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

ORIGINAL

PRINTED: 01/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435098	A. BUILDING ____ B. WING ____	C 01/03/2013

NAME OF PROVIDER OR SUPPLIER
GOOD SAMARITAN SOCIETY TYNDALL

STREET ADDRESS, CITY, STATE, ZIP CODE
2304 LAUREL STREET
TYNDALL, SD 57066

(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 Surveyor: 27457 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/2/13 through 1/3/13. Areas surveyed included resident behavior and facility practices, quality of care, nursing services, infection control, and administration. Good Samaritan Society Tyndall was found not in compliance with the following requirements: F226, F281, F323, F441, and F490.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 27457 Based on record review, interview, and review of the State of South Dakota reporting requirements, the provider failed to report one of one incident related to improper equipment usage resulting in injury to one of one sampled resident (1). Finding include: 1. Review of resident 1's progress note from 9/6/12 at 12:22 p.m. revealed: *Registered nurse (RN) A had spoken to the resident's daughter on the above date and time and had discussed an incident that had involved the resident hitting her head on her bed frame.	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie B Schenkel
TITLE: Administrator
(X6) DATE: 1/24/13

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.

RECEIVED JAN 23 2013 JAN 28 2013 SD DOH LSC

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F 226	Continued From page 1 *RN A wrote "Daughter updated et [and] had no further questions at this time." Review of all of the incident reports provided to surveyor 16385 at the time of the survey revealed no reports were present for September 2012 for resident 1. Review of the 9/5/12 faxed report to resident 1's physician regarding the incident noted above revealed: *She had struck her head on the foot board of her bed during a transfer in a Hoyer lift. *She had a 3.5 centimeters (cm) by 2.5 cm bruise on her forehead as a result of striking her head on the footrest of her bed. *Staff had reported she "Squirmed out of sling." Interview, record review, and review of the State of South Dakota reporting requirements on 1/3/13 at 1:00 p.m. with the administrator and the director of nursing regarding resident 1's above noted injury revealed: *They confirmed she had struck her head on the footrest of the bed while she was being transferred in a Hoyer lift from her bed to her Broda chair on 9/3/12 at 7:30 a.m. *She had partially slipped out of the Hoyer lift sling during the above transfer and had been caught by one of the certified nursing assistants (CNA) and the resident's roommate. *The administrator had found the wrong size sling had been used for the transfer. The resident care plan had called for a medium sling but a small sling had been used at the time of the incident. *They stated the rationale for staff using the wrong size sling had been the resident's medium sling, was soiled, and no other medium slings	F 226	F-226 ~~Unable to send~~ 2-9-13 Investigation ~~in report to the DOH~~. reported to DOH upon survey visit 1-3-13. All injuries sustained as a result of equipment failure or incorrect use will have an incident report filed and a report will be sent to the DOH. All nurses were educated on 1-17-13 and 1-18-13 by the administrator regarding the reporting of this nature to the DOH as well as an incident report. The administrator, DNS, and Social Worker will meet ~~daily and review incident reports. This committee will determine if a report to the DOH is needed. Nurses will also determine if an incident requires reporting to the DOH~~. 2-9-13 every workday to review resident incident reports. Charge nurses will be responsible for 2 hour reporting to DOH and the investigation team will follow up. Charge nurses will contact a member of the Investigation team on weekends or holidays for any 2-9-13 reportable incident. All other reports will be reviewed the next working day.	

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F 226	Continued From page 2 were available. *The corrective actions taken by the provider were more slings had been ordered, CNAs involved in the incident had been counseled, and the resident's care plan had been updated. *No one had reported the 9/3/12 incident to the South Dakota Department of Health. The administrator stated she had not thought the incident needed to be reported. *They were familiar with the South Dakota Department of Health required nursing facility event report form. *They agreed the South Dakota Department of Health required nursing facility event report form instructions under falls required them to report incidents when assistive equipment such as lifts' had not been used appropriately. *They agreed they should have reported the 9/3/12 incident to the South Dakota Department of Health. *No formal quality assurance processes had been started to monitor the use of the lifts and their slings after the 9/3/12 incident had occurred.	F 226	The QA coordinator or designee will audit all incident reports to assure proper reporting was done; these audits will be done weekly X4 and then monthly X4. The QA coordinator will report audit findings to the QA committee monthly for 3 months and the QA committee will determine if further auditing is needed. 2-9-13	2-1-13
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 27457 Based on record review, interview, and policy review, the provider failed to appropriately assess, monitor, intervene, transport, and document on one of two sampled residents (1) who had fallen and sustained an injury. Findings	F 281		

