

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/12/2013
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W000000	<p>This visit was for the investigation of complaint #IN00131430. This visit resulted in an Immediate Jeopardy.</p> <p>Complaint #IN00131430: Substantiated. Federal and state deficiencies related to the allegation are cited at W102, W104, W318, W331, W340, W406, and W454.</p> <p>Dates of Survey: July 1, 2, 3, 5, 8, 9, and 12, 2013.</p> <p>Facility number: 000730 Provider number: 15G580 AIM number: 100272190</p> <p>Surveyors: Susan Reichert, QIDP-TC Tim Shebel, LSW (7/9/13)</p> <p>The following federal deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 7/17/13 by Ruth Shackelford, QIDP.</p>	W000000	<p>By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings or allegations as part of my proceedings and submit these responses pursuant to our regulatory obligations. _____ Beverly Sayre Cowart Administrator</p>	

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review, the Condition of Participation: Governing Body and Management is not met for 9 of 9 clients (clients A, B, C, D, E, G, H, I and J) who were isolated for MRSA (methicillin-resistant Staphylococcus aureus) infection and/or exposure, and for 2 additional clients (clients F and K). The governing body failed to provide oversight and direction to ensure policy and procedures to promote health and safety practices for Universal Precautions and infection control measures were implemented to prevent infections.</p> <p>Findings include:</p> <p>1. The governing body failed to meet the Condition of Participation: Physical Environment. The governing body failed to provide oversight and direction to ensure policy and procedures to promote health and safety practices for Universal Precautions and infection control measures were implemented to prevent infections for 9 of 9 clients (clients A, B, C, D, E, G, H, I and J) who were isolated for MRSA (methicillin-resistant Staphylococcus aureus) infection and/or</p>	W000102	Refer to 406Refer to W318Refer to W104	08/11/2013			

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	<p>exposure, and for 2 additional clients (clients F and K). Please see W406.</p> <p>2. The governing body failed to meet the Condition of Participation: Health Care Services. The governing body failed to provide adequate health care monitoring, nursing services, and prompt preventative infection control measures for 9 of 9 clients (clients A, B, C, D, E, G, H, I and J) isolated for MRSA (methicillin-resistant Staphylococcus aureus) infection and/or exposure, and for two additional clients (clients F and K). The governing body failed to ensure the facility's nursing services adequately monitored skin integrity after exposure to MRSA, and failed for 1 of 4 sampled clients (client A) to address his identified allergy to sulfa when it was prescribed for infection. Please see W318.</p> <p>3. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure policy and procedures to promote health and safety practices for Universal Precautions and infection control measures were implemented to prevent infections for 9 of 9 clients (clients A, B, C, D, E, G, H, I and J) who were isolated for MRSA (methicillin-resistant Staphylococcus aureus) infection and/or exposure, and for 2 additional clients (clients F and K).</p>						

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	<p>Please see W104.</p> <p>This federal tag relates to complaint #IN00131430.</p> <p>3.1-13(a)</p>				

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based upon record review, observation and interview, the governing body failed to exercise general policy and operating direction over the facility to ensure policy and procedures to promote health and safety practices for Universal Precautions and infection control measures were implemented to prevent infections for 9 of 9 clients (clients A, B, C, D, E, G, H, I and J) who were isolated for MRSA (methicillin-resistant Staphylococcus aureus) infection and/or exposure, and for 2 additional clients (clients F and K).</p> <p>Findings include:</p> <p>1. Please see W331. The governing body failed to exercise general policy and operating direction over the facility for 9 of 9 clients (clients A, B, C, D, E, G, H, I and J) isolated for MRSA (methicillin-resistant Staphylococcus aureus) infection and/or exposure, and for two additional clients (clients F and K), to ensure the facility's nursing services adequately monitored skin integrity after exposure to MRSA, and failed for 1 of 4 sampled clients (client A) to address his identified allergy to sulfa when it was prescribed for infection.</p>	W000104	Refer to W331Refer to 340Refer to 454	08/11/2013			

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	<p>2. Please see W340. The governing body failed to exercise general policy and operating direction over the facility for 9 of 9 clients (clients A, B, C, D, E, G, H, I and J) isolated for MRSA (methicillin-resistant Staphylococcus aureus) infection and/or exposure, and for 2 additional clients, (clients F and K), to ensure staff implemented and followed the facility's Universal Precautions, Nursing Policy and Procedure for MRSA and their Isolation Room Cleaning Procedures training.</p> <p>3. Please see W454. The governing body failed to exercise general policy and operating direction over the facility for 9 of 9 clients (clients A, B, C, D, E, G, H, I and J) isolated for MRSA (methicillin-resistant Staphylococcus aureus) infection and/or exposure, and for 2 additional clients (clients F and K), to implement and follow Universal Precautions, Nursing Policy and Procedure for MRSA and their Isolation Room Cleaning Procedures.</p> <p>This federal tag relates to complaint #IN00131430.</p> <p>3.1-13(a) 3.1-13(r)</p>						

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W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on observation, record review, and interview, the Condition of Participation: Health Care Services, was not met as the facility failed to provide adequate health care monitoring, nursing services, and prompt preventative infection control measures for 9 of 9 clients (clients A, B, C, D, E, G, H, I and J) isolated for MRSA (methicillin-resistant Staphylococcus aureus) infection and/or exposure, and for two additional clients (clients F and K). The facility's nursing services failed to adequately monitor skin integrity after exposure to MRSA, and failed for 1 of 4 sampled clients (client A) to address his identified allergy to sulfa when it was prescribed for infection.</p> <p>Findings include:</p> <p>Please refer to W331. The facility failed for 9 of 9 clients (clients A, B, C, D, E, G, H, I and J) isolated for MRSA (methicillin-resistant Staphylococcus aureus) infection and/or exposure, and for two additional clients (clients F and K), the facility's nursing services failed to adequately monitor skin integrity after exposure to MRSA, and failed for 1 of 4 sampled clients (client A) to address his</p>	W000318	Refer to W331 Plus Addendum Refer to W340plus Addendum	08/11/2013			

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	<p>identified allergy to sulfa when it was prescribed for infection.</p> <p>Please refer to W340. The facility failed for 9 of 9 clients (clients A, B, C, D, E, G, H, I and J) isolated for MRSA (methicillin-resistant Staphylococcus aureus) infection and/or exposure, and for 2 additional clients (clients F and K), to ensure staff implemented and followed the facility's Universal Precautions, Nursing Policy and Procedure for MRSA and their Isolation Room Cleaning Procedures training.</p> <p>3.1-17(a)</p>			

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 9 of 9 clients (clients A, B, C, D, E, G, H, I and J) isolated for MRSA (methicillin-resistant Staphylococcus aureus) infection and/or exposure, and for two additional clients (clients F and K), the facility's nursing services failed to adequately monitor skin integrity after exposure to MRSA, and failed for 1 of 4 sampled clients (client A) to address his identified allergy to sulfa when it was prescribed for infection.</p> <p>Findings include:</p> <p>Observations were completed in group 6 on 7/1/13 from 4:45 PM until 5:00 PM. A sign on the door indicated "Contact Isolation." Staff #32 and #58 wore gowns and gloves. Client C had a discolored area one inch in diameter in the inside bend of his left elbow.</p> <p>The Assistant Director of Nursing (ADON) was interviewed on 7/1/13 at 5:25 PM. She indicated client B had been diagnosed with MRSA on 6/21/13. She stated, "Because the kids are in close contact, we kept them all together and treated them all prophylactically either the same day or next day." She indicated</p>	W000331	W331 Protocols related to specified areas of drug allergies, nursing services measures for monitoring and documentation, isolation precautions, cleaning and training guidelines and training for proactive implementation of preventative measures related to exposure, monitoring and treatment coupled with preventative strategies were modified. Facility nursing documentation strategies have been modified through revision of the incident/accident treatment flow sheet and the medical treatment follow up form requiring nursing assessment. Revisions to these documents (Att. A), include replacement of the narrative description related to identify areas with specific data, including: size, color, redness, edema, warmth, drainage, whether an area assessed is open or not and additional space to facilitate further description as warranted. Additionally, nursing personnel will review known drug allergies prior to initiating newly prescribed medications. Nursing review will be reflected through a documented check mark located on a physician telephone order for the prescribing medication. Nursing policy and protocols regarding identified occurrences of confirmed MRSA were	08/11/2013			

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	<p>client A had been isolated prior to that on 6/6/13 with a MRSA infection, and had been returned to the group after his follow up culture was negative for infection. She indicated client A had been treated again prophylactically with antibiotics after client B was diagnosed with MRSA on 6/22/13.</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 7/1/13 at 5:30 PM. A report dated 6/21/13 indicated client B had been sent to the ER (emergency room) for evaluation and possible treatment of a boil to the back of his left leg. A follow up report of 6/28/13 indicated the abscess/boil remained on client B's left calf and had been cultured and diagnosed with MRSA. The report indicated client B had been placed in isolation per physician's orders pending follow up culture to the abscess/boil on his left leg following completion of prescribed antibiotics. The report indicated nursing will continue to monitor client B's left calf area.</p> <p>A BDDS report dated 6/6/13 indicated client F had been taken to the hospital and admitted for an undetermined illness after he had projectile vomiting in the dining room, was shivering, pale, and with a blood sugar level of 475 and temperature</p>		<p>reviewed, noting the policy to be appropriate. But, nursing protocols were identified as lacking generalized implementation efforts. Modifications implemented for form revision and in-servicing for all nursing personnel were completed on 07-22-2013 Att. A and B) Client D's physician was contacted on three occasions with new orders received at each interval following nursing personnel update. Between 6-22-2013 and 6-27-2013, Client D's physician was updated on his condition. At no time or interval was nursing personnel given directives to culture any areas of treatment. The course of treatment for Client D's areas of treatment followed facility policy in regards to MRSA and monitoring efforts. It must also be noted that the raised areas noted for Client D were the result of his ingestion of a small amount of chocolate. As documented on his signed physician orders, Client D has a diagnosed sensitivity to chocolate resulting in the noted areas. In the future, should group isolation be deemed necessary, all affected individuals will be provided with regulated foot space, equipment, sleeping quarters and hygiene areas as regulated through the number of individuals required for isolation precautions. Hygiene facilities will be provided for each client under the umbrella of isolation</p>				

