STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146083	A. BUILDING _____ B. WING _____	03/24/2016

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F 000	INITIAL COMMENTS Annual Licensure and Certification Validation Survey for Subpart U: Alzheimers Unit--Manor Court of Princeton is in substantial compliance with Subpart U, 77 Illinois Administrative Code 300.7000.	F 000		
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 follow policies and procedures for conducting required back ground checks prior to hire for one of 10 employees reviewed for healthcare worker background checks. This has the potential to affect all 96 residents in the facility. Findings include: The facility's Abuse Prohibition policy (Revised June 2014) documents the following: "Screening of potential employees will be conducted and hiring will be dependent upon screening result. Screening shall include: Reference check with previous employees and/or current employer. Health care worker background checks on non-licensed direct care staff. Check with appropriate licensing board and registries when	F 226		

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

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F 226	Continued From page 1 applicable..." The facility's undated CNA (Certified Nursing Assistant) Roster documents that E10, Activity Aide/CNA, was hired at the facility on 10/20/15. E10's Health Care Worker Registry background check documents a background check was not conducted on E10 until 11/29/15. On 3/21/16 at 11:50 a.m., E9, Human Resources Manager, stated that E10 was hired at the facility on 10/20/15 as an Activity Aide, and transitioned into the role of a CNA on 11/29/15. E9 then stated that the facility is unable to provide documentation of any background check conducted on E10 prior to E10's hire date of 10/20/15. On 3/23/16 at 9:13 a.m., E2, Director of Nursing, stated that E10 was initially hired at the facility as an Activity Aide and had access to all residents throughout the facility. The Center for Medicare and Medicaid Services form 672 Resident Census and Condition of Residents form dated 3/21/16 and signed by E12, Licensed Practical Nurse/Minimum Data Set Coordinator/Care Plan Coordinator, indicates that 96 residents currently reside in the facility.	F 226		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 253	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to remove tube feeding liquid from a mattress for one of two residents (R21) reviewed for tube feedings in a sample of 20. FINDINGS INCLUDE: The facility policy, Housekeeping Policy and Procedure, dated (revised) 01/03 directs staff, "It is the policy of the facility to provide its residents a clean living environment...Upon entering resident living quarters, housekeeping is (to) wash beds and plastic mattresses as needed, using germicidal solution." On 3/21/16 during a tour of the facility at 9:15 A.M., R21's deep-cushioned, blue mattress had multiple areas of dried tube feeding material scattered across the entire edge of the mattress facing the room door. A pump next to R21's bed held a liquid tube feeding product that was infusing at 50 CC (cubic centimeters)/HR (hour). These same stains were present on 3/21/16 at 11:10 A.M., 12:44 P.M. and 2:40 P.M., and again on 3/22/16 at 8:35 A.M. On 3/22/16 from 9:23 A.M. until 9:45 A.M., E6 Housekeeper was present in R21's room, performing housekeeping chores. E6 dusted the furniture in R21's room, dusted under R21's bed, then went into R21's bathroom with cleaning supplies. E6 then proceeded to wet mop R21's room and bathroom floor, exited R21's room and placed a "Wet" sign at the entrance of R21's room. Scattered tube feeding stains remained on R21's mattress.	F 253		

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F 253	Continued From page 3 On 3/22/16 at 9:25 A.M., E6/Housekeeper stated, "Each day I dust, mop the floor, disinfect the toilet and mop the bathroom floor for each resident (room). I only clean the bed when (a resident) discharges." On 3/23/16 at 11:10 A.M., E7/Interim Housekeeping Supervisor stated, "Daily cleaning (of a resident's room) includes dusting; high and low, wiping off night stands and dressers, cleaning the bathroom and mopping the floor and bathroom floor. We clean the mattress also. If there is tube feeding residue on a mattress, it should be cleaned up immediately."	F 253		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		

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F 279	Continued From page 4	F 279		

This REQUIREMENT is not met as evidenced by:
Based on interview, observation and record review, the facility failed to develop an individualized care plan regarding dialysis, pressure ulcers, and communication barriers for four of 20 residents (R20, R24, R26 and R29) reviewed for care plans in the sample of 20.

