STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	04/04/2012

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GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(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 04/02/12 and completed on 04/04/12, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included six (6) additional residents to verify specific concerns during the survey.	F 000	F 000 General Disclaimer Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth the facts alleged or conclusions set forth the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes that facility's allegation of compliance in accordance with section 7305 of the State Operation Manual.	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES 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	F 156 5/9/12 1. The needs of resident #12 were met on 11/25/11 (for Medicare A benefit ending 11/27/11) when the SNF Determination on Continued Stay was signed; a copy of this signed form was not found during survey process but after exit took place. The needs of resident #12 were met on 4/24/12 (for Medicare A benefit ending 2/12/12) when resident was issued the SNF Determination on Continued Stay and resident agreed with the discontinuation of services and did not request a demand bill.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 4-24-12

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.	F 156	The needs of resident #13 were met on 12/19/11 (for Medicare A benefit ending 12/21/11) when the SNF Determination on Continued Stay was signed; a copy of this signed form was not found during survey process but after exit took place. The needs of resident #24 were met on 4/24/12 (for Medicare A benefit ending 2/24/12) when resident was issued the SNF Determination on Continued Stay and resident agreed with the discontinuation of services and did not request a demand bill. 2. Residents discharging from Medicare A coverage have the potential to be affected 3. Education provided to facility Medicare Nurse regarding Good Samaritan Policy and Procedure Medicare Part A Non-Coverage Notifications including SNF Determination on Continued Stay. Education included review of the Social Security Act. Education also included the CMS guidelines for Liability Notices and Beneficiary Appeal Rights. 4. Director of Nursing or designee will complete an audit of all Medicare A discharges monthly for six months. The results of the audits will be reported to	

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F 156	Continued From page 2 The facility must comply with the requirements 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 billing records and staff interview, the facility failed to issue denial notices to 3 supplemental residents (Resident #12, #13, and #14) whose Medicare coverage ended. Failure to issue denial notices does not ensure residents receive an option to request a demand bill, which is an infringement of the residents' rights.	F 156	QA/CQI committee for further recommendations.	

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F 156	Continued From page 3 Findings include: - Review of the facility's Medicare billing records occurred on 04/03/12. The records identified Resident #12, #13, and #14's Medicare coverage ended on the following dates: *Resident #12: 11/27/11 and 02/23/12 *Resident #13: 12/21/11 *Resident #14: 02/24/12 Although the above residents received a "Notice of Medicare Provider Non-Coverage," the facility failed to provide the residents with a denial notice (including the option to request a demand bill). During an interview on 04/03/12 at 4:05 p.m., an administrative nursing staff member (#1) stated she was uncertain as to when residents stopped receiving denial notices and stated, "We know we missed it."	F 156		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility procedure, and staff interview, the facility failed to meet professional standards of quality regarding the security of medications by 1 of 1 Certified Medication Aide (CMA) (#2) passing medications. Failure to secure medications in the medication cart could allow access to the medications by other residents, visitors, and staff not authorized access to medications.	F 281		

