DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145821	A. BUILDING ______ B. WING ______	07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ELGIN	**2355 ROYAL BOULEVARD ELGIN, IL 60123**

(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 Annual Certification Survey	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 observation, interview and record review the facility failed to document a medical symptom justifying the use of restraint and failed to document the checking and release of restraint as per the facility's policy. This applies to 1 of 3 residents (R12) reviewed for restraints in a sample of 20. The Findings include: R12 has a diagnoses of senile dementia, anemia, chronic obstructive lung disease (COPD), coronary artery disease (CAD), hypertension, diabetes, atrial fibrillation, degenerative joint disease, congestive heart failure, depression, dyspnea, hyperlipidema according to the July 1, 2015 medication administration record. R12's care plan intervention dated effective May 18, 2015 shows R12 had a self release seat belt with alarm. On May 26, 2015 she was changed to a self release velcro belt. On June 3, 2015 the belt was changed to a self release belt with a buckle for fall prevention related to unsafe attempts to transfer or ambulate without	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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F 221	Continued From page 1 assistance. On July 13, 2015 at 10:00 AM, R12 was in her room seated with the restraint belt buckle in place. On July 13, 2015 at 12:15 PM, R12 was in her room seated with the restraint belt buckle in place. On July 14, 2015 during the noon meal, R12 was sitting on the tip of her high back chair with the seat belt buckle in place while reaching forward to feed herself. On July 14, 2015 at 9:50 AM R12 was asked to release her buckled seat belt in the presence of E8 (certified nursing assistant) and E9 (registered nurse). R12 she was unable to do so stating she couldn't open it. E8 stated R12 used to be able to release the velcro styled belt. On July 14, 2015 at 4:23 PM R12 was in her room seated with the restraint belt buckle in place, she became upset and tossed a drawer in her room and E14 (certified nursing assistance) went in to assist her. E14 did not release the restraint belt buckle. E15 (licensed practical nurse) stated E14 should have released the belt. R12's medical record did not contain any documentation of R12's restraint being checked every thirty minutes or released at a minimum of every two hours with intervention documented as required per the facility's undated policy titled Physical Restraint Policies.	F 221		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 2	F 309		

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 accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to assess and report a resident's chronically elevated blood glucose, failed to assess a resident's pain, and failed to intervene, provide assistance, and redirection when a resident with senile dementia experienced an episode of unusual behavior. This applies to 3 of 7 residents (R3, R9, R12) reviewed for pain, glucose monitoring, and dementia care, in the sample of 20.

The findings include:

1. R9's MAR (Medication Administration Record), dated June 1-30, 2015, shows the following number of instances blood glucose values exceeded 200 mg/dL (milligrams per deciliter):

twenty-one instances at 6:00 AM,
eighteen instances at 12:00 PM,
fifteen instances at 6:00 PM,
twenty five instances at 12:00 AM.

R9's MAR, dated July 1-13, 2015, shows the following number of instances blood glucose values exceeded 200 mg/dL:

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ten of thirteen instances at 6:00 AM,
ten of thirteen instances at 12:00 AM,
six of thirteen instances at 6:00 PM,
eleven of thirteen instances at 12:00 AM.

On July 15, 2015, E12 (Dietitian) stated blood glucose consistently greater than 150 mg/dL should be reassessed. E12 stated she reviews residents on tube feedings monthly and tries to look at blood glucose monitoring.

On July 15, 2015, Z3 (Physician) stated there was a facility oversight and he was never notified of the chronically elevated blood glucose values in June and July of 2015. Z3 stated blood glucose consistently measuring in the 200's mg/dL should have warranted a call to the physician. Z3 stated his July 15, 2015 discussion with nursing regarding R9's chronically elevated blood glucose was the first time the issue had been brought to his attention. Z3 stated he adjusted both long and short acting insulin based on the July 15, 2015 report of the chronically elevated blood glucose.

Dietary Progress Notes, dated July 8, 2015 and June 7 and 15, 2015, May 11, 2015, and April 1 and 10, 2015, show no review of daily blood glucose values.

