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
	355091	A. BUILDING _____ B. WING _____ FEB 18 2010	01/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLEY MEDICAL CENTER NURSING HOME	612 CENTER AVE N ASHLEY, ND 58413

(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 two (2) residents for complete review, eight (8) residents for focused review, and one (1) closed record for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathleen Deyo | TITLE: Adm/COO | (X6) DATE: 2-18-10

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 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements	F 156		

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F 156	Continued From page 2 specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of Medicare records and staff interview, the facility failed to provide required notices for potential liability of payment to 3 of 3 supplemental residents (#12, #13, and #14). The Notice of Medicare Provider Non-coverage (CMS form 10123) informs the beneficiary of his/her right to an expedited review by the Quality Improvement Organization when Medicare coverage is terminated. Failure to provide the correct notices of non-coverage of Medicare benefits is an infringement of resident rights.	F 156	It is the policy of the Ashley Medical Center that to notify residents or legal representatives of non-coverage of Medicare benefits and to provide the opportunity to request a demand bill and/or appeal the decision of non-coverage. Social Service Designee (SDD) will notify the resident or legal representative of non-coverage and failure to provide the opportunity to request a demand bill and/or appeal the decision of non-coverage, which is an infringement of resident rights. LSW and SDD were instructed on 02-17-10 to utilize forms CMS -10123 and CMS-10124 for all Medicare residents. All residents from May, 2009 to December, 2009 will have the CMS-10124 completed by 03-25-10. All other and future Medicare residents will have form CMS-10123 and CMS 10124 utilized. A QA Study will be done monthly x 3 and quarterly x3 on the proper usage of forms for the Medicare denial letter. Responsible Parties: Licensed Social Worker and Social Service Designee	2-25-10

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F 156	Continued From page 3 Findings include: Review of the facility forms, "Medicare Denial On Continued Stay," for Resident #12, #13, and #14 occurred on 01/21/10 at 10:30 a.m. with an office staff member (#8). The records indicated these residents no longer received Medicare benefits as of the following dates: - Resident #12, Medicare coverage ended 05/19/09; - Resident #13, Medicare coverage ended 12/07/09; - Resident #14, Medicare coverage ended 12/06/09. During an interview with an office staff member (#8), he/she identified the facility provided only the "Medicare Denial On Continued Stay" letter. This confirmed the facility failed to provide the required CMS 10123 form to all residents whose Medicare coverage ended.	F 156		
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/07/09. Based on record review, resident, group, and staff interviews, the facility failed to provide medically related social services to attain or maintain the highest practicable psychosocial well-being of 1	F 250		

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F 250	Continued From page 4 of 3 sampled residents (Resident #8) with identified behaviors of verbal and physical aggression directed towards a roommate (Resident #15) and wandering into other resident rooms, and for 1 of 1 sampled residents (Resident #5) requesting to room with her spouse (Resident #16). Failure of the facility to assess and implement individualized behavioral interventions to prevent or reduce Resident #8's verbal and physical aggression placed Resident #15 and other residents of the facility at risk for injury. Failure to keep Resident #5 and #16 informed of the timeframe regarding their request to room together resulted in unnecessary emotional distress to these residents. Findings include: During the group interview conducted on 01/19/10 at 4:00 p.m., with residents identified by the facility as interviewable, three residents (Resident A, B, and C) stated Resident #8 wanders/enters into their rooms without their permission. Review of Resident #8's medical record occurred on 01/21/10, and identified the facility admitted the resident on 02/16/09. Resident #8's medical diagnoses include Alzheimer's disease, dementia with agitated behaviors, and anxiety. Review of Resident #8's quarterly Minimum Data Set (MDS), dated 11/13/2009, identified short- and long-term memory impairment; moderately impaired in daily decision making capability; behavior and mood patterns noted with up to five days per week of repetitive questions and sad, pained, worried facial expressions; behavioral symptoms of wandering, verbal and physical abuse, socially inappropriate/disruptive behavior,	F 250	It is the policy of the Ashley Medical Center to provide medically-related social services to attain, or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. A behavioral committee was developed, that includes LSW, DON, MDS Coordinator, floor nurse, and CNA. They will meet weekly to review all resident's that have had behavioral issues during the previous week. This is to ensure that all policies and procedures have been followed through and to see if anything new needs to be implemented. The LSW will keep a morning report log with social services concerns. These social services concerns will be documented in the resident's chart, when appropriate. See Exhibit F 250 A Resident to Resident Verbal Abuse Plan is in place and will be inserviced to SSD on 2-17-10, nursing on 2-23-10, and CNA's on 2-24-10. Staff will be instructed to follows the Ashley Medical Center policy on Resident to Resident Physical and Verbal Abuse. See Exhibit F 250 B.	02-25-10

