

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

PRINTED: 02/11/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2009
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703	
(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	F 000		
F 312 SS=E	<p>Complaint #14086, substantiated (all or in part) with deficiencies cited at F363 and F312</p> <p>Complaint #14134, substantiated (all or in part) with a deficiency cited at F441</p> <p>Complaint #14199, substantiated (all or in part) with a deficiency cited at F332.</p> <p>Complaint #14224, unsubstantiated.</p> <p>483.25(a)(3) ACTIVITIES OF DAILY LIVING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #14086, substantiated (all or in part) in these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure the penis, groin area, and scrotum were cleaned during incontinent care and a clean incontinent brief was applied for 1 (Resident #3) and the inner thighs and buttocks were cleaned during incontinent care for 1 (Resident #6) of 4 case mix residents who were incontinent of urine (Resident #2, 3, 5 and 6). These failed practices had the potential to affect 50 residents who were incontinent of bladder according to the Resident Census and Conditions of Residents form dated 1/26/09. The findings are:</p> <p>1. The facility's policy titled "Perineal Care" documented, "...Process:... II. Female Resident</p>	F 312		

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.

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F 312	<p>Continued From page 1</p> <p>a) Wash pubic area first, washing from front to back; ... b) Turn the resident on to her side and wipe from front to back wiping from vaginal area to rectum extending over the buttocks, changing wipes or corners as needed. III. Male Resident</p> <p>a) Wash perineal area starting with the urethra opening to the base of the penis. b) Continue to wash the perineal area including the penis, scrotum and inner thigh... d) Turn resident onto his side and wipe from front to back up an upward motion; wipe from the scrotum to the rectum extending over the buttocks changing wipes or corners as needed."</p> <p>2. Resident #3 had diagnoses of Vascular Dementia and Diabetes Mellitus. The Quarterly Minimum Data Set (MDS) dated 10/27/08 documented the resident was moderately impaired in cognitive skills for daily decision making, frequently incontinent of bowel and bladder, required extensive assistance with toilet use and totally dependent for personal hygiene.</p> <p>a. On 1/28/09 at 3:45 p.m., the resident was assisted to bed and placed on the right side. Certified Nurses Assistant (CNA) #8 checked the resident's incontinent brief and the resident was incontinent of stool and urine. CNA #8 removed the incontinent brief from the front of the resident and was cleaning stool when the resident voided. CNA #8 got a new incontinent brief and put it in front of the resident over the wet linens under the resident's penis. CNA #8 cleaned the resident's buttocks and rectal area, then turned the resident onto the back and cleaned the bilateral groins. CNA #8 pulled the front of the incontinent brief up and taped down the side tabs. CNA #8 did not clean the penis or the front of the scrotum.</p>	F 312			

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F 312	Continued From page 2 b. On 1/29/09 at 11:15 a.m., the resident was in bed on his right side. The resident stated "I think I've gone to the bathroom." CNA #7 entered the resident's room to provide incontinent care. CNA #7 pulled the resident's pants down and unfastened the front of the incontinent brief. The resident was incontinent of stool and urine. CNA #7 cleaned the buttocks, rectal area and back of the scrotum then put a new incontinent brief on the resident. CNA #7 did not clean the resident's penis, groins, or front of the scrotum. CNA #7 picked up the linens and trash and left the room. CNA #7 was asked if the resident's incontinent brief was wet. CNA #7 stated, "Yes. The lines were blue." CNA #7 was asked what did you not clean. CNA # 7 stated, "His front." 3. Resident #6 had diagnosis of Dementia with Behavior Disturbance, Anxiety, Generalized Pain and Depression. The Quarterly MDS dated 9/30/08 documented the resident was severely impaired in cognitive skills for daily decision making, incontinent of bowel and bladder and totally dependent on staff for personal hygiene. On 1/30/09, at 8:40 a.m., CNA #9 provided incontinent care. The resident's incontinent brief had blue lines indicating the incontinent brief was wet with urine. The CNA disposed of wipe, then turned the resident onto the left side, and removed the saturated incontinent brief. The CNA used one wipe and washed the rectal area, but did not wash the inter thighs or either buttocks. The CNA then applied a clean incontinent brief.	F 312			
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315			

