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| 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 08/23/2013 |
| NAME OF PROVIDER OR SUPPLIER ARCADIA DEVELOPMENTAL CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 303 FRANKLIN ARCADIA, IN 46030 | | |
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| W000000 | <p>This visit was for the post certification revisit to the investigation of complaint #IN00131430 completed on July 12, 2013.</p> <p>Complaint #IN00131430: Not Corrected.</p> <p>Dates of Survey: August 21, 22, and 23, 2013.</p> <p>Facility number: 000730 Provider number: 15G580 AIM number: 100272190</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 9/4/13 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.</p> <p>_____ Be verly Sayre Cowart</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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| 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 were implemented to promote health and safety practices for Universal Precautions and infection control measures were implemented to prevent infections for 6 of 6 sampled clients (clients A, B, C, D, E, and F) and for 6 additional clients (G, H, I, J, K, and L).</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/21/13 at 6:00 PM. Reports dated 8/19/13 indicated clients A, B, C, and J would receive prophylactic treatment for scabies as a "possible exposure to scabies." The report indicated facility infection control policy, related to contact isolation was implemented and "staff education measures had been reviewed."</p> <p>The Administrator was interviewed on 8/21/13 at 5:10 PM and indicated all clients at the facility were treated for</p> | W000104 | <p>W104 Policy measures related to contact precautions, specifically contact precautions for potential scabies, was conducted prior to implementation of facility protocol to reduce the risk of potential widespread transmission. Random audits were not conducted for contact precautions related to scabies, as audits for this intervention was unnecessary. After the potential for scabies was identified; prophylactic treatment was completed for all clients, environmental cleaning was conducted and sanitation methods were completed, random audits were not required. All contact precautions related to prophylactic treatment for scabies was completed within 24 hours. However, random audits related to general policy for universal precautions and infection control measures related to contact precautions, continues to be conducted on an ongoing basis. Random audits related to general policy for universal precautions and infection control measures have been documented and are completed on an ongoing basis as a proactive measure. Completed random audit forms were and are available for review. The facility previously</p> | 09/22/2013 | | | |

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| | <p>scabies on 8/20/13, and the environment of the facility had been cleaned including all rooms, bedding and linens.</p> <p>The Director of Nursing (DON) was interviewed on 8/21/13 at 5:55 PM and indicated suspicious areas on clients A, B, C, and J skin were found and the clients' primary care physician had examined them and ordered prophylactic treatment for scabies while skin scrapings were being analyzed for diagnosis. She indicated the facility had treated all of the clients in the facility to ensure no further spread of the suspected scabies had occurred on 8/20/13.</p> <p>The Administrator and the DON were interviewed on 8/21/13 at 5:45 PM and indicated random audits were completed by administrative and nursing staff to ensure staff adhered to Universal Precautions.</p> <p>Observations were completed in program group 6 on 8/21/13 from 6:40 PM until 7:10 PM. Client K was taken to the rest room by staff #36 at 6:55 PM to change into pajamas. The upholstered chair client K was sitting in had a wet stain 1 and 1/2 foot by 1/2 foot. The QIDP-D #62 (Qualified Intellectual Disabilities Professional Designee) was present in the room while client K was changing his</p> | | <p>used three separate audit forms as assessment tools for universal precautions and infection control measures: 1) Hand washing, 2) Dining room and 3) Sanitary control measures audit sheets. These audit forms have been modified in an effort to take a holistic approach as a proactive measure to ensure efforts of common practice for infection control are understood and implemented. Ongoing audits and education related to universal precautions continues to be conducted. In an effort to increase proactive participation, audit sheets have been modified to include open use of communication/information exchange among/between staff members (Att. A). While survey observations revealed a potential issue with cleaning a chair after a client accident, it was determined that the issue was not related to lack of knowledge for universal precautions. This noted oversight was determined to be more related to staff's lack of recognition for appropriate communication between/among related staff members involved. Additionally, information regarding appropriate cleaning methods for the soiled chair was correctly communicated to the surveyor. The chair the client had been seated in was a urine resistant chair. Specs for the chair were provided to the surveyor at the time of inquiry as supporting</p> | | | | |

