STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555115	A. BUILDING ______ B. WING _____	**05/16/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKHURST HEALTHCARE & WELLNESS CENTRE	**40131 HIGHWAY 49 OAKHURST, CA 93644**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0281 **Level of harm -** Actual harm **Residents Affected -** Some	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and clinical record review, the facility failed to implement appropriate infection control interventions based on professional standards of practice. This failure resulted in resident exposure to [DIAGNOSES REDACTED]icile, infection, and resident illness. Findings: On 4/26/13 at 2:25 p.m., during an interview, the Director of Staff Development (DSD) stated, I do the (infection control) inservice with the staff and with housekeeping. On 4/26/13 at 4:20 p.m., during an interview, the DSD stated she had recently provided infection control training to facility staff on 4/23/13. Training documents received indicated infection control reference information was taken from http://en.wikipedia.org downloaded on 9/13/12 and 3/8/13, a general information internet website, not recognized as a standard resource for professional infection control practice. On 4/26/13 at 4:21 p.m., during an interview, the Minimum Data Set (MDS)Coordinator stated she acted as interim DON prior to the new DON beginning employment at the facility. During that period she denied conducting research or seeking consultation on infection control measures for [DIAGNOSES REDACTED]icile infections. The MDS Coordinator stated she had talked to the administrator about it, but didn't feel the situation met the criteria to seek consultation. The MDS Coordinator denied seeking consultation from Madera County Public Health Department, Centers for Disease Control and Prevention materials, or other professionally recognized infection control resources. On 4/26/13 at 4:22 p.m., during an interview, the DSD denied conducting research or seeking consultation on [DIAGNOSES REDACTED]icile infections from professionally recognized infection control resources, stating, No, I didn't get in touch with anyone in particular .we talked about it, but no, we didn't. On 4/26/13 at 4:45 p.m., during an interview, the DON denied conducting research or seeking consultation with Madera County Public Health Department, Centers for Disease Control and Prevention, or other professionally recognized resources stating It was on my list to do . I just haven't done it yet. On 4/26/13 at 4:46 p.m., during an interview, the DSD, DON, and MDS Coordinator all denied conducting surveillance activities of non infected residents for signs and symptoms of potential [DIAGNOSES REDACTED]icile infection. Centers for Disease Control and Prevention Frequently Asked Questions about [MEDICAL CONDITION] for Healthcare Providers, indicated Healthcare facilities should monitor the number of [DIAGNOSES REDACTED]icile infections, and especially if rates at the facility increase .additional help should be sought from local and state health departments and/or infection control experts. Clinical Practice Guidelines for [MEDICAL CONDITION] Infection (CDI) in Adults: 2010 Update by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA) indicated under Epidemiology, 2. At a minimum, conduct surveillance for HCF-(Healthcare Facilities) onset, HCF-associated CDI in all inpatient healthcare facilities, to detect outbreaks and monitor patient safety.
F 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, clinical and administrative document review, the facility failed to implement and maintain a safe and sanitary environment to prevent transmission of resident infections when facility processes were not implemented for: 1) Hand hygiene for staff prior to and following resident care for residents on isolation and those who were not. 2) Effective staff education and training based upon professional standards of practice. 3) Environmental cleaning when staff did not consistently follow recommended guidelines. 4) Handling and processing of contaminated linens by laundry staff. 5) Staff sick leave and visitor guidelines when no evidence policies were established. This failure exposed residents and staff to infectious disease resulting in resident illness and harm to 7 residents (Residents 1, 2, 3, 4, 5, 6 & 7) and one staff member who was diagnosed with [REDACTED]. difficile) (a contagious gastrointestinal bacteria resulting in diarrhea and severe gastrointestinal illness). Findings: 1. On 4/26/13 at 1:45 p.m., during initial tour and concurrent interview, the Director of Nursing (DON) stated, The staff wash hands in the resident's rooms. On 4/26/13 at 2:15 p.m., during a concurrent observation and interview at the nurses station, Registered Nurse (RN) 1 was observed leaning over a medication cart, dressed in casual street attire (blue jeans and a T shirt). RN 1 stated, This is casual Friday in case you are wondering .We wash our hands in the utility room. On 4/26/13 at 2:16 p.m., during an observation, the utility room was observed locked, requiring key entry. The door key was observed on the wall adjacent to the utility room. No observations were made of staff washing hands in the utility room. On 4/26/13 at 2:17 p.m., during an observation, Gel-San (an alcohol based hand sanitizer) hand wipes and pump solution were noted on medication and treatment carts, and on the nurses station countertop. No gloves were observed on any carts. On 4/26/13 at 2:18 p.m., during an initial tour, Occupational Therapist, (OT) stated residents were being asked to use alcohol based sanitizer on their hands before entering the therapy room. On 4/26/13 at 3:00 p.m., during an interview, the Director of Staff Development (DSD) was asked how residents were being protected from healthcare associated infections and stated, We keep hand sanitizer and gloves in all the rooms. On 4/26/13 at 3:02 p.m., during an interview regarding components of the facility infection control program, the DON stated, I can't speak to that, you'd have to ask the DSD. On 4/26/13 at 3:05 p.m., during an interview regarding facility methods of monitoring for staff compliance with hand washing, the DSD paused and stated, I can't really answer that. On 5/4/13 at 3:05 p.m., during an observation of Resident 4's care at the bedside, RN 2 used hand sanitizer prior to entering Resident 4's room. RN 2 donned (put on) exam gloves and a disposable yellow gown. RN 2 assisted Certified Nursing Assistant (CNA 1) with skin care for Resident 4. RN 2 then pulled out a second pair of exam gloves which she placed over the dirty pair of exam gloves on both hands. RN 2 removed the cap from Resident 4's Gastrostomy Tube (GT) (a tube inserted

