STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525695	A. BUILDING _____ B. WING _____	09/25/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ANNA JOHN RESIDENT CENTERED CARE COMMUNITY	2901 SOUTH OVERLAND ROAD ONEIDA, WI 54155

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F 0225	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** Based on record review and staff interview, the facility did not ensure information obtained from 1 of 8 criminal background checks was thoroughly investigated to indicate the final disposition of a serious crime. As a result, the facility could not ensure it did not employ individuals who have been found guilty of abusing, neglecting or mistreating residents and report any knowledge it had of court actions against an employee which would indicate unfitness for service as facility staff to State licensing authorities. Facility Employee-F had a DOJCIB (Department of Justice Crime Information Bureau) background check which included a charge of Second Degree Murder/Felony Commission. The record did not disclose the disposition of the crime. The facility did not document evidence of a thorough investigation regarding the disposition of the crime. Findings include: On 9/24/13 surveyor # conducted a routine Caregiver Background Compliance Check. Eight employees were selected from the employee roster presented by NHA (Nursing Home Administrator)-C. The roster indicated Employee-F had been hired 2/12/12. Review of the DOJCIB, dated 1/18/12, indicated Arrest Data which included a charge: Statute # 940.02(2), 2nd-Degree Murder/Felony Commission, 1 count. The document did not reflect a disposition for this charge. However, for additional criminal charges shown at that same time, convictions indicated Employee-F was sentenced to prison. On 9/24/13 at 2:30 p.m., surveyor interviewed NHA-C about the background check for Employee-F. NHA-C was unaware of the most serious charge and had never seen the background check. NHA-C described the hiring process and indicated the ONT (Oneida Nation Tribe) conducted background checks at an offsite location via the human resources department. NHA-C indicated the ONT completed all hiring tasks and maintained the employee files. It was further revealed Employee-F was not employed or supervised by the facility but by the ONTDPW (Oneida Nation Tribe Department of Public Works). NHA-C revealed Employee-F began working at the new, recently built facility, just before it opened 6/13. When asked why his hire dated was reflected as 2/12/12, NHA-C indicated he may have worked elsewhere for the tribe but was assigned to the nursing home in June and had not worked at the previous facility. Surveyor # asked NHA-C how she handled performance issues involving Employee-F. NHA-C indicated a report had to be submitted to Employee -F's supervisor at the ONTDPW. NHA-C stated she was not aware of results of corrective action. NHA-C verified performance concerns had been reported to Employee-F's supervisor. On 9/25/13 at 9:00 a.m., surveyor # interviewed HR (Human Resources)-D who verified the a 2nd degree murder charge had been noted on the background check of Employee-F. HR-D also confirmed a background check had been conducted 1/18/12 but not immediately prior to initiation of employment at the nursing home. HR-D indicated background checks had been conducted when Employee-F worked in other departments of the tribe and that a phone call had been made to the county in which the serious crime allegedly occurred. HR-D verbalized understanding of the 4 year caregiver background check compliance laws and awareness of the crimes that prohibited individuals from working in nursing homes. HR-D stated he spoke to 'G,' at the Clerk's office, who told me it wasn't (Employee-F). HR-D further indicated the phone call took place several years ago and that no documentation with date, time, name, and details of the initial charge, were recorded. HR-D stated he would request documentation from the county in which the charge occurred, today, and provide to surveyor as soon as possible. HR-D also indicated a new criminal background check would be run today. HR-D verified there was not record of rehabilitation for Employee-F in the employee's file. On 9/25/13 at 9:10 p.m., surveyor # interviewed ASD-U and HSS-H who verified additional information regarding the charge of 2nd degree murder were desirable. On 9/25/13 at 2:45 p.m., surveyor # received a criminal background check dated 9/25/13 with the same charges. At the same time, NHA-C revealed she had no additional information from the county regarding the disposition of the serious crime. It was confirmed Employee-F remained working in the building during the entire survey.