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F 281	Continued From page 4 Findings include: Review of the facility procedure titled "Administration of Medication" with an attachment titled "Medication Storage" occurred on 04/03/12. This procedure, dated January 2009, stated in the attachment, "Medication Storage and Labeling. Medications and biologicals in medication rooms, carts and refrigerators were maintained within: Secured (locked) locations, accessible only to designated staff;. . ." - Observation of the CMA (#2) passing medications occurred on 04/02/12, at 5:22 p.m. During two observations the CMA (#2) left the medication cart to administer medications to the residents, the CMA (#2) closed the medication cards in the Medication Administration Record and inverted stock medication bottles leaving all the medications unsecured on top of the medication cart. The CMA (#2) would then return to the medication cart, sign off the medications as given, and then secure the medications in the medication cart. Observation of the medication cart on 04/02/12 at 5:35 p.m., showed the CMA (#2) away from the cart administering medications and two unsecured stock supply medications inverted on top of the medication cart. During an interview, following these observations, the CMA (#2) stated "I can't" when asked how she assured the safety of the medications left on top of the cart when she walked away to administer medications.	F 281	-81 5/9/12 1. CMA #2 was educated and became complaint with this standard of quality 4/6/12. 2. All residents have the potential to be affected. 3. Education provided to CMA #2 on 4/6/12 regarding Good Samaritan Policy and Procedure titled Acquisitions, Receiving and Dispensing and Storage of Medications and Medication Administration. Staff Development Coordinator observed CMA #2 during medication pass and completed the audit Medication Administration Competency Checklist 4/23/12. 4. Staff Development Coordinator will observe all nursing staff responsible for medication administration and complete the audit Medication Administration Competency Checklist. The results of the audits will be reported to QA/CQI committee for further recommendations. Per T.C. on 5/3/12 c Randi DON All Nursing Staff were educated on 4/19/12 re: securing medications	

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F 281	Continued From page 5 During an interview, on 04/04/12 at 12:01 p.m., an administrative nursing staff member (#1) stated the CMAs are taught they can leave medications on top of the cart if the resident comes to the cart for their medications, otherwise they are expected to secure the medications in the cart before leaving the medication cart unattended.	F 281		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to implement interventions to prevent pressure sores for 1 of 1 sampled resident (Resident #2) identified with a current pressure sore to the ankle and a history of a recurrent open area to the coccyx. Failure to implement interventions as care planned for Resident #2 may have contributed to the reoccurrence of the open area on the coccyx. Findings include: Record review for Resident #2 occurred April 2-4, 2012. The medical record showed Resident #2	F 314	F 314 5/9/12 1. Resident #2 was provided a wheelchair cushion on 4/5/12. 2. Residents who are at risk for pressure sores have the potential to be affected 3. A mandatory meeting for nursing staff was held 4/19/12; education was provided on the Good Samaritan Policy and Procedure titled Wheelchair Positioning. Nursing staff has been assigned the on-line training titled Wound Care 101: Interventions to Manage Tissue Load and Incontinence to be completed by 5/9/12. Case Manager, RN will review all residents for wheelchair cushion use per Good Samaritan Policy and Procedure titled Wheelchair Positioning and ensure that a cushion is placed in the seat of all resident wheelchairs.	

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F 314	Continued From page 6 had an area to the coccyx that opened and healed four times from August to October 2011. The care plan, dated 12/27/11, included the intervention "pressure relieving devices: gel cushion to wc [wheelchair]. . ." Observations of Resident #2 sitting in his wheelchair without a gel cushion in place occurred on 04/02/12 at 8:24 a.m., 12:43 p.m. and 4:45 p.m.; 04/03/12 at 9:40 a.m., 11:27 a.m., 11:50 a.m., 1:13 p.m. and 1:44 a.m.; and 04/04/12 at 9:20 a.m. and 11:15 a.m. Observation of personal cares for Resident #2 occurred on 04/03/12 at 1:44 p.m. During cares, observation showed the wheelchair lacked a gel cushion and the skin over the coccyx to be scarred and pink in color. During an interview, on 04/04/12 at 11:20 a.m., an administrative nursing staff member (#1) identified staff should use a gel cushion as care planned for Resident #2.	F 314	4. Director of Nursing Services or designee will complete focus audit Pressure Sores monthly for six months. The results of the audits will be reported to QA/CQI committee for further recommendations.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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, record review, review of	F 323	F 323 1. The needs of residents were met when education was provided to all nursing staff to provide an environment for residents that is as free of accident hazards as possible.	5/9/12