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **555115**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **05/16/2013**

NAME OF PROVIDER OF SUPPLIER **OAKHURST HEALTHCARE & WELLNESS CENTRE**	STREET ADDRESS, CITY, STATE, ZIP **40131 HIGHWAY 49** **OAKHURST, CA 93644**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0441

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 1)
through the skin into the stomach to feed or deliver medications) and placed the cap on top of the bag holding the enteral feeding.
On 5/4/13 at 3:15 p.m., RN 2 stated she had donned a second set of gloves over her first pair in order not to get bowel movement (BM) on the feeding tube. When asked what she might have done differently to maintain a sanitary environment for Resident 4, she stated she should have removed the first set of gloves, washed her hands, and put on a clean set of gloves prior to handling his GT. When asked if she had attended an in-service training in the area of infection control this week she stated she had, but, They just didn't get into details like that. They just talked about hand washing, gowning and gloving in isolation.
On 5/10/13 at 11:30 a.m., during an interview, the Housekeeping and Laundry Coordinator (HLC) stated, I have seen nurses and CNAs glove up (on entering a resident room), take the gloves off (after resident care), and leave the room and not wash hands. The only place I have seen staff washing their hands is in the break room.
The facility policy and procedure titled, Infection Control, Policy for Antibiotic Resistant Microorganisms (MDRO), undated, indicated under A. Standard Precautions including Contact Precautions, 1. Handwashing-before and after resident contact, and after removing gloves is the single most effective infection control measure known to reduce the potential for transmission of microorganisms, including .MDRO .
Review of Clinical Practice Guidelines for Clostridium difficile Infection (CDI) in Adults: 2010 Update by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America, Infection Control and Epidemiology, May 2010, indicated on p. 432, under Measures for Healthcare Workers, Patients, and Visitors, 14. Emphasize compliance with the practice of hand hygiene .p. 441 indicated Hand hygiene is considered to be the one of the cornerstones of prevention of . [DIAGNOSES REDACTED]icile in its spore form, is also known to be highly resistant to killing by alcohol .healthcare workers who decontaminate their hands with alcohol-based products could potentially increase the risk of transferring this organism to patients under their care.
2. On 4/26/13 at 2:25 p.m., during an interview, the Director of Staff Development (DSD) stated, I do the (infection control) inservice with the staff and with housekeeping.
On 4/26/13 at 4:20 p.m., during an interview, the DSD stated she had recently provided infection control training to facility staff on 4/23/13. Training documents received indicated infection control reference information was taken from http://en.wikipedia.org downloaded on 9/13/12 and 3/8/13, a general information internet website, not recognized as a standard resource for professional infection control practice.
Review of facility documents titled, Inservice Training Minutes,
indicated the DSD provided infection control inservice on the following dates: 8/1/12, 8/30/12, 9/2/12, 9/14/12, 10/18/12, 11/28/12, 1/9/13, 1/31/13, 2/26/13, and 3/11/13. No documented evidence of evaluations, observations of staff performance, or return demonstrations was provided.
On 4/26/13 at 2:25 p.m., during an interview, the Director of Nursing (DON) stated, We have three residents (Residents 1, 2 and 3) who are positive for Clostridium difficile (C.difficile) (a contagious gastrointestinal bacteria resulting in diarrhea and severe gastrointestinal illness). The DON stated she was waiting on test results for Resident 5.
On 4/26/13 at 3:00 p.m., during an interview, the Director of Staff Development (DSD) confirmed she was also the Infection Control Coordinator for the facility. The DSD stated Resident 1, 2 and 3 were diagnosed with [REDACTED].
On 5/4/13 at 3:05 p.m., during an observation of Resident 4's care at the bedside, RN 2 used hand sanitizer prior to entering Resident 4's room. RN 2 donned (put on) exam gloves and a disposable yellow gown. RN 2 assisted Certified Nursing Assistant (CNA) 1 with skin care for Resident 4. RN 2 then pulled out a second pair of exam gloves which she placed over the dirty pair of exam gloves on both hands. RN 2 removed the cap from Resident 4's Gastrostomy Tube (GT) (a tube inserted through the skin into the stomach to feed or deliver medications) and placed the cap on top of the bag holding the enteral feeding.