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F 250	Continued From page 5 and resistive with care that is not easily altered. Resident #8's current physician orders for psychotropic medications included: Aricept 5 milligrams (mg) daily (ordered initially on 06/01/09), Zoloft 75 mg daily (dose increased on 01/14/10), Risperdal 0.25 mg in AM and 0.125 mg in evening (dose decreased on 12/09/09). Review of Resident #8's care plan, dated 12/22/09, identified a "Problem" of ". . . history of anxiety and agitation r/t [related to] his dementia. Utilizers [sic] psychotherapeutic meds for these behaviors . . . ." The care plan identified approaches of "1. Psychotherapeutic meds [medications] as ordered, [sic] [follow up] psych [psychiatric] telmeds [telemedicine] as recommended, 3. Monitor for adverse side effects of medications . . . 4. Monitor for s/s [signs/symptoms] of anxiety, agitation, restlessness, . . . 5. Provide kind and caring environment. 6. Monitor mood behavior daily. 7. Consider possible causes of anxiety/agitation, - pain med for toileting,hunger/thirst, increase in confusion. When resident is angry, leave alone and reapproach leter [sic]." Review of Resident #8's Nurse's Notes, from May 2009 - January 2010, identified the following regarding the relationship between Resident #8 and his roommate: *07/07/09 at 4:30 p.m. - "Resident voices some agitation [with] roommate. Some name calling [and] [complaints of] spitting [and] picking his nose. Nurse tried reassuring that romate [sic] is a nice man." *09/14/09 at 11:00 p.m. - "Restless this PM. Upset- 'I need to get in my room, get him out!' Doesn't want roommate in room. Will cont	F 250	Nurses will be inserviced on 2-23-10 and CNA's on 2-24-10 that yellow strips with magnets and stop signs will be placed at the nurses' station to be placed at resident rooms, if the resident is wandering, in order to encourage the resident to stop from going into unwelcome areas. They will also be inserviced on the need to pass on appropriate concerns of the resident to Social Services as they become aware of them. Residents will be informed at the next Resident Council Meeting that yellow strips and stop signs are available for placing on their doors in the event of other wandering residents. A QA study will be conducted monthly x 3 and quarterly x 3 to ensure all policy and procedures were carried out on the Ashley Medical Center's Resident to Resident Physical and Verbal Abuse Policy on resident's who display behavior problems during the reporting period. A QA Study will be done monthly x 3 and quarterly x 3 to ensure all appropriate social service documentation has been completed. Responsible Party: Licensed Social Worker	02-25-10

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F 250	Continued From page 6 [continue] to monitor." *09/19/09 at 11:00 p.m. - "Very restless this PM. Cursing [at] roommate [and] staff. Feels we are make [sic] a fool out of him." *12/28/09 at 8:00 p.m. - "Resident calling his roommate [sic] names [and] yelling 'Get out of here you Jackass!' Informed resident that this man was his roommate [and] shared this room with him. Res [resident] continued to be vulgar [and] rude. Removed resident from room [and] pushed w/c [wheelchair] [up and down] hall. Redirection was effective." *01/03/10 at 4:30 - "Pts [patient's] behavior extremely unruly, belligerent, calling staff names; would not allow roommate to finish in BR [bathroom] [without] attempting to open door, would not allow staff to redirect him till roommate dressed and out of BR, attempted to throw himself on bed stating 'this is my bed and I want that old bastard out of here.' Roommate had visitors and this pt [patient] was so disruptive that roommate and family went to sun room to visit. [Resident #8] was finally redirected to 'have a cup of coffee an visit in the DR' [dining room] by staff." *01/08/10 at 11:00 p.m. - "Resident wheeling self into female residents room. Called them names. Redirected resident." *01/09/10 at 11:00 p.m. ". . . Calling resident's names . . . cursing . . . ." Resident #8's nursing "Weekly Progress Note", dated 01/05/10 stated the resident exhibited "several behavior problems, . . . rude to roommate, anxiety, repetitive movements & questions, confusion" and "Resident was moved to new room [number]. See nurses notes dated 01/01/10." Review of Resident #8's Social Service Notes,	F 250	Resident #8 Yellow strips and stop signs are available to be utilized when Resident #8 begins to wander to encourage resident to stop. Resident had a psychological tele-med on 02-15-10. Respirdal was increased to.25 mg in am and .5 mg at hs with follow-up in one month. Resident has been moved into a private room to decrease agitation and aggression. Staff have been instructed to follow Care Plan when interacting with resident. See Exhibit 250 C Refer to Initial F 250 Response	02-25-10

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F 250	Continued From page 7 dated May 2009 thru January 2010, identified the following entries: *06/19/09 - "Resident is somewhat agitated at times . . . wandering . . . ." *09/04/09 - "Resident having more behavior problems in last couple of days. Patient . . . has been angry with staff and roommate . . . [name of psychiatrist] was informed . . . medication was increased . . . Follow up in 1 month." *01/04/10 - ". . . Resident moving into another room. Spouse agreed to room change . . . ." Review of Resident #8's medical record identified this resident displayed behaviors towards his roommate beginning in July 2009. The record lacked nonpharmological interventions to manage this behavior from July 2009, until the facility moved Resident #8 to a different room on 01/04/10. The medical record failed to identify implementation of nonpharmological interventions aimed to ensure facility staff monitored Resident #8's interaction with his roommate and other residents in the facility and failed to identify interventions immediately implemented to respond to these situations. Review of Resident #8's plan of care failed to identify the resident's known behavior of wandering and failed to identify interventions to address the wander behavior. During interview on 01/21/10 at 12:00 p.m., an administrative nursing staff member (#4) stated currently Resident #8 has displayed no problems with his present roommate since the room change occurred on 01/04/10. Administrative staff member (#4) confirmed Resident #8's plan of care failed to identify behaviors of wandering and roommate conflicts and lacked specific nonpharmological interventions for staff to implement and utilize to decrease these	F 250		

