

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/07/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVERA MARYHOUSE LONG TERM CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>	
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F 000	<b>INITIAL COMMENTS</b>  Surveyor: 32333 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/5/15 through 10/7/15. Areas surveyed included quality of care including resident assessment, monitoring, and neglect. Avera Maryhouse Long Term Care was found not in compliance with the following requirement: F441.	F 000		
F 441 SS=E	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	<b>F441</b>  The corrective action includes review and revision of Infection Control Policy 6312.33. All residents are at risk. The facility does maintain an effective infection control program facility wide to include monitoring, tracking, and trending of infections. The facility also ensures adequate staff education on infection control procedures. A revised resident infection tracking form will be initiated by 11/3/15.  The Long Term Care (LTC) Clinical Nurse Coordinator will investigate the origin of infections, the contributing factors, antibiotic history, and the response to treatment. The Director of Nursing (DON) or designee will in-service all staff on our Infection Control and Prevention Program in order to be more proactive in preventing the development and transmission of disease and infections. The LTC Clinical Nurse Coordinator will be accountable for maintaining this program which includes initial and ongoing staff education for appropriate infection control such as: 1. Recognizing isolation procedures	<b>11/26/15</b>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Rasler TITLE: Administrator (X6) DATE: 10/28/15

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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**OCT 28 2015**  
SD DOH L&C

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F 441	<p>Continued From page 1</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, record review, and policy review, the provider failed to: *Implement and maintain an effective infection control program facility-wide to include monitoring, tracking, and trending of infections. *Ensure adequate and effective staff education on infection control procedures. Findings include:</p> <p>1. Review of the provider's Infection Report forms for August 2015 revealed: *A nurse would fill out the form if a resident had an infection. *That form would be given to the assistant director of nursing (ADON). *The ADON collected the forms and sent the forms to the infection control nurse.</p> <p>Review of the provider's May 2015 through August 2015 Infection Control Quarterly report revealed: *Infection data was gathered for the provider's quarterly quality assurance meetings. *The infection data was reported at the quality</p>	F 441	<p>2. Appropriate cleaning, disinfection, and maintenance of resident care equipment including tub and shower procedures. The in-services/education will be completed by 11/3/15.</p> <p>The DON or designee will perform 1 audit weekly X 4, then monthly X 3 to ensure that the infection control program is tracking and trending resident infections appropriately. The DON or designee will complete 2 audits observing cleaning procedures weekly X 4, then monthly X 3 to ensure proper disinfecting and cleaning procedures are being followed. Results of the audits will be reported by the DON and discussed at the quarterly Quality Assurance and Process Improvement (QAPI) for further review and recommendations and/or continuation/discontinuation of audits.</p>		

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F 441	<p>Continued From page 2</p> <p>assurance meetings and included:</p> <ul style="list-style-type: none"> <li>-How many residents had an infection that month.</li> <li>-The organism (cause of the infection) and/or symptoms.</li> <li>-The antibiotic ordered.</li> <li>-Whether or not the infection was present upon admission.</li> </ul> <p>Interview on 10/6/15 at 4:15 p.m. with the ADON revealed:</p> <ul style="list-style-type: none"> <li>*A nurse would fill out the infection report form.</li> <li>*They had not done anything with that form besides send it to the infection control nurse.</li> <li>*They had not been tracking or trending those infections.</li> <li>*They had not implemented any steps to determine the source of the infection.</li> </ul> <p>Interview on 10/6/15 at 4:30 p.m. with the infection control nurse revealed:</p> <ul style="list-style-type: none"> <li>*She was the infection control nurse for the hospital and nursing home.</li> <li>*The infection data was collected and forwarded to her.</li> <li>*She reported that data back at the quarterly quality assurance meetings.</li> <li>*She had not been tracking or trending the infections to determine the source of the infections.</li> <li>*They had not done anything to identify the source of the infection to prevent further infections.</li> </ul> <p>2. Observation and interview on 10/6/15 at 3:10 p.m. with housekeeper A revealed:</p> <ul style="list-style-type: none"> <li>*They used 25L Quat (quaternary) (3M HB) disinfectant to wipe hand rails and surfaces in the hallways and residents' rooms.</li> <li>*The 25L Quat disinfectant had to remain wet on</li> </ul>	F 441			

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F 441	<p>Continued From page 3</p> <p>a surface for ten minutes to disinfect that surface. *The 25L Quat disinfectant had not remained wet on surfaces for ten minutes. *That disinfectant would dry shortly after applying it to a surface. *She had a tote with a middle divider that included: -A sponge on each side. -One sponge was used to clean residents' room sinks. -The other sponge was used to clean residents' room toilets. -Both sponges were used in multiple residents' rooms. *She used a dry erasing sponge in multiple residents' rooms to remove marks on surfaces. *The sponges had not been disinfected between residents' rooms.</p> <p>Interview on 10/7/15 at 9:00 a.m. with the environmental services supervisor revealed: *The 25L Quat disinfectant would remain wet on a surface for a ten minute contact time. *The sponge used to clean the toilets in multiple residents' rooms were supposed to go into a disinfectant solution between each room being cleaned. *The sponge used to clean the sinks in multiple residents' rooms would not have to go into a solution between each resident room. *The reason the sink sponge had never gone into a disinfectant solution was because "They just never had."</p> <p>Observation and interview on 10/7/15 at 9:25 a.m. with the environmental services supervisor regarding the surface contact time of the 25L Quat disinfectant revealed: *She applied the disinfectant to a table surface.</p>	F 441			