On 5/4/13 at 3:15 p.m., RN 2 stated she had donned a second set of gloves over her first pair in order not to get bowel movement (BM) on the feeding tube. When asked what she might have done differently to maintain a sanitary environment for Resident 4, she stated she should have removed the first set of gloves, washed her hands, and put on a clean set of gloves prior to handling his GT. When asked if she had attended an in-service training in the area of infection control this week she stated she had, but, They just didn't get into details like that. They just talked about hand washing, gowning and gloving in isolation.
On 5/10/13 at 11:30 a.m., during an interview, the Housekeeping and Laundry Coordinator (HLC) stated, I have seen nurses and CNAs glove up (on entering a resident room), take the gloves off (after resident care), and leave the room and not wash hands. The only place I have seen staff washing their hands is in the breakroom.
Review of Clinical Practice Guidelines for Clostridium difficile Infection (CDI) in Adults: 2010 Update by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America, Infection Control and Epidemiology, May 2010, indicated on p. 432, under Measures for Healthcare Workers, Patients, and Visitors, 14. Emphasize compliance with the practice of hand hygiene .p. 441 indicated Hand hygiene is considered to be the one of the cornerstones of prevention of . C.difficile in its spore form, is also known to be highly resistant to killing by alcohol .healthcare workers who decontaminate their hands with alcohol-based products could potentially increase the risk of transferring this organism to patients under their care.
3a. On 4/26/13 at 2:18 p.m., during an initial tour, the Occupational Therapist, (OT) stated We wipe our equipment down first thing (in the morning) and then at the end of the day each staff person is responsible for wiping down therapy mats after resident use.
On 4/26/13 at 3:10 p.m., during an observation and concurrent interview, Housekeeper 1 (H1) was observed at the entry to a resident room with a cleaning cart. She produced a spray bottle from her cleaning cart and admitted she was unable to read measurement markings, stating, I just put bleach to that line (pointing to the bottom rim of the bottle, approximately 2 ounce mark) and fill the rest with water. The spray bottle measurement indicated it was a 32 ounce spray container. H1 stated For the floor (a 4 gallon container) I use two of these (producing a bleach container cap, approximately 1.5 Tablespoons - less than a 1:10 ratio) and then fill it with water. We use 10:1 ratio (10 parts water to 1 part bleach), that's what they said.
Review of Centers for Disease Control and Prevention Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 indicated under 5. Cleaning and Disinfecting Environmental Surfaces in Healthcare Facilities, 17. In units with high rates of .Clostridium difficile infection or in an outbreak setting, use dilute solutions of 5.25%-6.15% sodium hypochlorite (e.g., 1:10 dilution of household bleach) for routine environmental cleaning. According to this ratio (1:10 dilution), a 4 gallon container of water would have required 6.64 cups of bleach to obtain a 1:10 ratio; (instead of the 1.5 Tablespoons used).
On 4/26/13 at 3:40 p.m., during an interview regarding deep cleaning of the facility (as a result of [DIAGNOSES REDACTED]icile infections), the Director of Nursing (DON) was unable to state the date or time of a scheduled cleaning.
On 4/27/13 at 3:45, during an interview, the DON and Interim Administrator (IA) were unable to state who was responsible for cleaning medical equipment used by multiple residents. The IA stated, I'll need to call our maintenance supervisor to find that out.
On 4/30/13 at 12:15 p.m., during an observation and concurrent interview, H1 was observed mopping the floor of Isolation room [ROOM NUMBER]. H1 stated she was mopping the floor with a bleach solution. H1 stated someone else had mixed the bleach water for her, and was unable to verify it was the correct concentration.
On 4/30/13 at 1:15 p.m., during an interview, the IA was unable to provide a cleaning schedule for resident equipment, stating, My maintenance supervisor cleans them every Friday with bleach. We don't have a schedule or a log.
The facility policy and procedure titled, Infection Control, Policy for Antibiotic Resistant Microorganism (MDRO), undated, indicated under C. Environmental and Equipment Protection, 1. Disinfection of soiled surfaces and equipment daily or more frequently by the designated staff member should be done in order to prevent the spread of .MDRO and other pathogenic microorganisms.
On 5/10/13 at 11:00 a.m., during an interview, the Housekeeping and Laundry Coordinator (HLC) stated she had no documentation of observations, return demonstrations or other measures for validating staff competence in correctly mixing 1:10 (1 part bleach to 10 parts water) bleach solutions. The HLC stated housekeeping staff do not routinely clean patient equipment. The HLC stated housekeeping staff were not routinely informed of resident status and care changes requiring

