spots on her wrist area last week. She was concerned and went to her own doctor and he prescribed the scabies treatment lotion for her and her husband.

On July 12, 2016, E4 (Director of Nursing - DON) stated the facility had treated a few residents for scabies prior to receiving the confirmed scraping on June 30, 2016. E4 stated they had not utilized the abatement checklist for scabies (Appendix C of the facility infection control policy) for those residents. E4 stated the county health department was not notified because they were isolated cases, and not considered an outbreak.

On July 13, 2016 at 10:50 AM, E14 (Assistant Director of Nursing - ADON) stated part of her job includes preparing infection control reports. E14 stated the monthly infection control surveillance includes residents on antibiotics and infections. E14 stated R5 was treated, but scabies had not been confirmed. R6 was treated after R5. E14 stated she had not actually observed the rash on the R5 and R6; she conferred with the nurses and CNA to see if there was any improvement in the rash after the treatment. E14 stated the scabies abatement form was not utilized during the treatment for R5 and R6. E14 stated R7 was the roommate of R6 and she was treated when she later developed the rash. E14 stated she did not question, monitor or observe rash on any of the employees caring for these residents. E14 was aware of 1 CNA that sought medical treatment for

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a rash but thought the diagnosis was dermatitis. As far as she knew it has cleared up. E14 stated employee illness is monitored by E15 (Human Resources - HR). E14 stated it was odd so many residents on the dementia unit had a rash, " We thought it was a sensitive skin issue. We noticed increased rashes on the wandering residents; they were all females, but on different halls. We checked housekeeping products, cleaning products and such with no change in the rash. "

On July 13, 2016 at 10:50 AM, E14 stated she feels the CNA staff are knowledgeable in doing skin checks. However, she stated it is challenging to give a resident with dementia a shower and check their neck, arms and legs for changes. E14 stated the CNA chart their findings on the shower sheets and those are turned into the nurses.

On July 13, 2016 at 11:45 AM, E16 (CNA) off the top of her head, she listed 18 second floor staff that have had skin rashes in the past several weeks. E16 stated several employees have had the rash " several times " and described other employee rashes as " real bad " .

On July 13, 2016 at 12:30 PM, E17 (CNA) stated she was aware of a resident with a scabies rash in October 2015. E17 stated the facility staff told her it was not scabies, but that she was allergic to the carpet when it was being pulled up. Then later when the rash continued, the facility said it was dermatitis. E17 stated then the staff started getting rashes. Another CNA told her she was treated for scabies by her doctor in June 2016. E17 stated the employee skin rash was reported to E4 (DON).

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On July 13, 2016 at 12:55 PM, E18 (CNA) stated she had a rash last week and went to her doctor. The scabies scraping was negative, but she was treated with the scabies lotion and the rash disappeared. E18 stated, " I don ' t want to come to work, I ' m afraid I will get the rash again and give it to my family. It upsets me that it has gone on this long. These poor residents, they are constantly scratching themselves. Most are so confused up here, they can ' t tell you how to help them. " E18 stated she reported to E4 (DON) that she was treated for scabies. E18 stated she was not questioned about what residents I cared for or other personnel I worked with.

On July 13, 2016 at 12:00 PM, E19 (CNA) stated he noticed residents with a rash back in June 2015. E19 stated his skin is sensitive from being exposed to Norwegian scabies in the past. E19 reported he had received treatment in the past year 3 times for scabies rash. E19 stated he reported the scabies bites and rash to the ADON and she stated she thought I had dermatitis, but to " do what you got to do " . E19 stated the rash cleared each time after each treatment. E19 stated after the residents received the scabies treatment they gave them showers, but their rooms were not stripped or cleaned. The roommates were not treated and there were no questions asked of the staff providing care for the residents with rashes.

On July 13, 2016 at 1:55 PM, E15 (Human Resources Staff) stated she records employee illness for record keeping purposes only. E15 stated E20 (CNA) brought a note from her doctor on June 9, 2016 that she had a diagnosis of scabies and that she was treated. The employee log showed 8 reported staff call offs from work

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with the diagnosis of scabies between June 9, 2016 and July 9, 2016.