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F 250	Continued From page 8 behaviors. Failure to identify and implement nonpharmological interventions and failure to care plan and identify Resident #8's wandering behavior resulted in verbal and physical aggression towards Resident #15, resulted in Resident #8 entering the rooms of residents without their permission, and placed Residents A, B, and C and other facility residents at risk of potential aggression and injury related to Resident's #8 wandering behaviors. - During the initial tour of the facility on 01/19/10, observation identified Resident #5 seated on the edge of the bed in Resident #16's room. Resident #5 stated her desire to "share a room" with her spouse (Resident #16). Resident #5 stated her room in the facility is located down the hallway by the elevator. During interview on 01/20/10 at 9:00 a.m., Resident #5 stated the facility admitted her spouse (Resident #16) to the facility on 09/21/09. Resident #5 stated she and her spouse informed the facility at the time of his admission, of their desire to share/live in the same room. Resident #5 stated her unawareness and uncertainty of what facility staff implemented or planned to implement to grant her request to room with her spouse (Resident #16). Review of Resident #5's medical record identified the facility admitted the resident on 09/08/09. Review of Resident #5's admission Minimum Data Set (MDS) dated 09/15/09, and quarterly MDS dated 12/07/09, identified intact short and long term memory, and independent in daily decision making capabilities.	F 250	Resident # 5 Resident # 16 Licensed Social Worker visited with residents #5 and #16 , as well as their POA, and informed them of the plan to get them in a room together. (1-19-10) On 2-17-10, the residents were moved into a room together. Refer to Initial F 250 Response	02-25-10

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F 250	Continued From page 9 Review of Resident #5's social services notes identified: *09/16/09 - ". . . Resident is new admission [sic] from swing bed where she was admitted for syncope [and] falls [at] home. Resident is very pleasant, alert, [and] oriented. States she and her spouse planned to be admitted to SNF [skilled nursing facility] together but spouse recently became ill and had surgery. He is now in swing bed and plans to be admitted to SNF when there is an opening. She expresses she is satisfied [with] cares but misses her spouse. They do visit each other daily, call on phone and he eats lunch [and] supper [with] her at the SNF . . . ." *09/24/09 - ". . . Husband also a resident in the nursing home. They would like to room together when it would become available . . . ." *01/19/10 - "Talked to [name of Resident #5's Power of Attorney, (POA)], as she was concerned that her and [Resident #16] were not moving in together yet, in the same room that is. [sic]. Informed her they were next on the list. Stated we have some options, if the private room would become available it could be a private pay arrangement for the $8 daily fee if that were something they were interested in until other arrangements were available. [name of POA] stated she would discuss the situation with her sister and talk to her mother about what she found out." *01/20/10 - "Talked with [name of Resident #5] today and informed her that she was next on the list to move with her husband. She was relieved [sic] by this." Resident #5's Social Service Notes lacked information of the resident's desire to room with her spouse from 09/25/09 until 01/19/10, a period	F 250		

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F 250	Continued From page 10 of four months. Initial review of Resident #5's Social Service Notes occurred on the morning of 01/20/10. Review of these Social Service Notes identified the last entry in the medical record, written by a social service staff member (#3), pertaining to changing rooms for Resident #5, was dated 09/24/09. Social service staff member (#3) completed entries, dated January 19-20, 2010, after the surveyor inquired about the status of the room change for Resident #5 on the morning of 01/20/10. Review of Resident #16's social service notes identified: *09/21/09 - "Admitted. . . to SNF today. . . Plan is to have [name of Resident #16] and his wife in a room together when one becomes available." *10/15/09 - ". . . Plans to share room with his wife [Resident #5] when one becomes available." *12/18/09 - ". . . no other social service concerns . . ." Review of Resident #16's Social Service Notes dated September 25 and 28, November 02, 03, and 16, and December 18, 2009 failed to provide an update or any information on the status of their request to room together. During an interview conducted on 01/20/10 at 10:35 a.m., a social service staff member (#3) stated Resident #16's current roommate declined to move into a private room when one was available. Social service staff member (#3) stated the facility fulfilled a prior request for a married couple to room together in October 2009 and at this time the facility does not have a room available for another married couple. Social service staff member (#3) confirmed she failed to inform and keep Resident #5 and #16 notified of	F 250		

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F 250	Continued From page 11 the steps/process the facility is undertaking to grant their request to room together.	F 250		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and clean environment during 3 of 3 days of survey (January 19-21, 2010). Failure of facility staff to maintain the cleanliness of resident rooms, bathrooms, and equipment has the potential for these unkept areas to harbor bacteria and failure to repair/replace defective bathroom fixtures in residential rooms has the potential to cause resident injuries. Findings include: Observations during the initial tour of the facility occurred on the morning of 01/19/10 and showed the following: - An accumulation of dust on the fan blades of 3 personal fans in rooms 203, 205, and 211. - A black scuff mark, measuring approximately 18 inches in length, located beside the end of the bed and a second black scuff mark, measuring approximately 6-12 inches in length, located on the floor in front of a personal recliner in room 215. - A piece of gray duct tape covering a crack in the toilet tank cover in the bathroom in room 206. - A large piece of porcelain missing from the front	F 253	It is the policy of the Ashley Medical Center to provide housekeeping and maintenance services necessary to maintain a sanitary and clean environment. Staff will be in-serviced to report dirty fans, scuffs on floors and cracks in toilet tanks, as soon as possible, to the Environmental Director. A policy and procedure will be developed to ensure a facility system for the routine cleaning of resident's personal fans. Residents and facility fans will be checked and cleaned on the last Friday of every month. Housekeeping will be in-serviced and will be in charge of the cleaning. A QA study will be done on the cleanliness of the fans on a quarterly basis for a period of one year. Responsible Party: Environmental Director and Housekeeping	02-25-10

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	355091	A. BUILDING _____ B. WING _____	01/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLEY MEDICAL CENTER NURSING HOME	612 CENTER AVE N ASHLEY, ND 58413

