STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355079	A. BUILDING _____ B. WING _____	01/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA MARIA	3102 S UNIVERSITY DR FARGO, ND 58103

FEB 8 2010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on January 19, 2010 and completed on January 21, 2010 the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review.	F 000	**TAG # F0371 SANITARY CONDITIONS** 1. **Corrective Action:** It is the practice of this facility to maintain sanitization solution at proper concentration, food preparation equipment in sanitary condition and to store food in a sanitary manner. The microwaves were immediately cleaned and sanitized. The sanitization solution that was not at appropriate level was immediately changed out with new solution. Scoops were removed from containers of Fiber Basic. 2. **Identify other areas**: All facility microwaves used for resident food were checked to assure cleanliness. All pails of sanitization solution were checked for proper concentration levels. The DON sent out an email to nurses to remove scoops from all powdered medication containers. 3. **Measures put in place:** Dietary staff was educated regarding cleaning of microwaves in the nourishment centers on the units. Club staff was educated regarding the need to daily check and clean the microwave in this area. A process was created to assure regular cleaning of microwaves is completed on a regular basis. A different sanitizing solution was purchased that better maintains concentration levels within appropriate range. In-service education was completed with Dietary staff by the dietary manager on 2/11/10 on sanitation of dietary equipment and assuring proper concentration of sanitization solution. The nurses were educated at the 2/8/2010 nurses meeting on use of plastic medication cups for	
F 371 SS=B	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, manufacturer's recommendations, professional literature review, policy and procedure review, and staff interview, the facility failed to monitor sanitization solution in 1 of 1 facility kitchen, maintain food preparation equipment in sanitary condition in 1 of 2 nutrition stations (South) and 1 of 1 activity "club" room, and store food in a sanitary manner in 1 of 1 random observation of a medication cart. Findings include: Review of the facility's policy, "Sanitation/Food Handling and Preparation," reviewed/revised in January 2010, occurred on the afternoon of 01/21/10. The policy stated, "Procedure: . . . 3. Use clean, sanitized equipment and worktables. .	F 371		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Heiser	CEO	2/4/10

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 371	Continued From page 1 . . ." Review of a form, "Kitchen Cleaning Duties," included the weekly duty of "Clean . . . micro [microwave] in Pod [nutrition station]." The 2005 Food Code, published by the Food and Drug Administration (FDA), Public Health Reasons, page 377, stated, ". . . Soiled wiping cloths, especially when moist, can become breeding grounds for pathogens that could be transferred to food. Any wiping cloths that are not dry (except those used once and laundered) must be stored in a sanitizer solution at all times, with the proper sanitizer concentration in the solution. Wiping cloths soiled with organic matter can overcome the effectiveness of, and neutralize, the sanitizer. The sanitizing solution must be changed as needed to minimize the accumulation of organic material and sustain proper concentration. Proper sanitizer concentration should be ensured by checking the solution periodically with an appropriate chemical test kit . . ." The manufacturer's recommendations for "Oasis 144," a quaternary ammonia sanitizer, stated, "Sanitizing Equipment - . . . rinse equipment with sanitizing solution of 1 oz product to 4 gal. of water (200 ppm [parts per million]) . . . For Manual Operations fresh sanitizing solution should be prepared as soon as they become diluted or soiled. . . ." - The main tour of the kitchen occurred on 01/20/10 at 3:00 p.m. with an administrative dietary staff member (#1). Observation showed two buckets, containing a solution and cloth(s), one located on a counter near the three	F 371	measuring powdered medications and the premise behind not storing scoops in any powdered medications. 4. **Monitoring**: The Dietary Manager will conduct a quality audit of cleanliness of the microwaves and concentration levels of sanitizing solution in pails weekly for 1 month, monthly for 3 months and as needed until substantial compliance is obtained. Nurse managers will do initial QA on all medication carts to check for scoops in containers. This QA will be done initially and then monthly for one quarter. After that a check will be conducted with nurse evaluation med pass audits. 5. **Date:** The facility will be in substantial compliance with corrective actions implemented and initial QA's completed for F371 by 2/24/10. Reviewed by the facility's quality committee. Additions per phone call w/ DON 02/09/10. ICS	2/24/10