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKHURST HEALTHCARE & WELLNESS CENTRE	**40131 HIGHWAY 49 OAKHURST, CA 93644**

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F 0441

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 2)
isolation or contact precautions. The HLC stated, Usually I would hear about it by word of mouth from CNA staff .days have gone by before I knew someone had [DIAGNOSES REDACTED] or MRSA.
On 5/10/13 at 11:45 a.m., during an interview, the HLC stated, Some days I cannot finish my assignment because of interruptions and I get redirected to clean for (resident) room changes. There are a lot of room changes.
Review of the facility documents titled, Daily Census Report, (a report of daily resident admissions, discharges and bed changes), from January 2013 through April 2013, tracking room changes for residents with [DIAGNOSES REDACTED] infections indicated:
Resident 1's room locations: 19B, 25A, 27B, 16B, 25B, 21B.
Resident 2's room locations: 25B, 31C, 1B, 21B, 21C.
Resident 3's room locations: 10A, 25B.
Resident 5's room locations: 16A, 21A, 22A.
Resident 6's room locations: 17A, 25A.
Resident 7's room locations: 10A.
Making Health Care Safer, Stopping [DIAGNOSES REDACTED]icile Infections, Vital Signs, March 2012, Centers for Disease Control and Prevention, indicated, Make sure cleaning staff follows CDC recommendations, using an EPA-approved, spore-killing disinfectant in rooms where [DIAGNOSES REDACTED]icile patients are treated.
3b. On 5/2/13 at 1 p.m., during an observation of Resident 3 and 6's room (both positive for [DIAGNOSES REDACTED]icile), room [ROOM NUMBER] had 8 - 10 inches of water, half an inch deep on the floor surrounding the base of the toilet bowl in the bathroom. Brown flecks were observed floating in the water on the floor, on the toilet seat, and in the toilet bowl. Resident 3 stated, The toilet ran over in there about 10:30 this morning, the Maintenance Supervisor (MS) fixed it, but it hasn't been cleaned up yet. They told us they couldn't fix it until we were done eating.
4. On 4/26/13 at 1:45 p.m., during an initial tour of the facility laundry room, two open piles of resident laundry were observed lying on the floor adjacent to the washing machine.
On 4/26/13 at 1:46 p.m., during an interview, the Director of Nursing (DON) stated, I need to take care of that, and directed laundry staff to move the laundry to a covered laundry cart.
On 5/10/13 at 11:40 a.m., during an interview, the Housekeeping and Laundry Coordinator (HLC) stated there were no special handling procedures for resident laundry, including those on contact precautions, We don't do that. We were told it wasn't necessary .we don't get consistent information and direction on how to handle laundry."
On 5/15/13 at 4:30 p.m., during an interview, the Medical Director (MD) could not state the facility laundry procedures were in place for residents on contact precautions.
The facility policy and procedure titled, Infection Control, undated, indicated under Section D. Linens, Contaminated linens should be handled appropriately whether their source was an isolation room or a non-isolation room. All linen should be handled as if it were highly infectious.
5. On 4/26/13 at 1:30 p.m., during entry to the facility, no visitor instruction or guidance was posted at the entrance to the facility. Three to four visitors were observed talking with residents seated adjacent to the nurse's station.
On 4/26/13 at 5:45 p.m., during an interview, the Director of Staff Development (DSD) stated one staff person had been off work for several weeks, with a confirmed [DIAGNOSES REDACTED]icile infection.
On 4/30/13 at 4:00 p.m., during an interview, the Interim Administrator (IA) was unable to produce a sick leave policy for facility staff, stating, I'll have to look for it. The IA produced a new employee handbook, stating the policy was included in the handbook.
On 5/2/13 at 1:45 p.m., during a subsequent interview, the Administrator Consultant (AC) confirmed the handbook information was the only facility policy regarding staff illness.