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| | <p>clothing, but did not look toward the chair seat. When client K returned from the restroom, at 7:00 PM, he walked toward the chair. Clients A, B, C, D, E, F, G, H, I and J had access to the chair while client K was in the restroom. The surveyor notified the QIDP-D #62 of the wet stain before client K sat in the wet chair. The QIDP-D #62 immediately removed the chair to the hallway, and staff #36 then walked out of the room to obtain a sheet to place over the chair.</p> <p>Staff #36 was interviewed on 8/21/13 at 7:05 PM. He indicated he had noticed client K was wet with urine as he assisted him in changing into his pajamas. He indicated he should have assessed the chair after he realized client K was wet and removed it from the room. He stated the chair would be steam cleaned by maintenance or cleaned with alcohol by him "if I get time."</p> <p>The Administrator was interviewed on 8/21/13 at 7:10 PM and indicated there should have been a better communication process between staff #36 and the QIDP-D #62 to remove the chair when it was wet. She indicated the facility had purchased urine resistant chairs and indicated if the chair was one of those purchased, it could be cleaned with alcohol. She indicated she would provide</p> | | <p>documentation. As a result, staff communicated the appropriate information that the soiled chair could have been wiped clean with alcohol. The facility sanitation policy, regarding mopping and sanitation methods, has been modified. Committee reviewed noted that in the future, areas of saliva, drool or food matter measuring half dollar in size or less, may be sanitized using alcohol or an alcohol wipe. Mopping in this instance would not be required (Att. B). For client J and all other clients, hand washing techniques for staff and clients has been reviewed. For clients, such as Client J who experience increased episodes of hand-mouthing, staff may employ the use of alcohol-based wipes to assist the client with sanitizing his hands initially. Use of alcohol-based hand sanitizer may then be used, up to 5 times, to reduce the potential for spread of infection. Staff will continue to be provided education in the art of proactive recognition and participation for implementation of general policy for universal precautions and infection control practices. As a proactive measure and in an effort to maintain educational practices, universal control/infection control measures/practices will be monitored through random audits and small group education. Completed audit sheets will be reviewed by the DON and the</p> | | | | |

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| | <p>the cleaning and maintenance procedure information.</p> <p>During observation on 8/22/13 from 2:20 PM until 3:20 PM in program group 6, client J placed his hands in his mouth more than 10 times and his hands were wet with saliva. At 2:45 PM, client J was fed a snack of softened cookie by staff #55. At 2:50 PM, client J had a rim of cookie material around his mouth which fell to his shirt and stuck to it. Client J placed his hands in the back of his mouth and out again until at 3:00 PM, saliva and cookie matter dripped from his hands. At 3:02 PM, cookie and saliva dripped from his hands in 1/8 inch droplets on the floor next to where client L was sitting in a chair, and clients H and I were laying on the floor. At 3:05 PM, client J was taken to the restroom by staff #36 to wash his hands by staff #36. No other staff was present in the common area of the room. At 3:06 PM, clients B, G, I, and D walked around the room. At 3:10 PM, client B walked toward a one inch in diameter spot of cookie and saliva matter on the floor as the QIDP-D #62 walked into the room. The surveyor pointed out the cookie matter on the floor to the QIDP and she used the telephone to call for a mop. At 3:10 PM, the nurse walked through the room to give client C his medicine as he sat on a mat at the opposite corner of the</p> | | <p>Program Director to ensure thoroughness and identify any possible trends. Additionally, all necessary data regarding the use and practice of hand sanitation, the use of alcohol-based sanitizers, implementation of the newly modified floor sanitation protocols and the use of alcohol-based sanitation wipes for sanitation of saliva, drool or food matter will be carried by all staff during their interaction with clients. All necessary information will be contained on a 4x6 laminated card for easy access and sanitation purposes. All floor staff will be re-trained regarding common practice for mopping/sanitizing floors, hand sanitation and effective use of universal precautions. Audit sheets have also been modified to include hand-sanitation methods and methodologies necessary for environmental sanitation. 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. Ongoing training will be provided by the DON and/or the Program Director, or their designee, in an effort to maintain awareness and implementation of facility</p> | | | | |