F 0226	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and review of the facility's abuse policies and procedures, the facility did not develop clear policies and procedures that all alleged violations of abuse, neglect, misappropriation of resident property and injuries of unknown source were reported immediately to DQA, how they were going to prevent abuse from occurring, for screening employees and regarding resident-to-resident altercations. In addition, the facility had not developed written policies and procedures related to the reporting of a reasonable suspicion of a crime. The facility's abuse policies were ill defined regarding reporting requirements and employee screening. The facility did not develop written policies and procedures for the prevention of mistreatment and abuse and resident-to-resident altercations. The facility did not developed policies and procedures for reporting a reasonable suspicion of a crime to law enforcement and to the State survey and certification agency. Therefore staff had not been trained nor was the policy posted for employees to review. Findings include: The DQA Memo 10-008 UPDATE: Nursing Home Reporting Requirements for Alleged Incidents of Abuse, Neglect and Misappropriation, and The DQA Memo 11-032 Guidance for Investigating & Reporting Alleged Violations in Nursing Homes, indicates per CMS (Centers for Medicare and Medicaid Services) direction, all nursing homes must immediately report all alleged violations involving neglect, or abuse, including injuries of unknown source, and misappropriation of resident property to the facility administrator and to DQA. CMS defines immediately to be as soon as possible but not to exceed 24 hours after discovery of the incident. The memos also provide clarification regarding required online reporting & Incident Report form. In addition the DQA Memo 11-032, indicates facilities are required to develop written procedures specifying: * What incidents are to be reported and when; * How and to whom staff are to report incidents; * How internal investigations will be completed for different types of investigations and what constitutes a thorough investigation; * How residents will be protected from further incidents while an investigation is conducted; * How staff will be trained on the procedures related to allegations of caregiver misconduct; and * How residents (and guardians, as appropriate) will be informed of those procedures. The DQA Memo 11-032 also addresses Resident-to-Resident Altercations. The facility did not have written policies and procedures related to Resident-to-Resident Altercations. The facility's 9/16/13 policy only indicated for resident to resident contacts staff are to separate the residents immediately and follow as above according to the incident type (i.e. physical assault, sexual assault.). On 9/24/13 surveyor # reviewed the facility's policies and procedures for abuse, neglect, mistreatment and misappropriation of resident property. The facility provided a copy of their policy and procedures for Investigations of Allegations of Abuse, Neglect, Misappropriation of property and injury of Unknown Source dated 9-16-13.

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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F 0226	(continued... from page 1) This included Purpose statements. 1. Establish a systematic approach for the investigation of alleged violations involving mistreatment or abuse, including bruising or injury of unknown source and neglect, mistreatment and misappropriation of resident property. 2. To meet the states bureau of quality of assurance requirements on reporting of all investigations of alleged violations involving mistreatment or abuse, including bruising or injury of unknown source and neglect, mistreatment and misappropriations of resident property, 3. To protect the resident right to be free from involving mistreatment or abuse, including bruising or injury of unknown source and neglect, mistreatment and misappropriation of resident property. Also to inform a residents and family members on how to report concerns incidents and grievances without free of retribution. To provide mechanisms for feedback on concerns expressed. 4. To appropriately screen employees prior to hiring. 5. Train employees regarding the facility policies and procedures on abuse, neglect and misappropriation. Also to provide employees with support and assistance accordingly. The facility's abuse policies and procedures included the Wisconsin Caregiver Program Manual Chapter 6--Misconduct Reporting and Investigations dated 8/24/06. This also included the Caregiver Misconduct Reporting algorithm. Unfortunately, this algorithm does not include nursing homes. The facility initially indicated in their procedures for investigations for all allegations including physical assault, sexual assault, misappropriation of residents property, neglect, and verbal/psychological abuse that the facility will determine whether the incident must be reported further if so: submit required reports to other agencies, Division of Quality Assurance, DHS, Adult Protective Services, ect. In addition, the facility included a page that gives the website for online reporting, and indicates that this will be done by the licensed nurse on duty