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	<p>of 96.8. Client F was diagnosed with a bowel obstruction and admitted to the intensive care unit for further testing and treatment. A follow up report dated 6/13/13 indicated client F underwent surgery for a ruptured appendix. A follow up report dated 6/17/13 indicated client F returned to the facility with an abdominal binder in place for closed surgery sites for an appendectomy and pneumothorax.</p> <p>Client A's record was reviewed on 7/2/13 at 11:25 AM. Client A's physician's orders indicated he had been given the following medications to treat skin lesions: Client A was seen by a dermatologist who diagnosed allergic dermatitis on 5/22/13 and prescribed Prednisone 10 mg (milligrams); day 1-6 tabs, day 2-5 tabs, day 3-4 tabs, day 4-3 tabs, day 5-2 tabs, day 6-1 tab. On 6/5/13 client A was prescribed Levaquin 500 mg, Triamcinolone 0.1%. Other orders included on 5/31/13 Diflucan 150 mg give one time, on 6/7/13 "Client to be in isolation d/t (due to) wound with MERSA (sic) (left side with infection)," on 6/7/13, "d/c (discontinue) Levaquin. Begin Bactrim DS (sulfa based antibiotic) BID (twice daily) x (for) 10 D (days) for MRSA," "N.O. (new orders): #1 Diflucan 150 mg PO (by mouth) daily x 7 days for yeast to penis...#2 clotrimazole cream. Apply topically tid (three times daily) x 7</p>		<p>precautions. Hygiene facilities will be contained within the designated area or accessible through facility transfer policy as outlined in facility infection control policy. Additionally, individuals housed within one room will be provided with at least 3 feet of private space as guided by State and Federal regulations for all sleeping spaces. Addendum: As a measure to ensure that health care monitoring, preventative infection control measures and nursing services are delivered, the following monitoring protocols have been established. To ensure that drug allergies are reviewed prior to initiation of newly prescribed medications, nursing will document a check mark located on the physician telephone order for the prescribing medication. The documenting nurse will provide a copy of the newly prescribed medication for the DON's review to ensure that drug allergy review has been completed. Additionally, the newly revised monitoring forms for incident/accident treatment flow sheets and the medication flow sheets will be reviewed between nursing personnel during shift reports. Once completed, the incident/accident treatment flow sheets and medication flow sheets will be copied and provided for DON review to ensure accuracy and implementation. Efforts to</p>				

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	<p>days for yeast to penis, and on 6/22/13 N.O. Bactrim DS bid x 10 days prophylactic exposure to MRSA. Client A's physician's orders for 6/1/13-6/30/13 indicated he was allergic to sulfa. Nurse #10's notes indicated client A's contact isolation was discontinued on 6/20/13, and client A's physician was contacted on 6/23/13 regarding client A's allergy to sulfa at 6:00 AM. On 6/23/13 at 12:00 PM a note indicated client A had no symptoms of reaction to Bactrim, "[Dr.] has not responded at this time." There was no evidence in the nursing notes that client A's doctor was contacted regarding his allergy to sulfa when prescribed prednisone on 6/7/13. Nursing notes from 6/6/13 to 6/18/13 when the boil was documented as "resolved" failed to indicate specific location and size of client A's boil.</p> <p>Client B's record was reviewed on 7/2/13 at 12:05 PM. Physician's orders indicated on 6/21/13 Keflex 500 mg daily and Bactrim DS twice daily, 7/1/13 culture calf boil site. Nurse #10's notes indicated on 6/21/13 a boil "oozing serosanguinous (sic) drainage " was noted with pain to touch on the back of client B's leg. No size or specific location on the back of client's leg was documented in the notes. On 6/22/13 a nursing note at 12:00 AM indicated a 4 cm (centimeters) reddened,</p>		<p>ensure that measures of Universal precautions are regularly practiced were updated to include: staff access to readily available sanitation supplies, unscheduled spot checks for implementation, full staff PowerPoint training regarding infection control and small group review of Universal precautions. To ensure that measures of Universal precautions and knowledge of infection control protocols are commonly practiced, the QIIP's will perform random audits throughout the facility. Audits will include additional education following each audit as a result of individual findings. The DON will review all completed audits for thoroughness and trends. Should trends be identified, small group training sessions will be implemented for those staff requiring additional training. The Charge Nurses are responsible for documentation and monitoring of clients. The DON will monitor for compliance.</p>				

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	<p>circle area with 1 cm scab, warm to touch on client B's left calf, and a note on 6/22/13 at 12:00 PM indicated client A's physician had reported the lab results of the swab from client A's abscess is MRSA-"isolation continues." A diagram of of a body on a form dated 6/21/13 indicated a circle labeled "(boil)" on his left calf. "Sent for ER for eval/tx (treatment). Client B's nursing notes from 6/23/13 to 6/25/13 failed to indicate the size of client B's boil, and from 6/27/13, to 6/30/13 failed to indicate the size of client B's boil until "boil resolved" was documented on 7/1/13.</p> <p>Client D's record was reviewed on 7/2/13 at 12:55 PM. Client D's physician's orders indicated on 6/22/13 he was prescribed Erythromycin 333 mg three times daily for 10 days for boils to underarm and back. New orders dated 6/18/13 indicated Bactroban ointment to right arm twice daily and cover with a Band-Aid, and on 6/28/13 to discontinue the Erythromycin and start Levaquin 500 mg daily for 10 days for boils, and a Listerine swab for inside of left cheek for blister twice daily for 14 days. Client D's nursing notes indicated the following entries: on 6/27/13 at 6:00 AM, "[client D] continues Erythromycin/Boils-R (right arm), client continually...scratching areas...",on 6/28/13 at 7:45 AM, "Spoke</p>			

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	<p>with [Dr.] RE: (regarding) Erythromycin/Boils to R arm-back-not improving with this therapy." The note indicated client D's physician had discontinued the Erythromycin and to begin Levaquin. On 7/1/13 at 6:00 AM there was an entry at 6:00 AM "Boils to R arm continues to 2 cm open c (with) slight serous (watery) drainage. On 7/2/13 an entry indicated a 2 cm boil to the R arm and shoulder 2 cm in diameter. Nursing notes entries dated 6/18/13 to 6/26/13 did not indicate the size of client D's boils to his back and underarm. There was no evidence of client D's boil or blister having been cultured as to type of infection.</p> <p>Client C's record was reviewed on 7/2/13 at 1:30 PM. Client C's nursing notes indicated the following entries: on 6/24/13 at 3:40 PM, client C returned to the facility from the hospital with a picc (peripherally inserted central catheter) line "above R arm is hot, pink,...tender to touch. The entry indicated client C's doctor would be called regarding "possibly infected picc line." On 6/24/13 at 7:45 PM an entry indicated a call was placed to client C's doctor regarding a "possible infection to picc line site." New orders were given for Augmentin XR 1000 mg twice daily for 8 days. An entry on 6/24/13 at 10:00 PM indicated the</p>				

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	<p>picc line site was "red, warm to touch with swelling." On 6/25/13 at 9:30 AM client C's physician was contacted regarding possible infection and a need for removal of the picc line. Nursing notes on 6/25/13 at 1:30 PM indicated client C was sent to a medical facility to remove the picc line, and at 10:00 PM, the area was slightly red, warm to touch, and client C was showing signs and symptoms of pain. Entries on 6/26/13 indicated client C's picc line site remained red and painful to touch. On 6/27/13 at 5:15 PM, "R arm remains swollen, tender to touch. Client to go for labs (laboratory tests) in the AM." On 6/28/13 at 1:00 AM, an entry indicated client C "had better ability to move his med cup to his mouth with ease as compared to yesterday evening." On 6/28/13, an entry indicated client C went to see his physician and "R picc line site culture." On 6/30/13, a note indicated client C was diagnosed with MRSA by his physician. A note dated 7/1/13 indicated client C continued augmentin XR for infection to picc line site with MRSA, and R arm had edema, tender to touch. There was no evidence in the entries of the size of client C's redness and edema indicating infection to his picc line.</p> <p>Client F's record was reviewed on 7/2/13 at 2:10 PM. A nursing note dated 6/23/13</p>						

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	<p>at 10:00 AM indicated client F's incision site was "pink @ (at) staple site with pustules...purulent drainage." A note dated 6/23/13 at 12:30 PM indicated client F's doctor prescribed Bactrim DS twice daily for infection. A note dated 6/26/13 indicated "spoke with [Dr.]...ask about exposure to MRSA (sic) states 'almost everybody has MRSA and didn't think that it would be a problem.'" The doctor instructed to cover client F's abdominal incision with tape and leave his chest uncovered.</p> <p>The ADON was interviewed on 7/2/13 at 2:26 PM and indicated client A's doctor had responded to the concern about client A's allergy to sulfa and his taking Bactrim on 6/23/13, but the response was not recorded. She indicated client A's physician was not concerned about client A's allergy as the sulfa content of the Bactrim was a minimal amount and the effectiveness of the medication outweighed potential side effects.</p> <p>Observations were completed in program room 6 on 7/2/13 from 1:20 PM until 1:30 PM with the ADON (assistant director of nursing). Client D had a 1 inch round open area of skin on his left shoulder. Client A had more than 3 raised red areas on his legs, 1/8 of an inch in diameter. Client C had a closed purple</p>			

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	<p>area 1/8 of an inch in diameter midway up the front of his upper right arm where his picc line had been placed.</p> <p>The ADON was interviewed on 7/2/13 at 1:25 PM. She stated the clients in room 6 were bathed in the attached bathroom as a "bedside bath" and slept on the floor on mattresses. She stated "It looked like camp." She indicated client A was having additional allergy testing completed and client A had frequent rashes. She indicated client A had a rash before developing a boil with MRSA infection, and client C had returned from the hospital on 6/24/13 with a picc line that appeared to be infected. She indicated client C had been diagnosed with MRSA on 6/29/13. She indicated client F had lived in group 6 until his admission to the hospital, and when he was discharged back to the facility, had been assigned to another area. She indicated client D had ingested chocolate which caused him to itch.</p> <p>Client C's chest area was observed on 7/2/13 at 3:15 PM with QIDP #2. Client C had a G (gastrostomy) tube placed in his abdomen with a small amount of clear fluid leaking out of the stoma area. He had more than 3 red raised spots on his chest.</p>						