Review of the facility document titled, (Facility) Handbook dated 12/12, contained no direction to ill employees regarding not exposing residents of the facility to their illness.
Review of SHEA/APIC Guideline for Infection Prevention and Control in the Long Term Care Facility (LTCF), July 2008, indicated, Initial assessment of employees and education in infection control are also important, as is a reasonable sick leave policy. Ill employees may cause significant outbreaks in the LTC LTCFs are required to prohibit employees with communicable diseases .from direct contact with
residents .
The facility policy and procedure titled, Infection Control, Policy For ARM/MDRO undated, indicated under I. Visitors: Instruct visitors to wash their hands prior to resident contact, following contact with body fluids, before and after feeding the resident and following contact with other residents.
Review of Centers for Disease Control and Prevention Guideline for infection control in healthcare personnel, 1998, indicated under D. Elements of a Personnel Health Service for Infection Control, Certain elements are necessary to attain the infection control goals of a personnel health service (e) management of job-related illnesses and exposures to infectious diseases, including policies for work restrictions for infected or exposed personnel, (f) counseling services for personnel on infection risks related to employment or special conditions .
As a result of the above failures 6 residents (Residents 1, 2, 3, 5, 6, & 7)and one staff member contracted[DIAGNOSES REDACTED]icile.
On 4/26/13 at 5:45 p.m., during an interview, the DSD stated one facility staff person (HLC) had been absent from work for several weeks, with a confirmed [DIAGNOSES REDACTED]icile infection.
On 5/10/13 at 11:00 a.m. during a telephone interview, HLC stated her date of onset for[DIAGNOSES REDACTED]icile was on 3/30/13 and her culture was positive for[DIAGNOSES REDACTED]icile on 4/17/13.
Review of the administrative documents reported to Madera County Public Health Department titled, Confidential Morbidity Report, dated 4/29/13, indicated the following dates of [DIAGNOSES REDACTED]icile symptom onset and dates of Diagnosis: [REDACTED].
Resident 2: onset 3/31/13, diagnosis 4/1/13.
Resident 3: onset 4/18/13, diagnosis 4/19/13 (based on hospital records).
Resident 5: onset 4/4/13, diagnosis 4/5/13.
Resident 6: onset 4/24/13, diagnosis 4/26/13.
Resident 7: onset 5/1/13, diagnosis 5/6/13.
Review of clinical laboratory record documents titled, Diagnostic Laboratories and Radiology, dated 4/23/13, 4/1/13, 4/26/13, and 5/6/13 for Resident 1, 2, 5, and 7 respectively, all indicated Toxigenic [DIAGNOSES REDACTED] Positive . The 027/NAP1/BI strain has a high risk of sporulation and toxin production, and has been associated with epidemics of [DIAGNOSES REDACTED]icile infection. The lab record results identified all 4 residents were infected with the same strain of[DIAGNOSES REDACTED]icile.
On 4/26/13 at 5:45 p.m., Immediate Jeopardy was called with the Director of Nursing (DON), the Director of Staff Development (DSD) and the Minimum Data Set (MDS) Coordinator when there was an outbreak of Clostridium difficile (C. diff), there was no system in place, and staff were not knowledgeable of infection control practices to prevent the spread of[DIAGNOSES REDACTED].
Immediate Jeopardy was abated on 5/9/13 at 5:17 p.m. with the Interim Administrator and the DON, when the facility provided an acceptable Plan of Action to educate the licensed nurses, laundry, and housekeeping staff in Infection Control practices with training provided by an acceptable outside resource. The isolation rooms were provided dedicated equipment to prevent cross-contamination of residents and a dedicated Certified Nurse Assistant (CNA) for isolated residents. Multiple hand sanitizing stations were placed throughout the facility. The facility implemented routine standardized infection control precautions: caution signs to warn visitors, separation of infectious linens, and cohorting (housing residents with like disease processes) of residents.