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F 371	Continued From page 2 compartment sink in the kitchen and the other on a cart in the dishroom. The dietary staff member (#1) stated the buckets contained a sanitizer, "Oasis 144," and water solution used to sanitize countertops in the kitchen and tables in the dining room. When asked to test the concentration of the buckets of sanitizing solution, this staff member obtained a test strip for quaternary sanitizing solutions. The concentration of the solutions measured below 200 ppm (between 0 to 150 ppm) for both buckets. The dietary staff member (#1) refilled a bucket with sanitizing solution from an automatic dispenser located near the three compartment sink, and testing of this solution identified the required concentration of 200 ppm. During the main kitchen tour, observation showed two microwaves in the South nutrition station and one microwave in the activity "club" room. Observation showed the interior surfaces of the microwaves heavily soiled with food debris. When interviewed during the main kitchen tour and on the morning of 01/21/10, an administrative dietary staff member (#1) identified dietary staff should clean the microwaves per the cleaning schedule and facility staff should clean the microwave as needed. This staff member agreed dietary staff should use/maintain sanitizing solutions at a concentration recommended by the manufacturer. - On the morning of 01/21/10, inspection of a medication cart on Memory unit with a licensed nursing staff member (#4) identified a nine ounce container of Fiber Basic's instant soluable fiber. A blue plastic scoop used to measure the fiber rested inside the can, which was one-third full.	F 371		

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F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, and staff interview, the facility failed to ensure proper hand hygiene, glove usage, and/or sanitation of equipment for 8 of 21 sampled residents (Resident #2, #4, #6, #7, #9, #10, #14, and #17). Failure to practice proper infection control guidelines has the potential to transmit diseases and infections to, and between residents. Findings include: Review of infection control program policies and procedures occurred on 01/21/10. The following policies stated: * "Infection Control Program," dated January 2010: "POLICY: There is an active, facility-wide infection control program with established guidelines to follow in the investigation, prevention and control of contagious, infectious or communicable diseases. . . ."	F 441	**Tag # F 441** 1. **Corrective Action:** Specific CNA's observed during survey were educated on observations made by surveyors regarding infection control practices. The washbasin for resident #14 was removed from the room and disinfected. 2. **Identify other areas:** All CNA's were inserviced on infection control practices to be improved upon. This included demonstration of proper infection control practice related to hand hygiene and glove use, proper hand hygiene for resident's after assisting with toileting, how to determine which equipment belongs to which resident with cares, and proper technique for cleaning urine graduates after emptying catheter bags. 3. **Measures put in place:** Skills checklists for orientation, three month conditional evaluations and annual evaluation of CNA skills were updated to reflect good infection control practices. Medicine cabinets and vanities in resident rooms where washbasins are stored were labeled to distinguish which supplies belong to which resident. 4. **Monitoring:** QA's will be conducted to observe cares to assure hand hygiene is performed at appropriate times, especially with glove removal. Nurses will complete this initially for all CNA's. Random audits will be conducted monthly and then quarterly until substantial compliance is obtained. Nurses will complete QA observations of catheter bag emptying technique to assure graduate cleaning is done appropriately. This QA will be done initially, then monthly 10% c with goal of 100% by 2/24/10. of 90%	