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	<p>The QIDP-D #2 was interviewed on 7/2/13 at 3:15 PM and indicated client C received a topical acne treatment for the spots.</p> <p>The DON was interviewed on 7/3/13 at 3:42 PM and indicated there should have been documentation of wound size and location in the nurses notes regarding client A, B, C, D, and F's skin lesions.</p> <p>Observations in the dining room were completed on 7/3/13 from 4:50 PM until 5:50 PM. Client C had a scab 1/8 inch in diameter above his right elbow on the back of his arm resting on the dining room table. The DON swabbed the scabbed area with alcohol and placed a Band-Aid on the area at 5:50 PM.</p> <p>The DON was interviewed on 7/3/13 at 5:55 PM regarding client C's scabbed area found on the back of his arm. She stated the wound was "definitely a scab," and indicated she was told client C "picks" his skin "quite a bit." She indicated the skin around the scabbed area was pink and granulated, and she would call client C's physician to see if he wanted the wound covered. She stated "ideally" the scabbed area should have been covered to be safe, and indicated universal precautions should be used with client C and his infection until he had been cleared by the</p>						

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	<p>doctor.</p> <p>The ADON was interviewed on 7/3/13 and indicated client C's contact isolation was discontinued as his wound was healed and he had completed his 8 day antibiotic.</p> <p>The DON was interviewed on 7/3/13 at 6:20 PM and indicated staff had not documented client C's scabbed area under his right arm above his elbow and it would be investigated as to why the documentation had not been completed.</p> <p>Observations were completed in program room 6 on 7/5/13 from 1:14 PM until 2:16 PM. Client C had 3 rash like pin point scabbed area above one wrist and a 2 inch area rash-like reddened area on the other wrist. Client D had 1 inch scabbed spot on his right knee uncovered as he lay and kneeled on the floor. Client D had a 1/8 inch scabbed area on his left hand, and a superficial red scratch 1 inch in length at the bottom of his right cheek, and a reddened scratch under the length of his right eye. Client K put his hands in his mouth leaving saliva on his hands and was not taken to wash his hands. There was no sanitizer dispenser in the room. Client K had 5 spots on his right calf and 2 spots on the back of his left calf. The spots were reddened and 1 inch in</p>						

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	<p>diameter. Staff #59 was uncertain of the origin of the spots. Staff #90 mopped up a clear liquid on the floor using light brown water at 1:34 PM. Client B laid on the floor with his cheek resting on the floor. Staff #32 had a gauze covering over the top of his left wrist. Staff #90 brought clear mop water at 1:40 PM and re-mopped the area he had previously mopped. Client D rolled on the floor and client B banged his head on the floor and had a reddened scab on his right knuckle, and a scratch behind his right ear. Client F pulled up his shirt exposing a surgical scar and a loose abdominal binder. Staff #32 assisted client F to the restroom to refasten his binder.</p> <p>Staff #90 was interviewed on 7/5/13 at 1:34 PM. When asked if the mop water was clean, he stated, "Relatively," and indicated he would mop it later with clean water.</p> <p>Staff #90 was interviewed again on 7/5/13 at 1:42 PM. When asked how often he changed the mop water, he indicated it was changed every 3 hours or after mopping half the hallway, and stated, "Every time I get urine up."</p> <p>Staff #32 was interviewed on 7/5/13 at 1:46 PM and indicated he had been diagnosed with a boil by his physician,</p>			

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	<p>given an antibiotic and the boil was lanced on 6/28/13. He indicated the boil had not been cultured to determine the type of infection due to the expense. He indicated he had last worked in program room 6 on 6/15/13 and was aware of the clients having been diagnosed with MRSA.</p> <p>Staff #89 was interviewed on 7/5/13 at 2:00 PM and indicated he had spoken with nursing regarding client K's spots and was told the nurse would check the spots during med pass at 3:00 PM.</p> <p>LPN #6 was interviewed on 7/5/13 at 2:16 PM and indicated client J was being monitored with a skin assessment for spots found on the back of his leg.</p> <p>Laboratory testing results for client D dated 7/3/13 were reviewed on 7/5/13 at 2:20 PM and indicated there was no wound organisms or white blood cells found.</p> <p>Laboratory testing results for client F dated 7/3/13 were reviewed on 7/5/13 at 2:20 PM and indicated there was "rare gram positive organism and scant beta hemolytic organism (type of infection), identification to follow."</p> <p>Laboratory testing results for client B</p>						

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	<p>dated 7/3/13 were reviewed on 7/5/13 at 2:20 PM and indicated "rare white blood cells, rare gram positive cocci in pairs (type of infection), heavy gram positive (type of infection), isolation and identification to follow."</p> <p>The DON was interviewed on 7/5/13 at 2:40 PM and indicated client F's wound was to be covered per physician's orders until the final results were received.</p> <p>The DON was interviewed on 7/5/13 at 3:05 PM and indicated there was not ongoing documentation of clients C, D, E, G, H, I, and K for skin lesions after the skin assessments had been completed on 7/3/13 and clients had been removed from contact isolation.</p> <p>Skin assessments for clients A, B, C, D, E, G, H, I, J, and K dated 7/3/13 were reviewed on 7/5/13 at 3:42 PM. The assessments indicated clients C, G, H, and J did not have boils or skin irritation. Client A's assessment indicated there was a flow sheet monitoring in progress for "allergy flare up" and "waiting on labs test and dermatology appointment." Client B's assessment indicated a circle on his left calf indicating a reduced area on calf. Client I's assessment indicated there was a flow sheet in progress for monitoring a scabbed area on client I's lip (area not</p>						

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	<p>defined).</p> <p>Final laboratory testing results for client B dated 7/5/13 were reviewed on 7/8/13 at 12:15 PM. The culture wound indicated "heavy staphylococcus species, coagulase (protein type) negative, two colony morphologies, no further workup indicated." A notation dated 7/6/13 indicated client B's doctor had been notified with no treatment needed.</p> <p>Final laboratory testing results for client D dated 7/5/13 were reviewed on 7/8/13 at 12:15 PM. The culture wound indicated, rare normal skin flora isolated. A notation dated 7/6/13 indicated client B's doctor had been notified with no treatment needed.</p> <p>Final laboratory testing results for client F dated 7/5/13 were reviewed on 7/8/13 at 12:15 PM. The culture wound indicated MRSA, rare staphylococcus species, coagulase negative, no further workup needed, rare diptheroid (shape of bacteria) bacilli, no further workup needed. A notation dated 7/6/13 at 11:50 AM indicated continue Bactrim DS BID twice daily, cover with pad and abdominal binder, "no isolation indicated."</p> <p>This federal tag relates to complaint #IN00131430.</p>						

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W000340	<p>483.460(c)(5)(i) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>Based on observation, record review, and interview for 9 of 9 clients (clients A, B, C, D, E, G, H, I and J) isolated for MRSA (methicillin-resistant Staphylococcus aureus) infection and/or exposure, and for 2 additional clients (clients F and K), the facility failed to ensure staff implemented and followed the facility's Universal Precautions, Nursing Policy and Procedure for MRSA and their Isolation Room Cleaning Procedures training.</p> <p>Findings include:</p> <p>Observations were completed in group 6 on 7/1/13 from 4:45 PM until 5:00 PM. A sign on the door indicated "Contact Isolation." Staff #32 and #58 wore gowns and gloves. The floor was wet near client D. Clients B, C, D, E, G, I, J sat in chairs. Client A sat on the floor. Client C had a discolored area one inch in diameter in the inside bend of his left elbow.</p> <p>The Assistant Director of Nursing (ADON) was interviewed on 7/1/13 at</p>	W000340	W340 All staff have been re-inserviced regarding policy, practice and routine implementation of appropriate health and hygiene methods. Specifically, all staff have been re-trained in the efforts of sanitation methods and recognition of those times for common practice. Policy and protocol methods were reviewed, noting that all information was appropriate. But, in an effort to facilitate clear understanding and common practice of sanitation efforts, protocols have been condensed and modified to provide all necessary information in deliverable form to complete sanitation processes. Common practices used as preventative and ongoing efforts include: mopping soiled areas, sanitizing program items, sanitizing hard surface areas, sanitizing upholstered furniture, hand-washing techniques, and use of alcohol-based sanitizers for clients and staff, sanitation of floors beyond mopping efforts and processes for cleaning showers and tubs. All cleaning solutions are clearly identified on staff information sheets. During	08/11/2013			

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	<p>5:25 PM. She indicated client B had been diagnosed with MRSA on 6/21/13. She stated, "Because the kids are in close contact, we kept them all together and treated them all prophylactically either the same day or next day." She indicated client A had been isolated prior to that on 6/6/13 with a MRSA infection, and had been returned to the group after his follow up culture was negative for infection. She indicated he had been treated again prophylactically with antibiotics.</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 7/1/13 at 5:30 PM. A report dated 6/21/13 indicated client B had been sent to the ER (emergency room) for evaluation and possible treatment of a boil to the back of his left leg. A follow up report of 6/28/13 indicated the abscess/boil remained on client B's left calf and had been cultured and diagnosed with MRSA. The report indicated client B had been placed in isolation per physician's orders pending follow up culture to the abscess/boil on his left leg following completion of prescribed antibiotics.</p> <p>A BDDS report dated 6/6/13 indicated client F had been taken to the hospital and admitted for an undetermined illness after he had projectile vomiting in the dining</p>		<p>periods requiring isolation precautions, staff will be provided with a booklet containing approved processes and procedures for an identified episode of enhanced precautions. Specifically, once an infection, requiring isolation, is identified, staff will be provided with information regarding the infection, guidelines related to handling the identified infection (ex: MRSA, Measles, Scabies, etc.). Staff will review this data and identify their understanding of all required procedures through their signature prior to beginning their care of the affected client(s). These techniques will include, but are not limited to, the need for gowns, gloves and health measures related to an identified infection. Efforts to ensure that measures of Universal precautions are regularly practiced were updated to include: staff access to readily available sanitation supplies, unscheduled spot checks for implementation, full staff PowerPoint training regarding infection control and small group review of Universal precautions. Nursing policy and protocols regarding identified occurrences of confirmed MRSA were reviewed, noting the policy to be appropriate. But, nursing protocols were identified as lacking generalized implementation efforts. Modifications implemented for</p>		