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F 315	Continued From page 3 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure a different part of the wipe was used and a back to front motion was not used during incontinent care for 1 (Resident #6) of 4 case mix residents who were incontinent of urine (Resident #2, 3, 5 and 6). These failed practices had the potential to affect 50 residents who were incontinent of bladder and 37 residents who were incontinent of bowel according to the Resident Census and Conditions of Residents form dated 1/26/09. The findings are: Resident #6 had diagnosis of Dementia with Behavior Disturbance, Anxiety, Generalized Pain and Depression. The Quarterly MDS dated 9/30/08 documented the resident was severely impaired in cognitive skills for daily decision making, incontinent of bowel and bladder and totally dependent on staff for personal hygiene. a. On 1/30/09, at 8:40 a.m., CNA #9 provided incontinent care. The CNA unfastened the incontinent brief and used one wipe and, washed the pubic area, using back and forth motion, then washed the labia area (front to back) with the same wipe. The CNA completed incontinent care and applied a clean incontinent brief.	F 315		
F 332	483.25(m)(1) MEDICATION ERRORS	F 332		

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F 332 SS=E	<p>Continued From page 4</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #14199, substantiated (all or in part) in these findings.</p> <p>Based on observation of the 7:00 a.m. and 8:00 a.m. medication passes on 1/28/09 and 1/29/09 and the 12:00 p.m. medication pass on 1/28/08, and record review, and interview the facility failed to ensure that the medication error rate was less than 5%. Physician orders were not followed for 1 (Resident #10) of 5 residents (Resident #10, 11, 12, 15 and 16) observed during the medication passes resulting in medication errors. Medication errors were made by 2 Licensed Practical Nurses (LPN #1 and 5) of 5 nurses who administered medications during the medication passes. The medication error rate was 6.52% based on administration of 44 medications with 2 omissions for a total of 46 medications and one medication error observed (3 total errors and 46 opportunities). This failed practice had the potential to affect 27 residents who resided on the A and F halls where medication errors were made according to the listing provided by the Administrator on 1/30/08. The findings are:</p> <p>Resident #10 had a physician order dated 1/26/09 for "Aspirin 81 mg (milligram) chew tablet give 1 tab q (every) day... Allopurinol 100 mg tablet give one tab q day... Prednisone 20 mg tablet give 2 tabs to = (equal) 40 mg po (per mouth) x (times) 3 days..."</p>	F 332			

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F 332	Continued From page 5 a. On 1/28/09 at 8:02 a.m., LPN #1 set up the 7:00 a.m. and 8:00 a.m. medications. The computerized Medication Administration Record (MAR) screen showed that Allopurinol 100 mg was due. LPN #1 stated he could not find the medication. At 8:26 a.m., LPN # 1 took the medications to Resident # 10 and the resident swallowed his medications. b. On 1/28/09 at 8:30 a.m., LPN #1 was asked if he was done with the resident's medications. LPN #1 stated, "Done with this resident's meds except for his inhaler." c. On 1/28/09 at 8:59 a.m., LPN #1 administered the resident's inhaler. LPN #1 was asked if he was done with the resident's medications. LPN #1 stated, "Yes." d. On 1/28/09 at 11:30 a.m., LPN #1 was asked if he had found the Allopurinol that was due at 8:00 a.m. e. On 1/28/09 at 12:20 p.m., a print out of the computerized MAR documented Allopurinol was administered by LPN #1 at 8:00 a.m. f. On 1/28/09 at 12:25 p.m., LPN #1 stated, "I do not have Allopurinol, I clicked it as administered to get it off red (on computer screen)." g. On 1/28/09 at 12:35 p.m., LPN #1 showed this surveyor the Allopurinol blister pack that was found in the bin of discontinued medications. h. On 1/29/09 at 8:40 a.m., LPN #5 set up the 7:00 a.m. and 8:00 a.m. medications. The computerized MAR screen showed that Aspirin	F 332			