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F 441	Continued From page 4 * "Hand Hygiene," dated December 2009: "POLICY: Employees will perform hand hygiene following current CDC [Centers for Disease Control] guidelines. PROCEDURE: 1) Hand hygiene is to be performed . . . d) After contact with a residents intact skin. e) After contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings. f) If moving from a contaminated body site to a clean body site during resident care. . . . h) After removing gloves. . . . 3) Handwashing with soap and water is to be done: a) When hands are visibly dirty, contaminated with proteinaceous material, or visibly soiled with blood or other body fluids. . . ." * "Standard Precautions," revised January 2010: "POLICY: All Residents at [facility name] will be cared for using standard precautions for prevention of infections, following CDC guidelines. PROCEDURE: All employees will routinely use appropriate precautions to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection. All body fluids are to be treated as if they are contaminated with infectious pathogens. . . . Hand Hygiene . . . Wash hands with soap and water if.contact with spores (e.g. C. Diff. [for example, Clostridium Difficile]) is likely to have occurred. . . . GLOVES: a. Wear gloves when it is anticipated that direct contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated non-intact skin could	F 441	and then quarterly until substantial compliance is obtained. 5. **Date:** The facility will be in substantial compliance with corrective actions implemented and initial QA's completed for F441 by 2/24/2010. Reviewed by the facility's quality committee. Additions per phone call with DON 02/04/10. KS	2/24/10

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F 441	Continued From page 5 occur. . . . d. Gloves are to be removed after contact with the resident and or the surrounding environment. e. Change gloves during resident care if the hands will move from a contaminated body site to a clean body site. f. Hand hygiene is performed after glove removal. . . . Resident care equipment that is to be re-used will be . . . 2. Cleaned and disinfected before re-use, as appropriate. . ." * "ISOLATION PRECAUTIONS," dated 01-10: ". . . PROCEDURE: 1. All residents will be cared for following 'Standard Precautions' at all times. . . . 2. Transmission Based Precautions will be used for the care of specified residents with documented or suspected infections from highly transmissible or epidemiological significant pathogens for which additional precautions beyond Standard Precautions are needed . . . C. Contact Precautions: Reduce the risk of transmission by direct skin-to-skin contact or indirect contact with a contaminated intermediate object (usually inanimate). . . . 7. Contact Precautions: . . . c. Change gloves after having contact with infective material that may contain high concentrations of microorganism. (e.g. Urine, fecal material and wound drainage). . . . j. Ensure that resident care items, bedside equipment and frequently touched surfaces are cleaned daily. k. If common equipment used, adequately clean and disinfect items before use on another resident. . . ."	F 441		

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F 441	Continued From page 6 - Observation of a Certified Nurse Assistant (CNA) (#10) assisting Resident #4 with personal cares at 8:05 a.m. on 01/20/10 showed while CNA (#10) washed her hands, Resident #4 entered the bathroom, removed her disposable brief, and threw the brief on the floor. Resident #4's brief showed the resident had been incontinent of both bowel and bladder. Following handwashing, the CNA (#10) donned disposable gloves and while Resident #4 sat on the toilet, prepared Resident #4's toothbrush. After handing the resident her toothbrush, the CNA (#10) picked up the soiled disposable brief from the floor, placed it in the garbage container, and with the same gloved hands, obtained and handed Resident #4 a glass of water to rinse her mouth. As the CNA handed the glass to Resident #4, the CNA's contaminated gloved hand came in contact with the drinking surface/rim of the glass. With the same contaminated gloves, the CNA (#10) wet a washcloth from a basin of water, washed, and then dried Resident #10's face. The CNA (#10) then removed her gloves and left the resident's bathroom without washing her hands. Upon reentering the resident's room, the CNA (#10) donned clean gloves and wet another washcloth from the same basin of water, and washed and dried Resident #4's upper torso. Following the completion of washing the resident's upper torso, the CNA, with the same gloves again, wet a washcloth from the same basin of water, cleansed Resident #4's abdomen and lower/front perineal area, wet a clean washcloth from the same basin of water, and washed the resident's arms and hands. With the same gloves on, the CNA (#10) then obtained	F 441		