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	<p>room, was shivering, pale, and with a blood sugar level of 475 and temperature of 96.8. Client F was diagnosed with a bowel obstruction and admitted to the intensive care unit for further testing and treatment. A follow up report dated 6/13/13 indicated client F underwent surgery for a ruptured appendix. A follow up report dated 6/17/13 indicated client F returned to the facility with an abdominal binder in place for closed surgery sites for an appendectomy and pneumothorax.</p> <p>Observations were completed in group 6 on 7/1/13 from 6:00 PM until 6:15 PM. At 6:01 PM, QIDP-D (Qualified Intellectual Disabilities Professional Designee) #2 pushed a vinyl upholstered chair out of the room covered in feces. She took a mop from a bucket with light brown water and mopped the floor. After mopping the floor with the mop, the water was a darker shade of brown. Clients A, B, C, D, E, G, I and J were in the room while the QIDP mopped the floor. Client B walked around on the wet floor wearing his pajamas.</p> <p>The QIDP-D #2 was interviewed on 7/1/13 at 6:10 PM. When asked about the chair, she indicated it would be cleaned by maintenance. She indicated the water was changed each shift and as needed, and stated, she had called for assistance</p>		<p>form revision and in-servicing for all nursing personnel were completed on 07-22-2013. Additionally, Measures for cleaning isolation rooms were re-serviced on 7-15-2013 (Att. C) for all staff. In an effort to ensure that responsible staff understand and commonly practice efforts of Universal Precautions/infection control, a booklet has been created to address the most commonly observed infections. The booklet contains information regarding common isolation infections, isolation precaution policies and protocols, environmental cleaning of upholstered furniture and procedures for personal protection for both isolated individuals and their caretakers Addendum: As a measure to ensure that health care monitoring, preventative infection control measures and nursing services are delivered, the following monitoring protocols have been established. To ensure that drug allergies are reviewed prior to initiation of newly prescribed medications, nursing will document a check mark located on the physician telephone order for the prescribing medication. The documenting nurse will provide a copy of the newly prescribed medication for the DON's review to ensure that drug allergy review has been completed. Additionally, the newly revised</p>				

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	<p>and would change the water when staff arrived to help. She stated, "It's pretty gross." The QIDP had feces on the toe of her shoe. She indicated she would clean her shoe.</p> <p>Client A's record was reviewed on 7/2/13 at 11:25 AM. Client A's physician's orders indicated "Client to be in isolation d/t (due to) wound with MERSA (sic) (left side with infection)."</p> <p>Client B's record was reviewed on 7/2/13 at 12:05 PM. Physician's orders indicated on 6/21/13 Keflex 500 mg daily and Bactrim DS twice daily, 7/1/13 culture calf boil site. Nurse #10's notes indicated on 6/21/13 a boil "oozing serosanguinous (sic) (bloody) drainage" was noted with pain to touch on the back of client B's leg. A nursing note on 6/22/13 at 12:00 PM indicated client B's physician had reported the lab results of the swab from client B's abscess is MRSA-"isolation continues."</p> <p>Client D's record was reviewed on 7/2/13 at 12:55 PM. Client D's physician's orders indicated on 6/22/13 he was prescribed Erythromycin 333 mg three times daily for 10 days for boils to underarm and back.</p> <p>Client C's record was reviewed on 7/2/13 at 1:30 PM. Client C's nursing notes</p>		<p>monitoring forms for incident/accident treatment flow sheets and the medication flow sheets will be reviewed between nursing personnel during shift reports. Once completed, the incident/accident treatment flow sheets and medication flow sheets will be copied and provided for DON review to ensure accuracy and implementation. Efforts to ensure that measures of Universal precautions are regularly practiced were updated to include: staff access to readily available sanitation supplies, unscheduled spot checks for implementation, full staff PowerPoint training regarding infection control and small group review of Universal precautions. To ensure that measures of Universal precautions and knowledge of infection control protocols are commonly practiced, the QIIP's will perform random audits throughout the facility. Audits will include additional education following each audit as a result of individual findings. The DON will review all completed audits for thoroughness and trends. Should trends be identified, small group training sessions will be implemented for those staff requiring additional training. The Charge Nurses are responsible for documentation and monitoring of clients. The Program Director is responsible</p>		

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	<p>indicated the following entries: on 6/27/13 at 5:15 PM, "R arm remains swollen, tender to touch. Client to go for labs (laboratory tests) in the AM." On 6/30/13, a note indicated client C was diagnosed with MRSA by his physician.</p> <p>The maintenance, housekeeping and laundry supervisor was interviewed on 7/2/13 at 2:05 PM. He indicated there was a checklist used for a guideline for cleaning program room 6, but it was not documented when the room was cleaned each night. He indicated the upholstered chair had been taken outside and the upholstery cleaned with disinfectant. He indicated the clients' beds had been cleaned and were now back on the clients' bedrooms. He indicated the facility used Pine-Sol cleaner as a disinfectant. He indicated the mop water should have been clean when used to mop the floor clean up the feces in room 6, but indicated it was his understanding staff was cleaning a toileting accident.</p> <p>The facility's Isolation Room Cleaning Procedures (undated) were reviewed on 7/2/13 at 2:08 PM. The document indicated for the bathroom "clean toilet with porcelain shower cleaner poured into a Johnny mop, working downwards to the bottom of the toilet, clean outside the toilet, lid, and the tank with hard surface</p>		for monitoring the floor staff for compliance of common practices. The IDT will monitor.				

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	<p>cleaner and dry. Sink cleaner with hard surface cleaner sprayed on a cloth, sweep and mop floor with floor cleaner (clean mop water and mop head using a floor disinfecting cleaner)." For Bedrooms, "wash beds with bleach water and air dry, mattress to be washed in bleach water from a bucket- 1 oz. (ounce) bleach to 1 gallon of water. Sweep and mop the floors with a clean bucket of mop water and a clean mop head containing disinfecting floor cleaner...."</p> <p>QIDP-D #2 was interviewed on 7/2/13 at 2:44 PM. She stated the chair had been removed from the hallway and the floor had been re-mopped "shortly after you left (on 7/1/13)," because the floor "was still smelly." When asked about clients in program room 6, she indicated clients B and D had open wounds and client A had a healed wound. She did not indicate client C had a wound or had been diagnosed with MRSA.</p> <p>Observations were completed in group 6 on 7/2/13 from 3:00 PM until 3:30 PM. Staff #25 and #81 did not have a gown on, but wore gloves. There was a dispenser of sanitizing solution outside the door to room 6. The water in the sink did not work when the faucets were turned on. Client E picked up a scrap of paper 1 inch in diameter by 1/4 inch in</p>						

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	<p>diameter from the floor and ate it.</p> <p>Staff #25 was interviewed on 7/2/13 at 3:05 PM and indicated they were not wearing gowns because it was hot in the room. He stated, "He believed" client D had MRSA, but was uncertain, and client B had MRSA on his legs. He was uncertain of anyone else in the program room 6 who had MRSA.</p> <p>Staff #25 was interviewed on 7/2/13 at 3:10 PM and indicated client F had previously been assigned to program room 6 and would eat the sanitizer. When asked how staff wash their hands, he indicated there was a sink in the bathroom area. He indicated the water had been turned off because client D had been in the bathroom earlier that day for a dressing change by the nurse and he would drink the water. He indicated client D was to have his liquids thickened. When asked about client E eating the paper, he indicated client E would eat paper occasionally.</p> <p>Client C's chest area was observed on 7/2/13 at 3:15 PM with QIDP #2. Client C had a G (gastrostomy) tube placed in his abdomen with a small amount of clear fluid leaking out of the stoma area. He had more than 3 red raised spots on his chest.</p>			

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	<p>The QIDP-D #2 was interviewed on 7/2/13 at 3:15 PM and indicated client C received a topical acne treatment for the spots.</p> <p>Observations were completed in program room 6 on 7/2/13 from 4:25 PM until 4:55 PM. Staff #81 fed client H pureed food using gloves, then touched client J on the back without washing his hands or changing gloves. Staff #81 then wiped client B's mouth with client B's clothing protector. Staff #81 placed the clothing protector in a plastic bag without changing gloves or washing his hands after handling the soiled clothing protector. Client B took a piece of food from client I's plate and ate it. Staff #81 took the food from client I's mouth and then touched client H's skin without washing his hands or changing gloves. Client C removed his clothing protector and handed it to staff #81 who placed it in a laundry bag. Staff #81 did not wash his hands or change gloves after handling the soiled clothing protector. Client D sat on a cloth upholstered chair wearing an incontinence brief and jeans that had slipped down to his thigh area causing client D's bare buttocks to sit on the chair. When client D's bare buttocks were pointed out, staff #25 indicated he would pull client D's pants up after he was</p>						

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	<p>finished eating. Staff #25 and #81 did not remove the chair after client D sat on the floor after he finished eating. Staff #81 placed client A's fork back on his tray after it had laid on the table without washing his hands or changing gloves. Client E sat on the same upholstered chair that had been covered in feces on 7/1/13. The corner of the vinyl upholstery was worn on the right edge, exposing the fabric backing. Clients G, J, and E sat in chairs or walked around the room while clients A, B, C, D, and I ate their dinner. Clients A, B, C, or H and I were not assisted to wash their hands after eating. Staff #25 assisted client D to the bathroom to wash his hands, and indicated he was assist all the clients in the room to wash their hands after he finished assisting client D.</p> <p>Staff #81 was interviewed on 7/2/13 at 4:44 PM. When asked when he was to change gloves, he stated, "After an event," and "in between clients. I only fed one client and haven't changed them (gloves)."</p> <p>The facility's policy Arcadia Developmental Center Nursing Policy and Procedure MRSA dated 12/3/02 was reviewed on 7/2/13 at 5:40 PM and indicated "Patient placement-Place the patient in a private room, if possible.</p>			

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	<p>When a private room is not available, place the patient in a room with a patient who is colonized or infected with the same organism, but does not have any other infection (cohorting). Another option is to place an infected patient with a patient who does not have risk factors for infection...Infected or colonized patients should be permitted to participate in group meals and activities if draining wounds are covered, bodily fluids are contained, and the patients observe good hygienic practices...Caregivers should wash their hands with soap and water after physical contact with the infected or colonized person and before leaving the facility...In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, single-use, non-sterile gloves are adequate) when providing direct patient care or handling items potentially contaminated by the patient or on Contact Precautions...During the course of providing care for the patient, change gloves after having contact with infected material that may contain high concentrations of microorganisms (e.g., fecal material and wound drainage). " Standard precautions included "all patients blood and body fluids are considered contaminated. Standard Precautions shall be used with all patients regardless of diagnosis. Hand washing shall be carried out before and after</p>				

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	<p>contact with patients as well as after gloves have been removed...."</p> <p>The ADON, DON and Administrator were interviewed on 7/2/13 at 6:00 PM. The ADON indicated staff should wash their hands or change gloves in between contact with clients and infection control procedures had not been followed when staff failed to do so.</p> <p>Inservice records for the facility's Isolation procedures, and Universal Precautions were reviewed on 7/3/13 at 4:00 PM and indicated facility staff had been trained on the procedures on 7/2/13 and 7/3/13.</p> <p>Observations in the dining room were completed on 7/3/13 from 4:50 PM until 5:50 PM. Client C had a scab 1/8 inch in diameter above his right elbow on the back of his arm resting on the dining room table. The DON swabbed the scabbed area with alcohol and placed a Band-Aid on the area at 5:50 PM.</p> <p>The DON was interviewed on 7/3/13 at 5:55 PM regarding client C's scabbed area found on the back of his arm. She stated the wound was "definitely a scab," and indicated she was told client C "picks" his skin "quite a bit." She indicated the skin around the scabbed area was pink and</p>						