American Diabetes Association Standards of Medical Care in Diabetes, 2015, Older Adults, recommends blood glucose control of older adults with very complex / poor health (long-term care or end-stage chronic illnesses or moderate-to severe cognitive impairment or 2+ ADL (activities of daily living) dependencies to remain between 100-200 mg/dL.
2. R12's July 2015 Medication Administration

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F 309	Continued From page 4 Record shows contributing diagnoses of senile dementia and depression On 7/14/15 at 4:23 PM, E13 CNA (Certified Nursing Assistant) came by the 500 hall nursing station and stated to E5 RN(Registered Nurse) "(R12) is in one of her moods you need to be careful" and proceeded around the nurses' station to the 300 hallway. The RN (E5) did not respond to see what was happening with R12 and E13 did not return to assist R12. On 7/14/15 at 4:24 PM to 4:29 PM, R12 was in her room and grabbed the end of her bed with both hands and shook it roughly. R12 then backed her wheelchair into the wall four times hard enough where she slid to the edge of the seat. R12 then wheeled walked her wheelchair to her bedside table and threw a cup and some papers on the floor. R12 then grabbed the drawer to the bedside table and yanked it back and forth until it came out. R12 then took the drawer and turned it upside down dumping all the contents in the floor. R12 then banged the drawer on the floor three times. R12 then took the drawer in her left hand and rested it on her left leg and the floor. R12 stated "I hate this, I hate this. I just want out of here, I just want to be out of here. I don't understand this. Why are they doing this to me why do I have to be in here " R12 then put her right hand over her eyes and shook her head back and forth. At 4:29 PM E14 CNA(Certified Nursing Assistant) was coming up the hall and stopped to asked the surveyor if something was needed and the surveyor directed her towards R12. E14 then went and explained to R12 that she was on isolation and attempted to reassure her and clean up disarray in R12's room. On 7/14/15 at 4:50 PM E5 stated E13 should have immediately addressed R12's behavior and should not have walked away if it was bad. E5	F 309		

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F 309	Continued From page 5 confirmed she had not checked on R12 because E13 did not tell her it was a "bad" behavior and didn't know she had thrown the drawer out of her dresser. E5 stated she would have checked on R12 if she had realized she was that upset. On 7/13/15 at 10:00 AM, E6 RN/CPC(Care Plan Coordinator) stated R12 was on contact isolation and not allowed out of the room. E6 stated R12 would probably only be on isolation for 24 hours. E6 stated that was going to be difficult to maintain R3's isolation because she liked to be out of her room and be able to wheel herself around the facility. R12 was on isolation from 7/13/15 to 7/15/15. R12 was on isolation for 3 days. On 7/15/15 at 2:00 PM there was no documentation found in the nursing notes, Behavior Tracking Forms or nursing report regarding the behavior for R3 on 7/14/15. On 7/15/15 at 2:30 PM, E2 (DON) confirmed she was not aware of this and it should have been discussed at the daily AM stand up meeting. E2 stated if a resident has a behavior or agitation or anxiety it should be documented somewhere and if necessary the doctor and family would be made aware. E2 confirmed the behavior exhibited by R12 on 7/14/15 was not usual for her and was not her normal behavior. R12's Care Plan with effective date of 5/18/15 has multiple interventions dealing with her behaviors, anxiety, agitation as it relates to her diagnoses of senile dementia and depression. Some of these are provide quiet atmosphere with one on one support during periods of increased anxiety and allow R12 to talk about event and cause if known, record behavior on Behavior Tracking Form, observe for episodes of anxiety, monitor for side effects of medication (antidepressants) (constipation, dry mouth	F 309		

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F 309	Continued From page 6 anxiety, agitation, headache, falls), report promptly to the physician, observe R12 for changes in mood/behavior/crying, staff will comfort R12 when she is distraught, meeting her in her world, when that provides her the most comfort, and reminding her of today's reality when that comforts her, monitor/observe R12 for excessive/unsafe movement that could increase risk of injury or other negative outcome. On 7/15/15 at 2:30 PM, E2, Director of Nursing stated the staff should monitor the resident's behavior and should be following the resident's plan of care and the nursing staff should also respond and document on behaviors. E2 also stated this is unusual behavior for R12. 3. On 7/14/15 at 11:15 AM, Z1(Physician Assistant) stated R3 has issues with neuropathy pain and due to her altered mental status that it could present as complaints of her feet being cold. Z1 stated that due to R3's fluctuating mental status she would not always be able to use the normal number pain scale and staff should use other indicators when assessing her pain. Z1 stated R3 was on as needed Tramadol for this pain and she thought the nurses were giving R3 this medicine when she complained her feet being cold. Z1 stated R3 would not always be able to verbalize when she was in pain and nursing might have to do further questioning and assessment of the resident. Z1 stated R3 use to be on the Tramadol three times a day but due to an increase in falls it was reduced to as needed. Z1 stated that R3 had also been on a lidocain patch but because insurance did not cover it, it was discontinued. On 7/13/15 at 2:30 PM, Z3 (family member) stated R3 usually complains that her feet are cold. Z3 stated it is sometimes hard to tell if R3's feet are cold or are hurting due to her neuropathy.	F 309		