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| | <p>room. The QIDP-D #62 notified the nurse of the saliva and cookie matter on the floor and she walked around the spot. Client B walked on the spot with his shoes as he walked through the room, and client J also walked through the spot after returning from the restroom. Staff #33 walked through the spot when he entered the room at 3:14 PM. At 3:16 PM, staff #36 brought a bucket of opaque tan mop water and mopped the floor.</p> <p>Staff #36 was interviewed on 8/22/13 at 3:16 PM and indicated he had retrieved the mop water from Housekeeping staff #6.</p> <p>Staff #6 was interviewed on 8/22/13 at 3:25 PM, and indicated the mop water given to staff #36 was clean and had been prepared by him. When asked to demonstrate how the mop water was prepared, he pulled a mop bucket with clear water and an opaque tan substance floating in it and indicated the floating substance was Pine Sol cleaner. When asked to compare the mop water with that given to staff #36, he stated, "Sometimes the water turns color when the mop sits in it for awhile." Staff #6 indicated the buckets were cleaned on weekends and after each bucket of water had been used.</p> <p>The DON was interviewed on 8/21/13 at</p> | | <p>policy. Complete Dote as of 9-22-13 and On going</p> | | | | |

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| | <p>5:40 PM and indicated staff had been reminded to use standard precautions when interacting with clients and had used gowns and gloves with the clients for any contact until clients had been treated for scabies on 8/21/13. She indicated contact precautions were no longer necessary since clients had been treated for scabies.</p> <p>Training records and materials for the facility's Infection Control policy dated 10/14/08 were reviewed on 8/23/13 at 3:45 PM. The records indicated staff #36 had been trained on the following policies on 8/20/13. The policy indicated "Employees will adhere to the CDC (Centers for Disease Control) guidelines for hand hygiene in health care settings...The housekeeping employees with ensure all areas of the facility are clean and appropriately disinfected." Arcadia Sanitation Guidelines (undated) indicated "Program room floors should be cleaned any time there is a spill or contamination with human waste or fluids. The soiled area should be cleaned using a clean mop head, water and bucket. After mopping the area change the mop head, water and bucket and mop the area again...."</p> <p>The Administrator was interviewed on 8/22/13 at 3:35 PM and indicated client</p> | | | | | | |

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| | <p>J's hands should have been washed when soiled.</p> <p>The Administrator was interviewed on 8/23/13 on 3:09 PM. She indicated per policy the floor should have been mopped twice in program room 6 when client J's saliva and cookie matter fell on the floor.</p> <p>The facility's administrative staff audits for staff adherence to infection control procedures were reviewed on 8/21/13 at 5:50 PM. Audits were completed on 7/30/13 in program group 6 and in the dining room on 8/7/13.</p> <p>Additional infection control procedure audits completed by administrative staff were reviewed on 8/22/13 at 6:15 PM and indicated dining room audits on 8/7/13, 8/8/13 and 8/9/13. There were no additional audits to review to indicate administrative or nursing staff had audited staff working in program room 6 to ensure adherence to infection control procedures.</p> <p>Maintaining a Sanitary Environment audits were reviewed on 8/23/13 at 2:43 PM and indicated the following: on 8/7/13, 8/9/13, and 8/17/13 by QIDP-D #64 indicated the environment had been cleaned. There were no additional audits provided to indicate staff in program</p> | | | | | | |