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	<p>granulated, and she would call client C's physician to see if he wanted the wound covered. She stated "ideally" the scabbed area should have been covered to be safe, and indicated universal precautions should be used with client C and his infection until he had been cleared by the doctor.</p> <p>The ADON was interviewed on 7/3/13 at 6:00 PM and indicated client C's contact isolation was discontinued as his wound was healed and he had completed his 8 day antibiotic.</p> <p>The DON was interviewed on 7/3/13 at 6:20 PM and indicated staff had not documented client C's scabbed area under his right arm above his elbow and it would be investigated as to why the documentation had not been completed.</p> <p>Observations were completed in program room 6 on 7/5/13 from 1:14 PM until 2:16 PM. Client C had 3 rash like pin point scabbed area above one wrist and a 2 inch area rash-like reddened area on the other wrist. Client D had 1 inch scabbed spot on his right knee uncovered as he lay and kneeled on the floor. Client D had a 1/8 inch scabbed area on his left hand, and a superficial red scratch 1 inch in length at the bottom of his right cheek, and a reddened scratch under the length of</p>			

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	<p>his right eye. Client K put his hands in his mouth leaving saliva on his hands and was not taken to wash his hands. There was no sanitizer dispenser in the room. Client K had 5 spots on his right calf and 2 spots on the back of his left calf. The spots were reddened and 1 inch in diameter. Staff #59 was uncertain of the origin of the spots. Staff #90 mopped up a clear liquid on the floor using light brown water at 1:34 PM. Client B laid on the floor with his cheek resting on the floor. Staff #32 had a gauze covering over the top of his left wrist. Staff #90 brought clear mop water at 1:40 PM and re-mopped the area he had previously mopped. Client D rolled on the floor and client B banged his head on the floor and had a reddened scab on his right knuckle, and a scratch behind his right ear. Client F pulled up his shirt exposing a surgical scar and a loose abdominal binder. Staff #32 assisted client F to the restroom to refasten his binder.</p> <p>Staff #90 was interviewed on 7/5/13 at 1:34 PM. When asked if the mop water was clean, he stated, "Relatively," and indicated he would mop it later with clean water.</p> <p>Staff #90 was interviewed again on 7/5/13 at 1:42 PM. When asked how often he changed the mop water, he indicated it</p>				

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	<p>was changed every 3 hours or after mopping half the hallway, and stated, "Every time I get urine up."</p> <p>Observations were completed at the facility on 7/8/13 from 12:08 PM until 1:15 PM. Client B placed his hands in his mouth and saliva remained on his hands when they were removed from his mouth at 12:08 PM. Cards, broken crayons and three pillows were on the floor in the program room. The pillows did not have covers and a white pillow had a brown stain 1 inch in diameter. All of the windows in the room were streaked with an opaque substance. At 12:30 PM, client D crawled across the floor with streaks of feces on his clothing, smeared on his hands, and he had a streak of feces on his lips. Feces was oozing from the back of his adult brief and there was a pen cap with feces smeared on it on the floor and a streak of feces on the chair where client F was sitting. Staff #55 put on gloves and spot cleaned the floor of the corner where client D was sitting with liquid from a spray bottle, and removed the chair cover smeared with feces. Clients F and B then laid on the floor in the area where client D crawled across the floor. Staff #55 touched client B with her hand on the skin of his arm to redirect him before removing her gloves or washing her hands. Staff #55 then used the same</p>						

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	<p>gloved hands to call the supervisor for more clothing for client D. Staff #55 then touched client B's forehead to redirect him from banging his head, and touched his forearm without removing her gloves or washing her hands. Staff #55 left the room at 1:10 PM with a bag of clothing. The floor was not mopped where client D had crawled with feces smeared pants during the observation.</p> <p>Staff #55 was interviewed on 7/8/13 at 12:15 PM. When asked how often client B washed his hands, she stated, "Every 20 to 25 minutes." She stated program materials are cleaned "daily."</p> <p>Staff #55 was interviewed on 7/8/13 at 12:20 PM. When asked about the opaque marks on the window, she indicated clients B, D and I would touch the windows after placing their hands in their mouth.</p> <p>Staff #55 was interviewed on 7/8/13 at 1:10 PM. She indicated she should not have touched client B with the gloves that had been used to clean up feces.</p> <p>Staff #44 was interviewed on 7/8/13 at 1:15 PM. He indicated the floor was not mopped when clients were in the room, and stated, "We try to mop it when they're all outside. They won't sit in one spot."</p>						

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	<p>The ADON, Administrator, DON, and Program Director were interviewed on 7/8/13 at 1:30 PM. When asked if staff had followed the facility's infection control procedures during the observation on 7/8/13, the administrator indicated staff should not have touched the phone or client B with her contaminated gloved hands unless it was an emergency or to redirect self injurious behavior, and indicated the floor should have been mopped. She indicated staff had been trained on the policy and procedures and stated, "It sounds like we need to do more."</p> <p>This federal tag relates to complaint #IN00131430.</p> <p>3.1-37(a)</p>				

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W000406	<p>483.470 PHYSICAL ENVIRONMENT The facility must ensure that specific physical environment requirements are met.</p> <p>Based on observation, record review, and interview, the Condition of Participation: Physical Environment, was not met as the facility failed to systematically provide and promote health and safety practices for Universal Precautions and infection control to prevent potential exposure to infections for 9 of 9 clients (clients A, B, C, D, E, G, H, I and J) who were isolated for MRSA (methicillin-resistant Staphylococcus aureus) infection and/or exposure, and for 2 additional clients (clients F and K).</p> <p>This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 7/2/13 at 4:37 PM. The Immediate Jeopardy began on 6/22/13 when the facility's system failed to protect clients A, B, C, and D by failing to develop and implement infection control procedures to prevent the spread of MRSA for clients who had identified medical and infection control needs. The facility failed to protect clients A, B, C, D, E, G, H, I and J from infection control related exposure. The facility's Administrator, Assistant Director of Nursing (ADON), Director of Nursing (DON), QIDP #1, and Activities</p>	W000406	Refer to W454Plus Addendum	08/11/2013			

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	<p>Director/Social Services Director were notified of the Immediate Jeopardy on 7/2/13 at 6:10 PM.</p> <p>The facility submitted a plan of action to remove the immediate jeopardy on 7/3/13. The plan indicated "The Inter-Dispensary (sic) Team has met, developed and in-serviced the staff on Isolation and Infection Control Precautions and Guidelines. This also includes a booklet of instruction for future isolation procedures to follow. I am referring to the future as our clients have all been returned to their activities of daily living (sic) their own sleeping areas. The isolation procedures were discontinued by the physician when all antibiotics were completed. In the future, should group isolation be deemed necessary, all residents will be provided with regulated foot space, equipment, sleeping quarters and hygiene areas as regulated through the number of clients required for isolation precautions. (1) Shower facilities will be provided for each client under the umbrella of isolation restrictions. Hygiene facilities will be contained within the isolation room or accessible through facility transfer policy as documented in the infection control protocol. (2) Clients housed within one room will be provided with at least 3 feet of private space as guided by State and Federal regulations for sleeping areas. All available staff have been in-serviced regarding isolation precautions, hand washing procedures, universal precautions, and instruction booklet when clients are deemed necessary for</p>				

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	<p>isolation....A booklet has been created for all staff to ensure that infection control and isolation precautions will be implemented, understood and followed should isolation measures be deemed necessary in the future. The booklet contains information regarding common isolation infections, isolation precaution policy, infection control policy, environmental sanitation procedures, sanitation checklist, dietary protocols, environmental cleaning of upholstered furniture and procedures for personal protection for both isolated individuals and their caretakers....The infection control program will be monitored on an ongoing basis. The nursing staff and Director of Nursing will review all potentially infectious conditions and/or incidents within the facility...."</p> <p>The facility's protocol Isolation Precautions (undated) was reviewed on 7/3/13 at 6:20 PM. The protocol indicated a physician or nurse "may institute isolation precautions to confine or contain any suspected infectious disease agent." The protocol indicated only staff trained in isolation precautions may enter the designated area for isolation and the isolation incorporates the Center for Disease Control (CDC)'s guidelines. "Isolation Guidelines for Disease Specific Isolation along with Standard Precautions shall be used as reference in establishing appropriate isolation measures." Standard precautions indicated "hand washing shall be carried out before and after contact with patients as well as after gloves have been removed. When</p>			

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	<p>hands come in contact with blood or body fluids, they shall be washed thoroughly with soap and water...Gloves shall be changed after contact with each patient and between procedures for the same patient."</p> <p>The facility's Isolation Room Cleaning Procedures (undated) were reviewed on 7/3/13 at 6:20 PM and indicated in part, floors would be mopped with a clean bucket of mop water and clean mop head containing disinfecting floor cleaner (Pine-Sol), and furniture would be cleaned with bleach water (hard surface), and soft furniture with Lysol spray (disinfectant).</p> <p>Inservice records for facility staff dated 7/2/13 and 7/3/13 were reviewed on 7/3/13 at 4:00 PM and indicated staff had been trained on the facility procedures for Isolation and Universal Precautions.</p> <p>The Director of Nursing was interviewed on 7/9/13 at 2:06 PM. She indicated there were no new infections and she was monitoring daily skin assessments of clients to ensure wounds received appropriate assessment and treatment.</p> <p>Observations were conducted at the facility on 7/9/13 from 2:15 PM until 2:35 PM. During the observation, there were no observed uncovered wounds for clients A, B, C, D, E, F, G, H, I, J, and K. The environment had no observable infection control violations and staff and clients used handwashing practices as needed. Staff #32</p>			