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F 323	Continued From page 7 facility policy, and staff interview, the facility failed to utilize assistive devices or sufficient number of staff members as care planned for 2 of 2 sampled residents (Resident #1 and #6) who experienced falls during transfers and failed to utilize a gait belt appropriately for 2 of 4 sampled residents (Resident #3 and #7) observed during gait belt transfers. Failure to follow the residents' care plans related to transfers resulted in Resident #1 and #6 experiencing falls. Failure to assist residents with transfers as care planned has the potential for all residents to experience falls, injuries, and pain. Findings include: Review of the facility policy titled "Gait (Transfer) Belt" occurred on 04/04/12. This policy, dated 2009, stated, "PURPOSE: * To safely transfer or ambulate resident * To aid resident in maintaining balance * To avoid injury to both resident and staff member PROCEDURE: . . . 2. Place belt around resident's waist over clothing . . . 4. Make sure belt is securely buckled so it does not slide. Belt should not be twisted and should be just snug enough so you can get your fingers under it. 5. When holding the belt an underhand grasp should be used . . ." - Review of Resident #1's medical record occurred on all days of survey. Medical diagnoses included pain and morbid obesity. The admission Minimum Data Set (MDS), dated 11/21/11, and	F 323	2. All residents who need assistance with transfers and ambulation have the potential to be affected. 3. Education was provided to CNA #5, #3, #4 regarding the proper use of gait belts including the Good Samaritan Policy and Procedure Gait (Transfer) Belt. On 4/19/12 a mandatory nursing staff meeting was held. Education was provided to all staff on the Good Samaritan Policy and Procedure titled Gait (Transfer) Belt including demonstration of use. Education and demonstration on how to access care plan information in order to provide assistance with transferring and ambulation with the appropriate devices was provided to all nursing staff. 4. Director of Nursing Services or designee will complete focus audit Adequate Supervision and Assistance Devices every two weeks for two months and then monthly for four months. The results of the audits will be reported to QA/CQI committee for further recommendations.	

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the quarterly MDS, dated 02/14/12, identified the resident as cognitively intact and required extensive assistance of two or more staff members for transfers and toilet use. The MDS, dated 11/21/11, identified two falls prior to admission and the MDS, dated 02/14/12, identified two falls without injury since admission.

Resident #1's care plan, dated 12/16/11, identified the following:
* "Problems . . . Mobility deficit R/T [related to] obisity [sic], arthritis . . . recent fall w/ [with] injury to L) [left] knee . . . Approaches: . . . Transfers: 2 assist and stand lift w/all transfers . . ." The injury to the resident's left knee occurred prior to her admission to the facility.
* "Problems . . . Alteration in elimination D/T [do to] mobility issues R/T obesity, pain L) knee from fall . . . Approaches: Toilet: GB [gait belt], FWW [front wheeled walker] & 2-3 assist to transfer . . ."

Review of Resident #1's "Incident Details" identified the following fall:
* 12/21/11 at 1:45 p.m. - ". . . Comments: CNA [certified nursing assistant] reported res. [resident] slide [sic] out of her recliner [with] staff assisted transfer. Wearing polyester pants which are slippery et [and] pad in wc [wheelchair] slippery . . ." The report identified one CNA present during the transfer but failed to identify if the CNA utilized a gait belt or mechanical lift. Facility staff failed to transfer Resident #1 with the assistance of two staff members as stated in her care plan.

Resident #1's care plan, dated 02/08/12, identified the following:
* "Problems . . . Mobility deficit . . . Approaches: .