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| | <p>group 6 had been audited by administrative or nursing staff for their adherence to infection control procedures including hand washing.</p> <p>This deficiency was cited on 7/12/13. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>3.1-13(a) 3.1-13(r)</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. Based on observation, record review, and interview for 6 of 6 sampled clients (clients A, B, C, D, E, and F) and for 6 additional clients (G, H, I, J, K, and L), the facility failed to ensure staff implemented training to follow Universal Precautions and promote hand washing to prevent the spread of infection.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/21/13 at 6:00 PM. Reports dated 8/19/13 indicated clients A, B, C, and J would receive prophylactic treatment for scabies as a "possible exposure to scabies." The report indicated facility infection control policy, related to contact isolation was implemented and "staff education measures had been reviewed."</p> <p>The Director of Nursing (DON) was interviewed on 8/21/13 at 5:55 PM and indicated suspicious areas on clients A, B, C, and J skin were found and the client's</p> | W000340 | W340 Policy measures related to contact precautions, specifically contact precautions for potential scabies, was conducted prior to implementation of facility protocol to reduce the risk of potential widespread transmission. Random audits were not conducted for contact precautions related to scabies, as audits for this intervention was unnecessary. After the potential for scabies was identified; prophylactic treatment was completed for all clients, environmental cleaning was conducted and sanitation methods were completed, random audits were not required. All contact precautions related to prophylactic treatment for scabies was completed within 24 hours. However, random audits related to general policy for universal precautions and infection control measures related to contact precautions, continues to be conducted on an ongoing basis. Random audits related to general policy for universal precautions and infection control measures have been documented and are completed on an ongoing basis as a proactive measure. | 09/22/2013 | | | |

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| | <p>primary care physician had examined them and ordered prophylactic treatment for scabies while skin scrapings were being analyzed for diagnosis. She indicated the facility had treated all of the clients in the facility to ensure no further spread of the suspected scabies had occurred on 8/20/13.</p> <p>Observations were completed in group 6 on 8/21/13 from 6:40 PM until 7:10 PM. Client K was taken to the rest room by staff #36 at 6:55 PM to change into pajamas. The upholstered chair client K was sitting in had a wet stain 1 and 1/2 foot by 1/2 foot. The QIDP-D #62 (Qualified Intellectual Disabilities Professional Designee) was present in the room while client K was changing his clothing, but did not look toward the chair seat. When client K returned from the restroom, at 7:00 PM, he walked toward the chair. Clients A, B, C, D, E, F, G, H, I and J had access to the chair while client K was in the restroom. The surveyor notified the QIDP-D #62 of the wet stain before client K sat in the wet chair. The QIDP-D #62 immediately removed the chair to the hallway, and staff #36 then walked out of the room to obtain a sheet to place over the chair.</p> <p>Staff #36 was interviewed on 8/21/13 at 7:05 PM. He indicated he had noticed</p> | | <p>Completed random audit forms were and are available for review. The facility previously used three separate audit forms as assessment tools for universal precautions and infection control measures: 1) Hand washing, 2) Dining room and 3) Sanitary control measures audit sheets. These audit forms have been modified in an effort to take a holistic approach as a proactive measure to ensure efforts of common practice for infection control are understood and implemented. Ongoing audits and education related to universal precautions continues to be conducted. In an effort to increase proactive participation, audit sheets have been modified to include open use of communication/information exchange among/between staff members (Att. A). While survey observations revealed a potential issue with cleaning a chair after a client accident, it was determined that the issue was not related to lack of knowledge for universal precautions. This noted oversight was determined to be more related to staff's lack of recognition for appropriate communication between/among related staff members involved. Additionally, information regarding appropriate cleaning methods for the soiled chair was correctly communicated to the surveyor. The chair the client had been seated in was a urine resistant</p> | | | | |