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F 309	Continued From page 7 Z3 stated sometimes it is hard for R3 to tell the staff exactly what is wrong because mentally she cannot get her thoughts out or make her needs known. Z3 stated R3 has issues with neuropathy in her feet and had tried to get the staff to soak her feet at night but it didn't seem to work out too well. R3 complained of cold feet on 7/13/15 at 11:15 AM and E6 RN/CPC(Registered Nurse Care Plan Coordinator) was present. No pain assessment was done R3 complained of cold feet on 7/14/15 at 8:45 AM E16 (Nurse) was made aware by the surveyor and stated "ok". No pain assessment was done On 7/4/15 at 9:45 AM, E17(Nurse) was asked if R3 ever complained that her cold feet meant she was having pain in her feet. E17 proceeded to assess R3 for pain and she rated the pain in her feet as a 9 out of 10. R3's Pain Flow Sheet shows that on 7/14/15 at 9:15 AM, she was given Tramadol 50 mg(milligrams) by mouth. However as of 7/15/15 there was no follow up as to the effectiveness of the medication. R3 complained of cold feet on 7/14/15 at 4:08 PM and E5 (RN) and E9 (RN) were present, no pain assessment was done R3 complained of cold feet on 7/14/15 at 4:50 PM E5 was present and stated "Ya, she says that a lot." No pain assessment was done. R3's Medication Administration Record for July 2015 shows the resident only received Tramadol for pain one time on 7/14/15 at 9:50 AM. R3's order for Tramadol is 50mg by mouth every six hours as needed for pain. R3's Care Plan with goal date of 7/30/15 has an identified problem of pain/discomfort and the goal is the resident will achieve a consistent level of comfort and under intervention states to evaluate	F 309		

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F 309	Continued From page 8 location, nature, intensity and duration of pain, administer pain medications as ordered and monitor medications as ordered and monitor the effectiveness.	F 309		
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 observation, interview and record review, the facility failed to follow their policy for safe storage of unused oxygen tanks, and failed to follow fall interventions for a high fall risk resident. This applies to 2 of 9 residents (R17, R3) reviewed for specialty care and falls in the sample of 20, and 1 resident (R22) in the supplemental sample. The findings include: 1.) On July 13, 2015 at 10:00 AM, during initial tour of the facility with E3 (RN-Registered Nurse) in R22's room, an unsecured, unused oxygen tank was being stored on R22's overbed table. E3 immediately said "The oxygen tank should not be stored on the overbed table." On July 13, 2015 at 10:10 AM, in R17's room, an unsecured, unused oxygen tank was being stored	F 323		

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on R17's chair, among other resident belongings, including undergarments and crocheted blankets, at which time E3 said "The oxygen tank should not be stored on R17's chair."

The facility's policy entitled "Oxygen Storage" dated March 2013 shows "Policy: To ensure guest safety, Rosewood Care Center will store oxygen equipment in accordance with Life Safety Codes. Procedure: The Nurse will: 2. Return E-tanks to the oxygen storage room when empty or no longer in use. 3. Maintain security of the E-tanks by keeping them chained to the wall of the oxygen storage closet or placing them in the E-tank holder."

2.) R3's Care Plan with effective date of 4/30/15 has her as risk for falls and the goal is that she will maintain her current level of mobility with no increase in the incidence of falls/injuries. No new intervention can be identified after fall 5/4/15. One identified intervention is a tab alarm to be applied when in wheelchair. Another intervention shows to keep call light within easy reach and instruct R3 to use call bell or call out for assistance.
R3's Incident/Accident Reports from 5/1/15 through 5/23/15 shows R3 had 7 falls.
On 7/14/15 at 4:34 PM, R3 was sitting in her wheelchair behind the nursing station. E9 RN (Registered Nurse) and E5 RN were at the nurses' station charting. R3 was able to stand up and started pulling her wheelchair forward because of the excessive length of the alarm string. Due to the excessive length of alarm string R3's chair alarm tab did not come out of the monitor box and the alarm did not sound. E9 and E5 did not see R3 and she started to walk forward pulling the wheelchair behind her. The