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F 281	Continued From page 3 include: 1. Review of the required nursing facility event reports submitted to the South Dakota Department of Health on 11/10/12, 11/16/12, and 12/14/12 regarding resident 1's 11/9/12 fall revealed: *Her Broda chair was in the upright position while at the supper table. *Staff were not directly supervising her. *She had fallen face first from her Broda chair in the dining room while waiting for supper to be served. *The fall had resulted in facial trauma that included fractures of the sinuses and septum. *At the time of the incident she had significant bleeding that staff could not stop resulting in the transfer of the resident to the hospital. Review of the 11/9/12 nursing documentation for resident 1 revealed: *There had been no nursing documentation related to the circumstances, condition, transfer, or care of her after the above fall. *One set of vitals from 6:00 p.m. on 11/9/12 was present. The vitals taken were: pulse 90, respirations 20, and blood pressure 127/75. *One neurological check had been documented at 6:00 p.m. It stated the resident's: -Level of consciousness was "Persistent vegetative state, opens eyes/wakeful but no evidence of purposeful behavior of cognition." -Pupils were 2 millimeters in size and reacted to light. -All four extremities were "strong" and spontaneous movement to command was present.	F 281	F 281 The facility has provided education to all nurses on 1-17-13 and 1-18-13 regarding standards of practice, physical assessment, documentation, emergent situations and incident reporting by nurse consultant, Director of Nursing and Administrator. The Director of Nursing or designee will also meet with each nurse individually to work through an emergent case scenario where nurse must demonstrate assessment skills and appropriate use of assessment tools and a competency checklist will be completed. A skills	

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F 281	Continued From page 4 Review of all of the provider's investigation documents requested from the administrator related to resident 1's 11/9/12 fall revealed an internal fall report had been filled out. However no nursing documentation was present related to assessments, condition of the resident post fall, or how the resident had been transported to the hospital. Interview, record review, and policy review on 1/3/13 at 2:00 p.m. with the director of nursing (DON) and the administrator regarding resident 1's 11/9/12 fall revealed: *The administrator believed she had fallen around 5:30 p.m. and had been transported to the hospital per the facility van around 6:30 p.m. after nursing staff could not control the bleeding from her nose. She further stated she was the person who had transported her to the local hospital without any medically trained personnel in the van. When asked why the resident had been transported in the van without medical personnel assistance instead of calling the ambulance she stated "The nurses thought it was okay." *No documentation was present related to the resident's condition at the time of her transfer or during her transfer. The administrator confirmed she had not documented anything related to the resident's transfer in the facility van or the decision to not transport her via ambulance. *According to the provider's internal investigation the following had occurred on 11/9/12: -The resident had fallen face first from her Broda chair sustaining injury to her face with significant bleeding coming from her nose. -Nursing personnel had removed the resident from the floor minutes after the fall with a lift and had placed her back in her Broda chair. The	F 281	competency fair for all nursing staff has been planned for 2-5-13 and 2-6-13, where all nurses, med aides and C.N.A.s will be checked out on isolation procedures, handwashing, peri care, mechanical lifts, and the Broda chair. The investigation team of DNS, Social Services Coordinator and Administrator will review all incident reports on an every workday basis. Audits of documentation and assessment will be completed on at least 3 residents per week x 4 weeks and then monthly x 3 months and will continue as needed thereafter. The DNS will report audit results monthly to the QA committee. On weekends and holidays, the charge nurse will be responsible for all 2 hour reporting to the DOH. The charge nurse will also contact a member of the investigative team for further follow up.	2-15-13