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F 332	Continued From page 6 81 mg chew tab was due. LPN #5 set up Enteric Coated Aspirin 81 mg. i. On 1/29/09 at 8:45 a.m., LPN #5 was stopped prior to entering the resident's room to administer the medications. LPN #5 was asked to go back to the Aspirin order and then was asked what does it say. LPN #5 stated, "Chewable, I did enteric coated instead of chewable." LPN #5 was asked, "If I hadn't stopped you, would you have given the Enteric Coated Aspirin?" LPN #5 stated, "Yes, once it was in the cup I would have." j. On 1/29/09 at 8:40 a.m. to 8:45 a.m., Prednisone 40 mg did not appear on the MAR computer screen as due. k. On 1/29/09 at 9:15 a.m., LPN # 6 printed out the computerized MAR. The MAR documented "N" by LPN #6 for the 7:00 a.m. Prednisone 40 mg dose for 1/29/09 and was initialed as given for 8:00 a.m. by LPN #5. LPN # 6 was asked what does "N" mean. LPN #6 stated, "N on Prednisone with my initials equals not given. I was changing the time to 8:00 a.m." l. On 1/29/09 at 9:17 a.m., LPN #5 was asked if she had given Prednisone when it was due at 7:00 a.m. during the medication pass. LPN #5 stated "No, I don't know why it's initialed. I never saw it on the screen. I didn't give it."	F 332			
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance;	F 363			

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F 363	<p>Continued From page 7 and be followed.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #14086 substantiated (all or in part) in these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure therapeutic diets were provided for 5 (Resident #3, 5,7, 8 and 9) of 7 case mix residents (Resident #2, 3, 4, 5, 7, 8 and 9) who had an order for a consistent carbohydrate diet (CCD). This failed practice had the potential to affect 22 residents who had an order for a consistent carbohydrate diet according to the Physician Orders List provided by the Administrator on 1/26/09 at 2:40 p.m. The findings are:</p> <p>1. The supper menu for 1/28/09 documented applesauce for consistent carbohydrate diets.</p> <p>a. Resident #5 had diagnoses of Diabetes Mellitus, Anemia, and Nutrition Deficiency. The Quarterly Minimum Data Set (MDS) dated 10/22/08 documented the resident was moderately impaired in cognitive skills for daily decision making and independent with set up help only.</p> <p>1) A physician order dated 6/2/08 documented, consistent carbohydrate diet.</p> <p>2) On 1/28/09 at 6:00 p.m., the resident was served Apple Cobbler for dessert. The Diet. card documented, "Diet - CCD (Consistent Carbohydrate Diet)."</p>	F 363		

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F 363	<p>Continued From page 8</p> <p>b. Resident #8 had diagnoses of Diabetes Mellitus, Hyperlipidemia, and Nutrition Deficiency. The Quarterly MDS dated 1/18/09 documented the resident was moderately impaired in cognitive skills for daily decision making and required limited assistance of one person with eating.</p> <p>1) A physician order dated 9/17/08 documented, pureed consistent carbohydrate diet.</p> <p>2) On 1/28/09 at 5:30 p.m., the resident was served Apple Cobbler for dessert. The Diet. card documented, "Diet - CCD."</p> <p>c. Resident #9 had diagnoses of Dementia, Hypertension and Gastric Anomaly. The Quarterly MDS dated 11/12/08 documented the resident was moderately impaired in cognitive skills for daily decision making and independent with set up help only for eating.</p> <p>1) A physician order dated 5/24/06 documented, mechanical soft consistent carbohydrate diet with pureed meat.</p> <p>2) On 1/28/09 at 5:30 p.m., the resident was served Apple Cobbler for dessert. The Diet. card documented, "Diet - CCD."</p> <p>d. Resident #3 had a diagnosis of Diabetes Mellitus. The Quarterly MDS dated 10/27/08 documented the resident was moderately impaired in cognitive skills for daily decision making and required limited assistance of one person for eating.</p> <p>1) A physician order dated 10/24/08 documented, "Consistent Carbohydrate Diet."</p>	F 363			

