Amended

PRINTED: 06/12/2013
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345187	A. BUILDING _____ B. WING _____	C 04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEIGHTS HEALTH & REHAB CTR	109 FOOTHILLS DRIVE MORGANTON, NC 28655

(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 No deficiencies were cited as a result of the complaint investigation. Event ID #1QI311.	F 000		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, chart review and resident and staff interviews the facility failed to remove female resident facial hair for 2 of 3 residents observed for activities of daily living. (Residents #70 and #77) The findings include: 1. Resident #70 was admitted to the facility with diagnoses which included congestive heart failure, hypertension, diabetes and chronic obstructive pulmonary disease. Review of Resident #70's most recent Significant Change Minimum Data Set (MDS) dated 01/22/13 revealed she was cognitively intact and she needed assistance with activities of daily living (ADLs). Further review of the MDS revealed no rejection of care behaviors were noted. Review of Resident #70's care plan updated on 02/12/13 revealed she had self care deficits related to impaired vision, hearing and weakness. The goal for her ADL needs to be met with staff	F 312	F312 A. The facial hair on Resident #77 was removed the evening of 4/18/13. The facial hair on Residents #70 was removed on 4/19/13. B. All residents who are dependent for ADLs have the potential to be affected. Staff shall be educated to ask residents on their shower days if they want their facial hair removed. If the resident refuses, the staff member shall report this to the nurse and document this resistance or refusal. This shall be implemented now and the education shall be completed by 5/16/13. C. The CNAs shall document the facial hair removal or refusal on the residents' shower forms or in the computer. The nurse managers from each unit shall conduct random audits of facial hair removal and documentation 3 times a week for 4 weeks, then monthly for 2 months. The findings shall be reported to the Director of Nursing (DON) after each audit is complete. D. Results of the audits shall be presented by the DON at the monthly Quality Assurance meeting and revisions shall be made as necessary.	F312 5/16/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah H. Morgan
TITLE: Administrator
(X6) DATE: 05/09/13

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.

DHSR Raleigh Black Mountain Wing
Received
JUN 14 2013
by: SKH

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F 312	Continued From page 1 assistance. An observation was made on 04/18/13 at 1:16 PM during medication administration of Resident #70 having noticeable facial hair on her chin and upper lip. The facial hair was approximately 3/8 inch long. An interview was conducted on 04/18/13 at 4:56 PM with Resident #70. She stated having the facial hair made her feel neglected and she was afraid she looked like a man. She stated staff had shaved the hair before but it had been a long time since it was last done. During an interview on 04/18/13 at 5:19 PM with Nursing Assistant #1 she stated she was working with Resident #70. She further stated that she usually only shaved female facial hair while providing resident showers. An interview was conducted on 04/18/13 at 5:49 PM with Nurse #1. She stated she expected nursing assistants to shave female facial hair when they notice it or when they give a resident a shower. An interview with the Director of Nursing (DON) on 04/18/13 at 5:54 PM she stated her expectation is for staff to ask the residents if they would like to have their facial hair shaved. This should be done at any time staff notice the facial hair. She further stated if residents are dependent for care the nursing assistants should make an attempt to shave their facial hair but if residents refuse it should be documented. 2. Resident #77 was admitted to the facility with	F 312		

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diagnoses which included hypertension, depression and Alzheimer's disease. Review of Resident #77's most recent Quarterly Minimum Data Set (MDS) dated 02/09/13 revealed she had long and short term memory loss and was impaired for daily decision making. The MDS further assessed Resident #77 as needing extensive assistance with activities of daily living. Review of the MDS revealed there were no rejection of care behaviors noted.

Review of Resident #77's care plan dated 11/25/12 revealed a self-care deficit and an inability to perform ADLs independently due to mobility limitations and medical diagnoses.

An observation was made on 04/16/13 at 12:36 PM of Resident #77 with multiple chin hairs approximately 1 inch long.

An observation on 04/18/13 at 5:19 PM of Resident #77 who continued to have long facial hair on her chin of approximately 1 inch long.

An interview was conducted on 04/18/13 at 5:42 PM with Nurse #2. She stated she would expect for nursing assistants to shave female facial hair during showers or anytime they noticed it.

An interview with the Director of Nursing (DON) on 04/18/13 at 5:54 PM she stated her expectation is for staff to ask the residents if they would like to have their facial hair shaved. This should be done at any time staff notice the facial hair. She further stated if residents are dependent for care the nursing assistants should make an attempt to shave their facial hair but if residents refuse it should be documented.

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F 365 SS=E	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS	F 365	F 365	F 365 05/16/13

Each resident receives and the facility provides food prepared in a form designed to meet individual needs.