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| | <p>client K was wet with urine as he assisted him in changing into his pajamas. He indicated he should have assessed the chair after he realized client K was wet and removed it from the room. He stated the chair would be steam cleaned by maintenance or cleaned with alcohol by him "if I get time."</p> <p>The Administrator was interviewed on 8/21/13 at 7:10 PM and indicated there should have been a better communication process between staff #36 and the QIDP-D #62 to remove the chair when it was wet. She indicated the facility had purchased urine resistant chairs and indicated if the chair was one of those purchased, it could be cleaned with alcohol. She indicated she would provide the cleaning and maintenance procedure information.</p> <p>During observation on 8/22/13 from 2:20 PM until 3:20 PM in group 6, client J placed his hands in his mouth more than 10 times and his hands were wet with saliva. At 2:45 PM, client J was fed a snack of softened cookie by staff #55. At 2:50 PM, client J had a rim of cookie material around his mouth which fell to his shirt and stuck to it. Client J placed his hands in the back of his mouth and out again until at 3:00 PM, saliva and cookie matter dripped from his hands. At 3:02</p> | | <p>chair. Specs for the chair were provided to the surveyor at the time of inquiry as supporting documentation. As a result, staff communicated the appropriate information that the soiled chair could have been wiped clean with alcohol. The facility sanitation policy, regarding mopping and sanitation methods, has been modified. Committee reviewed noted that in the future, areas of saliva, drool or food matter measuring half dollar in size or less, may be sanitized using alcohol or an alcohol wipe. Mopping in this instance would not be required (Att. B). For client J and all other clients, hand washing techniques for staff and clients has been reviewed. For clients, such as Client J who experience increased episodes of hand-mouthing, staff may employ the use of alcohol-based wipes to assist the client with sanitizing his hands initially. Use of alcohol-based hand sanitizer may then be used, up to 5 times, to reduce the potential for spread of infection. Staff will continue to be provided education in the art of proactive recognition and participation for implementation of general policy for universal precautions and infection control practices. As a proactive measure and in an effort to maintain educational practices, universal control/infection control measures/practices will be monitored through random audits</p> | | | | |

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| 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 08/23/2013 | |
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| | <p>PM, cookie and saliva dripped from his hands in 1/8 inch droplets on the floor next to where client L was sitting in a chair, and clients H and I were laying on the floor. At 3:05 PM, client J was taken to the restroom by staff #36 to wash his hands by staff #36. No other staff was present in the common area of the room. At 3:06 PM, clients B, G, I, and D walked around the room. At 3:10 PM, client B walked toward a one inch in diameter spot of cookie and saliva matter on the floor as the QIDP-D #62 walked in to the room. The surveyor pointed out the cookie matter on the floor to the QIDP and she used the telephone to call for a mop. At 3:10 PM, the nurse walked through the room to give client C his medicine as he sat on a mat at the opposite corner of the room. The QIDP-D #62 notified the nurse of the saliva and cookie matter on the floor and she walked around the spot. Client B walked on the spot with his shoes as he walked through the room, and client J also walked through the spot after returning from the restroom. Staff #33 walked through the spot when he entered the room at 3:14 PM. At 3:16 PM, staff #36 brought a bucket of opaque tan mop water and mopped the floor.</p> <p>Staff #36 was interviewed on 8/22/13 at 3:16 PM and indicated he had retrieved the mop water from Housekeeping staff</p> | | <p>and small group education. Completed audit sheets will be reviewed by the DON and the Program Director to ensure thoroughness and identify any possible trends. Additionally, all necessary data regarding the use and practice of hand sanitation, the use of alcohol-based sanitizers, implementation of the newly modified floor sanitation protocols and the use of alcohol-based sanitation wipes for sanitation of saliva, drool or food matter will be carried by all staff during their interaction with clients. All necessary information will be contained on a 4x6 laminated card for easy access and sanitation purposes. All floor staff will be re-trained regarding common practice for mopping/sanitizing floors, hand sanitation and effective use of universal precautions. Audit sheets have also been modified to include hand-sanitation methods and methodologies necessary for environmental sanitation. 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. Ongoing training will be provided by the DON and/or the Program</p> | | | | |