Findings include:

1. R20's current electronic Facesheet documents that R20 has a diagnosis of Left Middle Cerebral Artery Cerebrovascular Accident and Aphasia.
R20's Social Service Progress Note (dated 10/21/15) documents the following: "(R20) was admitted to facility...with a diagnosis of a (Cerebrovascular Accident). (R20) is alert, family believes oriented, (R20) cannot speak or write due to (R20)'s stroke."
On 3/23/16 at 8:30 AM, E16 (Certified Nursing Assistant) communicated with R20 by asking R20 "yes" or "no" questions and having R20 indicate a response of "yes" with an open palm hand or a response of "no" with a close palm hand.
R20's current Care Plan (dated 1/28/16) does not document R20's impaired communication or communication technique as an identified problem with goals and interventions.
On 3/22/16 at 1:00 PM, E2 (Director of Nursing) stated that due to R20's Cerebrovascular Accident, R20 communicates with yes or no questions and responds "Yes" with an open palm and "No" with a closed fist. E2 verified that R20's communication methods were not addressed on R20's current care plan, and E2 would expect to see this listed on R20's care plan with goals and

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F 279	Continued From page 5 interventions. 2. The facility's Weekly Summary Log dated 3/12/16 documents R24 currently has a Stage III pressure ulcer on R24's buttocks. On 3/22/16 at 8:45 a.m., E13, Certified Nursing Assistant, assisted R24 with toileting. E13 applied a gait belt around R24's waist and assisted R24 to stand, pulled R24's pants down, and assisted R24 to sit on the toilet. While pulling R24's pants down, a medicated gauze padding was in place in R24's gluteal cleft. E13 pointed to the medicated gauze padding and stated, "That is where (R24's) pressure ulcer is." R24's current electronic care plan does not have a care plan in place addressing R24's current buttocks pressure ulcer. On 3/23/16 at 9:13 a.m., E2, Director of Nursing, verified that R24 does not have a care plan in place addressing R24's current buttocks pressure ulcer and stated that there should be one in place. 3. R26's current electronic Facesheet documents that R26 has a diagnosis of End Stage Renal Disease, Dependence on Renal Dialysis, and Fistula, Forearm for Dialysis. R26's current Care Plan (dated 2/25/16) does not document R26's renal dialysis as an identified problem with goals and interventions. On 3/23/16 at 12:15 PM, E2 (Director of Nursing) verified that R26's renal dialysis was not documented on R26's current care plan. E2 stated that R26's renal dialysis should be documented on R26's current care plan.	F 279		

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F 279	Continued From page 6 4. R29's Face Sheet dated 3/23/2016, documents R29's diagnosis to include End Stage Renal Disease-Dialysis. R29's current care plan dated 1/7/2016 does not have a care plan in place addressing R29's current dialysis status. On 3/23/2106 at 12:00 p.m., E2 (DON) Director of Nursing stated, "(R29) is receiving dialysis and it is not addressed on R29's care plan, and I expect it to be addressed on (R29's) care plan."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280		

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F 280	Continued From page 7	F 280		

by:
Based on interview and record review, the facility failed to update a fall care plan after each fall for two of seven residents (R9 and R28) reviewed for falls in the sample of 20.

Findings include:

1. R9's current electronic Facesheet documents the following diagnoses: "Difficulty in walking, not elsewhere classified...Unspecified abnormalities of gait and mobility... Other lack of coordination... History of Falling."
R9's Fall Risk Assessment (dated 8/18/15 and 1/12/16) documents a fall risk score of 18 indicating R9 is a high risk for falls.
The facility's current Falls Report documents that R9 had falls on the following dates: 9/4/15, 9/14/15, 9/18/15, 9/18/15 and 1/14/16.
R9's current Care Plan (dated 1/20/16) does not address R9's falls on 9/18/15 and 1/14/16 and does not document the implementation of new interventions following those falls.
R9's Problem Evaluation Report (dated 9/6/14) does not document any new or discontinued interventions for R9's 9/18/16 or 1/14/16 fall.
On 3/22/16 at 3:30 PM, E2 (Director of Nursing) verified that no additional interventions were put in place following R9's 9/18/15 or 1/14/16 falls and R9's care plan was not updated following those falls. E2 stated that a fall report and evaluation should be done after each fall to determine new interventions and care plan should be updated.
2. R28's electronic face sheet, dated 4/22/14, documents a diagnosis of lack of coordination and a fall from non-moving wheelchair.
R28's fall risk assessment, dated 2/26/16, documents that R28 is a high risk for falls.

