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

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
	155689	A. BUILDING 00 B. WING	10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD HEALTHCARE CENTER	2400 COLLEGE AVE GOSHEN, IN 46526

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 13, 14, 17, 18, 19, and 20, 2016 Facility number: 000091 Provider number: 1555689 AIM number: 100290080 Census bed type: SNF/NF: 155 SNF: 10 NF: 0 Total: 165 Census payor type: Medicare: 13 Medicaid: 123 Other: 29 Total: 165 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Please accept this Plan of Correction as our facility's Credible Allegation of compliance for our Recertification and State Licensure Survey which concluded on October 20, 2016. Submission of this Plan of Correction is not an admission by Courtyard Healthcare Center that the deficiencies alleged in the survey are accurate or that they depict the quality of nursing care and services provided to the residents of our facility. This plan of correction is being submitted solely because doing so is required by state and federal law. Considering the volume, scope, and severity of the alleged deficient practices noted in the CMS-2567, Courtyard Healthcare Center respectfully requests a desk review for this survey. If approved, we would be willing to provide any and all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised or implemented as part of this plan of correction.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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 0280 SS=D Bldg. 00	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. Based on record review and interview, the facility failed to ensure 1 of 3 residents reviewed for an increase in urinary incontinence (#106), had an individualized care plan updated after a significant change in urinary incontinence. Findings include: Resident #106's clinical record was	F 0280	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 will 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	11/04/2016

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	reviewed on 10/17/16 at 9:45 A.M. Resident #106 was admitted to the facility on 4/22/16 and had an admission Minimum Data Set (MDS) completed on 4/28/16 which indicated occasional urinary incontinence (less than 7 episodes of urinary incontinence in the 7 day review period). On the quarterly MDS of 7/29/16, Resident #106 was identified as being frequently incontinent of urine (7 or more episodes of urinary incontinence in the 7 day review period). On 10/17/16 at 10:34 A.M., an interview with LPN #1, an MDS nurse was conducted. LPN #1 stated for Resident #106's admission MDS on 4/28/16, there were 2 episodes of urinary incontinence for the 7 day review period of 4/22/16-4/28/16. LPN #1 stated for the quarterly MDS of 7/29/16, there were 11 episodes of urinary incontinence for the 7 day review period of 7/23/16-7/29/16. LPN #1 stated after the noted increase in urinary incontinence on 7/29/16, intervention was started for assist in toileting before and after meals, upon rising, bedtime and as needed. LPN #1 stated a 24 hour bladder toileting record was completed on 7/26/16, 6:00 A.M. through 7/27/166:00 A.M., which indicated Resident #106 had hourly tracking of urinary continence. The 7/26/16 bladder toileting record indicated		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. **Corrective Action:** Resident #106 urinary incontinence was assessed and her careplan was updated with individualized interventions to manage incontinent episodes. . **How others identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Residents careplans were reviewed for individualized toileting interventions to decrease incontinence episodes. The bladder retraining program policy was reviewed and updated. Staff education completed on updating plan of care related to changes in urinary incontinence. **Monitoring:** The D.O.N./Designee will conduct random audits on comprehensive care plans related to urinary incontinence 5x per week for 1 month, 3x per week for 3 months, and 2 x per week for 2 months. Results of this audit will be presented to QAPI for further need for monitoring.**Date of Completion:** November 4, 2016.	

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	Resident #106 had urinary incontinence episodes on 7/26/16 at: 6:00 A.M.; 11:00 A.M.; 2:00 P.M.; 5:00 P.M.; 8:00 P.M.; 9:00 P.M.; 11:00 P.M.. On 7/27/16, the bladder toileting record indicated Resident #106 had urinary incontinence episodes at 2:00 A.M. and 5:00 A.M.. Resident #106 had a care plan dated 4/25/16 for alternation in bladder and/or bowel elimination related to decreased mobility, overactive bladder. The original toileting intervention dated 4/25/16 indicated to assist Resident #106 with toileting. On 8/2/16, the toileting intervention was updated to offer assistance before and after meals, upon arising, bedtime and as needed. Review of follow-up question reports for urinary incontinence provided by LPN #1 on 10/20/16, at 10:45 A.M., indicated between 9/22/15/16-10/20/16, Resident # 106 had 89 episodes of urinary incontinence. An interview with the Director of Nursing Services (DNS) on 10/20/16, at 10:40 A.M., indicated Resident #106 should have had an individualized care plan for a toileting program based on the patterning established on the 24 hour tracking of 7/26/16-7/27/16.			