On July 19, 2016 at 11:15 AM, Z2 (Medical Director) stated he was first aware of a resident with a rash in February 2016. Z2 stated the rash went away and in May, the rash returned and the roommate had the rash also. In June 2016, other residents developed a skin rash and recently facility staff have reported rashes. Z2 was not aware of the total number of residents affected, " maybe the upper teens or low 20 ' s " . The facility log titled " Scabies Line list " dated July 8, 2016 showed 27 residents were identified as having a rash. Listed onset date for R11 ' s rash was listed as October 19, 2015.

On July 1, 2016 at 4:45 PM, R1 was observed at the dining room table for the evening meal. A white infant T-shirt was lying across R1 ' s lap. A small play doll was positioned next to R1. R1 was actively scratching her hands, neck, picking her nose, hands and arms. A bright red, fine rash was observed on her arms, legs and face/neck area.

The Minimum Data Set of April 11, 2016 shows R1 has short and long term memory impairment and is severely cognitively impaired in making decisions of daily living. R1 did not have a care plan addressing a skin rash. The medical record showed R1 developed a rash on January 21, 2016. The rash cleared February 2, 2016. The April 2016 monthly progress notes show the rash was observed again on April 22, 2016, and she enjoys having her hair done in the beauty shop. There is no documentation of rash until June 23, 2016 and the rash is described as " all over " . The physician note on July 1, 2016 states, " The

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resident with rash and severe itch for 1 month duration. Crusting excoriation worse on hands, arms and anterior trunk. Positive for scabies mite. "

On July 1, 2016 at 5:30 PM, R2 and R3 were observed sitting next to each other at a circular table in the large dining room. R2 periodically scratched the back of her head and arms while eating. After the meal, R2 was observed ambulating independently with a wheeled walker. A facility cotton blanket was tucked under the seat of the walker. R2 stopped and talked with staff and other residents with confused conversation. R3 was using the cloth clothing protector to rub her face and eyes. R3 moved herself back and forth in the chair to itch her back. R3 used the clothing protector to reach under her clothing to rub her chest, and then back to scratching her forehead. At 6:30 PM, R3 was in the same place at the dining room table. R3 continued to itch her head, neck and arms. A red rash was on her face, arms and hands.

The MDS of April 8, 2016 for R2 shows a BIMS (brief interview of mental status) score of 4. The care plan for R2 states she has hoarding behaviors; likes to collect dirty cloths, clothing protectors, dietary cards and activity items. There is no care plan to address skin rash. The progress notes show a rash was noted on April 7, 2016, described as worsened on May 3, 2016. The notes on May 26, 2016, " there is no improvement of the rash " . On June 30, 2016, the progress notes describe the rash as " worse " . The physician documention on July 1, 2016, describes R2 ' s rash as, " Erythematous crusting on trunk, arms, legs. Concern for scabies " .

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The BIMS score for R3 on June 6, 2016 was 4. R3 ' s behaviors included wandering in other resident ' s rooms and taking things. R3 is short tempered and easily annoyed. There is no care plan for R3 to address a skin rash. The monthly nursing progress notes on January 2016 notes R3 has a rash (no description). No comment of the rash on the February notes. The notes state R3 was treated for scabies on March 18, 2016. The rash was noted on the April and May notes. The rash was documented as clear on June 16, 2016.

The facility policy and procedure for Infection control revised on February 2014 shows contact precautions is to be used for 24 hours after start of effective therapy for scabies. The policy shows to utilize Appendix C, " Scabies Abatement (checklist)- Typical or Atypical " . The 2 page checklist identifies all measures that should be taken when treating a resident with scabies.

The facility communication memo dated July 1, 2016 states, " The facility cannot allow any non-staff visitors in the building including new resident admissions. We have a sign posted on the front door notifying our guests that we need to restrict access to the building until further notice " . On July 12, 2016 the visitor restriction was still being enforced throughout the facility.