STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145743	A. BUILDING _____ B. WING _____	06/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SUBURBAN HOSPITAL MED CTR	**3 ERIE COURT OAK PARK, IL 60302**

(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 156 SS=C	Annual Certification 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under o1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.	F 156		

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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F 156	Continued From page 1 The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 2 written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to display a brief synopsis of the Medicaid program on the unit and current information on the Medicare Program. This failure has the potential to affect all 28 residents residing on the hospital extended care unit. The findings include: On 6/7/13 at 10:35 AM with E13 (Environmental Service Director) during the environmental tour, there was no synopsis of the medicaid program posted on the unit. There was an address and phone number posted for the Medicaid program. E13 acknowledged there was no synopsis on the medicaid program. There was a brief synopsis on the Medicare program dated 2007. E13 stated she will find out if the information listed on Medicare information is current. Later at 11 AM, E13 stated she was informed that it was downloaded from the Internet and posted one month ago. The federal form 672 Resident Census and Conditions of Residents documents there are 28 residents residing on the hospital extended care unit. The form documents 18 residents are under	F 156		

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	145743	A. BUILDING _____ B. WING _____	06/07/2013

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F 156	Continued From page 3 Medicare and 10 residents under other source of payment.	F 156		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to have the latest annual survey available for review. This failure has the potential to affect all 28 residents in the hospital extended care unit. The findings include: On 6/7/13 at 10:45 AM with E13 (Environmental Service Director), the survey binder that hold the annual survey conducted on 5/17/12 was missing the federal form 2567 which documents the citations. The plan of correction was in the binder only. On 6/7/13 at 10:45 AM, E21 (admission Director) stated that it was over looked and missed when questioned why there was no 2567 with the citations.	F 167		

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	145743	A. BUILDING _____ B. WING _____	06/07/2013

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F 167	Continued From page 4 The federal form 672 Resident Census and Conditions of Residents, documents there are 28 residents residing on the hospital extended care unit.	F 167		
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 observation, record review and interview, the facility failed to recognize the resident's rights by implementing a restraint without consent or medical justification, failed to document the duration and outcome of alternatives tried for least restrictive restraint and failed to monitor restraint every 2 hours for 1 of 1 resident (R3) reviewed for physical restraints in a sample of 10. The findings include: On 6/5/2013 at 11:30am in R3's room, R3 was seated in her wheel-chair with a roll belt restraint around the waist attached to the wheelchair while eating breakfast. R3 observed to be calm, lethargic but easily aroused, pleasant, smiling, and oriented to self when seen with restraint on at 11:42am, 12:00pm, 12:30pm, 12:45pm, 1:00pm, 1:15pm and 1:30pm. Nursing documentation on 6/3/2013: 12:00am: Pt (patient) A/O (alert/oriented) x1. Pt very impulsive, pt has magnet alarm on. Pt in low bed but keeps trying to get off bed. Pt also	F 221		

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	145743	A. BUILDING _____ B. WING _____	06/07/2013

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F 221	Continued From page 5 has bed alarm. Will continue to monitor. 12:30am: RN (registered nurse) to CNA (certified nurse aide) has been in pt's room multiple times because pt keeps trying to get out of bed, pt still has magnet alarm, bed alarm too on low bed. Pt A/O x1. 1:30am: Pt found standing up by low bed, RN to CNA trying to get pt back in bed, pt is being combative and yelling refused to get back in bed. After 5min of calming pt, RN and CNA able to get pt in wheelchair. Pt placed at nurses Station. Pt A/O x1, magnet alarm on, chair alarm on. Will continue to monitor. 2:00am: Pt A/Ox1, yelling and screaming for "Bill." Reassured pt that she is in the hospital, offered pt snacks and water to keep busy, pt refused. Gave pt towels to fold and kept pt busy for at least 15 minutes. Pt then began to push bedside table away to stand from her wheelchair. Pt is at Nurses station, mag alarm on. Pt refused to fold towels or complete busy box puzzles. Will cont to monitor. On 6/4/2013 at 3:45am, a telephone order was obtained for a "roll belt, pt is combative and impulsive." The facility did not document how long alternative methods were attempted prior to the application of restraints and what the outcomes were. Nursing documentation: 6/4/2013 1:05pm Pt is alert and oriented x1 to self. Was uncooperative in the beginning of the shift. Then after awhile was cooperative took meds as ordered. Had to re-orient on roll belt as ordered. Was up in the chair with roll belt on at nurses station. Tried to reach husband to notify about roll belt was not successful. No answer tried several times at least 3 times. Endorsed PM's to follow up on it.	F 221		