F 0501

Level of harm - Actual harm

Residents Affected - Some

Choose a doctor to serve as the medical director to create resident care policies and coordinate medical care in the facility.
br>Based on staff interview, and administrative document review, the Medical Director failed to ensure the facility

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F 0501

Level of harm - Actual harm

Residents Affected - Some

(continued... from page 3)
implemented infection control policies necessary to prevent and control healthcare associated infection. This failure resulted in resident exposure, infection, and illness.
Findings:
On 5/15/13 at 3:15 p.m., during an interview, the Medical Director (MD) stated he spends an average of three hours per month in service to the facility as MD inclusive of site visits, travel time, fax dispositions and phone calls. The MD stated facility infection control policies and procedures were approved and reviewed on January 22, 2013 and April 24, 2013 at the facility Quality Assurance meeting.
On 5/15/13 at 3:30 p.m., during an interview, the MD stated his being notified by the Interim Administrator (IA) on 4/26/13 of the Immediate Jeopardy status of the facility and stated, I encouraged them to read and follow their (infection control) policies and procedures, and to contact county public health and CDPH.
On 5/15/13 at 3:45 p.m., during an interview, the Medical Director stated he conducted a site visit of the facility after being notified of the Immediate Jeopardy status of the facility and stated, I did a walk through of the facility .I was disappointed .I did see potential for resident harm. There were knowledge issues and a lack of understanding (by facility staff) regarding infection control. He was unable to state the date and time of his walk through.
On 5/15/13 at 4:15 p.m., during an interview, the Medical Director acknowledged the http://en.wikipedia.org resource utilized for staff inservice training was not appropriate, and had assumed staff was knowledgeable regarding appropriate infection control resources.
On 5/15/13 at 4:30 p.m., during an interview, the MD could not confirm the facility laundry procedures were in place for residents on contact precautions.