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| | <p>#6.</p> <p>Staff #6 was interviewed on 8/22/13 at 3:25 PM, and indicated the mop water given to staff #36 was clean and had been prepared by him. When asked to demonstrate how the mop water was prepared, he pulled a mop bucket with clear water and an opaque tan substance floating in it and indicated the floating substance was Pine Sol cleaner. When asked to compare the mop water with that given to staff #36, he stated, "Sometimes the water turns color when the mop sits in it for awhile." Staff #6 indicated the buckets were cleaned on weekends and after each bucket of water had been used.</p> <p>The DON was interviewed on 8/21/13 at 5:40 PM and indicated staff had been reminded to use standard precautions when interacting with clients and had used gowns and gloves with the clients for any contact until clients had been treated for scabies on 8/21/13. She indicated contact precautions were no longer necessary since clients had been treated for scabies.</p> <p>Training records and materials for the facility's Infection Control policy dated 10/14/08 were reviewed on 8/23/13 at 3:45 PM. The records indicated staff #36 had been trained on the following policies</p> | | Director, or their designee, in an effort to maintain awareness and implementation of facility policy. Completion Date 9-22-13 and ongoing | | |

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| | <p>on 8/20/13. The policy indicated "Employees will adhere to the CDC (Centers for Disease Control) guidelines for hand hygiene in health care settings...The housekeeping employees with ensure all areas of the facility are clean and appropriately disinfected." Arcadia Sanitation Guidelines (undated) indicated "Program room floors should be cleaned any time there is a spill or contamination with human waste or fluids. The soiled area should be cleaned using a clean mop head, water and bucket. After mopping the area change the mop head, water and bucket and mop the area again...."</p> <p>The Administrator was interviewed on 8/22/13 at 3:35 PM and indicated client J's hands should have been washed when soiled.</p> <p>The Administrator was interviewed on 8/23/13 on 3:09 PM. She indicated per policy the floor should have been mopped twice in program room 6 when client J's saliva and cookie matter fell on the floor.</p> <p>This deficiency was cited on 7/12/13. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>3.1-37(a)</p> | | | |

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| W000454 | <p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, record review, and interview for 6 of 6 sampled clients (clients A, B, C, D, E, and F) and for 6 additional clients (G, H, I, J, K, and L), the facility failed to implement and follow Universal Precautions and promote hand washing to prevent the spread of infection.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/21/13 at 6:00 PM. Reports dated 8/19/13 indicated clients A, B, C, and J would receive prophylactic treatment for scabies as a "possible exposure to scabies." The report indicated facility infection control policy, related to contact isolation was implemented and "staff education measures had been reviewed."</p> <p>The Director of Nursing (DON) was interviewed on 8/21/13 at 5:55 PM and indicated suspicious areas on clients A, B, C, and J skin were found and the client's primary care physician had examined them and ordered prophylactic treatment</p> | W000454 | <p>W454 Policy measures related to contact precautions, specifically contact precautions for potential scabies, was conducted prior to implementation of facility protocol to reduce the risk of potential widespread transmission. Random audits were not conducted for contact precautions related to scabies, as audits for this intervention was unnecessary. After the potential for scabies was identified; prophylactic treatment was completed for all clients, environmental cleaning was conducted and sanitation methods were completed, random audits were not required. All contact precautions related to prophylactic treatment for scabies was completed within 24 hours. However, random audits related to general policy for universal precautions and infection control measures related to contact precautions, continues to be conducted on an ongoing basis. Random audits related to general policy for universal precautions and infection control measures have been documented and are completed on an ongoing basis as a proactive measure. Completed random audit forms were and are available for review. The facility previously</p> | 09/22/2013 | | | |