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	A policy was provided by the DNS on 10/20/16, at 11:45 A.M., titled Bladder Retraining Program, dated 9/11/15. The policy indicated under Procedure: 3. "If they are a candidate for retraining, initiate a 24 hour voiding diary... 6. Develop a toileting program based upon their continent/incontinent episodes. The goal of the program is to anticipate needs and reduce incontinent episodes. 3.1-35(d)(2)(B)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow the plan of care for pressure ulcer care for 1 of 3 residents reviewed for pressure ulcers (Resident #62). In addition, the facility failed to ensure 1 of 4 residents (#39), with supplemental oxygen use,	F 0282	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. **Corrective Action:** Resident #62 wears a Prevelon boot on his right foot while up in his wheel chair per physician order. This order was	11/04/2016

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	physician's orders' were followed as ordered. The facility also failed to ensure, 1 of 5 residents (#20), reviewed for unnecessary medications, physician's orders for labs to monitor medication use were followed. Findings include: 1. On 10/14/16 at 12:47 P.M., Resident #62 was observed sitting in the hallway in a w/c (wheelchair) wearing socks on both of his feet. On 10/17/16 at 10:56 A.M., Resident #62 was observed sitting in a w/c, propelling himself with his feet. Resident #62 was wearing a prevalon boot (pressure relieving heel protection) with no sock, to his right foot. Resident #62's right forefoot was exposed, his toes protruded off the boot and the bottom of his toes were in contact with the carpeted floor. On 10/20/16 at 10:06 A.M., Resident #62 was observed sitting in the hallway in a w/c wearing socks on both of his feet. Resident #62 did not have the prevalon boot on his right foot. On 10/14/16 at 1:00 P.M., the clinical record was reviewed. Resident #62's diagnoses included, but were not limited to, dementia, venous insufficiency		added in the TAR so nurses can verify twice per shift that it is being utilized as ordered. Resident #20 had physician notification of missed labs. A Vitamin D level was drawn on 10/19/16 and was reviewed by the Nurse Practitioner. The Magnesium lab was discontinued. Resident #39 has oxygen delivered per nasal cannula per physician order which is 3 Liters. Physician was notified of medication error for oxygen delivery at 2 Liters. Resident #39 had no adverse reaction as a result of the medication error. **How others identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Residents with pressure ulcers reviewed for utilizing ordered devices. Orders were added to the TAR in addition to the Kardex. Residents reviewed for routine lab completion. A new policy and procedure was developed for lab tracking. Residents reviewed for oxygen administration per order and transcription of the appropriate liters was verified on the Kardex. Staff education completed on pressure ulcer prevention equipment, lab tracking, and oxygen administration per physician order. **Monitoring:** The D.O.N./Designee will conduct audits on pressure ulcer prevention equipment, lab tracking, and oxygen administration per physician order 5x per week for 1 month, 3x per week for 3 months, and 2 x per week for 2 months.	

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	(problem with flow of blood from the legs back to the heart), and pressure ulcer of right heel which was noted on 10/27/2015 and currently measured 1.1cm x .7cm x .2cm (centimeters). A physician's order, dated 12/22/15, was for Resident #62 to wear a prevalon boot to his right foot while up in w/c. A plan of care, initiated on 10/30/15, indicated Resident #62 had actual impairment to skin integrity r/t (related to) pressure to right heel. The goal was that Resident #62 would have no complications r/t pressure of the right heel. Interventions included, but were not limited to, prevalon boot to right foot when up. Resident #62's kardex indicated CNA's (Certified Nurse Assistants) were to apply the prevalon boot to his right foot when up in his w/c. On 10/20/16 at 11:05 A.M., CNA #5 was interviewed. During the interview, CNA #5 indicated Resident #62 was to wear a prevalon boot to his right foot when up in the w/c but it had not been put on this morning. On 10/20/16 at 11:07 A.M., the ADNS was interviewed. During the interview,		Results of this audit will be presented to QAPI for further need for monitoring. **Date of Completion:** November 4, 2016.	

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	she indicated Resident #62 was to wear the prevalon boot to his right foot when up in his w/c. 2. On 10/19/16 at 9:30 A.M., Resident #20's clinical record was reviewed and indicated a physician's order was received on 8/26/15 to obtain Vitamin D, and Magnesium blood levels now, and in one year. An interview with the Director of Nursing Services (DNS) on 10/19/16, at 10:50 A.M. indicated the lab draws for Vitamin D and Magnesium levels had been obtained 8/27/15, but were not completed in one year as indicated on the physician's order of 8/26/15. The DNS indicated the Vitamin D and Magnesium levels should have been completed one year from the Physician order. A policy provided by the DNS on 10/20/16, at 11:45 A.M., titled "Test Results", last revised April 2007, did not provide information on obtaining physician ordered labs in a timely manner. 3. On 10/18/16, at 2:05 P.M., an observation was made of Resident #39 in her room with a nasal cannula attached to an Oxygen (O2) pump set at 2 liters.			