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F 323	Continued From page 9 . . Transfers: 2 assist et [and] stand lift only for transfers . . ." * "Problems: . . . Alteration in elimination . . . Approaches: Toilet: 2 assist et stand lift . . ." Review of Resident #1's "Incident Details" identified the following fall: * 02/10/12 at 5:40 p.m. - ". . . Comments: During transfer res. c/o [complains of] knee pain & [and] sat early (toward front of recliner edge) et slid from recliner to floor [with] CNA assist . . ." The report identified the CNA utilized a gait belt for the transfer. The investigation report identified one CNA witnessed the incident. Facility staff failed to transfer Resident #1 with the assistance of two staff members and failed to utilize a stand lift as stated in her care plan. Failure of facility staff to follow Resident #1's care plan related to the number of staff required to assist with transfers and the type of equipment which should be utilized (gait belt and/or stand lift) resulted in Resident #1's falls from her recliner and may have contributed to her knee pain. - Record review for Resident #6 occurred April 02-04, 2012. Review of a document titled "Incident Report," dated 07/26/11, identified a CNA transferred Resident #6 without a gait belt and the resident experienced a fall, without injury, during the transfer. Review of the care plan in place for July identified the approach, "transfers: assist of 1 with gait belt . . ." Failure of staff to use the gait belt may have contributed to the fall experienced by Resident #6. - Record review for Resident #7 occurred April 03-04, 2012. A quarterly MDS, dated 02/14/12 identified the resident required extensive	F 323		

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assistance of one staff member for transfers. Review of the care plan for Resident #7 identified the approach "transfers: GB [and] 1-2 assist, 2 assist with decreased resident ability . . ."

A random observation of Resident #7, on 04/03/12 at 1:12 p.m., showed the resident ambulating in the hallway with the assistance of two unidentified staff members holding onto the gait belt and the resident's pants. The resident's pants were pulled up between the legs and the gait belt high up on the resident's back.

Observation, on 04/03/12 at 4:45 p.m., showed a CNA (#5) assisting Resident #7 with toileting. Using a gait belt, the CNA (#5) assisted the resident to stand, the gait belt was loose and slid up to the resident's shoulder blades as the CNA (#5) held onto the gait belt. Once the CNA (#5) finished dressing Resident #7, the CNA (#5) held onto the back of the resident's pants, the loose gait belt, and assisted Resident #7 to turn and sit in the wheelchair. The CNA (#5) failed to place the gait belt around Resident #7 in a manner to prevent sliding as per policy.

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and a history of falls. The current care plan stated, ". . . Altered mobility r/t [related to] heterotrophic ossification R [right] hip & bursitis/tendonitis, OA [osteoarthritis] BIL [bilateral] hips, cognitive def. [deficit] & poor safety awareness . . . Plans and Approaches . . . 1. Transfers: Assist of 1-2 [with] gait belt. . . ."

Observation on 04/02/12 at 2:53 p.m. showed two CNAs (#3 and #9) placed a gait belt around

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F 323	Continued From page 11 Resident #3's waist and assisted her to transfer from a recliner to her wheelchair. A CNA (#3) held on to the waistband of Resident #3's pants with one hand and the gait belt with the other. The CNA (#3) assisted the resident to stand from the recliner and guided her to the wheelchair by pulling on the waistband of her pants. Upon reaching the resident's room, the CNA (#3) again used Resident #3's waistband to assist her to stand from the wheelchair and pivot to the toilet. Observation on 04/03/12 at 1:22 p.m. showed two CNAs (#4 and #7) assisted Resident #3. A CNA (#4) held on to the gait belt and the waistband of Resident #3's pants and assisted the resident to stand from her wheelchair and pivot to the toilet. During the above observations, the CNAs primarily used the waistband of Resident #3's pants during the transfers, instead of using the gait belt as a transfer aid. During an interview on the morning of 04/04/12, a supervisory nursing staff member (#1) stated she expected staff to use gait belts appropriately.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, medical record review, review of facility policy, and review of professional references, the facility failed to ensure 1 of 3 interviewable residents	F 333		

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	355113	A. BUILDING _____ B. WING _____	04/04/2012

