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.

Provider's Plan of Correction
F 441
Ss=D
483.65 Infection Control, Prevent Spread, Linens

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

Nurse #1 was re-inserviced by Staff Development Coordinator on proper infection control practices as it related to dressing changes on 12/27/2012.

Licensed staff was re-inserviced by Staff Development Coordinator on proper infection control practices as it related to dressing changes on 01/04/2012.

DON or designee will conduct weekly audits for three weeks then monthly for three months to ensure that proper infection control practices are followed during dressing changes.

The findings of the audits will be reported to the Monthly Quality Assurance and Assessment committee by the DON or designee.

The Quality Assurance and Assessment Committee will determine the need for continued monitoring frequency at this time if 100% compliance has been met.

Completion Date: 01/06/2013

Administrator

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 60 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 required to continued program participation.
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This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation, and interview, it was determined the treatment nurse failed to maintain proper infection control practices by failing to obtain clean gloves during 1 of 1 dressing change observation.

The findings included:

Review of the facility’s "Dressings, Dry/Clean" policy documented, "The purpose of this procedure is to provide guidelines for the application of dry, clean dressings... Place the clean equipment on the bedside stand. Arrange the supplies so they can be easily reached... Put on clean gloves...".

Medical record review for Resident #109 documented an admission date of 12/14/12 with diagnoses of Urinary Tract Infection, Encephalopathy, Dementia, Pressure Ulcer, and End Stage Renal Failure. Review of the physician’s orders dated 12/15/12 documented, "...Apply [and] change dsg. [dressing] to... (posterior leg wound) daily...".

Observations during a dressing change in Resident #109’s room on 12/19/12 at 8:50 AM, revealed Nurse #1 changed a dressing to Resident #109's right lower leg and sacrum. Nurse #1 obtained gloves from her pocket and donned these gloves prior to removing the dressing to the sacrum. Nurse #1 removed the gloves, washed her hands, then obtained gloves from her pocket and donned these gloves prior to cleansing the wound and applying a clean
F 441. Continued From page 2 dressing to the wound.

During an interview at the 200-300 hall nurses' station on 12/19/12 at 3:35 PM, Nurse #1 confirmed she obtained the gloves from her pocket during the dressing change. Nurse #1 stated, "...Yea, I ran out of the gloves I had placed in the bag with my supplies..."