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F 253	Continued From page 12 corner of the toilet tank cover and a crack on the outside of the toilet tank in the bathroom in room 209. During interview on 01/21/01 at 10:30 a.m., an environmental staff member (#9) stated the facility lacked a system for the routine cleaning of resident personal fans. Environmental staff member (#9) stated his unawareness of these above areas. This environmental staff member stated the black marks on the floor in room 215 were caused by facility staff moving the locked wheels of the bed across the floor. The environmental staff member (#9) confirmed the large piece missing from the toilet tank posed a potential injury for the residents in room 209 when they utilized the bathroom.	F 253	The Fire and Safety Committee will be conducting a Quarterly Facility wide tour. On their check list will be scuff marks in resident's rooms. This will be reported to the Environmental Director. Housekeeping staff will be in-serviced to report scuffs immediately to the Environmental Director. Both scuff marks have been cleaned and the floor has been waxed. The braking wheels have been replaced with rubber wheels to eliminate scuff marks. A QA study will be one on a quarterly basis for one year on scuff marks in the facility. Responsible Party: Environmental Director, Housekeeping, Safety Committee	
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 2 sampled residents (Resident #6) who had experienced mouth pain. Failure of facility staff to assess the cause of Resident #6's mouth pain and to follow the approaches identified in the care plan to	F 309		02-25-10

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F 253	Continued From page 12 corner of the toilet tank cover and a crack on the outside of the toilet tank in the bathroom in room 209. During interview on 01/21/01 at 10:30 a.m., an environmental staff member (#9) stated the facility lacked a system for the routine cleaning of resident personal fans. Environmental staff member (#9) stated his unawareness of these above areas. This environmental staff member stated the black marks on the floor in room 215 were caused by facility staff moving the locked wheels of the bed across the floor. The environmental staff member (#9) confirmed the large piece missing from the toilet tank posed a potential injury for the residents in room 209 when they utilized the bathroom.	F 253	The Fire and Safety Committee will be conducting a Quarterly Facility wide tour. On their check list will be checking toilets for any cracks or chips on the toilet lids. This will be reported to the Environmental Director. Housekeeping will be in-serviced to report immediately any cracks or chips found on toilets. A QA Study will be done on a quarterly basis for one year. Responsible Parties: Environmental Director, Housekeeping, Safety Committee	02-25-10
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 2 sampled residents (Resident #6) who had experienced mouth pain. Failure of facility staff to assess the cause of Resident #6's mouth pain and to follow the approaches identified in the care plan to	F 309	It is the policy of the Ashley Medical Center that each resident must receive, and the facility must provide, the necessary care and services to attain and maintain the resident's highest practical physical, mental and psychological well being.	

13 B

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F 309	Continued From page 13 decrease pain, did not allow the resident to be as free of pain as possible. Findings include: - Observation of the breakfast meal on 01/20/10 showed Resident #6 ate one soft-fried egg, three-quarters of one slice of toast, and one third of his cold cereal. Resident #6 did not eat the two strips of bacon served at breakfast. - Observation of the noon meal on 01/20/10 showed Resident #6 received his tray at 12:15 p.m., and as the resident left the dining room, at 12:19 p.m., he stated his mouth hurt. - During care observations with two CNAs (#10 and #11), on 01/20/10 at 12:23 p.m., Resident #6 continued to express complaints of mouth pain. A nurse (#2) entered the room to assist him with oral cares. Resident #6 removed his lower dentures and observation showed no dental adhesive on the denture. Resident #6 identified the pain in his mouth was caused by his lower dentures. The nurse left the room and came back with a salt-water rinse for Resident #6 to swish around in his mouth. The resident swished with the salt-water three times. The nurse (#2) cleansed the resident's lower denture and applied a denture adhesive. The resident put his lower denture back in his mouth, tapping the denture into place. When the nurse (#2) asked the resident if he felt better, he told the nurse to ask again later. This nurse (#2) identified they are trying other interventions to help Resident #6's mouth pain, but he will probably need to see a dentist. Record review for Resident (#6) occurred January	F 309	The nurses were informed and inserviced on the deficiency and educated about keeping residents as free of pain as possible on 1-26-10. This inservice will be repeated on 2-23-10. The directives on pain evaluation given were: 1. The nurse will do an initial pain assessment and document the findings. 2. The physician will be informed of resident pain. 3. A plan of care will be developed and the nurses will follow the care plan interventions, that consist of a daily assessment of the resident's pain. 4. Nurses will give a daily follow up regarding the degree and location of the pain. A QA will be done weekly x 1 month, every 2 weeks x 1 month, monthly x 1 month and then quarterly x 1 year. Responsible Parties: Floor Charge Nurses, MDS Coordination, DON Resident # 6: The nurses were informed of the deficiency and educated about keeping residents as free of pain as possible on 1-26-10. This inservice will be repeated on 2-23-10. The directives presented are: 1. The nurse will do an initial pain assessment and document the findings. 2. The physician will be informed of resident pain.	02-25-10