at the time of the complaint and that the nurse will complete the Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report. CMS' definition of immediate is also provided. These two procedures are contradicting one another. The facility did develop well defined written policies and procedures regarding employee screening. According to the facility's policy and procedure they would provide a form to all potential employees to consent and complete prior to employment. Form #F- A Background Disclosure Form. Oneida will perform on all facility staff and agency staff will have this completed prior to hire through the agency and submitted to the Administrator for review. The facility did not develop written policies and procedures regarding Resident-to-Resident Altercations including if the incident meets the definition by being willful, procedures for investigating the altercation, and reporting the altercation immediately to the Administrator and DQA. The facility's policy and procedures do not indicate that they are screening employees for a history of abuse, neglect, or mistreatment of [REDACTED]. Nor that screening would include inquires into State licensing authorities, inquiries into Stat nurse aide registry, reference checks from previous and/or current employers, criminal background checks and dispositions or records from the clerk of courts as needed to gain additional information regarding criminal histories. The procedure also does not indicate that they will remain in compliance with the States four year background compliance check. See F225 for additional information. The facility's written policy and procedures did not address Prevention by listing: * prevention techniques such as providing ongoing supervision of residents and staff; * observation of care delivery; * observation and recognition of signs of resident-to-resident and/or resident-to-staff frustration or stress. * By describing how to identify, correct, and intervene in situations where abuse, neglect, and/or mistreatment are more likely to occur such as, secluded areas, sufficient staffing numbers for each shift to meet resident needs, staff demonstrating knowledge of individual resident needs, sufficient supervisory staff to identify inappropriate behaviors and residents with needs and behaviors that might lead to abuse e.g., resident-to-resident altercations. On 9/25/13 at 10:40 a.m. surveyor # met with NHA-C (Nursing Home Administrator) and DON-B (Director of Nursing) to discuss the facility's abuse policies and procedures. Both NHA-C and DON-B verified that they recognized that the policies and procedures did not address everything as required and that parts were confusing or misleading. Both NHA-C and DON-B indicated that they needed to update the facility's current policies and procedures. According to the CMS (Centers for Medicare and Medicaid) S&C: 11-30-NH Memo revised 01/20/12 Nursing Homes are to develop and maintain policies and procedures the ensure compliance with section 1150B Reporting Reasonable Suspicion of a Crime, including the prohibition of retaliation against any employee who makes a report, causes a lawful report to be made, or takes steps in furtherance of making a lawful report pursuant to the requirement of the statute. The facility must ensure their policy and procedures adhere to existing CMS and State policies and procedures for reporting incidents and complaints. The facility must also notify each covered individual (an owner, operator, employee, manager, agent or contractor of the facility) annually of their obligation to report any reasonable suspicion of a crime' to local law enforcement and to the State survey and certification agency. The facility must also post a conspicuous notice in an appropriate location for employees to review regarding the reporting of any reasonable suspicion of a crime without fear of retaliation. From 9/23/13 to 9/25/13 9:05 a.m. surveyor # had not been able to locate the posting for staff regarding Reporting Reasonable Suspicion of a Crime policy and procedure. In addition, surveyor # had reviewed the facility's abuse policy and procedures and it did not include Reporting Reasonable Suspicion of a Crime. At 9/25/13 9:05 a.m. surveyor # interviewed NHA-C regarding the facility's policy and procedure for Reporting Reasonable Suspicion of a Crime, and the required posting for staff. NHA-C stated to surveyor # that she was not sure if the facility had such a policy, nor did she know if they posted the necessary information for staff. NHA-C indicated that SW-T (Social Worker) was responsible for the postings. At 9:27 a.m. surveyor # and NHA-C met with SW-T, and SW-T was unsure if Reporting Reasonable Suspicion of a Crime policy and procedure was posted. NHA-C indicated we should check DON-B. At 10:29 a.m. surveyor # interviewed NHA-C and DON-B, and at that time DON-B indicated that they now had the required information regarding the reporting of any reasonable suspicion of a crime without fear of retaliation posted in an appropriate location. DON-B verified that they had not developed a policy and procedure regarding Reporting Reasonable Suspicion of a Crime, nor had staff been provided training or were notified as required. DON-B added that they would be begin staff training this afternoon.