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	On 10/18/16, at 2:21 P.M., RN #15 verified Resident #39's O2 was set at 2 liters. On 10/20/16, at 11:13 A.M., Resident #39 was in her wheelchair with a portable O2 tank. The O2 was set at 2 liters. On 10/20/16, at 11:13 A.M., the Assistant Director of Nursing Services (ADNS) verified Resident #39's O2 was set at 2 liters. An interview with the ADNS was conducted on 10/20/16, at 11:16 A.M. The ADNS indicated Resident #39's O2 should have been set at 2 liters. Review of Resident #39's most current Physician's orders (noted as all Active Orders for October 2016), provided by the ADNS on 10/20/16, at 11:15 A.M., contained an order dated 12/30/15 for O2 set at 3 liters. 3.1-35(g)(2)			

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F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.			
	Based on record review and interview, the facility failed to ensure 1 of 3	F 0315	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	11/04/2016

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	residents reviewed for an increase in urinary incontinence (#106), had an individualized toileting program to prevent further decrease in urinary continence. Findings include: Resident #106's clinical record was reviewed on 10/17/16 at 9:45 A.M.. Resident #106 was admitted to the facility on 4/22/16 and had an admission Minimum Data Set (MDS) completed on 4/28/16 which indicated occasional urinary incontinence (less than 7 episodes of urinary incontinence in the 7 day review period). On the quarterly MDS of 7/29/16, Resident #106 was identified as being frequently incontinent of urine (7 or more episodes of urinary incontinence in the 7 day review period). On 10/17/16 at 10:34 A.M., an interview with LPN #1, an MDS nurse was conducted. LPN #1 stated for Resident #106's admission MDS on 4/28/16, there were 2 episodes of urinary incontinence for the 7 day review period of 4/22/16-4/28/16. LPN #1 stated for the quarterly MDS of 7/29/16, there were 11 episodes of urinary incontinence for the 7 day review period of 7/23/16-7/29/16. LPN #1 stated after the noted increase in urinary incontinence on 7/29/16,		indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. **Corrective Action:** Resident #106 urinary incontinence was assessed and her careplan was updated with individualized interventions to manage incontinent episodes and restore normal bladder function as much as possible. **How others identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Residents were reviewed for individualized toileting interventions that will restore normal bladder function as much as possible. The Bladder retraining program policy was reviewed and updated. Staff education completed on urinary incontinence and restoring normal bladder function. **Monitoring:** The D.O.N./Designee will conduct random audits on residents with urinary incontinence and their toileting programs to restore bladder function 5x per week for 1 month, 3x per week for 3 months, and 2 x per week for 2 months. Results of this audit will be presented to QAPI for further need for monitoring.**Date of Completion:**	

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	intervention was started for assist in toileting before and after meals, upon rising, bedtime an as needed. LPN #1 stated a 24 hour bladder toileting record was completed on 7/26/16, 6:00 A.M. through 7/27/166:00 A.M., which indicated Resident #106 had hourly tracking of urinary continence. The 7/26/16 bladder toileting record indicated Resident #106 had urinary incontinence episodes on 7/26/16 at: 6:00 A.M.; 11:00 A.M.; 2:00 P.M.; 5:00 P.M.; 8:00 P.M.; 9:00 P.M.; 11:00 P.M.. On 7/27/16, the bladder toileting record indicated Resident #106 had urinary incontinence episodes at 2:00 A.M. and 5:00 A.M.. Resident #106 had a care plan dated 4/25/16 for alternation in bladder and/or bowel elimination related to decreased mobility, overactive bladder. The original toileting intervention dated 4/25/16 indicated to assist Resident #106 with toileting. On 8/2/16, the toileting intervention was updated to offer assistance before and after meals, upon arising, bedtime and as needed. Review of follow-up question reports for urinary incontinence provided by LPN #1 on 10/20/16, at 10:45 A.M., indicated between 9/22/15/16-10/20/16, Resident # 106 had 89 episodes of urinary incontinence.		November 4, 2016.	