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F 280	Continued From page 8 R28's Problem Evaluation Notes Report, documents that R28 has fallen on the following dates: 3/3/16, twice on 2/2/16, and 12/8/16. This same form documents that no change to the care plan is needed for these falls. R28's current care plan, documents the following: R28 is at increased risk for falls, related to advanced Parkinson's, and muscle rigidity and R28's goal is that R28 will have a decrease in falls through the next review. The care plan includes no new interventions to prevent future falls since 11/25/15. On 3/23/16 at 1:00 p.m., E2, Director of Nursing verified that R28's care plan did not document any new interventions to prevent future falls. E2 stated that E2 expects the staff to document new interventions for every fall.	F 280		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to perform passive range of motion exercises as ordered, for one of nine residents (R21) reviewed for range of motion in a sample of 20. FINDINGS INCLUDE:	F 318		

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The facility policy titled, Range of Motion (Passive and Active) dated (revised) 03/09 directs staff, "The purpose (of range of motion exercises) is to prevent contractures, to maintain normal range of motion, to increase joint motion to the maximum possible range, to maintain and build muscle strength, to stimulate circulation, to prevent deformities and to prevent contractures from becoming worse if they are already present."

On 3/22/16 at 8:35 A.M., E4 and E5 Certified Nursing Assistants (CNA) performed morning care for R21. E4 and E5/CNAs bathed and dressed R21, performed oral care, then assisted R21 into a reclining back wheelchair. Without performing PROMs (Passive Range of Motion Exercises), E4 and E5 then left R21's room.

R21's current Physician Order Sheet dated March 2016 includes the following diagnoses: Multiple Sclerosis, Seizure Disorder, Abnormal Posture, Muscle Weakness, and also includes the following physician orders: PROMs (Passive Range of Motion Exercises) to all 4 extremities twice daily, 7 days a week.

R21's current Care Plan, dated 2/25/16 includes the following identified problems: (R21) is at increased risk for contracture development related to history of MS (Multiple Sclerosis) and decreased muscle tone and also includes the following approaches: PROMs (Passive Range of Motion Exercises) to BUE (Bilateral Upper Extremities) shoulders, elbows, wrists, head, neck and hands; BLE (Bilateral Lower Extremities) hips, knees and ankles.

R21's Quarterly Contracture Assessment, dated

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F 318	Continued From page 10 2/16/16 indicates that R21 is "Moderate Risk" for developing further contractures. R21's Nursing Rehab Time Log dated 1/22/16 through 3/22/16 documents "Zero" for "Total Daily Minutes for Passive Range of Motion (exercises) provided by Certified Nursing Assistants. On 3/22/16 at 8:50 A.M., E4 Certified Nursing Assistant stated, "I like to do PROMs on (R21) when (R21) is up in (R21)'s chair. I don't always get to them though. I was in a hurry this morning, so I didn't do them (PROMs)." On 3/22/16 at 11:35 A.M., E2 Director of Nurses stated, "PROMs are ordered through the physician, after an evaluation by therapy. I have no further documentation for (R21)'s PROMs. I don't know why staff haven't been doing PROMs on (R21)."	F 318		
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	F 322		

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F 322	Continued From page 11 skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to check placement of a gastrostomy tube prior to administering medications for one of two residents (R21) reviewed for tube feedings in a sample of 20. FINDINGS INCLUDE: The facility policy, Tube Feeding, dated (revised) 10/13 directs staff, "Placement of the tube must be checked before every feeding or medication administration. Placement may be verified by aspirating gastric contents, using a protective towel or barrier when tube is disconnected or as needed." On 3/21/16 at 12:44 P.M., E3 Licensed Practical Nurse (LPN) prepared to administer medications to R21. E3/LPN placed the tube feeding pump on hold and disconnected the gastrostomy tube from the pump tubing. Without verifying placement of the feeding tube, E3/LPN attached the barrel of the syringe, added 30 ML (milliliters) of water to a crushed pill, poured the mixture into the barrel of the syringe while placing a stethoscope on R21's abdomen. E3/LPN then administered two liquid medications and followed with 30 ML of tap water. E3/LPN reattached the feeding tube to the pump tubing and restarted the tube feeding via the pump at 50 CC/HR. E3/LPN then left the room.	F 322		

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F 322	Continued From page 12 R21's current Physician Order Sheet, dated March 2016 includes the following physician orders: Nothing by mouth. Fibersource HN 50 ML/HR per pump continuous. Check placement of tube prior to each feeding or medication administration. On 3/22/16 at 9:00 A.M., E3/LPN stated, "I didn't have the other part of the syringe (plunger) to check for (R21's tube) placement yesterday. I just checked for placement at the same time I gave the medicine." On 3/22/16 at 11:35 A.M., E2 Director of Nurses stated, "Staff are to check (gastrostomy tube) placement with an air bolus and (aspirating) for residual before giving medications, water or tube feeding."	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 investigate and implement new fall interventions to prevent further falls for two of seven residents (R26 and R28) reviewed for falls in the sample of 20.	F 323		