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F 281	Continued From page 5 resident was taken to her room until around 6:30 p.m. when it was decided to transport her to the local hospital as noted above. *No nursing documentation related to the care she had received post fall was available other than the information noted above. *The DON agreed with the following: -Basic first aid principles had not been followed related to a fall with face and potential head/neck injury; such as stabilizing the persons neck in case of neck fracture, calling 911 for assistance due to potential fracture, and not moving the resident until properly immobilized. -The basic tenants of nursing documentation had not been followed for the post fall care of the resident. -The resident should have been transported per ambulance. However after the decision had been made to transport the resident a nurse should have accompanied the administrator to ensure the safety and well being of the resident. *They had not evaluated or interviewed any staff related to the post fall emergency care she had received after her 11/9/12 fall. *They confirmed the provider's revised October 2012 fallen and injured resident policy had not been followed. *No formal quality assurance processes had been started as a result of the resident's 11/9/12 fall from the Broda chair. Interview on 1/3/13 at 2:49 p.m. with licensed practical nurse (LPN) B regarding resident 1's 11/9/12 fall revealed: *She had not performed any nursing assessments or vital signs on the resident. *She had not observed any other nursing staff performing vitals or assessments prior to moving	F 281		

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F 281	Continued From page 6 the resident. *She had not been involved in moving/transferring the resident. *She stated "I mainly was involved in the clean-up of all the blood." *LPN C and registered nurse (RN) D had been taking care of her after the fall. *She agreed basic first aid principles had not been followed after the resident's 11/9/12 fall. Interview on 1/3/13 at 2:30 p.m. with LPN C regarding resident 1's 11/9/12 fall revealed: *She was one of the nurses who had cared for the resident that night. *She had been left in charge of the resident the majority of the time the resident was in her room while RN D made phone calls to family and doctors. *A staff member who she could not remember came to her and stated an ambulance was needed as resident 1 had fallen. She had not called the ambulance as she had wanted to see what the problem was first. After arriving at the scene of the fall she and RN D decided an ambulance was not needed. *She and RN D had decided to move the resident off the dining room floor to her Broda chair and then to her room, so the other residents' supper was not disturbed further. When asked what clinical data had been gathered to ensure the resident was stable prior to moving the resident she stated she was unsure. *She and RN D had cared for the resident for an hour or so prior to deciding to transfer the resident to the hospital due to being unable to control the bleeding from her nose. *When asked how she and RN D cared for the resident after the fall she stated they had applied	F 281		

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F 281	Continued From page 7 ice to the back of her neck and face initially and then packed the resident's nose with tissue to help slow the bleeding. *When asked how she and RN D had assessed the resident's oxygen saturations and breathing as the resident's nostrils were occluded and she was still actively bleeding she stated she could not remember listening to her lung sounds or whether or not oxygen saturations had been taken. *When asked why no documentation was present regarding the care and interventions she had provided after the resident's fall she was unable to explain, and then stated "I should have." *When asked how frequently the resident's vital signs had been checked she stated she could not remember. *When asked if she had felt the basic principles of first aid had been followed after the resident's 11/9/12 fall she stated no and could not explain why they had not been. *When asked why the resident had been transported to the local hospital in the facility van per the administrator without nursing personnel LPN C stated the administrator had stated she was not needed. When asked if nurses should turn the care of a significantly injured resident over to non-medically trained personnel she stated "No." Phone interview on 1/4/13 at 11:00 a.m. with RN D regarding resident 1's 11/9/12 fall revealed: *She was a part-time nurse at the facility *She was the first nurse at the scene of the resident's fall on 11/9/12 and had been her primary nurse that day. *She had initially asked for the ambulance to be called. However she had changed her mind after	F 281		

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F 281	Continued From page 8 LPN C had arrived and told her "We don't need to call an ambulance for a bloody nose." *She had confirmed and had agreed with all of the above comments of LPN C except she stated she had not packed the resident's nostrils with tissue. *She confirmed as the RN on duty she had responsibility for supervision and documentation of the care administered after the resident's fall. *No physician's orders had been written as a result of the 11/9/12 fall that she could remember. That included the order to transfer to the hospital without using an ambulance. Review of Medline Plus Encyclopedia, "Head Injury and Neck Injury", Service of the National Institute of Health, http://www.nlm.nih.gov/medlineplus/ency/article/000028.htm, (June 27, 2011) revealed: *In the case of a serious head or neck injury 911 should be contacted immediately. *Signs of head and neck trauma can include: agitation, confusion, restlessness, fluid draining from the nose mouth and ears, changes in the size of the pupils, behavioral changes, and lack of coordination. *Persons with suspected significant head and neck injuries should not be moved. All attempts should be made to immobilize the injured persons neck and back to prevent further injury. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th ED., St. Louis, MO, pg. 477, revealed: *Complete and appropriate documentation was a vital aspect of nursing practice. *"Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve	F 281		