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F 363	Continued From page 9 2) On 1/28/09 at 5:20 p.m., the diet card documented, "Diet: CCD." The resident was served apple cobbler. e. Resident #7 had a diagnosis of Diabetes Mellitus. An Initial MDS dated 1/16/09 documented the resident was moderately impaired in cognitive skills for daily decision making and required supervision with set up only for eating. 1) A physician order dated 1/6/09 documented, "Consistent Carbohydrate Diet." 2) On 1/28/09 at 5:28 p.m., the diet card documented, "Diet: CCD/NAS (Consistent Carbohydrate Diet/No Added Salt)." The resident was served apple cobbler. 2. On 1/28/09 at 5:21 p.m., the Dietary Manager was asked what deserts were they serving tonight. The Dietary Manager stated, "Apple cobbler. I have fruit if they don't like the cobbler or if they want it." The Dietary Manager was asked was that all. The Dietary Manager stated, "Yes." 3. On 1/28/09 at 5:55 p.m., the Dietary Manager was asked "Do you know why I asked what you were serving for desert tonight?" The Dietary Manager stated, "Yes, our CCDs were getting apple cobbler instead of applesauce. As soon as you asked it, I checked the menus and found out the CCDs were supposed to have applesauce. I talked with my staff right away and got it fixed."	F 363			
F 441 SS=F	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	F 441			

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F 441	<p>Continued From page 10</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #14134, substantiated (all or in part) in these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure a disinfectant was utilized to clean the shower chair/bench before and shower floors after showers were given for 3 case mix residents (Resident #12, 13, and 14) of 15 case mix residents (Resident #1 - 15) who were showered in the shower rooms. These failed practices had the potential to affect 96 residents who used the showers according to the listing provided by the Administrator on 1/30/09. The findings are:</p> <p>1. The facility's policy titled "Shower/Tub Cleaning Instructions" documented, "Purpose: To prevent the spread of infection from resident to resident... Process:... b) Squirt an ample amount of disinfectant... Squirt on the seat and under the seat... d) Using a long-handled brush in a swirling motion, thoroughly scrub all areas of the tub and seat. e) After scrubbing, rinse the tub and seat with warm water. Note: Follow manufacturer's instructions for handling and diluting disinfectants."</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703		
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F 441	<p>Continued From page 11</p> <p>2. The manufacturer's directions for Johnson Wax Professional Triad Disinfectant Cleaner documented, "...For Use as a One-Step Cleaner/Disinfectant: 1. Pre-clean heavily soiled areas. 2. Apply Solution to hard non-porous environmental surfaces. 3. All surfaces must remain wet for ten minutes. 4. Wipe surfaces and let air dry. Note - Rinsing is not necessary..."</p> <p>3. On 1/26/09 at 2:34 p.m. and 4:30 p.m.; 1/28/09 at 10:30 a.m., and 11:55 a.m.; and 1/29/09 at 9:55 a.m., 11:07 a.m. and 2:09 p.m., there was no disinfectant in the first shower room with a single shower on B hall.</p> <p>4. On 1/26/09 at 2:39 p.m. and 4:30 p.m.; 1/28/09 at 10:35 a.m., and 11:55 a.m.; and 1/29/09 at 9:57 a.m., 11:07 a.m. and 2:15 p.m., there was no disinfectant in the second shower room with two showers on the B hall.</p> <p>5. On 1/29/09 at 2:09 p.m., Certified Nurses Assistant (CNA) #3 went into the first shower room on B hall. CNA #3 rinsed off the shower bench with water.</p> <p>a. On 1/29/08 at 2:35 p.m., CNA #3 was showering Resident #13. On completion of the shower, CNA #3 picked up and discarded the wet linens but did not disinfect the shower bench. There was no disinfectant present in the shower room. CNA #3 took the resident down B hall toward the resident's room.</p> <p>b. On 1/29/08 at 3:30 p.m., CNA #3 was asked if she had gone back into the shower room after showering Resident #13. CNA #3 stated no. CNA #3 was asked if she disinfected the shower bench between residents. CNA #3 stated, "I clean mine</p>	F 441			