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	An interview with the Director of Nursing Services (DNS) on 10/20/16, at 10:40 A.M., indicated Resident #106 should have had an individualized care plan for a toileting program based on the patterning established on the 24 hour tracking of 7/26/16-7/27/16. A policy was provided by the DNS on 10/20/16, at 11:45 A.M., titled Bladder Retraining Program, dated 9/11/15. The policy indicated under Procedure: 3. "If they are a candidate for retraining, initiate a 24 hour voiding diary... 6. Develop a toileting program based upon their continent/incontinent episodes. The goal of the program is to anticipate needs and reduce incontinent episodes. 3.1-41(a)(2)			
F 0441 SS=D Bldg. 00	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			

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(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
	infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review and interviews, the facility failed to follow contact isolation precautions for residents identified as requiring contact isolation to prevent spread of infection to others, for 2 of 2 residents reviewed for infections (Resident #44 and Resident #208). Findings include: On 10/13/16 at 2:52 P.M., Resident #208 was observed lying in bed in her room with a family member visiting at her	F 0441	The facility will 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. Personnel will handle, store, process and transport linens so as to prevent the spread of infection. **Corrective Action.** Resident #208 remains in Contact Isolation. Her antibiotic therapy continues. She remains on hourly checks to observe for self-contaminating behaviors such as	11/04/2016

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	155689	A. BUILDING 00 B. WING	10/20/2016

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	bedside. A sign was posted on the door which indicated visitors should see the nurse before entering. The family member indicated Resident #208 had an infection with C-Diff (Clostridium Difficile). The family member indicated Resident #208 had the infection for the past two months and "wasn't able to get rid of it". Further,the family member indicated her belief that Resident #208 kept "reinfecting herself" because Resident #208 had dementia and would put her hands into her own feces. The family member indicated Resident #208 would have feces under her fingernails when she visited. 10/13/16 at 3:00 P.M., Resident #208's record was reviewed. Resident #208 was diagnosed with c-diff infection and had been on contact isolation precautions since 8/10/16. On 10/17/16 at 1:04 P.M., Resident #208 was observed sitting in her w/c (wheelchair) in the hallway, by the nurses station, after being transported back from the main dining room. Resident #208 had small bits of dark debris under her fingernails. On 10/17/16 at 1:05 P.M., LPN #6 was interviewed. During the interview, he indicated that Resident #208 was in		playing in her excrement. Areas that resident #208 were in and staff #7, such as the nurse's station, were disinfected using Micro Kill Bleach Wipes. Resident #44 Contact Isolation was discontinued because he has no symptoms of C-Diff infection. The resident's loose stools are not an indicator of active C-Diff infection per current CDC guidelines. Staff #9 and Staff #7 were educated on infection control practices regarding contact isolation rooms and hand washing. **How others identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Residents with contact isolation were reviewed for risk of spreading the infection to others. Careplans were updated to reduce or eliminate risk. Staff education was completed on procedures for entering rooms with contact isolation and handwashing. **Monitoring:** The D.O.N/Designee will conduct isolation room surveillance 5x per week for 1 month, 3x per week for 3 months, and 2x per week for 2 months. Results of this audit will be presented to QAPI for further need for monitoring. **Date of Completion:** November 4, 2016.	

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contact isolation for c-diff infection but was allowed to eat meals in the main dining room because the infection was contained in the resident's brief.

On 10/18/16 at 10:12 A.M., Resident #208 was observed laying in bed with her left hand in her brief and right hand, covered with liquid stool, lifted up towards the ceiling.

On 10/18/16 at 10:20 A.M., Resident #208 was observed being transported to the shower room by two CNA's who were not wearing gloves or gowns. During an interview, at this same time, LPN #7 indicated Resident #208 "does this frequently", "digs at herself", and is often found with stool on her hands.

On 10/19/16 at 12:17:16 P.M., LPN#7 was observed to walk into Resident #208's room wearing gloves and a gown. On 10/19/16 at 12:17:46 P.M., LPN #7 was observed to walk out of Resident #208's room without gloves or gown on. LPN #7 returned to the nurse's desk, poured a small amount of hand gel into his hands, rubbed them for few seconds, then proceeded to use the computer mouse sitting on the nurse's desk area.