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F 309	Continued From page 14 19-21, 2010. The annual Minimum Data Set, dated 01/04/10, identified the resident has a short-term memory problem; modified independence in daily decision making; needs limited assistance with one person physical assist for personal hygiene; independent in eating after setup; and moderate pain daily in soft tissue. Nurse's notes in relation to Resident #6's mouth pain identified the following: "12/28/09, 7:00 [a.m. or p.m. not identifiable] C/O [complains of] gums hurting [lower] dentures 'Don't fit well!' Will leave a message [with] LSW [licensed social worker] re [regarding] [lower] dentures. Res. gargled [with] Na h2o [salt water] [and] will cont [continue] to monitor." "01/07/10, 11 A [a.m.] Spoke [with] SSD [social service designee] regarding resident's sore mouth from dentures and scheduling a dental appt [appointment]. Stated she is checking into which dental clinic she should schedule with - typically the wait period is long in [name of town], will possibly need an appt [at] a clinic out of town." A physician visited later this same day, notes do not reflect the staff notified the physician or Resident #6's mouth pain. "01/20/10, 12:35 p.m. Called [health practitioner's name] orders received for salt water rinse to mouth for sore from dentures. Salt water rinse done patient states 'ask me later' when asked if they feel better now. Dentures rinsed and poli-grip adhesive applied to hold them in place." "01/20/10, 2 p.m. Ask patient how teeth/dentures are doing now he stated 'Better'." Social Service notes in relation to Resident #6's mouth pain identified the following: "01/08/2010 [no time] Resident states his dentures aren't working for him, they are loose. I	F 309	3. A Care Plan will be developed and the nurses will follow the care plan interventions, that consists of daily assessment of resident's mouth. Remove the lower dentures and assess for any changes such as increased redness or open areas in the mouth/gums. 4. Daily follow up regarding the degree and location of pain. 5. To apply denture adhesive daily to the lower dentures. 6. Resident had a dental appointment on 2-10-10. A QA will be done weekly x 1 month, every 2 weeks x 1 month, monthly x 1 month and then quarterly x 1 year. Responsible Parties: Floor Charge Nurses, MDS Coordinator, DON See Attachment F 309	02-25-10

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F 309	Continued From page 15 called Dentist in [name of town] but they are on vacation until 01/10/2010. Will call again." "01/12/2010 [no time] Appointment was made for [Resident #6] with Dentist but POA [power of attorney] refused appointment, stating first try an adhesive." "01/12/2010 [no time] Staff was informed of using adhesive." "01/18/2010 [no time] POA brought Poligrip for Resident. Staff was informed." Signed "01/21/10 [no time] . . . Resident's POA . . . She asked how the Poligrip was working for his dentures. Informed her that salt water rinses were started and he informed nurse that things were better. [POA] was concerned with cost but also informed her that dental services should be covered under Medicaid." Resident #6's care plan identified the following: + "Problem 01/07/09 [sic] Having some mouth soreness d/t [due to] dentures." + "Goal; 01/07/09 [sic] [Resident #6's] mouth soreness will be addressed and improve within 14 days." + "Approaches: May gargle with saline water for comfort; SS [social services] aware, to make dental appt.; 01/19/10 Family requests to use denture adhesive before making dental appt." + "Estimated Completion Date: 03/28/10." The medical record lacked evidence an assessment had been completed to determine the cause of Resident # 6's mouth pain. Lack of an assessment by nursing staff and failure to consistently implement the interventions identified on the care plan, may have contributed to Resident #6 experiencing continued mouth pain.	F 309		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION	F 323		

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F 441	Continued From page 24 providing assistance with pericares. - Observation on 01/19/10 at 3:45 p.m. showed a CNA (#1) assisted Resident #7 in the bathroom. The CNA wore a glove on the hand she used to provide perineal care after Resident #7 had a bowel movement. The CNA removed her glove and assisted the resident back to her chair in the room. The CNA (#1) did not wash her hands with soap and water, nor did she use hand sanitizer prior to leaving the resident's room. - Observation on 01/20/10 at 8:29 a.m., showed a CNA (#10) providing peri care for Resident #6 after toileting. At the end of this care, the CNA (#10) used an alcohol hand sanitizer to cleanse her hands. The CNA (#10) failed to wash her hands with soap and water. - Observation of tray line in the dining room occurred from 7:50 a.m. to 8:20 a.m. on 01/20/10. Observation showed a dietary staff member (#7) cough into her sleeve while setting up food on resident trays. The staff member had another coughing episode where she left the tray line and coughed into her sleeve. The staff member continued with tray line and did not wash or sanitize her hands after either of these observations. - Observation of the breakfast meal, the morning of 01/20/10, showed a nurse (#2) spreading jam on a slice of toast while she held the toast in her bare hand. The nurse did not use gloves, tissue, or a utensil while touching the ready-to-eat food. - Random observations of meal service on 01/20/10 from 7:50 a.m. to 8:25 a.m. and from 12:10 p.m. to 12:23 p.m.; and on 01/21/10 from	F 441	CNA #1 Refer to Initial F 441 Response CNA #10 Refer to Initial F 441 Response Nurse #2 The Infection Control Nurse and the Dietitian Consultant will present an inservice on 01-24-10 to the CNA's addressing Hand Hygiene and bare hand contact, with regard to eating food, opening straws etc. Refer to Initial F 441 Response	02-25-10 02-25-10 02-25-10

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F 441	Continued From page 25 12:10 p.m. to 12:35 p.m.; showed the following: * A CNA (#15) assisted a resident to eat, held the resident's toast in her bare hand to spread on jelly and to cut the toast into smaller pieces. Later, during the same meal, the CNA (#15) handed bacon to the resident with an ungloved hand. * A CNA (#14) assisted a resident with eating toast, holding it in her bare hand. * A facility staff member (#17) removed a slice of bread from a wrapping with bare hands and gave the bread to a resident. *A CNA (#15) held the resident's butter and jelly bread in her bare hand, and placed it into the hands of the resident. *A CNA (#10) held the resident's butter and jelly bread in her bare hand, and placed it into the hands of the resident. * A CNA (#11) opened a straw and touch both open ends of the straw with bare hands before placing the straw in the resident's beverage and gave the resident a drink with the straw. * A facility staff member (#16) removed a slice of bread from a wrapping with bare hands and gave it the resident to eat. - During interview on 01/21/10 at 9:45 a.m., an administrative dietary staff member (#6) stated employees should not have bare hand contact with ready-to-eat food. The staff member (#6) stated the facility held an inservice for staff regarding this topic last week. - Review of five new employee records, showed staff completed the facility form "Employee Orientation Checklist-Safety" and an untitled form used as a new hire checklist. Infection control topics on the "Employee Orientation Checklist-Safety" covered "Personal Protective	F 441	CNA #15 Refer to Initial F 441 Response CNA #14 Refer to Initial F 441 Response CNA # 17 Refer to Initial F 441 Response CNA #15 Refer to Initial F 441 Response CNA # 10 Refer to Initial F 441 Response CNA # 11 Refer to Initial F 441 Response Facility # 16 Staff Refer to Initial F 441 Response Responsible Parties: Infection Control Nurse and DON	02.25-10 02.25-10 02.25-10 02.25-10 02.25-10 02.25-10 02.25-10 02-25-10