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	<p>used sanitizer and wipes to wipe client K's wet hands, then disposed of the wipes in a plastic bag. Staff #32 used sanitizer after assisting client K. Staff #81 and staff #32 had sanitizer available for use in a zippered pouch carried with them and unidentified staff used gloves when assisting client D to get up from the ground.</p> <p>The QIDP-D provided a copy of undated handwashing procedures and sanitation guidelines on 7/9/13 at 2:28 PM. She indicated the forms were located in the front of each program book and had been reviewed by staff.</p> <p>The handwashing guide and sanitation guidelines were reviewed on 7/9/13 at 2:40 PM. The handwashing procedure indicated staff were to use sanitizer or soap and water to wash their hands. The sanitation guidelines indicated program materials were to be washed after dropped on the floor or after each client's use, hard surface areas were to be cleaned with a solution of bleach water after each shift, and items should be cleaned each time they are soiled. "Program room floors should be cleaned any time there is a spill or contamination with human waste or fluids. The soiled area should be mopped using a clean mop head, water and bucket."</p> <p>Medical Treatment Follow Up Forms dated 7/8/13 and 7/9/13 were reviewed on 7/9/13 at 2:40 PM and indicated clients A, B, C, D, E, F, G, H, I, J, and K were monitored daily to assess for skin lesions.</p>						

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	<p>The Administrator, Program Director, QIDP-D (Qualified Intellectual Disabilities Professional Designee), Director of Nursing (DON), and Assistant Director of Nursing (ADON) were notified of the removal of the Immediate Jeopardy on 7/9/13 at 2:51 PM. Though the facility's corrective action removed the immediate jeopardy, the facility remained out of compliance at the Condition level because the facility needed to demonstrate ongoing implementation of the plan to implement effective infection control procedures to prevent the spread of infection to clients A, B, C, D, E, G, H, I, J, and K.</p> <p>Findings include:</p> <p>Please refer to W454. The facility failed for clients A, B, C, D, E, G, H, I, and J who were isolated for MRSA (methicillin-resistant Staphylococcus aureus) infection and/or exposure, and for 2 additional clients (clients F and K), to implement Universal Precautions, Nursing Policy and Procedure for MRSA and their Isolation Room Cleaning Procedures.</p> <p>This federal tag relates to complaint #IN00131430.</p> <p>3.1-18(l)</p>						

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W000454	<p>483.470(l)(1) INFECTION CONTROL</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, record review, and interview for 9 of 9 clients (clients A, B, C, D, E, G, H, I and J) isolated for MRSA (methicillin-resistant Staphylococcus aureus) infection and/or exposure, and for 2 additional clients (clients F and K), the facility failed to implement and follow Universal Precautions, Nursing Policy and Procedure for MRSA and their Isolation Room Cleaning Procedures.</p> <p>Findings include:</p> <p>Observations were completed in group 6 on 7/1/13 from 4:45 PM until 5:00 PM. A sign on the door indicated "Contact Isolation." Staff #32 and #58 wore gowns and gloves. The floor was wet near client D. Clients B, C, D, E, G, I, J sat in chairs. Client A sat on the floor. Client C had a discolored area one inch in diameter in the inside bend of his left elbow.</p> <p>The Assistant Director of Nursing (ADON) was interviewed on 7/1/13 at 5:25 PM. She indicated client B had been diagnosed with MRSA on 6/21/13. She stated, "Because the kids are in close contact, we kept them all together and treated them all prophylactically either the</p>	W000454	<p>W454 – All sanitation policies and protocols were reviewed as a measure to ensure that all aspects/efforts to maintain a safe and healthy environment is maintained. Housekeeping protocols have been modified to include daily documentation of sanitation efforts. A daily checklist was previously used to alert housekeeping personnel of items/tasks necessary for daily care. The checklist will now be utilized as a tool for documentation to ensure that daily processes are complete. Also, the checklist will be used as a reference tool for environmental supervisor for completion. The checklist also includes efforts for steam cleaning upholstered furniture and guidelines for identifying soiled items and its ultimate return to the program room after sanitation efforts have been completed. Additionally, Measures for cleaning isolation rooms were re-inserviced on 7-15-2013 for all staff. In an effort to ensure that responsible staff understand and commonly practice efforts of Universal Precautions/infection control, a booklet has been created to address the most commonly observed infections. The booklet contains information regarding</p>	08/11/2013

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	<p>same day or next day." She indicated client A had been isolated prior to that on 6/6/13 with a MRSA infection, and had been returned to the group after his follow up culture was negative for infection. She indicated he had been treated again prophylactically with antibiotics.</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 7/1/13 at 5:30 PM. A report dated 6/21/13 indicated client B had been sent to the ER (emergency room) for evaluation and possible treatment of a boil to the back of his left leg. A follow up report of 6/28/13 indicated the abscess/boil remained on client B's left calf and had been cultured and diagnosed with MRSA. The report indicated client B had been placed in isolation per physician's orders pending follow up culture to the abscess/boil on his left leg following completion of prescribed antibiotics. The report indicated nursing will continue to monitor client B's left calf area.</p> <p>A BDDS report dated 6/6/13 indicated client F had been taken to the hospital and admitted for an undetermined illness after he had projectile vomiting in the dining room, was shivering, pale, and with a blood sugar level of 475 and temperature of 96.8. Client F was diagnosed with a</p>		<p>common isolation infections, isolation precaution policies and protocols, environmental cleaning of upholstered furniture, sanitation of hard surfaces and procedures for personal protection for both isolated individuals and their caretakers. Staff has been re-trained in the art of proactive participation of Universal precautions and infection control practices. Staff has been re-trained regarding common practice for using gloves, hand sanitation and effective use of universal precautions. As a proactive measure and in an effort to maintain educational practice, infection control practice will be monitored on an ongoing basis through random audits. Additionally, all necessary data regarding the use of gloves, hand-washing, the use of alcohol-based sanitizers and sanitation procedures will be carried by all direct care staff during their interaction with clients. All necessary information will be contained on a 4x6, laminated card for easy access and sanitation purposes (Att. D). W454</p> <p>Addendum:</p> <p>As a proactive measure and in an effort to maintain educational practice, infection</p>				

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	<p>bowel obstruction and admitted to the intensive care unit for further testing and treatment. A follow up report dated 6/13/13 indicated client F underwent surgery for a ruptured appendix. A follow up report dated 6/17/13 indicated client F returned to the facility with an abdominal binder in place for closed surgery sites for an appendectomy and pneumothorax.</p> <p>Observations were completed in group 6 on 7/1/13 from 6:00 PM until 6:15 PM. At 6:01 PM, QIDP-D (Qualified Intellectual Disabilities Professional Designee) #2 pushed a vinyl upholstered chair out of the room covered in feces. She took a mop from a bucket with light brown water and mopped the floor. After mopping the floor with the mop, the water was a darker shade of brown. Clients A, B, C, D, E, G, I and J were in the room while the QIDP mopped the floor. Client B walked around on the wet floor wearing his pajamas.</p> <p>The QIDP-D #2 was interviewed on 7/1/13 at 6:10 PM. When asked about the chair, she indicated it would be cleaned by maintenance. She indicated the water was changed each shift and as needed, and stated, she had called for assistance and would change the water when staff arrived to help. She stated, "It's pretty gross." The QIDP had feces on the toe of</p>		<p>control practice will be monitored on an ongoing basis through random audits by the QIIP's and the DON. Additionally, all necessary data regarding the use of gloves, hand-washing, the use of alcohol-based sanitizers and sanitation procedures will be carried by all direct care staff during their interaction with clients. All necessary information will be contained on a 4x6, laminated card for easy access and sanitation purposes that floor supervisors will monitor for daily use.</p> <p>Housekeeping protocols have been modified to include daily documentation of sanitation efforts. A daily checklist was previously used to alert housekeeping personnel of items/tasks necessary for daily care. The checklist will now be utilized as a tool for documentation to ensure that daily processes are complete. Also, the checklist will be used</p>				

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	<p>her shoe. She indicated she would clean her shoe.</p> <p>Client A's record was reviewed on 7/2/13 at 11:25 AM. Client A's physician's orders indicated he had been given the following medications to treat skin lesions: Client A was seen by a dermatologist who diagnosed allergic dermatitis on 5/22/13 and prescribed Prednisone 10 mg (milligrams); day 1-6 tabs, day 2-5 tabs, day 3-4 tabs, day 4-3 tabs, day 5-2 tabs, day 6-1 tab. On 6/5/13 client A was prescribed Levaquin 500 mg, Trianiolone 0.1%. Other orders included on 5/31/13 Diflucan 150 mg give one time, on 6/7/13 "Client to be in isolation d/t (due to) wound with MERSA (sic) (left side with infection)," on 6/7/13, "d/c (discontinue) Levaquin. Begin Bactrim DS (sulfa based antibiotic) BID (twice daily) x (for) 10 D (days) for MRSA," "N.O. (new orders): #1 Diflucan 150 mg PO (by mouth) daily x 7 days for yeast to penis...#2 clotrimazole cream. Apply topically tid (three times daily) x 7 days for yeast to penis, and on 6/22/13 N.O. Bactrim DS bid x 10 days prophylactic exposure to MRSA. Client A's physician's orders for 6/1/13-6/30/13 indicated he was allergic to sulfa. Nurse #10's notes indicated client A's contact isolation was discontinued on 6/20/13, and client A's physician was contacted on</p>		<p>as a reference tool for environmental supervisor for completion. The checklist also includes efforts for steam cleaning upholstered furniture and guidelines for identifying soiled items and its ultimate return to the program room after sanitation efforts have been completed. The environmental supervisor will reflect review of the housekeeping checklist through his initials placed on the check list at least daily. Random review of items on the checklist will be completed by the environmental specialist to ensure that checked items have been properly sanitized.</p> <p>The Environmental Supervisor is responsible. The Program Director is responsible. The IDT will monitor.</p>				

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	<p>6/23/13 regarding client A's allergy to sulfa at 6:00 AM. On 6/23/13 at 12:00 PM a note indicated client A had no symptoms of reaction to Bactrim, "[Dr.] has not responded at this time."</p> <p>Client B's record was reviewed on 7/2/13 at 12:05 PM. Physician's orders indicated on 6/21/13 Keflex 500 mg daily and Bactrim DS twice daily, 7/1/13 culture calf boil site. Nurse #10's notes indicated on 6/21/13 a boil "oozing serosanguinous (sic) drainage" was noted with pain to touch on the back of client B's leg. No size or specific location on the back of client's leg was documented in the notes. On 6/22/13 a nursing note at 12:00 AM indicated a 4 cm (centimeters) reddened, circle area with 1 cm scab, warm to touch on client B's left calf, and a note on 6/22/13 at 12:00 PM indicated client B's physician had reported the lab results of the swab from client B's abscess is MRSA-"isolation continues."</p> <p>Client D's record was reviewed on 7/2/13 at 12:55 PM. Client D's physician's orders indicated on 6/22/13 he was prescribed Erythromycin 333 mg three times daily for 10 days for boils to underarm and back. New orders dated 6/18/13 indicated Bactroban ointment to right arm twice daily and cover with a Band-Aid, and on 6/28/13 to discontinue</p>				