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F 323	Continued From page 10 Social Service Director attempted to stop R3. R3 stated she had to go to the bathroom. The Social Service Director had to yell out three times to obtain assistance from nursing staff for R3. R3's tab alarm was attached to her shoulder. On 7/14/15 at 4:50 PM, R3 wheeled herself out of her room, which is right next to the nurses' station and looked around and stated " I have to go to the bathroom " . There was a Certified Nursing Assistant and a nurse at the end of her hallway. E5 (RN) was at the nurses' station next to R3's room. R3 looked around again and said " I have to go to the bathroom." R3 looked up the hallway again. R3 then turned around wheeled herself back into her room. R3 then unhooked her wheelchair tab alarm that was attached to her shoulder. R3 then stood up and walk into the bathroom. At this time the surveyor prompted E5 that R3 was up out of her wheelchair and ambulating without assist and had removed her chair alarm. E5 went into room and assisted R3 at that time. On 7/14/15 at 5:00 PM, E5 stated R3 is at high fall risk and has fallen several times and needs assistance when ambulating. E5 stated R3's tab alarm should not be placed where she can reach it, because she knows how to remove it. E5 stated R3 had removed it in the past and fallen as a result. E5 stated R3's string to the alarm should not be real long. E5 stated R3's alarm string should be short so she cannot move very far from the chair without it alarming. On 7/15/15 at 3:30 PM, E2 (Director of Nursing) confirmed R3 had fallen due to her removing the wheelchair alarm. E2 confirmed staff should be placing the clip to R3's alarm where she cannot reach it, so she will not remove it. E2 stated R3 has a history of getting up and going to the bathroom without help without assistance and	F 323		

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F 323	Continued From page 11 falling. R3's nursing note dated 5/5/15 at 4:45 PM, states resident was found on floor by closet door, denies any pain and prior to incident, nurse took resident to bathroom, checked on resident and R3 was still was not done, so the nurse told R3 to pull the call light when she was done. On 7/15/15 at 8:30 AM, E3 (Registered Nurse) stated staff should not be leaving R3 unattended in the bathroom and confirmed she was at high risk for falls. The facilities document undated titled "Electronic Monitoring Device Fact Sheet" shows the cord must be at an appropriate length so the device sounds when the guest attempts to exit the chair. The length of the cord may need to be shortened depending on the residents height	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to prevent a resident from experiencing significant weight gain resulting in resident's	F 325		

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weight exceeding her ideal body weight. This applies to 1 of 14 residents (R9) reviewed for weight changes in the sample of 20.

The findings include:

On July 13, 2015, R9 and R9's family expressed concern with R9's weight gains and questioned why continuous weight gain had not been addressed.

Dietitian Nutritional Assessment, dated November 19, 2014, shows R9's weight was 132 pounds, ideal weight range was 120 pounds plus/minus 10% (a range of 108-144 pounds), estimated daily nutritional needs of 1500-1800 calories. R9's diet included general regular milk three times a day, double protein food item at breakfast, ice cream at lunch and dinner, and a high calorie supplement 120 ml (milliliters) daily. Assessment shows R9's Body Mass Index was 22.7 (within normal limits) and diet plan provided 2600 calories and intake was approximately 75% of meals which would provide approximately 1900 calories of intake daily.

Dietary Progress Notes, dated December 15,2014, showed R9's weight was 145 pounds and increase was likely due to fluid which was treated with a diuretic.

Dietary Progress Notes, dated January 12, 2015, showed R9's weight was 149 pounds and no edema was noted. Progress note states R9's intake and appetite is good. Resident remained on high calorie supplement 120 ml four times a day.

Dietary Progress Notes, dated March 16, 2015,

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showed R9's weight was 158 pounds, no edema noted, and appetite was good. Dietitian recommended decreasing the high calorie protein to 60 ml four times a day and discontinuing the ice cream. Dietary Progress Note dated 3/18/2015, showed ice cream was resumed per resident request, however no adjustments to high calorie supplement were made.

Physician progress note, dated April 18, 2015, showed R9 was experiencing "stable pedal edema".

Dietary Progress Notes, dated April 29, 2015, R9's weight was 175 pounds and appetite was good. Dietitian recommended continue present management at that time.

Dietary Progress Notes, dated May 14, 2015, R9's weight was 163 pounds and continued on high calorie supplement 60 ml four times daily, continued on a general diet with double portions at breakfast, and additional ice cream twice a day.