F 0520

Level of harm - Actual harm

Residents Affected - Some

Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, staff interview, and administrative document review the facility failed to ensure the Quality Assurance (QA) Committee identified issues related to infection control and implement an appropriate plan of action to prevent resident infections.
This failure resulted in residents and staff exposure to healthcare associated infection and resident/staff illness.
Findings:
On 4/26/13 at 1:27 p.m., during an observation of the facility entrance, no visitor instructions or notification signs were posted.
On 4/26/13 at 2:17 p.m., during an observation, Gel-San (an alcohol based hand sanitizer) hand wipes and pump solution were noted on medication and treatment carts, and on the nurse's station countertop. No gloves were observed on any carts.
On 4/26/13 at 2:18 p.m., during an initial tour, the Occupational Therapist, (OT) stated We wipe our equipment down first thing (in the morning) and then at the end of the day each staff person is responsible for wiping down therapy mats after resident use.
On 5/10/13 at 11:00 a.m., during a telephone interview, the Housekeeping and Laundry Coordinator (HLC) confirmed she had no documentation of observations, return demonstrations or other measures for validating staff competence in correctly mixing 1:10 bleach solutions. The HLC stated she contracted[DIAGNOSES REDACTED] on 3/30/13 and her culture was positive for[DIAGNOSES REDACTED] on 4/17/13.
On 5/10/13 at 11:30 a.m., during an interview, the HLC stated, I have seen nurses and CNAs (Certified Nursing Assistants) glove up (on entering a resident room), take the gloves off (after resident care), and leave the room and not wash hands. The only place I have seen staff washing their hands is in the break room.
On 5/10/13 at 11:40 a.m., during an interview, the HLC stated there were no special handling procedures for resident laundry, including those on contact precautions, We don't do that. We were told it wasn't necessary .we don't get consistent information and direction on how to handle laundry."
On 5/15/13 at 3:15 p.m., the Medical Director stated the Quality Assurance Committee (identifies quality deficiencies and develops and implements plans of action to correct these quality deficiencies) included the Department Heads (Dietary, Social Services Designee, Activities Coordinator, Housekeeping/Maintenance), Director of Staff Development, Director of Nursing, Medical Director and Administrator.
On 5/15/13 at 3:15 p.m., during an interview, the MD stated facility infection control policies and procedures were approved and reviewed on January 22, 2013 and April 24, 2013 at the facility Quality Assurance meeting. The MD stated his role was to work closely with the DSD, DON and Administrator by advising and consulting but it did not include the implementation of Infection Control Policy and Procedures. The MD stated his role in the QA committee was that he runs the meeting and he depended on staff to report to him if their were any unusual circumstances.
On 5/15/13 at 3:45 p.m., during an interview, the Medical Director stated he conducted a site visit of the facility after being notified of the Immediate Jeopardy status of the facility and stated, I did a walk through of the facility .I was disappointed .I did see potential for resident harm. There were knowledge issues and a lack of understanding (by facility staff) regarding infection control. He was unable to state the date and time of his walk through.
On 5/15/13 at 4:30 p.m., during an interview, the Medical Director (MD) could not confirm the facility laundry procedures were in place for residents on contact precautions.
The facility policy and procedure titled, Infection Control-Policies and Procedures dated January 12, 2012, indicated under Procedure III, The Quality Assessment and Assurance committee, through the Infection Control Committee oversees implementation of infection control policies and procedures, and helps department heads ensure that they are implemented and followed.
As a result of the above failures 6 residents (Residents 1, 2, 3, 5, 6, & 7)and one staff member contracted[DIAGNOSES REDACTED]icile.
Review of the administrative documents reported to Madera County Public Health Department titled, Confidential Morbidity Report, dated 4/29/13, indicated the following dates of [DIAGNOSES REDACTED] symptom onset and dates of Diagnosis: [REDACTED].
Resident 2: onset 3/31/13, diagnosis 4/1/13.
Resident 3: onset 4/18/13, diagnosis 4/19/13 (based on hospital records).
Resident 5: onset 4/4/13, diagnosis 4/5/13.
Resident 6: onset 4/24/13, diagnosis 4/26/13 (based on hospital records).
Resident 7: onset 5/1/13, diagnosis 5/6/13.