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F 281	Continued From page 9 critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice." Review of the South Dakota Board of Nursing's Administrative Rules, Chapter 20:48, revealed: *"A licensee is personally responsible for the actions that the licensee performs relating to the nursing care furnished to clients and cannot avoid this responsibility by accepting the orders or directions of another person." *"The registered nurse is responsible for the nature and quality of nursing care that a client receives under the nurse's direction." *"The registered nurse shall recognize and understand the legal implications of delegation and supervision. The nurse may delegate to another only those nursing interventions which that person is prepared or qualified to perform and shall provide minimal or direct supervision to others to whom nursing interventions are delegated. The registered nurse may only delegate nursing tasks to unlicensed assistive personnel in accordance with the standards in chapter 20:48:04.01." *The licensed practical nurse may practice in two general settings: with at least minimal supervision when providing nursing care in a stable nursing situation; and with direct supervision when providing nursing care in a complex nursing situation; *"The licensed practical nurse shall consult with a registered nurse or other health team members and seek guidance as necessary and shall obtain instruction and supervision as necessary."	F 281		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 10 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: Surveyor: 27457 Based on observation, interview, record review, policy review, and manufacturer's instructions review, the provider failed to: *Ensure one of three sampled residents (1) who used Broda chairs were properly monitored when the chair was left in the upright position. *Ensure staff members were trained on the use and safety precautions of Broda chairs according to the manufacturer's instructions. *Have care plans that contained resident specific instructions for the use of the Broda chair for three of three sampled residents (1, 6, and 8) as called for in the manufacturer's instruction manual. Findings include: 1. Review of the required nursing facility event reports submitted to the South Dakota Department of Health on 11/10/12, 11/16/12, and 12/14/12 regarding resident 1's 11/9/12 fall revealed: *Her Broda chair had been in the upright position while at the supper table. *Staff had not directly been supervising her. *She had fallen face first from her Broda chair in the dining room while waiting for supper to be	F 323	F- 323 Resident # 6 and 8 are positioned in the Broda chair correctly; residents are never positioned in an upright position and left unattended. Care plans for these residents have been updated to include specific instructions and interventions. All residents using the Broda chair will have specific care plan instructions and interventions and be positioned properly with chair never placed in an upright position without staff present. Cushions will be assessed carefully prior to use with the Broda chair. No staff will operate the Broda chair without training using the Broda chair manual. All staff were educated on the use of the Broda chair	

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F 323	Continued From page 11 served. *The fall had resulted in facial trauma that had included fractures of the sinuses and septum. *The provider had documented the resident's plan of care had been followed for her Broda chair. Review of the provider's Broda chair operating manual revealed: *No one should had operated or maintained a Broda chair including a family member unless they had read the operation manual. *"A copy of the instruction manual must always be available." *The resident's primary caregiver was responsible to ensure no one who was unfamiliar with, unwilling, or unable to adhere to the safety and operating instructions, was not permitted to operate or move the chair. *"The primary caregiver must maintain a list of caregivers who have read this manual and who they have authorized to operate and move the chair." *Section 2.5 (Hazards) of the manual reviewed falling, tipping, skin injury, clamping, and collision. *Section 2.5.1 stated the manufacturer recommended the chair's seat be tilted sufficiently immediately after the resident was placed in the chair to prevent sliding and falling. *Each person using the Broda chair was to have resident specific instructions to ensure safe and effective use of the chair. Those specific instructions were to have been based on the provider's professional experience and knowledge of the caregivers as well as the resident's specific conditions and requirements. The manufacturer stated "These instructions form an essential part of the Safety Requirements for	F 323	by the administrator on 1-15-13 or 1-18-13. The Broda chair manual will be available for all staff to reference. The administrator or designee will audit proper use of the Broda chair by those trained to assure correct positioning and use, weekly X4 and then monthly X4. The DNS or designee will audit care plans for residents using the Broda chair to assure specific interventions 2-9-13 and instructions are present. ~~added, in one week~~ this will be ~~and then quarterly~~ audited weekly x4 ~~there after~~. The and then monthly x4. administrator and DNS will report audit findings to the QA committee monthly and the QA committee will determine if further auditing is needed.	2-1-13