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| | <p>for scabies while skin scrapings were being analyzed for diagnosis. She indicated the facility had treated all of the clients in the facility to ensure no further spread of the suspected scabies had occurred on 8/20/13.</p> <p>Observations were completed in group 6 on 8/21/13 from 6:40 PM until 7:10 PM. Client K was taken to the rest room by staff #36 at 6:55 PM to change into pajamas. The upholstered chair client K was sitting in had a wet stain 1 and 1/2 foot by 1/2 foot. The QIDP-D (Qualified Intellectual Disabilities Professional Designee) was present in the room while client K was changing his clothing, but did not look toward the chair seat. When client K returned from the restroom, at 7:00 PM, he walked toward the chair. Clients A, B, C, D, E, F, G, H, I and J had access to the chair while client K was in the restroom. The surveyor notified the QIDP-D of the wet stain before client K sat in the wet chair. The QIDP-D immediately removed the chair to the hallway, and staff #36 then walked out of the room to obtain a sheet to place over the chair.</p> <p>Staff #36 was interviewed on 8/21/13 at 7:05 PM. He indicated he had noticed client K was wet with urine as he assisted him in changing into his pajamas. He</p> | | <p>used three separate audit forms as assessment tools for universal precautions and infection control measures: 1) Hand washing, 2) Dining room and 3) Sanitary control measures audit sheets. These audit forms have been modified in an effort to take a holistic approach as a proactive measure to ensure efforts of common practice for infection control are understood and implemented. Ongoing audits and education related to universal precautions continues to be conducted. In an effort to increase proactive participation, audit sheets have been modified to include open use of communication/information exchange among/between staff members (Att. A). While survey observations revealed a potential issue with cleaning a chair after a client accident, it was determined that the issue was not related to lack of knowledge for universal precautions. This noted oversight was determined to be more related to staff's lack of recognition for appropriate communication between/among related staff members involved. Additionally, information regarding appropriate cleaning methods for the soiled chair was correctly communicated to the surveyor. The chair the client had been seated in was a urine resistant chair. Specs for the chair were provided to the surveyor at the time of inquiry as supporting</p> | | | | |

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| | <p>indicated he should have assessed the chair after he realized client K was wet and removed it from the room. He stated the chair would be steam cleaned by maintenance or cleaned with alcohol by him "if I get time."</p> <p>The Administrator was interviewed on 8/21/13 at 7:10 PM and indicated there should have been a better communication process between staff #36 and the QIDP-D to remove the chair when it was wet. She indicated the facility had purchased urine resistant chairs and indicated if the chair was one of those purchased, it could be cleaned with alcohol. She indicated she would provide the cleaning and maintenance procedure information.</p> <p>During observation on 8/22/13 from 2:20 PM until 3:20 PM in group 6, client J placed his hands in his mouth more than 10 times and his hands were wet with saliva. At 2:45 PM, client J was fed a snack of softened cookie by staff #55. At 2:50 PM, client J had a rim of cookie material around his mouth which fell to his shirt and stuck to it. Client J placed his hands in the back of his mouth and out again until at 3:00 PM, saliva and cookie matter dripped from his hands. At 3:02 PM, cookie and saliva dripped from his hands in 1/8 inch droplets on the floor</p> | | <p>documentation. As a result, staff communicated the appropriate information that the soiled chair could have been wiped clean with alcohol. The facility sanitation policy, regarding mopping and sanitation methods, has been modified. Committee reviewed noted that in the future, areas of saliva, drool or food matter measuring half dollar in size or less, may be sanitized using alcohol or an alcohol wipe. Mopping in this instance would not be required (Att. B). For client J and all other clients, hand washing techniques for staff and clients has been reviewed. For clients, such as Client J who experience increased episodes of hand-mouthing, staff may employ the use of alcohol-based wipes to assist the client with sanitizing his hands initially. Use of alcohol-based hand sanitizer may then be used, up to 5 times, to reduce the potential for spread of infection. Staff will continue to be provided education in the art of proactive recognition and participation for implementation of general policy for universal precautions and infection control practices. As a proactive measure and in an effort to maintain educational practices, universal control/infection control measures/practices will be monitored through random audits and small group education. Completed audit sheets will be reviewed by the DON and the</p> | | | | |