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F 441	Continued From page 26 Equipment" and "[Company name] Employee Training . . . Blood Borne Pathogens." The new hire checklist identified staff receive a "Mantoux Test" and "Complete Hepatitis Vaccine." Both forms lacked orientation information on general infection control, and hand hygiene. During an interview, on 01/21/10 at 9:40 a.m., with two administrative staff members (#18 and #19), who identified they provide the orientation and campus wide training for the facility, reported they only provided the training as listed on the orientation check list and the "Employee Orientation Checklist-Safety" to new hires. During a discussion with facility staff on 01/21/10 at 3:00 p.m., an administrative staff member (#4) identified she would provide the staff members responsible for orientation training with the required infection control materials.	F 441	The "Employee Orientation Checklist-Safety" and the new hire checklist have been updated to include orientation information videos on Infection Control, Communicable Diseases, Handwashing, Blood Born Pathogens, General Safety, Gait Belt and Mechanical Lift useage. Inservicing will be given to the administrative staff members who provide the orientation on the correct videos to utilize. A QA will be done quarterly for one year on the orientation process and the information used and presented to new employees. See F 441 Exhibit F Responsible Party: DON	02-25-10

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F 323	Continued From page 16 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of facility policy, and review of professional literature, facility staff failed to utilize a gait belt when ambulating 1 of 1 sampled resident (Resident #7) observed with weakness and unsteady gait, and failed to engage the brakes on a wheelchair and/or a mechanical lift during 4 observations of staff assisting residents (Residents #3, #4, #6 ,and #7) who require extensive assistance with transfers during 2 of 2 days of resident care observations (January 19-20, 2010). Failure to appropriately use a gait belt, and engage the brakes on either a wheelchair or mechanical lift placed Residents #3, #4, and #6 at risk for falls and injury, and failure to utilize a gait belt on Resident #7 prior to ambulation placed this resident at increased risk for falls. Findings include: Review of the facility policy titled, "Gait/Transfer Belts - Application, Use and Care" occurred on 01/21/10. This policy, undated, stated, "APPLICATION- These belts, worn by the patient, are used by the staff to assist in providing a secure hold while lifting, transferring or walking with the patient . . . USE- 1. Place the belt around	F 323	It is the policy of the Ashley Medical Center that the facility must ensure that the resident remains as free of accident hazards as possible, and that each resident receives adequate supervision and assistive devices to prevent accidents. The CNA's were inserviced on the deficiency on 1-27-10 regarding the correct use of gait belts, the correct way to engage the brakes on a wheelchair when assisting a resident, and the correct way to engage the brakes on a mechanical lift when assisting a resident. On 2-24-10 The Physical Therapist and Occupational Therapist will present an inservice to the CNA's on: 1. Ambulating residents with the use of a gait belt. Instructions of how to place the gait belt safely on the resident for ambulation or assistance. 2. The correct procedure for the locking of wheel chair brakes, and/or the locking of mechanical lift brakes, while assisting a resident. 3. Review and update the facility Gait/Transfer Belt Policy, application, use and care of. The presentation of 2-24-10 by the PT and OT will be videoed for use for general inservicing and for the orientation of future new hires. A QA will be done monthly x 3 and then quarterly. Responsible Parties: Charge Nurses, CNA's, PT/OT, and DON	02-25-10

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F 323	Continued From page 17 the patient's waist . . . 3. Belt should fit snugly. There should be enough room to fit both of your hands around webbing. 4. Grasp belt at patient's back and at patient's right or left side . . . ." Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 8th Edition, Pearson/Prentice Hall, Upper Saddle River, New Jersey, page 1141, stated, "Because wheelchairs and stretchers are unstable, they can predispose the client to falls and injury. Guidelines for the safe use of wheelchairs and stretchers are shown in the accompanying Practice Guidelines. . . . Practice Guidelines, Wheelchair Safety. Always lock the brakes on both wheels of the wheelchair when the client transfers in or out of it . . . ." - Observation on 01/19/10 at 3:45 p.m. showed a certified nursing assistant (CNA #1) assisted Resident #7 to walk from her bed to the bathroom for toileting. CNA (#1) grabbed underneath Resident #7's left arm and assisted the resident to a standing position. Resident #7 walked slowly and observation showed the resident short of breath while walking. Resident #7's roommate stated to the CNA (#1), "You should get some help, she [referring to Resident #7] isn't doing good today." The CNA (#1) failed to place a gait belt when assisting Resident #7 during the above observation. - Observations of cares for Resident #6 showed facility staff failed to lock the wheelchair brakes when transferring the resident in and out of his wheelchair on 01/20/10 at 8:30 a.m. and at 12:23 p.m., when assisted by the same two CNAs (#10 and #11) during both observations. Later the same day at 2:55 p.m., two CNAs (#12 and #13) transferred Resident #6 in and out of his	F 323	Resident # 7 Staff will be inserviced on the necessity of using the gait belt, with the proper applications of the gait belt, as will be demonstrated to the CNA's on 02-24-10. Refer to Initial F 323 Response Resident #6 Staff will be inserviced regarding the necessity of locking wheelchair brakes when transferring the resident in and out of the wheelchair. This will be done on 02-24-10. Refer to Initial F323 Response	02-25-10 02-25-10