F 0329	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility did not ensure that 2 (resident #4 and resident #7) of 6 residents who were prescribed antipsychotic medications, from a total sample of 10 residents, received behavioral interventions in an effort to discontinue these drugs. Resident #4 and resident #6 were prescribed [MEDICATION NAME], an antipsychotic medication, for dementia with behaviors. The written plan of care did not identify targeted behaviors to monitor or give individualized non-pharmacological interventions to treat the behaviors of resident #4 and resident #6. Findings include: 1. On 9/23/13 surveyor # reviewed the medical record of resident #4. The 9/12/13 facesheet contained within the medical record indicated resident #4's admitting [DIAGNOSES REDACTED].#4 was moderately cognitively impaired and developmentally delayed. According to the same MDS, resident #4 exhibited no recent behaviors. The physicians orders of resident #4 demonstrate [MEDICATION NAME] 0.5 mg (milligrams) daily, was prescribed for resident #4 on 4/8/13. A GDR (Gradual Dose Reduction) was attempted on 8/23/13 when the dose was decreased to 0.25 mg daily. On 9/12/13, [MEDICATION NAME] was increased for resident #4 back to 0.5 mg. Nurses notes for resident #4, dated 8/25/13, after the dose reduction, indicated, (resident #4) unpleasant mood this morning.stated, 'not good'. On 8/26/13, nurses notes indicated resident #4 swears. On 8/28/13, nurses notes indicated, no behavior problems. On 9/7/13, nurses notes indicated, yells and swears at times.with staff.easily altered. On 9/11/13, nurses notes indicated, yells, occurs with staff.multiple times per shift.resident #4 stated, Did laundry come yet, I'm missing clothes.Resident also became upset that a wheelchair was missing from room.repeatedly asking staff Where is my wheelchair? even though staff have determined resident never had a wheelchair and the wheelchair (the resident) had been using was a courtesy wheelchair of the facility.resident insists on being argumentative with staff. [MEDICATION NAME] recently decreased. On 9/13/13, the day after the dose increase, nurses notes indicated, Resident (#4) has had a recent medication change and has been having outbursts Medication is being adjusted. The written plan of care for resident #4, dated 6/3/13, indicated the primary [DIAGNOSES REDACTED]. Interventions included, I am forgetful and sometimes get anxious when I can't remember things. Give my cues when I am forgetful.Reassure me that my clothes will go down to laundry and will be returned to my closet.I enjoy playing cards. 2. On 9/24/13, surveyor # reviewed the medical record of resident #7. The 9/12/13 facesheet contained within the medical record indicated resident #7 was admitted with [DIAGNOSES REDACTED].#7 was mildly cognitively impaired. The most recent quarterly MDS dated [DATE] for resident #7 indicated the resident was severely cognitively impaired. Neither the 7/12/13 MDS, nor the 4/29/13 significant change MDS triggered for hallucinations or [MEDICAL CONDITION]. A total plan of care summary note documented in the medical record of resident #7 on 5/2/13, indicated, (Resident #7) said she had trouble sleeping, but that has been for some

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F 0329	(continued... from page 2) time.resident enjoyed tub bath.staff very helpful.being at AJNH (Anna John Nursing Home) is a bit of a change but agrees it is appropriate.(resident #7) has improved dramatically, overall, since admission. Originally was admitted for palliative care, but it looks like resident #4 will be a resident for some time.resident had no suggestions for improvement. Behaviors noted in nurses notes dated 5/16/13 included, self abusive acts - rubs head often, has a bald patch to top of head from rubbing scalp when nervous. The nursing home built a new facility and this resident was transferred to the new building on or about 6/1/13. Nurses notes from 4/1/13 were reviewed by surveyor # . The first indication of hallucinations were documented 6/26/13, resident told staff there were squirrels in the room.no distress related to hallucination. Nurse notes dated 7/2/13, rubs head continuously. Nurses notes dated 7/9/13, indicated, hallucinates multiple times per shift, not easily altered. A total plan of care summary note documented in the medical record of resident #7 on 7/18/13, indicated, (resident's daughter) said that her mother (resident #7) reports hallucinations to her, which may be due to her current UTI. According to physicians orders, resident #7 was prescribed [MEDICATION NAME] 0.25 mg daily on 7/23/13. On 8/16/13, nurses notes indicated, Resident has displayed a great reduction in head rubbing since [MEDICATION NAME] started, no recent hallucinations. The written plan of care most recently updated 8/12/13, indicated a [DIAGNOSES REDACTED].#7, and indicated the following problem dated 6/2/13, My health has declined and I miss how independent I use to be. The interventions included, I am trying to adjust to my current health status that is different from when I was at home. My children are not able to take care of me and that makes me sad sometimes. Visit with me.talk to me about depression to see if this is an issue for me.encourage me to take part in activities. No additional targeted behaviors were noted in the written plan of care. When asked, the facility did not present additional documentation identifying targeted behaviors to monitor or treat targeted behaviors for resident #7. No changes were made to the written plan of care after resident #7 presented with hallucinations on 7/18/13. Non-pharmacological interventions were not indicated in the written plan of care for resident #7. On 9/25/13 at 9:30 a.m., surveyor # interviewed FM (Family Member)-S, the daughter of resident #7. FM-S indicated resident #7 had become increasingly depressed since admission to the nursing home, It's getting worse, she said, (resident #7) doesn't want to be there. On 9/25/13 at 10:30 a.m., surveyor # interviewed CNA (Certified Nursing Assistant)-E regarding interventions for residents with behaviors. CNA-E stated if a resident was exhibiting behaviors, she would notify the nurse, I'm not a psych expert, there's nothing I could do but re-direct. On 9/25/13 at 12:35 p.m., surveyor # interviewed DON (Director of Nursing)-B. When asked about the targeted behaviors indicated for giving [MEDICATION NAME] to resident #4, DON-B pointed to the written plan of care indicated, looking for clothing and other things are the behaviors.(resident #4) gets anxious. When asked, DON-B verified an anxiolytic medication could also be tried rather than and antipsychotic. Regarding non-pharmacological interventions, staff were directed to reassure the resident, according to DON-B. DON-B indicated neither resident #4 or resident #7 were referred for psych services for an evaluation as the primary physician ordered [MEDICATION NAME]. DON-B verified no other targeted behaviors were identified or monitored in the medical records of resident #4 or #7. No other interventions individualized for resident #4 or #7 were noted in the written plan of care.