Dietary Progress Notes, dated June 25, 2015, R9's weights for June were recorded as 179 pounds and 187 pounds. At time of assessment, R9 was receiving high protein supplement 60 ml four times a day as well as the general diet with double protein portions at breakfast, and additional ice cream twice a day. At the weight of 187 pounds, R9 was 130% her high end of her ideal body weight range. R9 gained a total of 55 pounds since November, 2014 and 42 pounds (28% gain) in six months.

Facility Weight Monitoring Procedure, dated November 2008, shows Significant Weight

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Change Criteria includes:
a. 5% or more in one month
b. 7.5% or more in two months
c. 7.5% or more in three months
d. 10% or more in four months
e. 10% or more in five months
f. 10% or more in six months

On July 15, 2015, at in the main dining room, E12 (Dietitian) stated R9's diet of General, extra ice cream twice a day, double portions of protein at breakfast, and 120 ml high protein supplement provided approximately 2610 calories per day if meal intake was assumed to be 50-75% of all meals. E12 confirmed that R9's estimated caloric needs were 1500-1800 calories per day at the time of her last nutritional assessment dated November 19, 2014. E12 confirmed no further assessments of caloric needs had been estimated since the November 19, 2014 assessment.

Facility Care Plan Report, dated May 21, 2015, shows R9 "has unplanned weight gain in last six months. Weight will remain stable to be within her ideal body weight range over the next 90 days." Approaches include, "Monitor food intake at each meal. Offer appropriate substitutes for uneaten food. Monitor and document weight."

On July 15, 2015 at 10:00 AM, E1 (Administrator) stated there are no meal monitoring records for R9 for the past six months. E1 also confirmed that weights recorded in the record were verified by re-weighing the resident to ensure the weights were not obtained in error.

Facility Weekly Summaries (information based seven days prior to date of assessment) dated

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F 325	Continued From page 15 January 15 and 22, 2015, February 5 and 12, 2015, March 5 and 19, 2015, April 2, 16, and 30, 2015, June 4, and 11, 2015, and July 9 and 11, 2015, showed R9 had a good appetite at the time of assessments. Facility Weekly Summaries (information based seven days prior to date of assessment) dated January 15 and 22, 2015, February 5 and 12, 2015, March 5 and 19, 2015, April 2, 16, and 30, 2015, June 11, 2015, and July 9 and 11, 2015, showed R9 was experiencing no edema at the time of assessments.	F 325		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the respiratory equipment supplies and tubings were covered and dated according to the facility policy. This applies to 7 residents (R23 through R28, and R30) reviewed for specialty care in the supplemental sample.	F 328		

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F 328	Continued From page 16 The findings include: On July 13, 2015 at 10:15 AM, R24 had a suction machine on her bedside table that was not covered. E6 (Registered Nurse/ Care Plan Coordinator) stated it should be covered. On July 13, 2015 at 10:17 AM, R25's oxygen tubing and cannula were lying on the floor. E6 stated the oxygen tubing and cannula should be in a bag and dated and not on the floor. On July 13, 2015 at 10:20 AM, R26's oxygen tubing and cannula were not covered. The nebulizer mask was also not covered. E6 stated the nebulizer mask and tubing were to be kept in a bag and dated if not in use. On July 13, 2015 at 10:25 AM, R27's nebulizer machine was attached to the mask and tubing which was dated October 15, 2014. E6 stated the tubing was to be changed at least every week and should not be there over a month. On July 14, 2015 at 9:00 AM, R28's nebulizer mask was dated July 3, 2015. E9 (RN/Registered Nurse) stated it should have been changed on July 8, 2015 based on the Treatment Administration Record schedule. E9 stated the nebulizer mask and tubings were to be changed weekly. On July 13, 2015 at 10:10 AM, R30's oxygen tubing was wrapped around the oxygen tank and was not covered and labeled. On July 13, 2015 at 10:40 AM, R23's oxygen concentrator did not have a filter and the humidifier bottle was almost empty, did not have a tubing and was not dated. The facility policy and procedure titled, "Oxygen Administration," revised 3-2015, requires, "8. Change and date the humidifier bottle weekly per protocol. 9. Change and date the oxygen tubing	F 328		

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F 328	Continued From page 17 (and cannula/mask) weekly per protocol. 10. Keep tubing with cannula/mask in plastic bag attached to the concentrator when not in use per infection control protocol."	F 328		
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	F 441		