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	355091	A. BUILDING _____ B. WING _____	01/21/2010

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F 323	Continued From page 18 wheelchair they also failed to lock the wheelchair brakes. - Observations of cares for Resident #4 showed facility staff failed to lock the wheelchair brakes when transferring the resident in and/or out of his wheel chair on 01/20/10 at 8:40 a.m. and at 1:00 p.m., when assisted by the same two CNAs (#10 and #11) at both observations. - Observation on 01/20/10 at 8:50 a.m. showed two CNAs (#13 and #14) assisted Resident #3 to transfer from her wheelchair with the use of a mechanical lift (E-Z Stand Lift) into the bathroom. After placing the canvas sling around Resident #3 and attaching it to the mechanical lift, CNAs (#13 and #14) failed to engage the brakes of either the wheelchair or mechanical lift prior to lifting the resident to a standing position. After transferring Resident #3 into the bathroom and lowering her onto the toilet, the CNAs partially closed the bathroom door to provide the resident with privacy. CNA (#14) stated the right brake on the mechanical lift "does not lock" and she did not know how long the equipment was not functioning properly but stated facility maintenance staff were aware of the broken right brake on the mechanical lift. CNA (#14) failed to engage the the left brake on the mechanical lift after placing the resident on the toilet. Observation on 01/20/10 at 1:45 p.m., showed a CNA (#14) transferred Resident #3 from her recliner to her wheelchair by operating the control of the mechanical lift with her right hand and holding onto Resident #3's wheelchair with her left hand. Observation showed the CNA (#14) failed to engage the brakes on the wheelchair prior to lowering Resident #3 into the wheelchair.	F 323	Resident # 4 CNA's will be inserviced on 02-24-10 on the necessity of locking the wheelchair brakes when transferring the resident in and out of his wheelchair. Refer to Initial F 323 Response.	02-25-10

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F 323	Continued From page 19 Observations of facility staff transferring Residents #3, #4, and #6 identified staff members failed to consistently engage the wheelchair or mechanical lift brakes prior to transferring these residents in/out of wheelchairs. During the environmental tour, conducted on 01/21/10 at 10:30 a.m., an environmental staff member (#9) stated his unawareness of the broken right brake on the mechanical lift. Environmental staff member (#9) stated he would follow up on this issue however, failed to provide any further information to the survey team. During interview on 01/21/10 at 12:30 p.m., an administrative nursing staff member (#4) stated she expected facility staff to "lock" both wheelchair and E-Z Stand lift brakes during all resident transfers.	F 323	Resident # 3 CNA's will be inserviced on 02-24-10 about the importance of locking the wheelchair brakes and locking the mechanical lift before lifting the resident to the standing position. CNA's will be inserviced to report any parts of the mechanical lift that are not functioning properly, or broke, to complete a "Maintenance Request Form" versus 'verbally' telling maintenance. The CNA's will be inserviced on 02-24-10 addressing the necessity of locking wheelchair chair brakes before lowering residents in or out of the wheelchair by the lift. Refer to Initial F 323 Response. See Attachment F323	02-25-10
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 the facility's infection control program, review of Infection	F 441		

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F 441	Continued From page 20 Control Meeting minutes, review of facility policy/procedures, review of professional literature, and staff interview, the facility failed to implement infection control practices that are consistent with acceptable professional standards of practice and failed to maintain an infection control program designed to ensure the prevention, control, and limit the spread of infection within the facility during 3 of 3 days of survey (January 19-21, 2010). Failure to implement infection control practices and implement an active infection control program has the potential to affect the health and safety of all facility residents, staff, and visitors. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the requirements for an Infection Control Program as follows: "The facility's infection control program must have a system to monitor and investigate causes of infection (nosocomial and community acquired) and manner of spread. . . .The system must enable the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. Surveillance data should be routinely reviewed and recommendations made for the prevention and control of additional cases. The written infection control program should be periodically reviewed by the facility and revised as indicated." Review of the facility's infection control policies occurred on 01/21/10. The undated policy titled "INFECTION CONTROL POLICY," stated "PURPOSE: To contribute to an maintain an overall control of the occurrence and transmission of infection in the facility and to acquire the data	F 441	It is the policy of the Ashley Medical Center to implement infection control practices that are consistent with acceptable professional standards of practice, to maintain an infection control program designed to unsure the prevention, control and limit the spread of infection within the facility. It is the policy of the Ashley Medical Center to be proactive in monitoring and managing infections in nursing home residents. An infection log was developed for staff nurses to record resident infections, which will be reported to infection control on a daily basis. Refer to Exhibit F 441 A A revised culture/antibiotic review form will be completed by SNF staff nurse when an antibiotic is prescribed and/or culture is done. Refer to Exhibit F 441 B Use of these forms will be inserviced at the next monthly nurses monthly meeting. (2-23-10) Infection control will review these forms monthly and a report will be given to medical staff. A QA will be done to determine if antibiotics prescribed are reported and cultures are reviewed. This study will be monthly x 3, bi-monthly x 2 and quarterly for the remained of the year. Responsible Party: Infection Control Nurse	02-25-10