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F 441	<p>Continued From page 4</p> <p>*It had a contact time of approximately six minutes.</p> <p>*She voiced the 25L Quat disinfectant would not need to remain wet on a surface to meet the required contact time of ten minutes.</p> <p>-The disinfectant would have needed to remain wet or dry to meet the required ten minute contact time on a surface before someone used that surface.</p> <p>Review of the 25L Quat disinfectant's manufacturer's directions for use revealed the AIDS virus was inactivated after one minute of contact time and for all other viruses and bacteria use a ten minute contact time.</p> <p>Observation and interview on 10/7/15 at 9:50 a.m. of certified nursing assistant B while she demonstrated cleaning the tub and shower revealed she:</p> <p>*Was responsible for any showers or baths of the residents she had been assigned to care for during a shift.</p> <p>*Was unsure of the procedure for the shower cleaning and had made up her own procedure.</p> <p>*Had never been trained how to clean the shower.</p> <p>Interview on 10/7/15 at 10:50 a.m. with the director of nursing and administrator revealed:</p> <p>*They could have incorporated more into their infection control program.</p> <p>*The program should have been focused on being more proactive (preventing infection) rather than reactive.</p> <p>*They would have expected staff to have been appropriately trained on infection control procedures including cleaning the shower.</p>	F 441		

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F 441	<p>Continued From page 5 Surveyor: 27473 3. Observation and interview on 10/7/15 at 8:40 a.m. with CNA D while cleaning the shower cart revealed:</p> <ul style="list-style-type: none"> <li>*The cart consisted of a PVC pipe frame, a mesh material support for the mattress, vinyl covered mattress, and a heavy plastic tarp-like holding shelf for collection of the water.</li> <li>*CNA D put on gloves and pulled several wipes from the PDI Sanicloth AF Germicidal Disposable Wipes container.</li> <li>*She proceeded to wipe all surfaces of the mattress turning it over, and then positioned it on its side.</li> <li>*She wiped the mesh mattress support on the top and underside, then wiped the PVC frame.</li> <li>-As she used the wipes she transferred them from one hand to the other using five wipes to complete the wiping of the mattress, mesh support, and frame.</li> <li>*She drained the water from the collection shelf and stated the cart was not to be used for at least 5 minutes.</li> <li>*She said she had been taught that cleaning process when she had been hired within the last year. There was no written policy that she was aware of.</li> <li>*The information label for use of the wipes stated they were for disinfecting hard non-porous surfaces only. The mesh material support was porous. The information label also stated an "alcohol-free, bleach-free" wipe offered a three-minute kill time (for germs).</li> </ul> <p>Interview on 10/7/15 at 9:20 a.m. with the ADON confirmed there was no written policy or procedure for the care, cleaning, or disinfecting of the shower cart. Staff that were working during orientation would have shown a newly hired</p>	F 441		

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F 441	<p>Continued From page 6</p> <p>employee the way to do it. She referenced an Infection Control policy and a policy Equipment-Disinfecting Of included bathing or showering.</p> <p>Review of Infection Control Policy number: 6312-33 with a reviewed and revised date of October 2015 reflected:</p> <p>"... IV. Standard precautions should be observed when caring for all patients/residents.</p> <p>E. Patient/Resident-Care Equipment - Handle and clean used patient/resident-care equipment in a manner that prevents transfer of microorganisms [germs]. Ensure that single-use items are discarded properly.</p> <p>F. Environmental Control - Ensure that routine care, cleaning, and disinfection of environmental surfaces, beds, handrails, bedside equipment, tables and frequently touched surfaces, occurs."</p> <p>Review of an undated Equipment-Disinfecting Of policy reflected:</p> <p>***Staff is responsible for ensuring that reusable patient/resident equipment is not used for the care of another individual until it has been cleaned with a facility approved disinfectant. (Sani-Cloth Plus wipes and Wet Task wipes)."</p> <p>***Please ensure that food surface safe wipes are used for counter tops and other surfaces that may come in contact with food. There is a Wet Task wipe preparation that is food surface safe (#16L)."</p> <p>***Please ensure that lids for all wipe containers are kept closed when they are not being used."</p> <p>***Patient/Resident Care Equipment includes but is not limited to: Stethoscopes, thermometers, blood pressure cuffs, glucometers, scales, lifts, slings, shower chairs, shower carts, bed pans, toilet seats, walkers, crutches, wheelchairs, and</p>	F 441			

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