F 0356	**Post nurse staffing information/data on a daily basis.** Based on observation, staff interview, and record review, the facility had not included all required nurse staffing data on the daily staffing posting during 3 of 3 survey days. This had the potential to affect all residents in the facility. The daily staffing posting did not include the actual hours worked by licensed and unlicensed staff. Findings include: On 9/23/13 at 9:00 a.m., on 9/24/13 at 1:00 p.m., and on 9/25/13 at 8:20 a.m., surveyor # observed the facility's Report of Nursing Staff Directly Responsible for Resident Care posting. The postings observed on all three survey days contained the facility name, the current dates, number of hours worked per discipline, and the resident census for each day. The forms did not contain the actual hours/ times worked by each disciple, just the total number of hours worked. On 9/25/13 at 10:26 a.m. DON (Director Of Nursing)-B and NHA (Nursing Home Administrator)-C verified to surveyor # the nurses are responsible for completing the staffing data on the staffing postings. DON-B and NHA-C also verified the postings did not contain the actual times or hours worked for licensed and unlicensed nursing staff as required.
F 0371	**Store, cook, and serve food in a safe and clean way.** Based on observation and staff interview, the facility did not prepare and serve food under sanitary conditions in the main kitchen used to serve all the residents at the facility. The dietary staff in the main kitchen were were not all following the same procedure when sanitizing clean equipment, food and non-food contact surfaces and this was not known by the DM-K (Dietary Manager). Staff who were diluting the sanitizer in water did not have test strips to ensure the sanitizer was at the appropriate concentration for effective sanitization. In addition, dietary staff were using CDC-10 disinfectant to clean and sanitize clean equipment, food preparation and non-food contact surfaces. According the the EPA registered label and the Manufacturer, CDC-10 is not approved for and should never be used in food service. Therefore, clean equipment, food preparation and non-food contact surfaces were chemically contaminated which could have potentially contaminated food served to the residents for approximately the last four months. The facility practices had the potential to affect the majority of the residents in the facility. Findings include: The five major risk factors related to forborne illness identified in the 2009 Federal Food Code's preface 1 and preface 11 indicate that Epidemiological outbreak data repeatedly identify five major risk factors related to employee behaviors and preparation practices in retail and food service establishments: 1. Improper holding temperatures, 2. Inadequate cooking, such as undercooking raw shell eggs, 3. Contaminated equipment, 4. Food from unsafe sources, and 5. Poor personal hygiene. On 9/23/13 at 8:35 a.m. DM-K verified to surveyor # that the facility used the 2009 Federal Food Code as their standards of practice. On 9/23/13 during the initial tour of the main kitchen with DM-K from 8:30 a.m. to 8:55 a.m., DM-K when asked by surveyor # indicated that they used a pre-mixed sanitizer to sanitize clean equipment, food preparation and non-food contact surfaces. DM-K explained that staff use the red buckets for soapy water for cleaning only. On 9/24/13 at 12:40 p.m. surveyor # observed dishwashing in the main kitchen. DC-M (Dietary Cook) was handling clean dishes after being washed in the dishmachine. At 12:50 p.m. surveyor # observed DC-M remove a wash cloth from a red bucket in the sink located just outside the dishmachine room and wipe a cart to be used for drying clean dishes. Surveyor # did not observed DC-M spray sanitizer on the cart. When questioned, DM-M indicated that the red bucket contained sanitizer. According to DC-M she filled the red bucket to the line marked with a five and then added a capful of the sanitizer. When asked about testing the concentration of the sanitizer, DC-M indicated that they were out of test strips. DC-M indicated that she thought that they had some a month ago. DC-M indicated that the sanitizer should be at 200 ppm (part per million). Surveyor # asked DC-M to show this surveyor the bottle of sanitizer. Located in the chemical closet were multiple bottles of CDC-10 clinging disinfectant. Surveyor # read the label on the bottle of CDC-10 and could not find specific instructions for sanitizing food contact surfaces. The label did indicate the area needed to remain wet for five minutes. At 12:58 p.m. surveyor # interviewed DC-Q regarding