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F 323	Continued From page 13 Findings include: 1. R26's current electronic Facesheet documents the following diagnoses: "Fall... Difficulty in walking, not elsewhere classified... Muscle weakness (generalized)..." R26's Fall Risk Assessment Score (dated 2/4/16) documents a score of 20 indicating a high risk for falls. The facility's Fall Log (dated 3/21/16) documents R26 had a fall on 2/6/16 at 2:20 AM. R26's Nursing Progress Notes (dated 2/5/16-2/6/16) documents the following: "2/5/16 at 7:00 PM: At approximately 7:00 PM, this nurse was notified that (R26) had fallen. (R26) was found sitting in the television room watching television. Asked Certified Nursing Assistant what had happened, they stated about five minutes before they went into (R26's) room and found (R26) in the bathroom holding on to (R26's) wheelchair hovering inches above the ground. Right leg had no shoe on it due to (R26) removing it and it was bent up behind the wheelchair.....2/6/16 at 2:20 AM: Call light to (R26's) room went on. Upon entering room, (R26) was observed sitting along side of (R26's) bed resting on (R26's) right hip with (R26's) bed spread wrapped around (R26)..." R26's current electronic medical record does not document a fall investigation report with a fall determination or interventions for R26's 2/5/16 fall. On 3/23/16 at 12:15 PM, E2 (Director of Nursing) stated that R26 had a change of plane on 2/5/16 and that the change of plan would mean that R26 had a fall. E2 verified that no event investigation was done for R26's 2/5/16 fall and that an investigation should have been conducted to determine a root cause and implement additional	F 323		

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F 323	Continued From page 14 interventions. 2. R28's electronic face sheet, dated 4/22/14, documents a diagnosis of lack of coordination and a fall from non-moving wheelchair. R28's fall risk assessment, dated 2/26/16, documents that R28 is a high risk for falls. R28's Problem Evaluation Notes Report, documents that R28 has fallen on the following dates: 3/3/16, twice on 2/2/16, and 12/8/16. This same form documents that no new fall interventions were implemented for R28. On 3/23/16 at 1:00pm, E2, Director of Nursing verified that R28's falls on 3/3/16, 2/2/16 and 12/8/16 did not have new fall interventions implemented. E2 stated that E2 expects facility staff to implement new fall interventions to prevent future falls.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329		

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F 329	Continued From page 15 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to document a medical symptom and monitor for adverse behaviors to warrant the use of an antipsychotic medication for one of three residents (R19) reviewed for antipsychotic medication use in a sample of 20. Findings include: The facility's Psychopharmacological Drug Usage Procedure Policy, revised 09/08, documents "To provide appropriate assessment and monitoring of residents receiving these medications...Documentation of behaviors and conditions requiring the use of these medications must be done on a routine basis, as well as medication response and adverse consequences. R19's electronic face sheet dated 3/7/16, documents the following diagnosis: dementia with behaviors, transient ischemic attack, weakness, back pain, abnormality of gait, tobacco use, hyperlipidemia, depression, anxiety, diverticulosis, hypercalcemia, osteoporosis, chronic obstructive pulmonary disease, cholecystitis, hypertension. R19's electronic Physician Order Sheet, dated 3/7/16, documents an order for Seroquel 25 milligrams, (antipsychotic medication), to be given two times a day. R19's Progress Notes, dated from 3/7/16 through 3/22/16, does not have any documentation of	F 329		

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F 329	Continued From page 16 R19 having any adverse behaviors. On 3/21/16 at 9:00am, R19 was participating in activities. R19 was friendly and cooperative during the activities. On 3/21/16 at 12:30pm, R19 was ambulating independently in the hall and did not display any adverse behaviors. On 3/22/16 at 8:30am, R19 was in the lounge area doing morning stretch exercises and did not exhibit any adverse behaviors. On 3/22/16 at 1:00pm, R19 was in the dining area working on a puzzle. R19 did not exhibit any adverse behaviors at this time. On 3/22/16 at 1:30pm, E8, Alzheimer's Unit Coordinator, verified that R19 is not being monitored for any behaviors. E8 also verified that R19 has not exhibited any adverse behaviors since R19's admission to the facility. On 3/22/16 at 10:10am, E2, Director of Nursing, verified that R19 does not have an appropriate medical symptom documented to warrant the use of an antipsychotic medication. E2 stated that the facility is not monitoring R19 for any behaviors since R19 has not exhibited any adverse behaviors since R19's admission to the facility.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to administer medications as ordered by the physician for one	F 332		