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| | <p>next to where client L was sitting in a chair, and clients H and I were laying on the floor. At 3:05 PM, client J was taken to the restroom by staff #36 to wash his hands by staff #36. No other staff was present in the common area of the room. At 3:06 PM, clients B, G, I, and D walked around the room. At 3:10 PM, client B walked toward a one inch in diameter spot of cookie and saliva matter on the floor as the QIDP-D walked in to the room. The surveyor pointed out the cookie matter on the floor to the QIDP and she used the telephone to call for a mop. At 3:10 PM, the nurse walked through the room to give client C his medicine as he sat on a mat at the opposite corner of the room. The QIDP-D notified the nurse of the saliva and cookie matter on the floor and she walked around the spot. Client B walked on the spot with his shoes as he walked through the room, and client J also walked through the spot after returning from the restroom. Staff #33 walked through the spot when he entered the room at 3:14 PM. At 3:16 PM, staff #36 brought a bucket of opaque tan mop water and mopped the floor.</p> <p>Staff #36 was interviewed on 8/22/13 at 3:16 PM and indicated he had retrieved the mop water from Housekeeping staff #6.</p> | | <p>Program Director to ensure thoroughness and identify any possible trends. Additionally, all necessary data regarding the use and practice of hand sanitation, the use of alcohol-based sanitizers, implementation of the newly modified floor sanitation protocols and the use of alcohol-based sanitation wipes for sanitation of saliva, drool or food matter will be carried by all staff during their interaction with clients. All necessary information will be contained on a 4x6 laminated card for easy access and sanitation purposes. All floor staff will be re-trained regarding common practice for mopping/sanitizing floors, hand sanitation and effective use of universal precautions. Audit sheets have also been modified to include hand-sanitation methods and methodologies necessary for environmental sanitation. 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. Ongoing training will be provided by the DON and/or the Program Director, or their designee, in an effort to maintain awareness and implementation of facility</p> | | | | |

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| | <p>Staff #6 was interviewed on 8/22/13 at 3:25 PM, and indicated the mop water given to staff #36 was clean and had been prepared by him. When asked to demonstrate how the mop water was prepared, he pulled a mop bucket with clear water and an opaque tan substance floating in it and indicated the floating substance was Pine Sol cleaner. When asked to compare the mop water with that given to staff #36, he stated, "Sometimes the water turns color when the mop sits in it for awhile." Staff #6 indicated the buckets were cleaned on weekends and after each bucket of water had been used.</p> <p>The DON was interviewed on 8/21/13 at 5:40 PM and indicated staff had been reminded to use standard precautions when interacting with clients and had used gowns and gloves with the clients for any contact until clients had been treated for scabies on 8/21/13. She indicated contact precautions were no longer necessary since clients had been treated for scabies.</p> <p>Training records and materials for the facility's Infection Control policy dated 10/14/08 were reviewed on 8/23/13 at 3:45 PM. The records indicated staff #36 had been trained on the following policies on 8/20/13. The policy indicated "Employees will adhere to the CDC</p> | | policy. Completion Date as of 9-22-13 and on going | | | | |

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| | <p>(Centers for Disease Control) guidelines for hand hygiene in health care settings...The housekeeping employees with ensure all areas of the facility are clean and appropriately disinfected." Arcadia Sanitation Guidelines (undated) indicated "Program room floors should be cleaned any time there is a spill or contamination with human waste or fluids. The soiled area should be cleaned using a clean mop head, water and bucket. After mopping the area change the mop head, water and bucket and mop the area again...."</p> <p>The Administrator was interviewed on 8/22/13 at 3:35 PM and stated "scabies can come from anywhere. Skin to skin contact or on shoes."</p> <p>The DON was interviewed on 8/22/13 at 3:42 PM and indicated scabies can be present in the environment or on the skin, and can take up to 14 days to diagnose.</p> <p>The CDC website http://www.cdc.gov/handhygiene/Basics.html was reviewed on 8/23/13 at 12:10 PM and indicated hand washing should occur after contact with human body fluids.</p> <p>The CDC website http://www.cdc.gov/parasites/scabies/prev ent.html was reviewed on 8/23/13 at</p> | | | | | | |

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| | <p>12:28 PM and indicated scabies was usually spread by direct skin contact.</p> <p>The Administrator was interviewed on 8/23/13 on 3:09 PM. She indicated per policy the floor should have been mopped twice in program room 6 when client J's saliva and cookie matter fell on the floor.</p> <p>This deficiency was cited on 7/12/13. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>3.1-18(L)</p> | | | | |