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	435098		C 01/03/2013

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F 323	Continued From page 12 using the chair and must be made available to all caregivers." A form was provided by the manufacturer in section 2.9 of the manual to document the resident specific instructions. Observations, interviews, and Broda chair operating manual review on 1/3/13 from 7:30 a.m. through 10:30 a.m. revealed: *Residents 6 and 8 were currently using Broda chairs. *They had signs taped to the back of their chairs that directed staff not to leave residents unattended when the seat was in the upright position. *Certified nursing assistant (CNA) G who was assigned to the hallway where residents 6 and 8 were stated: -She did not remember ever reading the Broda chair manual. -She did not know where the Broda chair manual was kept. -The only training she remembered receiving specific to the Broda chair was when another CNA had showed her how to use it (on-the-job training). -Residents were to never have been left unattended when the chair was in the upright position. -She was not aware of any specific instructions for the use; such as degree of incline or position for meals for either resident 6 or 8. -She had never seen the resident specific instruction sheet located on page 10 of the operator's manual. -She was not sure what the care plan was for the use of the Broda chair for residents 6 and 8. *Licensed practical nurse (LPN) B who was assigned to the hallway where residents 6 and 8	F 323		

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F 323	Continued From page 13 were had the same answers as CNA G. *Certified nursing assistant (CNA) H who was assigned to the hallway where residents 6 and 8 were had the same answers as CNA G and LPN B. Interview, record review, and Broda chair operating manual review on 1/3/13 at 10:30 a.m. with the director of nursing (DON) and the administrator regarding the provider's current Broda chair procedures and practices revealed: *The provider had no policies and procedures in place for Broda chairs. *No formal staff training had been conducted related to the proper use and maintenance of the Broda chairs. *No list of authorized users of the Broda chair was kept. *No physician's orders or therapy orders were present for the use of the Broda chairs as nursing staff made the decision to use that piece of equipment. *No nursing assessments were present for residents 6 and 8's specific needs for and specific uses of the Broda chair. *The signs currently on the back of resident 6 and 8's Broda chairs had been placed there after resident 1's 11/9/12 fall from the Broda chair. *They both confirmed the manufacturer's Broda chair operating manual had not been followed currently and in the past. *They agreed resident 6's and 8's care plans were not reflective of each of the residents' individual care needs as outlined in the Broda chair manual. Interview, record review, and Broda chair operating manual review on 1/3/13 at 2:20 p.m.	F 323		

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F 323	Continued From page 14 with the DON and the administrator regarding the fall of resident 1 from her Broda chair on 11/9/12 revealed: *Based on the provider's internal investigation resident 1 had her Broda chair in the upright position while she was at the dining room table on 11/9/12 and was not directly monitored by staff members when she had fallen from her chair face first resulting in significant facial trauma. After multiple staff interviews the provider had been unable to find out who had put the resident's Broda chair in the upright position. *Both confirmed the resident should not have been left in her Broda chair in the upright position on 11/9/12 without having been directly monitored. *The resident's care plan interventions dated 8/2/12 related to the use of her Broda chair were: -"Assist of 1 staff. Broda chair." -"Monitor when in Broda chair between meals. If restless may be in recliner or bed with legs elevated." -"Uses 4 inch cushion in Broda chair." *No evaluation of the use of the four inch cushion placed in the resident's Broda chair was in place. Both the administrator and the DON confirmed that cushion elevated the resident in the chair making the side arms of the Broda chair shorter and hence making the chair easier to fall out of. The DON stated those cushions had now been removed from all of the other Broda chairs as a result of the resident's 11/9/12 fall. *No nursing assessments were present for residents 1's specific needs for and specific uses of the Broda chair. *They agreed the resident's care plan was not reflective of her individual care needs and outlined in the Broda chair manual.	F 323		

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F 323	Continued From page 15 *They again confirmed the manufacturer's Broda chair operating manual had not been followed. *No formal quality assurance process had been implemented as a result of the resident's Broda chair fall.	F 323		
F 441 SS=D	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.	F 441	F-441 1. Staff will provide proper hand-washing and hand-hygiene and contact isolation procedures when caring for resident #8. All staff will use proper hand hygiene while caring for residents. If a resident requires isolation precautions all isolation steps will be adhered to. In-service education for all staff was done on 1-15-13 and 1-18-13 by the Infection Control Nurse regarding proper hand hygiene, isolation procedures, cleaning spills, and the use of disinfectants. DNS or	