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	<p>the Erythromycin and start Levaquin 500 mg daily for 10 days for boils, and a Listerine swab for inside of left cheek for blister twice daily for 14 days. Client D's nursing notes indicated the following entries: on 6/27/13 at 6:00 AM, "[client D] continues Erythromycin/Boils-R (right arm), client continually...scratching areas...", on 6/28/13 at 7:45 AM, "Spoke with [Dr.] RE: (regarding) Erythromycin/Boils to R arm-back-not improving with this therapy." The note indicated client D's physician had discontinued the Erythromycin and to begin Levaquin. On 7/1/13 at 6:00 AM there was an entry at 6:00 AM "Boils to R arm continues to 2 cm open c (with) slight serous (watery) drainage. On 7/2/13 an entry indicated a 2 cm boil to the R arm and shoulder 2 cm in diameter. Nursing notes entries dated 6/18/13 to 6/26/13 did not indicate the size of client D's boils to his back and underarm. There was no evidence of client D's boil or blister having been cultured as to type of infection.</p> <p>Client C's record was reviewed on 7/2/13 at 1:30 PM. Client C's nursing notes indicated the following entries: on 6/24/13 at 3:40 PM, client C returned to the facility from the hospital with a picc (peripherally inserted central catheter) line "above R arm is hot, pink,...tender to</p>						

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	touch. The entry indicated client C's doctor would be called regarding "possibly infected picc line." On 6/24/13 at 7:45 PM an entry indicated a call was placed to client C's doctor regarding a "possible infection to picc line site." New orders were given for Augmentin XR 1000 mg twice daily for 8 days. An entry on 6/24/13 at 10:00 PM indicated the picc line site was "red, warm to touch with swelling." On 6/25/13 at 9:30 AM client C's physician was contacted regarding possible infection and a need for removal of the picc line. Nursing notes on 6/25/13 at 1:30 PM indicated client C was sent to a medical facility to remove the picc line, and at 10:00 PM, the area was slightly red, warm to touch, and client C was showing signs and symptoms of pain. Entries on 6/26/13 indicated client C's picc line sight remained red and painful to touch. On 6/27/13 at 5:15 PM, "R arm remains swollen, tender to touch. Client to go for labs (laboratory tests) in the AM." On 6/28/13 at 1:00 AM, an entry indicated client C "had better ability to move his med cup to his mouth with ease as compared to yesterday evening." On 6/28/13, an entry indicated client C went to see his physician and "R picc line site culture." On 6/30/13, a note indicated client C was diagnosed with MRSA by his physician. A note dated 7/1/13				

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	<p>indicated client C continued augmentin XR for infection to picc line site with MRSA, and R arm had edema, tender to touch. There was no evidence in the entries of the size of client C's redness and edema of the infection to his picc line.</p> <p>Client F's record was reviewed on 7/2/13 at 2:10 PM. A nursing note dated 6/23/13 at 10:00 AM indicated client F's incision site was "pink @ (at) staple site with pustules...purulent drainage." A note dated 6/23/13 at 12:30 PM indicated client F's doctor prescribed Bactrim DS twice daily for infection. A note dated 6/26/13 indicated "spoke with [Dr.]...ask about exposure to MRSA (sic) states 'almost everybody has MRSA and didn't think that it would be a problem.'" The doctor instructed to cover client F's abdominal incision with tape and leave his chest uncovered.</p> <p>The ADON was interviewed on 7/2/13 at 2:26 PM and indicated client A's doctor had responded to the concern about client A's allergy to sulfa and his taking Bactrim, but the response was not recorded. She indicated client A's physician was not concerned about client A's allergy as the sulfa content of the Bactrim was a minimal amount and the effectiveness of the medication</p>				

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	<p>outweighed potential side effects.</p> <p>Observations were completed in program room 6 on 7/2/13 from 1:20 PM until 1:30 PM with the ADON (assistant director of nursing). Client D had a 1 inch round open area of skin on his left shoulder. The ADON stated, "I bet you are ready for a shower." The attached bathroom had a toilet, but no shower. Client A had more than 3 raised red areas on his legs, 1/8 of an inch in diameter.</p> <p>The ADON was interviewed on 7/2/13 at 1:25 PM. She stated the clients in room 6 were bathed in the attached bathroom as a "bedside bath" and slept on the floor on mattresses. She stated "It looked like camp." She indicated client A was having additional allergy testing completed and client A had frequent rashes. She indicated client A had a rash before developing a boil with MRSA infection, and client C had returned from the hospital on 6/24/13 with a picc line that appeared to be infected. She indicated client C had been diagnosed with MRSA on 6/29/13. She indicated client F had lived in group 6 until his admission to the hospital, and when he was discharged back to the facility, had been assigned to another area. She indicated client D had ingested chocolate which caused him to itch.</p>						

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	<p>The maintenance, housekeeping and laundry supervisor was interviewed on 7/2/13 at 2:05 PM. He indicated there was a checklist used for a guideline for cleaning program room 6, but it was not documented when the room was cleaned each night. He indicated the upholstered chair had been taken outside and the upholstery cleaned with disinfectant. He indicated the clients' beds had been cleaned and were now back on the clients' bedrooms. He indicated the facility used Pine-Sol cleaner as a disinfectant. He indicated the mop water should have been clean when used to mop the floor clean up the feces in room 6, but indicated it was his understanding staff was cleaning a toileting accident.</p> <p>The facility's Isolation Room Cleaning Procedures (undated) were reviewed on 7/2/13 at 2:08 PM. The document indicated for the bathroom "clean toilet with porcelain shower cleaner poured into a Johnny mop, working downwards to the bottom of the toilet, clean outside the toilet, lid, and the tank with hard surface cleaner and dry. Sink cleaner with hard surface cleaner sprayed on a cloth, sweep and mop floor with floor cleaner (clean mop water and mop head using a floor disinfecting cleaner)." For Bedrooms, "wash beds with bleach water and air dry,</p>						

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	<p>mattress to be washed in bleach water from a bucket- 1 oz. (ounce) bleach to 1 gallon of water. Sweep and mop the floors with a clean bucket of mop water and a clean mop head containing disinfecting floor cleaner...."</p> <p>QIDP-D #2 was interviewed on 7/2/13 at 2:44 PM. She stated the chair had been removed from the hallway and the floor had been re-mopped "shortly after you left (on 7/1/13)," because the floor "was still smelly." When asked about clients in program room 6, she indicated clients B and D had open wounds and client A had a healed wound. She did not indicate client C had a wound or had been diagnosed with MRSA.</p> <p>Observations were completed in group 6 on 7/2/13 from 3:00 PM until 3:30 PM. Staff #25 and #81 did not have a gown on, but wore gloves. There was a dispenser of sanitizing solution outside the door to room 6. The water in the sink did not work when the faucets were turned on. Client E picked up a scrap of paper 1 inch in diameter by 1/4 inch in diameter from the floor and ate it.</p> <p>Staff #25 was interviewed on 7/2/13 at 3:05 PM and indicated they were not wearing gowns because it was hot in the room. He stated, "He believed" client D</p>						

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	<p>had MRSA, but was uncertain, and client B had MRSA on his legs. He was uncertain of anyone else in the program room 6 who had MRSA.</p> <p>Staff #25 was interviewed on 7/2/13 at 3:10 PM and indicated client F had previously been assigned to program room 6 and would eat the sanitizer. When asked how staff wash their hands, he indicated there was a sink in the bathroom area. He indicated the water had been turned off because client D had been in the bathroom earlier that day for a dressing change by the nurse and he would drink the water. He indicated client D was to have his liquids thickened. When asked about client E eating the paper, he indicated client E would eat paper occasionally.</p> <p>Client C's chest area was observed on 7/2/13 at 3:15 PM with QIDP #2. Client C had a G (gastrostomy) tube placed in his abdomen with a small amount of clear fluid leaking out of the stoma area. He had more than 3 red raised spots on his chest.</p> <p>The QIDP-D #2 was interviewed on 7/2/13 at 3:15 PM and indicated client C received a topical acne treatment for the spots.</p>						

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	<p>Observations were completed in program room 6 on 7/2/13 from 4:25 PM until 4:55 PM. Staff #81 fed client H pureed food using gloves, then touched client J on the back without washing his hands or changing gloves. Staff #81 then wiped client B's mouth with client B's clothing protector. Staff #81 placed the clothing protector in a plastic bag without changing gloves or washing his hands after handling the soiled clothing protector. Client B took a piece of food from client I's plate and ate it. Staff #81 took the food from client I's mouth and then touched client H's skin without washing his hands or changing gloves. Client C removed his clothing protector and handed it to staff #81 who placed it in a laundry bag. Staff #81 did not wash his hands or change gloves after handling the soiled clothing protector. Client D sat on a cloth upholstered chair wearing an incontinence brief and jeans that had slipped down to his thigh area causing client D's bare buttocks to sit on the chair. When client D's bare buttocks were pointed out, staff #25 indicated he would pull client D's pants up after he was finished eating. Staff #25 and #81 did not remove the chair after client D sat on the floor after he finished eating. Staff #81 placed client A's fork back on his tray after it had laid on the table without washing his hands or changing gloves.</p>			

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	<p>Client E sat on the same upholstered chair that had been covered in feces on 7/1/13. The corner of the vinyl upholstery was worn on the right edge, exposing the fabric backing. Clients G, J, and E sat in chairs or walked around the room while clients A, B, C, D, and I ate their dinner. Clients A, B, C, or H and I were not assisted to wash their hands after eating. Staff #25 assisted client D to the bathroom to wash his hands, and indicated he was assist all the clients in the room to wash their hands after he finished assisting client D.</p> <p>Staff #81 was interviewed on 7/2/13 at 4:44 PM. When asked when he was to change gloves, he stated, "After an event," and "in between clients. I only fed one client and haven't changed them (gloves)."</p> <p>The maintenance supervisor was interviewed on 7/2/13 at 5:55 PM and indicated room 6 where clients A, B, C, D, E, G, H, I and J had been isolated had 560 square feet with an attached bathroom of 64 square feet. He indicated the room was cleaned nightly using Pine-Sol cleaner and bleach with clients staying in the room. He indicated the clients had vacated the room on 7/1/13 in the morning, so the room could be cleaned. He indicated the upholstered</p>						