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F 441	Continued From page 18 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 post a sign outside the residents' room to alert the staff and visitors of isolation precaution, failed to don Personal Protective Equipment (PPE) during provision of care, failed to transport linens from the contact isolation room in a protective bag and failed to follow the facility's policy for handwashing, and isolation precautions. This applies to 3 of 20 residents (R10, R11, R12) reviewed for infection in the sample of 20 and 3 residents (R23, R28, R29) in the supplemental sample. The findings include: 1.) On July 13, 2015 at 10:40 AM, E3 (RN-Registered Nurse), E3 and this surveyor entered R23 and R29's room as part of the initial tour of the facility. Upon exiting the room, a bag containing isolation supplies was hanging on the inside wall of R23's room. When asked why isolation equipment was hanging inside R23 and R29's room, E3 said, "R23 is in contact isolation for ESBL (Extended spectrum beta-lactamase) in the urine and received treatment with topical scabicidal agent on July 12, 2015. R29 is on contact isolation following treatment with topical scabicidal medication. A sign should have been posted outside the door to alert staff and visitors of isolation precautions before we entered."	F 441		

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F 441	Continued From page 19 The facility's policy entitled "Infection Control Isolation Transmission Based Precautions" revised October 2013 showed: Contact Precautions: 1. Determine the category of transmission based on precautions needed. Gloves: Wear gloves when entering the room. 5. Notify staff of need for precautions." 2.) On July 14, 2015 at 9:56 AM, E4 (CNA-Certified Nursing Assistant) was providing perineal care to R11 following a bowel movement on the bedpan. E4 washed her hands and donned clean gloves. E4 assisted R11 to turn onto her left side and removed the bedpan from under R11. E4 used 3 different disposable wipes to clean stool from R11's buttocks area. E4 cleaned R11's front perineal area after cleaning R11's buttocks area, while R11 remained on her left side. After providing perineal care to R11, E4 removed her soiled gloves and donned a clean pair of gloves without washing her hands. E4 applied moisture barrier cream to R11's perineal area and buttocks. E4 removed her gloves after applying the barrier cream to R11 and immediately donned a clean pair of gloves, at which time she placed a clean incontinence brief on R11. E4 removed the bedpan from the bedside with her gloved hands and emptied the contents into the toilet. E4 removed her gloves and donned a clean pair of gloves before placing pants on R11, and assisting her to the wheelchair. E4 was not observed washing her hands between glove changes. The facility's face sheet dated April 9, 2015 showed R11's diagnoses included peripheral vascular disease, amputation below the knee, amputation above the knee, and vascular dementia. R11's MDS (Minimum Data Sheet)	F 441		

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dated July 2, 2015 shows R11 has severe cognitive impairment and required extensive assistance with hygiene and toileting and is frequently incontinent of bladder and bowel.

The facility's policy entitled "Infection Control: Handwashing" revised September 2014 shows, "Times to perform hand hygiene: Before putting on gloves and after removing gloves, before and after providing resident care including bathing, oral care, incontinence care catheter care, any direct contact with the resident (such as taking a blood pressure/pulse, transferring the resident) etc, before and after assisting a resident with toileting, after handling soiled or used linens bedpans, catheters, and urinals."

3.) On 7/13/15 at 9:55 AM E5 RN(Registered Nurse) was in R10's room and had no Personal Protective Equipment and was giving medications to R10. R10's July 2015 Physician Orders Sheet states Contact Isolation Precautions.
4.) On 7/13/15 at 10:00 AM, E6 RN/CPC (Registered Nurse/Care Plan Coordinator) stated R12 was on contact isolation for possible scabies. E8 CNA(Certified Nursing Assistant) walked out of resident's room with resident's linens in her hands and the linens were not bagged. E8 then proceeded to take the soiled linens down the hall to the soiled linen room at the other end of the hall. E6 stated the linens should be in a protective bag.
5.) On 7/13/15 at 10:10 AM, R28 was out in the hallway. E6 stated R28 had refused the prophylaxis treatment for possible scabies. R28 stated to E6 no one had told him he should not be out of his room. R28 stated he realized he did not want the treatment but did not realize he could spread it up and down the hall and he had

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F 441	Continued From page 21 already been to the dining room. R28 told E6 that he was also concerned because some of the staff had been putting on the special equipment and some had not when they came into his room. R28 went on to say he had visitor that did not know they were supposed to be wearing the special equipment either. E6 stated they might need to do some staff education.	F 441		