This REQUIREMENT is not met as evidenced by:
Based on observations, medical record review and staff interviews the facility failed to provide meat in a food form consistent with the diet order for five of five sampled residents. (Residents #7, #66, #139, #98 and # 181)

The findings are:

1. Resident #7 was admitted to the facility 04/19/07 with diagnoses which included cerebrovascular accident with right hemiplegia, expressive nominal aphasia and dysphagia.

The last care plan update on 02/15/13 for Resident #7 included a summation that, "Resident remains alert and able to make her needs known verbally. She has a history of cerebrovascular accident with right hemiplegia with speech difficult to understand at times. Resident has had episodes of choking in dining room. Resident in dining room with supervision with orders to take small bites and sit at 90 degrees. Speech was consulted". The care plan for Resident #7 was last updated 02/28/13 and included a problem area, At risk for weight loss related to mental status and has history of cerebrovascular accident with right hemiplegia. Approaches to this problem area included, puree meat with mechanical soft diet.

1. Residents # 7, 66, 139, 98, and 181 are served their meals in the correct food forms and consistencies.
2. All residents have the potential to be affected by this alleged deficient practice.
3. The dietary manager reviewed food service orders against diet orders to ensure the orders matched. Dietary staff were educated about food forms and food consistencies by the dietary manager. The dietary manager or designee shall audit the tray line to ensure residents receive the correct food forms and consistencies as ordered. These tray audits shall be conducted 2 times a week for 1 month, one time per week for two months then monthly for three months.
4. The audit findings shall be reported at the monthly Quality Assurance meetings with revisions made as indicated.

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Resident #7 was treated by the speech language therapist from 01/29/13-02/28/13 due to concerns the resident was choking on food. On 02/14/13 the speech language therapist changed the resident's diet to mechanical soft with puree meal. This remains the current diet order for Resident #7.

On 04/17/13 at 12:15 PM Resident #7 was observed in the main dining room eating her lunch meal. The tray card for Resident #7 indicated she should be served a mechanical soft diet with puree meat. The select menu was included with the tray card for Resident #7 and she had chosen chicken breast as the meat preference. The meat served to Resident #7 was chopped chicken; served in large chunks. Resident #7 was observed eating the chicken and did not have any choking episodes.

On 04/17/13 at 12:35 PM the Food Service Director (FSD) and cook (that prepared the lunch meal and served the food) were interviewed. The FSD stated Resident #7 should have been served pureed meat, not chopped. The cook stated she had only prepared puree pork for the lunch meal which was why puree chicken had not been served to Resident #7. The cook stated that all tray cards and select menus are reviewed prior to meal preparation to ensure food is prepared in the quantity and consistency to meet all resident needs. The cook stated she missed the need for puree chicken.

On 04/18/13 at 3:12 PM the consultant dietitian stated she expected diet orders to be followed in conjunction with select menu items to meet the

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F 365	Continued From page 5 needs of residents. 2. Resident #66 was admitted to the facility 05/8/12 with diagnoses which included dementia. The care plan last updated 01/29/13 for Resident #66 included the problem area, Eats only 25-50% of meals/slightly overweight but no weight loss recommended at this time. Approaches to the problem area included, diet as ordered. The current diet order for Resident #66 was mechanical soft. The tray card for Resident #66 stated, mechanical soft diet with ground meat. On 04/17/13 at 11:50 AM Resident #66 was observed served her lunch meal in her room. The resident had been served chicken which was in approximate 1/2 inch chunks. The nursing assistant working with Resident #66 went to the kitchen to request ground chicken and returned with chicken in approximate 1/2 inch chunks. The nursing assistant fed the 1/2 inch chunks of chicken to Resident #66 and the resident spat the chicken out of her mouth. On 04/17/13 at 12:45 PM the Food Service Director (FSD) and cook (that prepared the lunch meal and served the food) were interviewed. The FSD reviewed the preplanned menu which indicated chopped meat should be served to a resident on a mechanical soft diet. The FSD looked at the food that was prepared for the lunch meal and noted ground meat had not been prepared. The cook stated that normally she processed meat in the food processor into a ground beef consistency for residents requiring ground meat. The cook offered no explanation why the chicken had not been ground. The FSD	F 365		

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stated it was her expectation the preplanned menus would be followed and that ground meat would be prepared for residents with a soft, ground meat diet order.

On 04/18/13 at 3:12 PM the consultant dietitian (RD) stated she expected diet orders to be followed in conjunction with the preplanned menu to meet the needs of residents. The RD stated if a diet order was mechanical soft with ground meat she expected meat to be ground into a consistency like ground beef.