how staff sanitize clean equipment, food preparation and non-food contact surfaces. DC-Q indicated that she washes the area first with soapy water, rinses and then sprays the area with CDC-10. DC-Q indicated she leaves the area wet for five minutes then uses a clean wash cloth with water and rinses the area. On 9/24/13 at 1:02 p.m. surveyor # interviewed DA-P (Dietary Aide) and she indicated that she diluted the CDC-10 in water to clean and sanitize clean equipment, food and non-food contact surfaces. DA-P also indicated they used test strips to test the concentration, but when she looked she could not find any. DC-L by the stove and DA-P asked her at approximately 1:07 p.m. where the test strips were. DC-L indicated to both DA-P and surveyor # that they did not have any since they moved to the new building four months ago. When asked, DC-L indicated she dilutes the sanitizer in water. When asked by surveyor # how staff test the concentration of the sanitizer, DC-L said we don't. At 1:10 p.m. on 9/24/13 there was discussion between surveyor # , DC-L, DA-P and DC-M regarding ordering new test strips. DC-M indicated that she spoke with DM-K several times about where to order new test strips, but he never got back to her. Surveyor # had recorded the EPA registered label number, EPA 5741-21 to review the current information regarding CDC-10 on the EPA website. The EPA registered label for CDC-10 did not have any instructions for sanitizing food contact surfaces. The label indicated before using the disinfectant to remove all food or food packages from the area. The registered label also indicated the area must remain wet for five minutes and then rinsed with potable water. On 9/25/13 at 8:00 a.m. surveyor # met with DM-K to ask for information from the manufacturer indicating CDC-10 clinging disinfectant could be used on clean equipment, food and non-food contact surfaces in a food service setting. DM-K shared with surveyor # that he had contacted his chemical representative who indicated that CDC-10 was not the best product to use and gave him the name of a more appropriate product. DM-K indicated he would be getting the new product later that day. Surveyor # shared the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0371	(continued... from page 3) information found on the EPA website regarding CDC-10. DM-K also explained that he never ordered more test strips because he thought staff were using the premixed product directly from the bottle, and indicated he had not been aware that some staff diluting the product which he said would make it ineffective. DM-K indicated that they had been using CDC-10 since they moved into the new building, but could not say how they came to use it over the sanitizer they had used at the old building. Staff were using the CDC-10 differently. DM-K had not been monitoring the dietary staff to ensure that they were using the CDC-10 according to manufacturer's directions and if it could actually be used to sanitize clean equipment and food and non-food contact surfaces in the main kitchen. At 8:35 a.m. surveyor # interviewed DA-O regarding how she used CDC-10, and she indicated she diluted sanitizer in water and wiped it on the surface and allowed the area to air dry. DA-O was unaware how long the area should remain wet for effective sanitization. At 8:40 a.m. surveyor # interviewed DC-M again, and she explained that she cleaned surfaces with the diluted CDC-10, but when she sanitized the surface area used full concentration in the spray bottle. When asked, DC-M indicated that she did not rinse the areas afterwards. DC-M verified to surveyor # that she sanitized all clean equipment, food and non-food contact surfaces this way. At 8:49 a.m. surveyor # interviewed DA-N regarding how she used the CDC-10 to sanitize clean equipment and food and non-food contact surfaces. DA-N indicated that after she clean the area she would spray it with the CDC-10, leave it wet for five minutes and then wipe the area with a wash cloth wet with hot water. On 9/25/13 at 12:50 p.m. surveyor # interviewed SCSM-R (Spartan Customer Services Manager) via telephone regarding the use of CDC-10. SCSM-R indicated that CDC-10 was a bathroom disinfectant and should never be used in a food preparation or food service area. SCSM-R explained even if staff rinse after spraying the product on a food contact surface a soapy film my remain and this could contaminate food. SCSM-R when asked, did not feel the product posed a big risk to the residents This information was shared with DM-K at 1:25 p.m. and at that time he indicated the all of the bottles of CDC-10 were removed from the kitchen.