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	145743	A. BUILDING _____ B. WING _____	06/07/2013

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WEST SUBURBAN HOSPITAL MED CTR	3 ERIE COURT OAK PARK, IL 60302

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F 221	Continued From page 6 Last restraint assessment documented on 6/5/2013 10:00am, "bed alarm, chair alarm, close observation, family involved, orient intervention, roll belt. CMS (circulation/motion/sensation) WDL (within define limits). Integrity WDL confused, disoriented, respirations WDL 18 bpm (breaths per minute), call light reach, offer fluids, offer nutrition, repositioned, toileted." No nursing documentation for 6/5/2013 at 12:00pm or after. Resident should be monitored every 2 hours. R3's physician wrote an order to discontinue the use of the belt on 6/5/2013 at 11:00 am. On 6/5/13 at 1:30 PM, E2 (Registered Nurse/RN) acknowledged the order and placed the consent form (incorrectly dated 6/4/2013) for restraint in the paper chart. E2 (RN) stated, "I spoke with the nephew today to obtain consent for the restraint because the nurses could not get a hold of the husband yesterday." E2 (RN) removed the roll belt on 6/5/2013 at 1:43pm and stated to E3 (Certified Nursing Assistant/CNA), the doctor wrote an order to discontinue the belt, but I waited for you to return from lunch before I removed the belt. Upon removal of the roll belt, R3 pointed to her abdomen and stated, "Ow, it hurts here." E2 (RN) stated to R3, "wow, you have been so good today." Nursing documentation on 6/5/2013 7-3p: Notified nephew regarding roll belt today cause could not reach husband. On 6/5/2013 at approximately 3:10pm, Z1 (R3's family member) stated during interview that they just called him today about placing the restraint. The facility's policy Patient Services, Restraint and Protective Devices revised 2/2011: "Process: All residents have the right to be free from restraint, of any form, imposed as a means	F 221		

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WEST SUBURBAN HOSPITAL MED CTR	3 ERIE COURT OAK PARK, IL 60302

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F 221	Continued From page 7 of coercion, discipline, convenience. Definitions: Restraints are never used to punish or discipline a resident or are they to be used as a convenience for the staff. The type or technique of restraint used must be the least restrictive intervention that will be effective to protect the resident or others from harm. Orders for Restraint Use: Consent from resident or resident's representative must be obtained prior to restraint use. Evaluation of the resident ' s medical and psychological condition. Evaluation of the need to continue or terminate restraint. Restraint must be discontinued at the earliest possible time, regardless of the length of time specified in the order. Alternatives and least restrictive measures must be documented in the resident's record prior to usage of restraints. Modification of Plan of Care: Care plans are modified to reflect restraint intervention. The plan of care considers the use of appropriate alternative measures before a restraint device is considered and/or applied. Monitoring: All residents who are restrained should be monitored every 2 hours for: Behavior, Use of Alternatives, Type of restraint Documentation: Supporting documentation in the resident's record prior to restraint usage to include behavior/medical symptoms and/or reasons for restraints. Document least restrictive devices/interventions tried in the resident's record. Document every two hours on the Restraint Flowsheet. Document reason for restraint removal in the resident's record." This policy was not followed. On 6/7/13 at 12:15 PM, E21 (Admission Director) stated all policies presented during the	F 221		

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	145743	A. BUILDING _____ B. WING _____	06/07/2013

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WEST SUBURBAN HOSPITAL MED CTR	3 ERIE COURT OAK PARK, IL 60302

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F 221	Continued From page 8 survey are current.	F 221		
F 226 SS=C	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 have an Abuse Policy that is detailed and tailored to their facility and failed to recognize that all allegations of abuse are to be reported immediately without delay to the State. This failure has the potential to affect all 28 residents in the hospital extended care unit. The findings include: On 6/6/13 at 10:35 AM, E14 (Social Service/Abuse Coordinator) stated when a resident alleges abuse to a staff person, that staff is to get as much information as possible and report it to E14. E14 stated she will follow through with gathering more information before she takes it to E15 (Risk Management). E15 will look at the information, determine if it is credible and report it within 24 hours to the State. E14 stated if E15 is not working or not available she will not wait to report to the State. E14 stated she will report within 24 hours. E14 stated the facility has had no allegation of abuse in the past year. On 6/6/13 at 1:40 PM, E15 stated that the	F 226		

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	145743	A. BUILDING _____ B. WING _____	06/07/2013

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WEST SUBURBAN HOSPITAL MED CTR	3 ERIE COURT OAK PARK, IL 60302

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F 226	Continued From page 9	F 226		

person informed of the allegation will give that information to Social Service Department and the Social Service Department will come and gather the facts. Social service will then contact her to go over the facts gathered. E15 stated if it looks serious and not made up, it is definitely reported to the State within the 24 hours. E15 stated there have been no allegations of abuse in the past year.