3. Resident #139 was admitted to the facility 08/5/11 with diagnoses which included a head injury. The current care plan dated 01/12/13 for Resident #139 included a problem area, Poor intake at times/potential for weight loss. Approaches to this problem area included, diet as ordered.

The current diet order for Resident #139 was mechanical soft with chopped meat. This tray card for Resident #139 included, mechanical soft with chopped meat.

On 04/17/13 at 11:45 AM Resident #139 was observed in her room with a family member at her side. The lunch meal had been served to Resident #139 and consisted of a whole pork riblet. The family member stated the resident was supposed to be served chopped meat and indicated they would ensure the meat was appropriately cut up prior to feeding Resident #139 her meal.

On 04/17/13 at 12:45 PM the Food Service Director (FSD) and cook (that prepared the lunch

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F 365	Continued From page 7 meal and served the food) were interviewed. The FSD reviewed the preplanned menu which indicated a chopped riblet should be served to a resident on a mechanical soft diet. The FSD looked at the food that was prepared for the lunch meal and noted chopped meat had not been prepared. The cook stated she thought the riblet was tender enough to serve and was afraid it would turn into a mushy consistency if it had been put into the food processor. The FSD stated it was her expectation the preplanned menus would be followed. The FSD stated the riblet should have been chopped for Resident #139. On 04/18/13 at 3:12 PM the consultant dietitian (RD) stated she expected diet orders to be followed in conjunction with the preplanned menu to meet the needs of residents. The RD stated if a diet order was mechanical soft with chopped meat she expected meat to be cut into bite sized pieces. 4. Resident #98 was admitted to the facility on 01/13/11 with diagnoses including aspiration pneumonia, dysphagia, dementia, moderate protein malnutrition and chronic kidney disease Stage III. Review of the Resident # 98's diet order dated 03/09/13 revealed the resident had an order for a mechanically altered diet with ground meat and honey-thick liquids. Medical record review of a care plan note, dated 03/09/13 revealed Resident #98 was re-evaluated by speech therapy and had	F 365		

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aspiration precautions and was to remain on a mechanically soft diet with ground meats and honey-thick liquids.

An interview on 04/15/13 at 4:10 PM was conducted with Resident #98's daughter. She stated she usually visited the resident during the supper meal. She had observed him not receiving ground meat. She added she had reported this to staff and it had continued to occur.

On 04/15/13 at 5:25 PM Resident #98 was observed in the dining room eating supper. The tray card noted his ordered diet was mechanical soft with ground meats and honey-thick liquids. He was served a whole chicken breast pattie, soup and a shredded salad with ½ inch hard croutons. Resident #98's daughter was observed cutting up his chicken into smaller pieces and putting the hard croutons in his soup.

On 04/17/13 at 12:00 PM Resident #98 was observed in the dining room eating his lunch without assistance. He was served ½ inch chunks of crusted chicken breast. He had a fresh salad and one large cucumber 2 inches by 2 inches in diameter in the salad.

On 04/17/13 at 11:18 AM the preparation of lunch trays was observed. When the cook plated the food there was only whole meat (riblet, pork, chicken) and puree meat prepared. There was no ground meat prepared on the tray line. The cook served a whole chicken pattie to Resident #98.

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F 365	Continued From page 9 On 04/17/13 at 2:40 PM the Food Service Director (FSD) was interviewed. The FSD reviewed the preplanned menu which indicated ground chicken should have been served to Resident #98 who had a mechanical soft diet with ground meats. The FSD observed the food prepared for the lunch meal and noted ground or chopped meats had not been prepared. The FSD stated it was her expectation the preplanned menus would be followed. On 04/18/13 at 9:55 AM an interview was conducted with the Speech Therapist. She stated Resident #98 had been in and out of speech therapy from 02/28/13 through 03/13/13 for problems with dysphagia and difficulty with swallowing. The Speech Therapist reported that nursing had sent communications on 02/21/13, 02/23/13 and 02/24/13 that Resident #98 was having frequent coughing with his meals. The Speech Therapist evaluated Resident #98 during the above dates at meals. The Speech Therapist stated Resident #98 was put on ground meats for the mechanical soft diet and he should be receiving the ground meats. On 04/18/13 at 3:12 PM the facility consultant Registered Dietician was interviewed. She stated her expectation was that kitchen staff follow the ordered diets on the tray cards. She stated that if a diet is ordered as mechanical soft and ground, the food should have a ground meat consistency. 5. Resident #181 was admitted to the facility on 03/18/13 with diagnoses including end stage renal disease (ESRD). The Minimum Data Set (MDS) coded Resident #181 as having a mechanically altered and therapeutic diet.	F 365		

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The care plan for Resident #181 revealed a speech language pathologist (SLP) goal for the Resident to safely swallow mechanical soft solids. The nursing care plan updated on 03/27/13 noted he was on a consistent carbohydrate, dialysis diet with a mechanical soft consistency.