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	<p>chair had been cleaned with a Rug Doctor carpet cleaner with upholstery attachment and sanitized before being placed back into room 6. When asked about the tear in the upholstery, he indicated the cleaner would sanitize the area.</p> <p>The facility's policy Arcadia Developmental Center Nursing Policy and Procedure MRSA dated 12/3/02 was reviewed on 7/2/13 at 5:40 PM and indicated "Patient placement-Place the patient in a private room, if possible. When a private room is not available, place the patient in a room with a patient who is colonized or infected with the same organism, but does not have any other infection (cohorting). Another option is to place an infected patient with a patient who does not have risk factors for infection...Infected or colonized patients should be permitted to participate in group meals and activities if draining wounds are covered, bodily fluids are contained, and the patients observe good hygienic practices...Caregivers should wash their hands with soap and water after physical contact with the infected or colonized person and before leaving the facility...In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, single-use, non-sterile gloves are adequate) when providing direct patient care or handling items</p>						

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	<p>potentially contaminated by the patient or on Contact Precautions...During the course of providing care for the patient, change gloves after having contact with infected material that may contain high concentrations of microorganisms (e.g., fecal material and wound drainage). " Standard precautions included "all patients blood and body fluids are considered contaminated. Standard Precautions shall be used with all patients regardless of diagnosis. Hand washing shall be carried out before and after contact with patients as well as after gloves have been removed...."</p> <p>The ADON, DON and Administrator were interviewed on 7/2/13 at 6:00 PM. The ADON indicated staff should wash their hands or change gloves in between contact with clients and infection control procedures had not been followed when staff failed to do so. They indicated all clients were removed from the contact isolation as of 4:00 PM. The ADON indicated the clients had been isolated to prevent the spread of infection to other clients living in the facility as they had been exposed to MRSA and stated, "It was our decision," and indicated the clients' physicians' had not ordered the contact isolation for clients A, D, E, G, H, I, and J.</p>			

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	<p>Observations in the dining room were completed on 7/3/13 from 4:50 PM until 5:50 PM. Client C had a scab 1/8 inch in diameter above his right elbow on the back of his arm resting on the dining room table. The DON swabbed the scabbed area with alcohol and placed a Band-Aid on the area at 5:50 PM.</p> <p>The DON was interviewed on 7/3/13 at 5:55 PM regarding client C's scabbed area found on the back of his arm. She stated the wound was "definitely a scab," and indicated she was told client C "picks" his skin "quite a bit." She indicated the skin around the scabbed area was pink and granulated, and she would call client C's physician to see if he wanted the wound covered. She stated "ideally" the scabbed area should have been covered to be safe, and indicated universal precautions should be used with client C and his infection until he had been cleared by the doctor.</p> <p>The ADON was interviewed on 7/3/13 at 6:00 PM and indicated client C's contact isolation was discontinued as his wound was healed and he had completed his 8 day antibiotic.</p> <p>Observations were completed in program room 6 on 7/5/13 from 1:14 PM until 2:16 PM. Client C had 3 rash like pin</p>			

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	<p>point scabbed areas above one wrist and a 2 inch area rash-like reddened area on the other wrist. Client D had 1 inch scabbed spot on his right knee uncovered as he lay and kneeled on the floor. Client D had a 1/8 inch scabbed area on his left hand, and a superficial red scratch 1 inch in length at the bottom of his right cheek, and a reddened scratch under the length of his right eye. Client K put his hands in his mouth leaving saliva on his hands and was not taken to wash his hands. There was no sanitizer dispenser in the room. Client K had 5 spots on his right calf and 2 spots on the back of his left calf. The spots were reddened and 1 inch in diameter. Staff #59 was uncertain of the origin of the spots. Staff #90 mopped up a clear liquid on the floor using light brown water at 1:34 PM. Client B laid on the floor with his cheek resting on the floor. Staff #32 had a gauze covering over the top of his left wrist. Staff #90 brought clear mop water at 1:40 PM and re-mopped the area he had previously mopped. Client D rolled on the floor and client B banged his head on the floor and had a reddened scab on his right knuckle, and a scratch behind his right ear. Client F pulled up his shirt exposing a surgical scar and a loose abdominal binder. Staff #32 assisted client F to the restroom to refasten his binder.</p>			

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	<p>Staff #90 was interviewed on 7/5/13 at 1:34 PM. When asked if the mop water was clean, he stated, "Relatively," and indicated he would mop it later with clean water.</p> <p>Staff #90 was interviewed again on 7/5/13 at 1:42 PM. When asked how often he changed the mop water, he indicated it was changed every 3 hours or after mopping half the hallway, and stated, "Every time I get urine up."</p> <p>Staff #32 was interviewed on 7/5/13 at 1:46 PM and indicated he had been diagnosed with a boil by his physician, given an antibiotic and the boil was lanced on 6/28/13. He indicated the boil had not been cultured to determine the type of infection due to the expense. He indicated he had last worked in program room 6 on 6/15/13 and was aware of the clients having been diagnosed with MRSA.</p> <p>Staff #89 was interviewed on 7/5/13 at 2:00 PM and indicated he had spoken with nursing regarding client K's spots and was told the nurse would check the spots during med pass at 3:00 PM.</p> <p>LPN #6 was interviewed on 7/5/13 at 2:16 PM and indicated client J was being monitored with a skin assessment for</p>						

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	<p>spots found on the back of his leg.</p> <p>Laboratory testing results for client D dated 7/3/13 were reviewed on 7/5/13 at 2:20 PM and indicated there was no wound organisms or white blood cells found.</p> <p>Laboratory testing results for client F dated 7/3/13 were reviewed on 7/5/13 at 2:20 PM and indicated there was "rare gram positive organism and scant beta hemolytic organism (type of infection), identification to follow."</p> <p>Laboratory testing results for client B dated 7/3/13 were reviewed on 7/5/13 at 2:20 PM and indicated "rare white blood cells, rare gram positive cocci in pairs (type of infection), heavy gram positive organisms (type of infection), isolation and identification to follow."</p> <p>The DON was interviewed on 7/5/13 at 2:40 PM and indicated client F's wound was to be covered per physician's orders until the final results were received.</p> <p>The DON was interviewed on 7/5/13 at 3:05 PM and indicated there was not ongoing documentation of clients C, D, E, G, H, I, and K for skin lesions after the skin assessments had been completed on 7/3/13 and clients had been removed from</p>						

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	<p>contact isolation.</p> <p>Skin assessments for clients A, B, C, D, E, G, H, I, J, and K dated 7/3/13 were reviewed on 7/5/13 at 3:42 PM. The assessments indicated clients C, G, H, and J did not have boils or skin irritation. Client A's assessment indicated there was a flow sheet monitoring in progress for "allergy flare up" and "waiting on labs test and dermatology appointment." Client B's assessment indicated a circle on his left calf indicating a reduced area on calf. Client I's assessment indicated there was a flow sheet in progress for monitoring a scabbed area on client I's lip (area not defined).</p> <p>Final laboratory testing results for client B dated 7/5/13 were reviewed on 7/8/13 at 12:00 PM. The culture wound indicated "heavy staphylococcus species, coagulase (protein enzyme) negative, two colony morphologies, no further workup indicated." A notation dated 7/6/13 indicated client B's doctor had been notified with no treatment needed.</p> <p>Final laboratory testing results for client D dated 7/5/13 were reviewed on 7/8/13 at 12:00 PM. The culture wound indicated, rare normal skin flora isolated. A notation dated 7/6/13 indicated client B's doctor had been notified with no</p>						

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	<p>treatment needed.</p> <p>Final laboratory testing results for client F dated 7/5/13 were reviewed on 7/8/13 at 12:00 PM. The culture wound indicated MRSA, rare staphylococcus species, coagulase negative, no further workup needed, rare dipheroid (shape of bacteria) bacilli, no further workup needed. A notation dated 7/6/13 at 11:50 AM indicated continue Bactrim DS BID twice daily, cover with pad and abdominal binder, "no isolation indicated."</p> <p>Observations were completed at the facility on 7/8/13 from 12:08 PM until 1:15 PM. Client B placed his hands in his mouth and saliva remained on his hands when they were removed from his mouth at 12:08 PM. Cards, broken crayons and three pillows were on the floor in the program room. The pillows did not have covers and a white pillow had a brown stain 1 inch in diameter. All of the windows in the room were streaked with an opaque substance. At 12:30 PM, client D crawled across the floor with streaks of feces on his clothing, smeared on his hands, and he had a streak of feces on his lips. Feces was oozing from the back of his adult brief and there was a pen cap with feces smeared on it on the floor and a streak of feces on the chair where client F was sitting. Staff #55 put on gloves and</p>						

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	<p>spot cleaned the floor of the corner where client D was sitting with liquid from a spray bottle, and removed the chair cover smeared with feces. Clients F and B then laid on the floor in the area where client D crawled across the floor. Staff #55 touched client B with her hand on the skin of his arm to redirect him before removing her gloves or washing her hands. Staff #55 then used the same gloved hands to call the supervisor for more clothing for client D. Staff #55 touched client B's forehead to redirect him from banging his head, and touched his forearm without removing her gloves or washing her hands. Staff #55 left the room at 1:10 PM with a bag of clothing. The floor was not mopped where client D had crawled with feces smeared pants during the observation. Client B did not wash his hands during the observation.</p> <p>Staff #55 was interviewed on 7/8/13 at 12:15 PM. When asked how often client B washed his hands, she stated, "Every 20 to 25 minutes." She stated program materials are cleaned "daily."</p> <p>Staff #55 was interviewed on 7/8/13 at 12:20 PM. When asked about the opaque marks on the window, she indicated clients B, D and I would touch the windows after placing their hands in their mouth.</p>						

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	<p>Staff #55 was interviewed on 7/8/13 at 1:10 PM. She indicated she should not have touched client B with the gloves that had been used to clean up feces.</p> <p>Staff #44 was interviewed on 7/8/13 at 1:15 PM. He indicated the floor was not mopped when clients were in the room, and stated, "We try to mop it when they're all outside. They won't sit in one spot."</p> <p>The ADON, Administrator, DON, and Program Director were interviewed on 7/8/13 at 1:30 PM. When asked if staff had followed the facility's infection control procedures during the observation on 7/8/13, the administrator indicated staff should not have touched the phone or client B with her contaminated gloved hands unless it was an emergency or to redirect self injurious behavior, and indicated the floor should have been mopped. She indicated staff had been trained on the policy and procedures and stated, "It sounds like we need to do more." She indicated it was not necessary to ensure client D took a shower after a toileting accident involving feces if staff were able to clean client D sufficiently.</p> <p>This federal tag relates to complaint #IN00131430.</p>				

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