The facility's policy on Abuse Prevention Program is very general and vague as to who to report the allegations of abuse to and when to report. The section VI. Internal Investigation of Allegations and Response documents "once the administrator or designee determines there is reasonable cause for possible mistreatment, the administrator or designee will appoint a person to take charge of the investigation." " The appointed investigator will follow the resident Protection Investigation Procedures." "After a conclusion based on the facts of the investigation is determined, internal reports, interviews and witness statements shall be released only with permission of the administrator or the facility's attorney." Under the section VII for External Reporting of Potential Abuse documents "when the administrator is aware of abuse/neglect of a resident, the resident's representative and the Department of Public Health shall be notified immediately."

On 6/7/13 at 12:15 PM, E21 (Admission Director) stated all policies presented during the survey are current.

The federal form 672 Resident Census and Conditions of Residents documents there are 28

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	145743	A. BUILDING _____ B. WING _____	06/07/2013

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F 226	Continued From page 10 residents residing on the hospital extended care unit.	F 226		
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. (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	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145743	A. BUILDING _____ B. WING _____	06/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SUBURBAN HOSPITAL MED CTR	3 ERIE COURT OAK PARK, IL 60302

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F 441	Continued From page 11 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow current standards of infection control practices with regards to hand-washing, glove usage, during and following the provision of care for two residents in the sample (R2 and R3) out of 10 residents reviewed for infection control and 3 residents in the supplemental sample (R14, R15, and R16). Findings include: 1. On 6/6/2013 at 11:30 AM E7 (Kitchen Aide) was passing trays to residents (R14, R15, and R16) on the Extended Care Unit for lunch meal. E7 donned gloves, entered the resident's rooms (R14, R15, and R16) and placed the residents meal trays on the over bed tables. E7 proceeded to exit the residents rooms while removing and disposing of the latex gloves. This action was repeated for each of the three resident rooms. E7 did not wash or gel his hands between tray passes. This process continued until all trays were passed for the subacute north hall unit. On 6/5/2013 at 11:37am, E6 (dietary aide) entered R3's room with gloved hands and placed lunch tray on table cart. E6 then removed food cover, placed on table cart, and touched resident's table cart. With the same gloved hands, E6 exited R3's room, grabbed another meal tray from food cart, touched top of food cart, and proceeded the same steps to the rooms of R11, R12, and R13. E6 stated she did not need	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 12	F 441		

to change gloves when entering or exiting resident rooms because she did not make any patient contact. She only placed trays on the table and did not touch anything. If she were to make patient contact, then she would just change gloves with no need to hand-wash or sanitize hands.

On 6/6/2013 at 12:30 PM E10 (Dietary Manager) and E11 (Regional Dietary Director) stated "Staff are to gel in and gel out between tray passes." Dietary provided Operational Support Protocol entitled Patient Tray Service: Distribution of Trays (519.02) dated 12/2004. According to Patient Tray Service: Distribution of Trays "(item)11. Food service workers will follow proper sanitation procedures." E11 provided Policy Protocol 207.02 dated 5/2007 "Standard Precautions will be followed when passing, retrieving, and washing trays...,Staff passing trays will perform hand hygiene before/upon entering the patient's room and after leaving the patient's room."

On 6/6/2013 at 9:45am, E1 (Director of Nursing/DON) stated dietary attendants should be washing hands in between each meal tray pass, especially when going from room to room and when putting on a new pair of gloves.

2. On 6/5/2013 at 11:42am, E3 (Certified Nursing Assistant/CNA) entered R3's room, donned gloves without performing hand hygiene, assisted R3 with meal set-up and touched call light. E3 stated employees are to "gel in and gel out ... I just put on my gloves when I went in there, sorry."