A medical record review revealed a dietary order dated 03/18/13 for a consistent carbohydrate, dialysis with a mechanical soft consistency and with all meats ordered ground. An SLP assessment dated 03/22/13 recommended therapy 5 times a week for 3 weeks for oral dysphagia. An SLP assessment dated 03/28/13 revealed a review of Resident #181's mechanical soft diet recommendation made while in the hospital.

On 04/15/13 at 12:05 PM Resident #181 was observed in his room eating lunch. The tray card stated his ordered diet to include mechanical and ground meat. On his plate was observed one piece of sliced pork cut up into approximately 1 inch sized pieces.

On 04/15/13 at 12:16 PM, Nurse Aide (NA) #8 stated the pork was a regular slice and the resident was served a mechanical soft diet with regular meat.

On 04/15/13 at 5:35 PM by NA #9 was observed assisting Resident #181 in his room with his tray set up. The tray card stated his ordered diet to include mechanical and ground meat. On the plate was noted a hamburger in plastic wrap with one formed meat patty in the bun.

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F 365	Continued From page 11 On 04/17/13 at 11:00 AM the preparation of lunch trays in the kitchen was observed. The pork riblet as noted on the preplanned menu for this day was on the tray line in whole meat form or pureed with no ground meats available. Resident #181's plate was prepared with a whole piece of pork riblet. The tray card stated his ordered diet to include mechanical and ground meat. On 04/17/13 at 12:15 PM Resident #181 was observed eating lunch. Approximately 1 inch of his meat was cut and missing from the end with the remainder in one whole piece. On 4/17/13 at 12:45 PM the FSD and cook (that prepared the lunch meal and served the food) were interviewed. The FSD reviewed the preplanned menu which indicated a chopped riblet should be served to a resident on a mechanical soft diet. The FSD looked at the food that was prepared for the lunch meal and noted chopped meat had not been prepared. The cook stated she thought the riblet was tender enough to serve and was afraid it would turn into a mushy consistency if it had been put into the food processor. The FSD stated it was her expectation the preplanned menus would be followed. On 04/17/13 at 2:42 PM the FSD was interviewed. She stated the pork, the hamburger patty and the riblet served to Resident #181 should have been ground as ordered. The FSD stated that NAs had been trained to read tray cards and bring any discrepancies to the kitchen's attention. On 04/18/13 at 9:00 AM the SLP was interviewed.	F 365		

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F 365	Continued From page 12 She stated, in the absence of a current regular diet order, she would have to do a swallowing evaluation during a meal. She stated her expectation that for a mechanical soft diet meat would be ground up. On 04/18/13 at 3:12 PM the facility consultant dietitian stated her expectation that kitchen staff adhere to the ordered diets on the tray cards. She stated that if a diet is ordered as mechanical soft and ground, the food should have a ground meat consistency.	F 365		
F 441 SS=D	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	F 441	F441 A. The vital sign machine was taken out of use and secured until it was cleaned with hypochlorite solution on 4/17/13. All available nursing staff were immediately educated about using hypochlorite solution for disinfection of equipment that was used or in close proximity to Resident #73 and instructed to follow the enteric contact precautions as posted. Resident #73 remained on contact isolation until she passed away on 4/23/13. The privacy curtains were removed and cleaned as per policy for the room of Resident #73. B. All residents have the potential to be affected by the need for contact isolation any time in the future. Nursing staff shall be educated about the types of isolation and what is required for each. This shall include how residents requiring isolation are identified, how protective equipment is to be used, hygiene practices, and how patient equipment is to be cleaned. The education shall be completed by 5/16/13. Each new nursing employee shall receive this education during orientation with the Staff Development Coordinator.	F441 05/16/13

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	345187	A. BUILDING _____ B. WING _____	C 04/18/2013

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F 441	Continued From page 13 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to follow infection control practices for 1 of 2 residents (Resident #73). The findings included: Review of the Centers for Disease Control and Prevention (CDC) 2007 Guideline for Isolation Precautions revealed the bacteria clostridium difficile (c. diff) is a major cause of healthcare-associated diarrhea which is extremely difficult to control. Prevention of transmission focuses on application of contact precautions for patients with diarrhea including use of soap and water for mechanical removal of spores from hands. CDC recommends use of a 1:10 dilution of 5.25% sodium hypochlorite (household bleach) solution for cleaning and disinfecting non-critical medical equipment (e.g. blood pressure cuff) before use on another patient, and a strong recommendation for	F 441		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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healthcare personnel to wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in close proximity to the patient.

