F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it:
1. Investigates, controls, and prevents infections in the facility;
2. Decides what procedures, such as isolation, should be applied to an individual resident; and
3. Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
1. When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
2. The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
3. The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.
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This REQUIREMENT is not met as evidenced by:

Based on policy review, observations and interview, it was determined 1 of 5 nurses (Nurse #3) failed to ensure infection control practices were used to prevent the spread of infection by not cleaning the stethoscope and pulse oximeter prior to and after use.

The findings included:

Review of the facility's "INFECTION CONTROL" policy documented, "...GLUCOMETERS, BLOOD PRESSURE CUFFS, STETHOSCOPES, ETC [etcetera] CLEANED BETWEEN USE WITH PDI SANI-CLOTH BLEACH WIPE..."

Observations on the 200 hall in Room 209A on 5/24/10 at 8:45 AM, revealed Nurse #3 removed the stethoscope from around her neck and listened to Resident #6's breath sounds. After listening to Resident #6's breath sounds Nurse #3 placed the stethoscope back around her neck. Nurse #3 was holding the pulse oximeter under her arm and proceeded to check Resident #6's oxygen saturation level. The fire drill sounded at which time Nurse #3 left the room. As Nurse #3 left the room towels from the clean linen cart fell on the floor. Nurse #3 picked the towels up and placed them on a barrel in the soiled utility room. After the fire drill was over Nurse #3 returned to Resident #6's room (209A) and was preparing to check Resident #6's percutaneous endoscopic gastrostomy (PEG) tube placement and realized she didn't have her stethoscope. Nurse #3 returned to the soiled utility room and retrieved her stethoscope from the top of the soiled linen barrel. Nurse #3 returned to Resident #6's room and proceeded to use the stethoscope to check...
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<th>ID TAG</th>
<th>ID PREFIX</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>F 441</td>
<td>F.441</td>
<td>Continued From page 2 the placement of Resident #6's PEG tube. After checking the PEG tube placement, Nurse #3 placed the stethoscope around her neck and returned the pulse oximeter to the top of the medication cart. Nurse #3 was not observed to clean the stethoscope or pulse oximeter before or after using them. During an interview on the 200 hall on 5/25/10 at 1:15 PM, Nurse #3 stated, &quot;Didn't wash my stethoscope off, I should have washed it after I threw it in there [referring to soiled utility room]. I should have cleaned it [referring to stethoscope] and pulse oximeter before and after using them.&quot;</td>
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