3. On 6/5/2013 at 1:51pm, E4 (CNA) did not wash hands prior to donning PPE (personal protective equipment) and entering room 539.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145743	A. BUILDING _____ B. WING _____	06/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 13 4. On 6/5/2013 at 1:55pm, E5 (Housekeeping) removed PPE and used hand-gel to sanitize hands before exiting R2 ' s room. E5 stated "the resident is in isolation for something in the stool or blood." R2 is in isolation for c-diff (clostridium difficile) per the current physician's order sheet. On 6/6/2013 at 11:15am, E1 (DON) stated during interview that hand-washing must be performed when entering and exiting resident rooms in isolation for c-diff and using hand sanitizer is not enough. 5. On 6/5/2013 at 2:15pm, E2 (Registered Nurse/RN) and E3 (CNA) rendered incontinence care to R3. E2 first wiped rectal area with wash cloth, folded same wash cloth (now soiled with stool) in half, wiped away more stool, folded wash cloth again and wiped again. E2 then grabbed another wash cloth, wiped perineal area upward from the rectum to perineum (back to front), folded same wash cloth (soiled with stool) in half, wiped stool off of perineal from back to front again, and repeated the same step. With the same gloved hands, E2 picked up barrier cream located on R3's bed and applied barrier cream to perineal and rectal areas. E2 changed gloves without washing hands, applied incontinence brief, picked up telephone, assisted R3 to chair and dropped telephone on R3's bed. E2 then removed gloves, placed telephone beneath armpit then washed hands. 6. R2 is on contact isolation for Clostridium difficile (C diff.) per current Physicians order sheet (POS). On 6/5/13 at 12:35pm, R2 was sitting in wheelchair in room while E8 (Laboratory Technician) was attempting to obtain a blood specimen. The door was open and the privacy curtain was not pulled. E8 had laboratory coat on and gloves. After unsuccessful attempt to obtain	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145743	A. BUILDING _____ B. WING _____	06/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 14 a blood specimen, E8 went to the corridor door where E9 (Laboratory Technician) stood and requested assistance. At 12:40pm, E9 entered the room without any hand hygiene and put gloves on then proceeded to attempt to obtain blood specimen. During the attempt E8 frequently walked to the door where supply cart was and with contaminated gloves touched specimen tubing and handrails then reentered the room to assist E9. E9 removed right hand glove and would touch R2's forearm during blood draw. At 12:50pm, E8 and E9 removed gloves disposed in trash container, used hand sanitizer and left R2's room. E8 and E9 walked to the nurses station and leaned on the nurses station. E8 notified E12, Registered Nurse (RN) of unsuccessful blood draw. On 6/5/13 at 12:55pm, E12 entered the room with proper protective equipment (PPE) to obtain blood sample. E9, who was present at R2's doorway, would put hands in pocket looking for extra needles. E8 and E9 entered the room as well but with no PPE to assist E12. While in the room E8 and E9 put gloves on and would touch R2 and surrounding area. E8 would frequently go to the supply cart outside of the room with contaminated gloves on and would reach for extra blood tubes. Once blood specimen obtained, E8 and E9 removed gloves, used hand sanitizer and exited room. While outside of R2's room, E8 would frequently touch gown and left the unit to have blood specimen processed. On 6/5/13 at 1:00pm, E12 stated R2 is on contact isolation for C diff. E12 also stated need to wash hands with soap and water not only hand sanitizer. Contact isolation posting on the door	F 441		

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F 441	Continued From page 15 states to use PPE and to wash hands with soap and water. The facility's Hand-washing policy revised May 2013, "If hands are not visibly soiled, use an alcohol based hand-rub (ABHR) or wash hands with soap and water for routine decontamination in the following clinical situations: Before and after direct contact with patient's skin and/or clothing. After handling soiled or contaminated items and equipment, including linens. Before donning gloves and after removing gloves ..... ABHR are not effective against spore-forming bacteria such as clostridium difficile. When caring for patients with suspected or confirmed clostridium difficile infection, ABHR must not be used as a substitute for hand washing with soap and water. Hand hygiene must be performed with soap and water before leaving a contact plus isolation room." This policy was not followed. The facility's Operational Support Titled: Infection Control: Isolation Patients Revised 8/2010 "Standard Precautions will be followed when passing, retrieving, and washing trays. Staff passing trays will perform hand hygiene before/upon entering the patient's room and after leaving the patient's room. Staff retrieving trays will perform hand hygiene before/upon entering the patient's room and after leaving the patient's room. If gloves are worn by staff, they must be changed between patient rooms and hand hygiene performed appropriately." This policy was not followed. The facility's procedure for female perineal care, "wash the labia majora. Using a clean washcloth or perineal wipe, wipe in direction from perineum to rectum (front to back). Repeat on the opposite side, using a new washcloth or perineal wipe...	F 441		

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F 441	Continued From page 16 With the dominant hand, wash downward from the pubic area toward the rectum in one smooth stroke." This procedure was not followed. On 6/7/13 at 12:15 PM, E21 (Admission Director) stated all policies presented during the survey are current.	F 441		