Review of the facility's policy titled Infection Prevention and Control Recommended Practices, with an effective date of 06/12, revealed CDC hand hygiene guidelines are followed throughout the facility. Contact precautions applied to specified patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact (hand or skin-to-skin contact that occurs when performing patient care activities that require touching the patient's dry skin) or indirect contact (touching patient care items in the patient's environment). Caregivers were directed to wear a gown for substantial contact with a patient or if the patient had diarrhea. When possible, use of non-critical patient care equipment should be restricted to a single patient to avoid sharing, but if this is not possible, then adequately clean and disinfect equipment with an appropriate solution before use with another patient.

A medical record review revealed an order dated 04/16/13 to check loose diarrhea stool for c. diff. A laboratory report dated 04/17/13 revealed Resident #73 as positive for c. diff. An order dated 04/17/13 revealed contact precautions for c. diff.

On 04/17/13 at 12:15 PM, a white metal box containing personal protective equipment was observed hanging on the door to Resident #73's room. On this box was attached a laminated sign

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titled Contact Precautions with a brown box highlighting the phrase "Special Enteric- perform hand hygiene before entering room and wash hands with soap and water before leaving room." Other phrases were "use patient-dedicated or single disposable shared equipment or disinfect shared equipment (BP cuff, thermometers) between patients" and "wear gown when entering room or cubicle and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces."

On 04/17/13 at 2:24 PM Nurse Aide (NA) #5 was observed in Resident #73's room talking to her roommate in bed B. NA #5 left the room and approached another resident in a wheelchair in the hallway immediately outside Resident #73's room, greeting this resident and touching her wheelchair.

On 04/17/13 at 2:28 PM NA #5 was interviewed. She stated she did not notice the sign and PPE on the door. NA #5 stated the warning sign meant hands were to be washed before leaving the room and she should have done so before greeting the resident in the hall and touching her wheelchair.

On 04/17/13 at 4:43 PM NA #7 was observed entering Resident #73's room, wearing gloves and carrying medical supplies. She approached the Resident's bedside, placed the supplies on her bed tray table and proceeded to perform a blood specimen collection. Upon completion, NA #7 washed her hands in Resident #73's bathroom sink and left her room.

On 04/17/13 at 5:08 PM NA #7 was interviewed.

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She stated that blood specimen collection did not require wearing a gown and she was told gowns were not necessary unless performing incontinence care.

On 04/17/13 at 4:52 PM NA #6 was observed rolling a vital sign machine into Resident #73's room. NA #6 approached Resident #73 in her bed with the vital sign machine and pulled the privacy curtain.

On 04/17/13 at 4:59 PM, NA #6 was observed opening the privacy curtain around Resident #73's bed. She removed a pair of gloves, washed her hands with soap and water in Resident #73's bathroom sink and left her room with the vital sign machine. NA #6 took the vital machine to a small room off the nursing station, put on a pair of gloves and proceeded to wipe the entire machine down with disposable disinfecting wipes dispensed from a container with a purple lid. Upon completion of wiping the vital sign machine down, NA #6 removed her gloves, washed her hands with soap and water in a nearby sink and left the vital sign machine in the small room unattended.

On 04/17/13 at 5:05 PM, NA #6 was interviewed. She stated Resident #73 was on contact precautions which required the cleaning of patient equipment. NA #6 obtained the container of disposable disinfecting wipes with the purple lid she used to wipe down the vital sign machine. Review of the label on the container revealed a list of microbes the disinfecting wipes were effective against and c. diff was not on the list.

On 04/17/13 at 5:15 PM the DON was

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F 441	Continued From page 17 interviewed. She stated the facility used a disinfecting product containing a hypochlorite solution that is effective against c. diff spores and the disinfecting wipes dispensed from the container with the purple lid were not effective. The DON stated she would remove the vital sign machine from use and have it disinfected with the hypochlorite solution product. On 04/18/13 at 3:15 PM the Director of Nursing (DON) was interviewed. The DON stated her expectation that staff caring for a resident on contact isolation with c. diff must wash their hands before leaving the room and to wear a gown if they should have contact with anything potentially infected.	F 441	Plan of correction disclaimer statement Preparation and/or execution of this plan of correction does not constitute admissions or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of the deficiencies. The Plan of Correction is prepared in/or executed solely because the provision of the Federal and State Law require it. OM 05/09/13	