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F 441	Continued From page 7 clean clothing from the closet, and opened two dresser drawers to obtain clean underwear and socks for Resident #4. After obtaining the clothing and underwear, the CNA (#10) removed her gloves, wet a clean washcloth, washed and dried Resident #4's feet, and fixed the resident's hair. The CNA (#10) again applied gloves, wet another washcloth from the same basin of water, assisted Resident #4 to a standing position from the toilet, and washed the resident's buttocks and rectal area. The CNA (#10) removed her gloves, adjusted the resident's clothing, assisted the resident to the sink where the CNA applied soap to the resident's hands, and using her hands, washed the resident's hands under running water. - During observation of a CNA (#11) assisting Resident #9 with personal care at 9:30 a.m. on 01/20/10, the CNA donned gloves, lowered the resident's wet incontinent brief to the resident's ankle area and assisted the resident to a sitting position on the toilet. After the resident voided, the CNA (#11) cleansed the resident's front perineal area, and removed her gloves. With bare hands, the CNA removed the resident's incontinent brief from around the resident's ankles, placed it in the garbage container, and removed and closed up the bag of garbage. During the above described observation, the CNA (#11) completed no handwashing and utilized only a hand sanitizer after helping the resident locate her sweater, and prior to leaving the resident's room. - Review of Resident #7's record identified a culture report obtained from Resident #7's left lower leg as positive for Methicillin Resistant	F 441		

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F 441	Continued From page 8 Staphylococcus Aureus (MRSA). Resident #7's current care plan identified the presence of this infection and a nursing intervention of contact precautions. Nursing notes, dated 01/19/10, identified the onset of a two centimeter (slit) to Resident #7's buttock, and the treatment sheet identified treatment with a Duoderm dressing to this area. Observation of cares provided to Resident #7 in his room, by a CNA (#12), occurred on the afternoon of 01/20/10. Upon entering the room, observation showed a supply cabinet hanging on the bathroom door with items (gowns and gloves) for contact precautions. Observation of cares occurred while the resident laid in bed. The CNA (#12), after donning a gown and gloves, removed an incontinence pad and provided rectal pericares. Observation showed a small amount of incontinent stool on the incontinence wipe. The CNA (#12) then removed the gloves, reached into the box of gloves in the supply cabinet, and applied another pair of gloves. The CNA (#12) obtained a tube of Aquaphor cream, applied it over various areas of the resident's buttocks, and removed the gloves. The CNA (#12) then obtained another pair of gloves from the supply cabinet (reaching into the box of gloves), donned the gloves, and obtained a graduate (plastic measuring container) from the resident's bathroom and emptied Resident #7's Foley drainage bag. Following emptying the drainage bag, the CNA (#12) swabbed the drainage port with an alcohol swab, transported and emptied the graduate in the toilet. With the same contaminated gloves on, the CNA obtained the package of incontinent wipes off the resident's bed and returned them to a cupboard in the bathroom. The CNA (#12) then removed the	F 441		

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F 441	Continued From page 9 gloves, did not wash his hands, donned new gloves, repositioned the resident in bed, handed the resident the bed controls, moved the bedside table within reach, and then emptied the garbage. The CNA (#12) removed the gown, and the gloves, and then entered the bathroom, and washed his hands with soap and water. - Observation of cares provided to Resident #2 in her room, by a CNA (#13), occurred on the afternoon of 01/20/10. The CNA (#13) informed the resident she would change her incontinent brief. After the CNA (#13) washed her hands and applied gloves, the CNA (#13) stood the resident with a stand lift (Sara 3000), removed the resident's incontinent brief, removed her gloves and washed her hands. The CNA (#13) then reached into the glove box for another pair of gloves, applied the gloves, provided Resident #2's frontal, and then rectal, pericares. Observation showed a small amount of stool present with the rectal pericares. The CNA (#13) removed her gloves, did not wash her hands, reached into the glove box for another pair of gloves, applied the new gloves, and applied Aloe Vesta cream over the resident's buttocks area. The CNA (#13) removed the gloves, did not wash her hands, reached into the glove box for another pair of gloves, applied a new incontinent brief, sat the resident down with the lift, removing the harness and leg straps, and returned the Aloe Vesta cream to the top of the resident's bedside stand. The CNA (#13) then went to the sink and washed her hands. An interview occurred with three administrative staff members (#3, #14 and #15) on the morning of 01/21/10. The three staff members agreed hand washing should occur after removing	F 441		

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F 441	Continued From page 10	F 441		

gloves, including following incontinence cares, provided the resident is in a safe position at that time. The staff members also agreed reaching for a new pair of gloves (into a box of gloves) prior to completing hand washing/hand hygiene could cause contamination of the box of gloves.