On 10/19/16 at 12:30 P.M., LPN #7 and ADNS (Assistant Director of Nursing

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	Services) were interviewed. LPN #7 indicated that he went into Resident #208's to "fix the bed" because the bed frame didn't work. LPN #7 indicated he removed his gown and gloves and washed his hands prior to leaving the room. The ADNS provided a copy of the facilities policy for handwashing and hand rub. The ADNS indicated that after removing gloves, LPN #7 should have washed his hands for 40-60 seconds per facility policy. Further, she indicated use of hand gel for hand hygiene should be done for 20-30 seconds. 2. On 10/17/16 at 9:18 A.M., Resident #44 was observed in his room. A sign indicating visitors should see the nurse before entering the room was posted on Resident #44's door. On 10/18/16 at 10:05 A.M., CNA #8 was interviewed. During the interview, CNA #8 indicated Resident #44 was in contact isolation for c-diff infection. CNA #8 indicated that gloves, gowns, and masks should be put on before going into Resident #44's room. On 10/19/16 at 9:51 A.M., HH #9 (Helping Hand) was observed passing ice water to resident's room. HH #9 was observed to put on gloves when she entered Resident #44's room. HH #9			

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	picked up Resident #44's water pitcher off his overbed table, walked back out of the room into the hallway while wearing gloves, and removed the lid of the water pitcher. HH #9 placed the pitcher lid with a straw sitting in the hole of the lid, onto the rectangular ice chest and filled up the pitcher with ice from the round ice chest. HH #9 then replaced the pitcher lid, walked back into Resident #44's room and placed the pitcher back on the resident's overbed table. HH #9 then removed her gloves, exited the room and went back into the hallway. HH #9 did not wash her hands after removing her gloves. On 10/19/16 at 9:54 A.M., HH #9 was interviewed. She indicated she was to wear gloves when going into Resident #44's room. Further, HH #9 indicated it was "okay" to bring the resident's pitcher out of his room, while wearing gloves, and into the hallway to fill the pitcher with ice. On 10/19/16 at 10:16 A.M., LPN #10 was interviewed. During the interview, LPN #10 indicated resident's who are on contact isolation precautions for c-diff infections should not have water pitchers brought out of the room and into the hallway to be filled. Further, she indicated staff were to remove their			

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	gloves and wash their hands prior to leaving the room of resident's in contact isolation. On 10/19/16 at 3:00 P.M., the DON (Director of Nursing) was interviewed. During the interview, the DON indicated staff had contacted Resident #44's physician and obtained an order to discontinue contact isolation, which had been in place since 7/6/16 for c-diff infection, due to the resident no longer having loose stools. On 10/20/16 at 1:12 P.M., Resident #44's MAR's (Medication Administration Record) were reviewed. The MAR indicated Resident #44 had received a prn (as needed) medication for loose stools, 2 times on 10/19/16 at 1:44 P.M. and on 10/20/16 at 7:16 A.M. On 10/20/16 at 1:37 P.M., the DON was interviewed. During the interview, the DON indicated that she had not been aware that Resident #44 had had loose stools on 10/19/16 or that Resident #44 had loose stools this morning. Further, the DON indicated it was "her practice" to follow physicians orders regarding contact isolation. The DON indicated the facility had a policy for c-diff contact isolation precautions which followed the CDC's (Center for Disease Control)			

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	recommendations. On 10/20/16 at 1:48 P.M., the DON provided copies of the facilities current policies which indicated the following: Policy "Isolation-Categories of Transmission-Based Precautions"...Contact Precautions...4. Gloves and Handwashing: a... wear gloves when entering the room. b. While caring for a resident, change gloves after having contact with infective material (for example, fecal material and wound drainage). c. Remove gloves before leaving the room and perform hand hygiene...5. Gown a. Wear disposable gown upon entering the Contact Precautions room or cubicle...." Policy "Clostridium Difficile...Preventative measures will be taken to prevent the occurrence of Clostridium difficile infections among residents and precautions will be taken while care for residents with C. difficile (to prevent transmission of C. difficile to others)....10. Residents with diarrhea associated with C. difficile will be placed on Contact Precautions. a. Healthcare workers will wear gloves and gowns upon entering the room of a resident with C. difficile infection, and will remove gowns and gloves prior to exiting the room....11. When caring for residents with diarrhea or fecal incontinence			

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	caused by C. difficile, staff will maintain vigilant hand hygiene. Hand washing with soap and water is superior to ABHR (alcohol based hand rub) for the mechanical removal of C. difficile spores from hands...."How to Handwash? Duration of the entire procedure: 40-60 seconds...How to Handrub? Duration of the entire procedure: 20-30 seconds...." "Clostridium difficile Infection Information for Patients" (February 2015) was retrieved on 10/21/16 from the Centers for Disease Control (CDC) website and indicated the following: "General information...The bacteria are found in the feces. People can become infected if they touch items or surfaces that are contaminated with feces and then touch their mouth or mucous membranes. Healthcare workers can spread the bacteria to patients or contaminate surfaces through hand contact". "Use Contact Precautions: for patients with known or suspected Clostridium difficile infection". 3.1-18(b)(2)			