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F 441	<p>Continued From page 12</p> <p>before I go in with the soap that's in the shower room" CNA #3 was asked what soap. CNA #3 stated, "Large bottle of soap, Dial is what's there."</p> <p>6. On 1/29/09 at 2:15 p.m., CNA #4 took Resident #12 into the second shower room on B hall with two shower stalls, undressed the resident and sat the resident on the shower bench in the stall on the left. There was no disinfectant in the shower room. On completion of the shower, CNA #4 picked up the dirty laundry from the shower room and left the shower room. CNA #4 did not disinfect the shower bench. CNA #4 was asked will you be back to the shower room. CNA #4 stated, "After I pass out ice, I'll get ..., she's my last one [shower]."</p> <p>On 1/29/08 at 3:25 p.m., CNA #4 was asked, "Before you took [Resident # 12] into the shower room did you disinfect the shower bench?" CNA #4 stated, "I used soap and water... used soap in the shower room." CNA #4 was asked, "After [Resident #12's] shower did you go back and clean and disinfect?" CNA #4 stated no.</p> <p>7. On 1/29/09 at 3:20 p.m., CNA #11 took Resident #14 to the second shower room on B hall with two shower stalls, and gave Resident #14 a shower in the left hand shower stall. CNA #11 was asked, "What is the solution in the dispenser on the stall wall." CNA #11 stated "Body wash we use for showers." CNA #11 was asked, "After you've finished a shower what do you do?" CNA #11 stated, "Dress the resident, take them back to their room or where ever. Put linen in barrel." CNA #11 was asked, "Do you clean the shower or disinfect it with anything?" CNA #11 stated, "No. The housekeeping would do that after we finish with the showers."</p>	F 441			

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F 441	Continued From page 13 On 1/29/09 at 3:36 p.m., CNA #11 was asked, "Did you clean or disinfect the shower bench before or after shower for Resident #14?" CNA #11 stated, "I used soap and water, used the soap in the shower room." CNA #11 was asked, "Did you use disinfectant/sanitizer?" CNA #11 stated no. 8. On 1/28/09 at 4:20 p.m., CNA #1 was asked if a resident was incontinent of urine or stool on the floor how would you clean it up. CNA #1 stated, "Clean up first then call housekeeper." CNA #1 was asked, "When you clean it up first what do you use?" CNA # 1 stated, "Paper towel or towel with water and put 'wet' sign over so housekeeping can come and clean." CNA #1 was asked, "Have you seen shower rooms with feces on the floor?" CNA #1 stated, "Yes, I've been there when it happened." CNA #1 was asked, "How do you clean up feces in the shower?" CNA #1 stated "Paper towels, put it in a trash bag, get disinfectant, spray and kind of scrub it down with a washcloth, tell housekeeper." CNA #1 was asked, "How long do you leave the disinfectant on?" CNA #1 stated, "A couple of minutes." 9. On 1/29/09 at 1:05 p.m., CNA #2 was asked if a resident was incontinent of urine or stool on the floor how would you clean it up. CNA #2 stated, "Pick up with a washcloth and put it in a plastic bag and take to the bio room, feces into toilet, clothes rinsed and to laundry. Put sanitizer on floor, normally a bottle around there. Leave it on for a couple of minutes." 10. On 1/29/08 at 3:30 p.m. CNA #5 was asked if a resident was incontinent urine or stool on the	F 441			

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F 441	<p>Continued From page 14</p> <p>floor how would you clean it up. CNA #5 stated, "Take wipes in with me, then I try to clean up the floor after I'm done." CNA #5 was asked what would she clean up the floor with. CNA #5 stated, "Disinfectant spray." CNA #5 was asked, "How long do you leave the disinfectant spray on?" CNA #5 stated, "A minute or so."</p> <p>11. On 1/29/08 at 4:21 p.m., CNA #6 was asked if a resident was incontinent urine or stool on the floor how would you clean it up. CNA #6 stated, "Make sure there's a plastic bag to the side, I have gloves on and pick it up with a paper towel, put it in the bag in bio trash, have scrubber in shower room to clean the floor, sanitize every thing down." CNA #6 was asked, "How long do you leave the sanitizer on?" CNA #6 stated, "Two minutes."</p> <p>12. On 1/29/09 at 4:40 p.m. the Director of Nursing (DON) was asked to tour the shower rooms with this surveyor. In the second shower room on B hall with two stalls, the DON was asked if there was any disinfectant present. The DON stated, "No." In the first shower room on B hall with one stall, the DON was asked if there was any disinfectant present. The DON stated, "No". The DON was asked how should staff disinfectant shower chair/bench after/between residents or the floor after incontinent episodes. The DON stated, "They are supposed to spray with disinfectant. I'm not sure how long to leave the disinfectant on."</p>	F 441			