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F 441	Continued From page 21 needed taking appropriate measures to investigate, prevent, and control all infections. Surveillance activities seek to identify any trends or increased rates of infection or potential for infection. The Infection Control Nurse monitors reported infections utilizing various combinations of clinical findings, laboratory and diagnostic tests and logs them monthly monitoring for trends, cross-contamination and nosocomial infections. Data collected will be date of onset of infection (if known), if infection present on admission to hospital, type of culture, results of culture, and action taken. Results are tabulated and a summary is sent to Medical Staff. If the Infection Control Nurse identifies a problem, a special meeting of the Infection Control Committee will be called . . . Infection Control Nurse . . . will schedule a minimum of yearly in-services and additional training as needed on the topics of good hand washing, blood borne pathogens, isolation procedures, universal (standard) precautions and/or communicable disease. Each department must have in place infection control policies/procedures and these will be reviewed by the Infection Control Nurse annually. It is the responsibility of each department supervisor to monitor and update their policies and procedures timely and instruct their staff on changes. Employee infectious illness reports are generated by department managers on a monthly basis and reported . . . ." - An interview with an infection control staff member (#5) occurred on 01/19/10 at 1:45 p.m. Infection control staff member (#5) stated the facility's nursing staff completes the infection control information sheets when they identify a resident with an infection. Infection control staff member (#5) reported she receives the infection	F 441		

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F 441	Continued From page 22 control information sheets at the end of each month. This staff member (#5) also reported she was not aware of any facility resident with a current infection. During an interview on 01/21/10 at 1:15 p.m., an infection control staff member (#5) stated the facility's current Infection Control Program lacked any form/type of "proactive" surveillance system (such as completion of random staff observations of resident care) to identify breeches in infection control practices within the facility. Review of the facility Infection Control Quarterly Meeting minutes, dated 12/21/09, stated, ". . . Hand hygiene was discussed and handouts have previously been provided to appropriate departments. Dietary department has been inserviced re: [regarding] handwashing and hand sanitizer use. Sanitizers may only be used in addition to handwashing, never as only means of cleaning hands." Review of the aforementioned attachments stated, "Hand Hygiene. Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene - . . . Before and after assisting a resident with toileting* . . . NOTE: *These situations require that hands must be washed with soap and water . . . Use of Hand Antiseptics in the Dietary Department- Proper handwashing reduces the spread of fecal-oral pathogens from the hands of a food employee to foods. Handwashing can also help to reduce the transmission of other pathogens from environmental sources. What is effective handwashing? It is the act of cleansing hands by applying soap and water, rubbing them together vigorously, rinsing them with clean water, and	F 441	It is the policy of the Ashley Medical Center to maintain standard precautions to prevent the spread of infection among staff and nursing home residents. In-sevicing regarding proper hand washing before and after using gloves will be accomplished by review at Nurse's (2-23-10) and CNA (2-24-10) meetings. These meetings will include CNA helpers and provide handouts posted on bulletin boards for staff to read and review. Refer to F 441 Exhibit C. A QA will be done on staff care of patients This will be monitored weekly x 4, bi-weekly x2, monthly x2 and then quarterly for the remainder of the year. Refer to F 441 Exhibit D	02-25-10

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F 441	Continued From page 23 thoroughly drying them. This process gets rid of dirt and germs. Every handwashing stage is important and effectively contributes to soil removal and reduction of microorganisms that can cause illness. Can hand antiseptics (hand sanitizers) be used in place of adequate handwashing in food establishments? No. Hand antiseptics should be used only in addition to proper handwashing . . . ." Review of the facility policy "DIETARY DEPARTMENT SANITATION AND SAFETY," occurred on 01/21/10. This policy, dated 10/25/05, stated, ". . . PROCEDURE: 1. Proper utensils will be used for food handling. 2. When direct skin contact with food occurs, gloves must be worn. Before handling ready-to-eat foods such as salads, fruit, sandwiches, meats, breads, or ice, put gloves on as a barrier to the bacteria on hands. . . . " Review of the facility policy, "HYGIENE POLICY," occurred on 01/21/10. This policy, dated 09/17/05, stated, "All employees. . . must comply with the following: . . . Hands must be washed before beginning work and after the following activities: . . . 4) sneezing, coughing, . . ." - Observation on 01/19/10 at 3:45 p.m., showed a certified nursing assistant (CNA #21) assisted Resident #2 to the bathroom. Following the completion of pericares with gloved hands, the CNA (#21) removed her gloves, and assisted the resident to her wheelchair. The CNA (#21) used hand sanitizer, but failed to wash her hands with soap and water prior to leaving the resident's room. Observation of the CNA (#21) from 3:45 p.m. to 4:05 p.m. failed to show the CNA (#21) utilized soap and water to cleanse her hands after	F 441	Staff responsible for feeding residents and delivering fluids will be in inserviced for the proper method of handling foods and feeding utensils. A QA study will be done on the proper handling of foods and feeding utensils will be done weekly x 4, bi-weekly x3 monthly x and then quarterly for the remainder of the year. Refer to F 441 Exhibit D Refer to F 441 Initial Response Responsible Parties: Infection Control Nurse and DON CNA #21 The Infection Control Nurse will inservice the SNF nurses on 02-23-10 addressing the facility Infection Control Program, and Hand Hygiene. The Infection Control Nurse will present an Infection Control Inservice as well, to the CNA's on 02-24-10 addressing Hand Hygiene. She will go over when to do hand washing and when to use the hand sanitizers. Refer to Initial F 441 Response.	02-25-10 02-25-10

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