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F 441	Continued From page 16 (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: Surveyor: 27457 Based on observation, interview, and policy review, the provider failed to follow isolation protocols for one of one sampled resident (6) in contact isolation. Findings include: 1. Observation on 1/2/13 at 3:14 p.m. of resident 6 being transferred from his bed to his Broda chair by certified nursing assistants (CNA) E and F revealed: *He was on contact isolation precautions. *CNA E and F had gloves on when they were assisting the resident. Neither CNA E or F had a gown on. *The resident had a bowel accident prior to the CNAs placing him into the lift sling. CNA E cleaned-up the resident with CNA F. CNA E never changed her gloves until right before she left the room. CNA E cross-contaminated the lift, the resident's Foley (urinary catheter), and multiple other surfaces. The lift was taken back out into the hallway uncleaned after the transfer had occurred. *The resident's Foley bag had ruptured during the transfer and urine had leaked onto the floor. That urine spill was cleaned up by CNA F with paper towels. No disinfectant was utilized to clean up that spill.	F 441	designee will audit personal cares of resident to assure proper hand hygiene weekly X4 and then monthly X4. DNS or designee will observe cares of residents in Isolation to assure staff adhere to isolation procedures weekly X4 and then monthly X4. DNS or designee will report audit findings to the QA committee monthly X4. The DNS or designee will observe cleaning and disinfection of spills 2-9-13 of at least 4 staff 2-9-13 At least 3 times per week	

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F 441	Continued From page 17 Interview and policy review on 1/3/12 at 11:15 a.m. with the director of nursing and the administrator regarding the above observation revealed: *The resident was in contact isolation related to Methicillin-resistant Staphylococcus Aureus infection in his urine. *They confirmed the above observations were breaches in contact precautions and proper handwashing. They confirmed the provider's revised November 2011 contact precautions policy had not been followed.	F 441	techniques weekly X4 and then monthly X4. The DNS or designee will report all audit findings to the QA committee monthly and the QA committee will determine if further auditing is needed.	2-1-13
F 490 SS=G	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 27457 Based on observation, interview, record review, policy review, and manufacturer's manual review, the provider failed to: *Report one of one incident related to improper equipment usage resulting in injury to resident 1. *Appropriately assess, monitor, intervene, transport, and document for one of two sampled residents (1) who had fallen and sustained an injury. *Ensure one of three sampled residents (1) who used Broda chairs were properly monitored when the chair was left in the upright position.	F 490	F 490 All staff have been educated on the Broda chair and its functions on 1-15-13 or 1-18-13. On 2-5-13 and 2-6-13, all nursing staff received additional hands-on Broda chair training including the manufacturer's training video and demonstration and return demonstration for each individual. All licensed nursing staff were educated on emergent procedures and when ambulative transportation is necessary on 1-17-13 and 1-18-13. QA Coordinator is auditing all incident reports to assure proper reporting and will also check on proper transportation, if necessary. These audits are weekly x 4 weeks, then monthly x4. QA Coordinator will report monthly at QA meeting. (cont.)	

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F 490	Continued From page 18 *Ensure staff members were trained on the use and safety precautions of Broda chairs according to the manufacturer's instructions. *Have care plans that contained resident specific instructions for the use of the Broda chair for three of three sampled residents (1, 6,and 8) as called for in the manufacturer's instruction manual. *Follow isolation protocols for one of one sampled resident (6) in contact isolation. *Develop formal quality assurance processes related to improper use of equipment after incidences of injury have occurred. Findings include: 1. All of the above findings are addressed in the following deficiencies. Refer to F226, F281, F323, and F441.	F 490	~~F 490~~ ~~All of the~~ 2-9-13 ~~cited deficiencies are being audited per~~ 2-9-13 ~~specific F tag.~~ F490 (cont.) Audits on documentation and assessments will be completed for at least 3 residents weekly x4, then monthly x3. The DNS will report results monthly to QA committee. The Administrator or designee will audit the proper use of Broda Chair weekly x4, then monthly x4. The DNS will audit care plans for residents using the Broda chair weekly x4, then monthly x4. The Administrator and DNS will report monthly to the QA committee. The DNS or designee will audit proper hand hygiene, observing at least 4 staff members each week x4 weeks, then monthly x4. The DNS or designee will observe cares of residents in Isolation at least 3 times per week x4 weeks and then monthly x4. The Administrator will audit all current staff to ensure Broda Chair training is complete. Administrator will audit all new staff training records to ensure proper training x 4 months. Administrator will report audit findings to QA monthly.	2-15-13