- On 01/20/10 at 9:30 a.m., observation showed a CNA (#7) assist Resident #10 to the bathroom. Observation showed the CNA (#7), after applying gloves, removed Resident # 10's soiled incontinence pad (soiled with urine). After the resident sat on the toilet, with the same gloved hand that touched the incontinent pad, the CNA (#7) applied Bengay cream (topical pain relief) to Resident #10's left foot. The CNA (#7) removed the gloves, did not wash her hands, applied new gloves, and provided pericares to Resident #10.

During an interview on the afternoon of 01/21/10, an administrative nurse (#3) agreed the CNA should have changed gloves after removing the soiled pad and prior to applying the Bengay cream.

- Observation of personal cares for Resident #14 occurred on 01/21/10 at 9:05 a.m. A CNA (#2) placed bed linens, towels, wash clothes and a pair of disposable gloves on the resident's bedside stand. While preparing Resident #14 for personal cares one of the disposable gloves fell from the bedside stand to the floor. The CNA picked up the glove from the floor and placed it back on top of the pile of linens on the bedside stand. The CNA filled a basin with water and proceeded to wash Resident #14's face. While the CNA provided cares, one of the disposable gloves again fell from the bedside stand to the floor. The CNA picked up the glove from the floor

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VILLA MARIA	3102 S UNIVERSITY DR FARGO, ND 58103

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F 441	Continued From page 11 and placed it back on top of the linens on the bedside stand. Prior to performing perineal cares for Resident #14, the CNA donned the pair of gloves which had fallen on the floor. The basin the CNA used during the provision of cares had a paper tape label identifying another resident's name. At the conclusion of Resident #14's personal cares, the CNA (#2) confirmed the name on the basin was Resident #14's roommate. The CNA rinsed the basin with water and stored it in the cabinet under the sink. Failure to sanitize the basin prior to use and using gloves that were on the floor put the resident at risk for spread of infection. During an interview on 01/21/10 at 1:00 p.m., an administrative nurse (#3) agreed the CNA should not have used the gloves that fell on the floor and would expect the basin to be sanitized before storing due to the fact the basin belonged to Resident #14's roommate. - Observation on 01/20/10 at 8:00 a.m., showed two CNAs (#8 and #9) assisting Resident #6 to toilet. After the resident expelled a loose stool, the resident completed her frontal pericare. The CNA (#8) stated, "she likes to do that herself [frontal pericare]." The CNAs did not encourage Resident #6 to wash her hands following the potential contact with body fluids. - On 01/21/10 at 8:57 a.m., observation showed a CNA (#5), donned gloves, emptied Resident #17's urine collection bag into a graduate, and then poured the urine into the toilet. The CNA went to the resident's sink, filled the graduate with tap water, poured the water into the sink, filled the graduate with water a second time, and again poured it into the sink. The CNA then wiped the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355079	A. BUILDING _____ B. WING _____	01/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA MARIA	3102 S UNIVERSITY DR FARGO, ND 58103

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F 441	Continued From page 12 graduate dry with a paper towel and placed it in a bathroom cupboard next to a box of gloves and a brief. Observation showed the toilet to have a sprayer arm attached. A sprayer arm sprays water for cleaning an item after it is emptied into the toilet. On 01/21/10 at 1:20 p.m., an administrative staff member (#3) agreed staff should not rinse graduates out in a resident's sink.	F 441		