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F 332	Continued From page 17 of sixteen residents (R21) reviewed for medication pass, in the sample of 20. This failure resulted in three medication errors out of 37 opportunities for error, for an 8% medication error rate. FINDINGS INCLUDE: The facility policy, Medication Administration, dated (revised) 02/04 directs staff, "All medications must be administered to the resident in the manner and method prescribed by the physician." On 3/21/16 at 12:44 P.M., E3, Licensed Practical Nurse (LPN) prepared to administer medications to R21. E3/ LPN poured 10 ML (milliliters) of Keppra (anti-seizure medication) 100 MG (milligrams)/ ML into a 30 ML plastic medication cup. E3 / LPN removed one dose of Reglan (anti-spasmodic) 5 MG from a punch card, placed the tablet in a plastic bag, crushed it and poured the powder into a 30 ML plastic medication cup. E3 /LPN then poured 20 ML of Potassium Chloride (potassium replacement) 20 MEQ (mill-equivalents)/ 15 ML into a 30 ML plastic medication cup. E3 /LPN then administered each medication separately to R21 via R21's enteral feeding tube. R21's Physician Order Sheet, dated March 2016 includes the following medications: Keppra 100 MG/ ML, administer 10 ML every 12 hours at 11:00 A.M. and 11:00 P.M., Reglan 5 MG, administer one tablet every 6 hours at 11:00 A.M., 5:00 P.M., 11:00 P.M. and 5:00 A.M. and Potassium Chloride 20 MEQ/15 ML, administer 15 ML every 12 hours at 11:00 A.M. and 11:00 P.M.	F 332		

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F 332	Continued From page 18 R21's Medication Administration Record, dated March 2016 documents R21 received Keppra, Reglan and Potassium Chloride at 12:52 P.M. on 3/21/16. On 3/22/16 at 9:00 A.M. E3/LPN stated, "By the time I got down there to give (R21) (the 11:00 A.M.) medications, I was already late." On 3/22/16 at 11:35 A.M., E2 Director of Nurses (DON) stated, "Medications are to be given as ordered by the physician. Medications may be administered one hour before the scheduled (administration) time or up to one hour after (the scheduled time)."	F 332		
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	F 441		

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F 441	Continued From page 19 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow policies and procedures regarding hand hygiene and glove changing and failed to prevent potential cross-contamination during incontinence care for four of 17 residents (R3, R9, R20 and R21) reviewed for infection control in a sample of 20. FINDINGS INCLUDE: The facility policy Infection Control, dated (revised) 08/09 directs staff, "Hand washing is the foundation of controlling infectious disease. Personnel must wash their hands when coming on duty, when they are visibly soiled, between residents, when gloves are removed... Gloves will be changed after direct contact with resident's secretions or excretions."	F 441		

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F 441	Continued From page 20 The facility's Categories Transmission- based Precautions policy (revised 8/2009) documents the following: "Gloves and Hand hygiene: Wear gloves upon entering the room if contact with resident or potentially contaminated surfaces is possible...During the course of caring for resident, change gloves and perform hand hygiene (wash hands if dealing with Clostridium difficile) after having contact with infective material... 1.) On 3/22/16 at 8:35 A.M., E4 and E5 Certified Nursing Assistants (CNA)s prepared to perform morning care, including incontinence care for R21. Both E4 and E5/CNA washed their hands and applied gloves. E4/CNA washed and dried R21's face and upper torso. E4/CNA then performed perineal care for R21. E4/CNA washed and dried perineal area and without removing gloves nor performing hand hygiene, E4/CNA went to R21's closet, rummaged through the closet, selected a blouse for R21 and returned to R21's bedside and dressed R21. E4/CNA then swished the same cloth that was previously used for R21's perineal care back in the soapy water, wrung the cloth out and with the assistance of E5/CNA, rolled R21 onto (R21)'s"s back and washed R21's buttocks. E4/CNA then removed gloves and performed hand hygiene before continuing to provide care for R21. On 3/22/16 at 8:50 A.M., E4 Certified Nursing Assistant stated, "I forgot to take my gloves off before I washed (R21)'s bottom. I should have taken them off (Gloves) before I got (R21)'s shirt out (of the closet)." 2.) On 3/22/16 at 9:30 A.M., E3 Licensed Practical Nurse (LPN) and E5 Certified Nursing	F 441		