F 0441	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility did not require staff to wash their hands after 2 (resident #3, resident #5) of 4 observations of resident contact for which handwashing was indicated. Staff assisted resident #3 with toileting and did not remove gloves and perform hand hygiene before touching personal items in the resident room. Staff provided pericare to resident #5 and with soiled gloves touched a container of [MEDICATION NAME] and a tube of barrier cream and applied some to the resident. In addition, staff removed gloves and did not perform hand hygiene before touching personal items in the resident's room. Findings include: The facility policy entitled, Hand Hygiene, dated 8/26/13, indicated: Handwashing, when done correctly, is the single most effective way to prevent the spread of communicable diseases.1. Hands should be washed with an antimicrobial soap and water in the following situations:.c. after having contact with bodily fluids or excretions, mucous membranes, non-intact skin, .The alcohol based hand cleanser may be used in the following situations:.a. Before and after having direct resident contact with the resident.c. after removing gloves, 1. On 9/24/2013, at 10:55 a.m., surveyor # observed CNA (Certified Nursing Assistant)-A, provide toileting assistance to resident #4. CNA-A removed a soiled brief with gloved hands, then touched resident's shoes, pants, a clean brief and the resident's walker before discarding the gloves. Without performing hand hygiene, CNA-A donned new gloves and provided peri care, pulled up resident ' s clean brief and pants, then discarded gloves and washed hands. On 9/24/13 at 11:01 a.m., surveyor # interviewed CNA-A, who stated yes attended in-services at this facility and no, has not had any training on hand washing at this facility. CNA-A's understanding of hand hygiene at this facility is: Wipe and use cream, need to change gloves. Wash hands after each care. 2. On 9/24/13 at 8:45 a.m. surveyor # observed CNA-J and CNA-I provide cares to resident #5. Staff transferred resident #5 into bed from her Broda chair with a Hoyer lift. Once in bed CNA-J checked the resident's brief and indicated to surveyor # when asked at 8:56 a.m., that the brief was dry. Staff proceeded to provide cares to resident #5 even though she had not been incontinent. Staff washed their hands and donned gloves. CNA-I provided frontal pericare to the resident and then with her soiled glove picked up the bottle of [MEDICATION NAME] and applied some to the resident. CNA-J turned resident #5 onto her right side and CNA-I provided pericare to the resident's backside. With the same soiled glove CNA-I picked up the tube of barrier cream and applied some to the resident. CNA-I removed her gloves and donned a new pair without performing hand hygiene and pushed the clean wipe back into the package and closed the package. CNA-I removed her gloves and without performing any hand hygiene she touched the resident's clean brief, pants, shirt and Hoyer strap. CNA-I then went into the resident's bathroom and retrieved the Hoyer lift. CNA-I assisted CNA-J in hooking up the straps to the Hoyer lift to transfer resident #5 into her Broda chair. CNA-I moved the resident's Broda chair and touched the arm rests, the seat cushion and Dycem on the cushion. Once resident #5 was seated in her Broda chair CNA-I continued to touch her clothing, Hoyer sling and again the arm rest on the Broda chair. CNA-I then picked up the resident's hair brush and brushed her hair. When she was finished CNA-I placed the bottle of [MEDICATION NAME] and tube of barrier cream into a plastic bag and then placed it and the package of wipe into the resident's drawer. CNA-I then went to the resident's bathroom and washed her hands. At 9:10 a.m. surveyor # interviewed CNA-I and she verified that she should not have touched the bottle of [MEDICATION NAME] and tube of barrier cream with her soiled gloves. CNA-I also verified that she should have performed hand hygiene after removing her gloves and touching the resident's personal items. When asked, CNA-I indicated she did not have a bottle of hand sanitizer on her, nor did she know if the facility provided them.