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Assistant (CNA) prepared to perform incontinence care on R3. Both staff members entered the room with gloves on. E3/LPN and E5/CNA positioned R3 onto (R3)'s left side. R3 had a moderate amount of stool on buttocks, scrotum and inner thighs. E3/LPN began by washing R3's buttocks with soapy water, rinsed the area with a wet wash cloth, dried the area with a dry wash cloth and placed the soiled linens in a plastic bag. E3/LPN and E5/CNA started to roll R3 onto (R3)'s right side and noticed a moderate amount of stool present between R3's legs. E3/LPN reached into the soiled linen plastic bag, grabbed a previously used soiled wash cloth, handed it to E5/CNA and instructed E5/CNA to take the soiled wash cloth to R3's bathroom and wet it. E5/CNA wet the soiled wash cloth, returned to R3's bedside, handed the wet soiled wash cloth to E3/LPN who proceeded to wipe feces from (R3)'s inner thighs and scrotum. E3/LPN and E5/CNA then repositioned (R3)onto (R3)'s back and adjusted (R3)'s bedcovers before removing their gloves and performing hand hygiene.

On 3/23/16 at 3:00 p.m., E2, Director of Nursing, stated facility staff should never reuse soiled washcloths at any time.

3.) On 3/22/16 at 11:00 A.M., E4 and E5 both Certified Nursing Assistants (CNAs) prepared to perform incontinence care on R20. Both E4 and E5/CNAs performed hand hygiene and applied gloves. E4/CNA cleansed under (R20)'s abdominal fold with a soapy, wet wash cloth. Using the same wash cloth, E4/LPN then cleansed R20's perineal area.

On 3/22/16 at 11:35 A.M., E2 Director of Nurses

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stated, "Staff have been instructed to remove their gloves and wash their hands after gloves become soiled."

On 3/23/16 at 9:45 AM, E3 (Licensed Practical Nurse) performed R20's right buttock wound care. E3 removed R20's contaminated dressing and cleansed R20's wound with wound cleanser. E3 then applied a medicated pressure ulcer dressing and covered R20's wound with a bordered foam dressing. E3 did not remove E3's contaminated gloves, perform hand hygiene or put on new gloves after removing R20's contaminated dressing and cleaning R20's wound and prior to putting on R20's clean medicated pressure ulcer dressing and bordered foam dressing.
On 3/23/16 at 10:00 AM, E3 verified E3 did not remove E3's contaminated gloves, perform hand hygiene and put on new gloves after removing R20's contaminated dressing and cleaning R20's wound and prior to placing a new dressing on R20's wound. E3 stated that E3 should have removed E3's contaminated gloves, performed hand hygiene and put on clean gloves after removing R20's dressing and cleaning R20's wound and prior to placing a new dressing on R20's wound.
On 3/23/16 at 12:15 PM, E2 (Director of Nursing) stated that E2 would expect staff to remove contaminated gloves, perform hand hygiene and put on clean gloves after touching a contaminated dressing and prior to touching a clean surface or object.
4. On 3/23/16 at 8:05 AM, E14 (Certified Nursing Assistant) and E15 (Certified Nursing Assistant) transferred R9 to the toilet and performed perineal care. E15 assisted R9 to stand from the toilet while E14 performed perineal care. E14

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F 441	Continued From page 23 then pulled up R9's adult brief and pants up and assisted with R9's transfer back to the wheelchair. E14 removed R9's gait belt and wheeled R9 out of the bathroom. E14 did not remove E14's gloves, perform hand hygiene and put on clean gloves after performing R9's perineal care and prior to touching R9's pants and gait belt. On 3/23/16 at 8:15 AM, E14 verified that E14 performed R9's perineal care and then pulled up R9's pants up, removed R9's gait belt and transferred R9 out of the bathroom with the same contaminated gloves. E14 stated that E14 should have removed E14's contaminated gloves, performed hand hygiene and put on new gloves after performing R9's perineal care and prior to touching R9's pants and gait belt and transferring R9 out of the bathroom. On 3/23/16 at 12:15 PM, E2 (Director of Nursing) stated that E2 would expect staff members to remove contaminated gloves, perform hand hygiene and put on clean gloves after touching a contaminated surface and prior to touching a clean object or surface.	F 441		