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F 333	Continued From page 12 (Resident #11) remained free from significant medication errors. Failure to administer medications within the specified time frame has the potential to affect the therapeutic level of medications, the potential for medications to be administered too frequently or not frequently enough, and resulted in Resident #11 experiencing discomfort. Findings include: Review of the facility policy titled "Administration of Medication" occurred on 04/04/12. This policy, revised October 2009, stated, ". . . PROCEDURE . . . 4. . . . administer medications to the resident according to the "Five Rights:" . . . Right time . . . 7. Administer medications at least within 60 minutes on each side of ordered time . . ." Saxton and Clark, "Geriatric Medication Handbook," 7th ed., American Society of Consultant Pharmacists, Alexandria, VA, page 81, stated, "Eyedrop Administration Procedure for Adults . . . Note: When two or more different eyedrops must be administered at the same time, allow a 5-minute period between each. . . ." An interview with Resident #11 occurred on 04/03/12 at 9:27 a.m. Resident #11 stated, "I haven't gotten my pills yet. I usually get them at 7:00 [a.m] or a little after. It's almost 9:30 [a.m.]." Review of Resident #11's medical record identified diagnoses of bilateral frozen shoulder, generalized pain, hypertension, glaucoma, edema, gastroesophageal reflux disease (GERD), depression, and constipation. The current Minimum Data Set (MDS), dated	F 333	F333 5/9/12 1. The needs of resident #11 were met 4/24/12 when the statement "all eye drops should be at least 5 minutes apart" was added to her MAR for the three eye drops she is prescribed. 2. All residents have the potential to be affected. 3. Director of Nursing Services will provide education to Nurse # 6 on 4/25/12 on the Good Samaritan Policy and Procedure titled Medication Administration, Documentation of Medication, and Eye Medication. Staff Development Coordinator will observe Nurse #6 during medication pass and completed the audit Medication Administration Competency Checklist 4/25/12. 4. Staff Development Coordinator will observe all nursing staff responsible for medication administration and complete the audit Medication Administration Competency Checklist. The results of the audits will be reported to QA/CQI committee for further recommendations.	

Per T.C. on 5/3/12 @ 5:07pm c Randi DON
All Staff were educated on 4/19/12 regarding eye medication administration
K. Buchie

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F 333	Continued From page 13 03/20/12, identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS also identified a scheduled pain medication regimen, no non-medication interventions for pain, limited daily activities due to pain, and a pain rating of "10" on scale of 0-10 (with 10 being the worst pain imaginable). Review of Resident #11's Medication Administration Record (MAR) identified the following medications: *Celexa (an antidepressant) 20 milligrams (mg) at 8:00 a.m. *Lasix (a diuretic) 80 mg at 8:00 a.m., and 40 mg at 2:00 p.m. *Combigan eyedrops (used to manage glaucoma) one drop to the left eye at 7:00 a.m. and 8:00 p.m. *Prilosec (used to treat GERD) 20 mg at 7:00 a.m. *Potassium 20 milliequivalents at 8:00 a.m. *Artificial Tears one drop to both eyes at 8:00 a.m. and 4:00 p.m. *Senna-S (a laxative/stool softener) one tablet at 8:00 a.m. and 8:00 p.m. *Tramadol (a pain reliever) 50 mg at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. *Cardiazem CD (an antihypertensive) 120 mg at 8:00 a.m. *Aspirin 81 mg at 8:00 a.m. Review of Resident #11's MAR at 9:58 a.m. and 10:33 a.m. on 04/03/12 identified that nursing staff had not yet administered the morning medications. On 04/03/12 at 11:30, Resident #11 stated, "I finally got my meds [medications] at quarter to eleven." Review of the MAR at 11:45 a.m.	F 333		

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F 333	Continued From page 14 showed the nurse (#6) signed off the morning medications as given, and also signed off the 12:00 p.m. dose of Tramadol. The nurse (#6) stated, "It's taking me a long time. I don't know where anything is." During an interview on 04/03/12 at 4:55 p.m., Resident #11 stated she got her 12:00 p.m. dose of Tramadol at 2:00 p.m., along with her 2:00 p.m. dose of Lasix. She confirmed she did not receive any medications at noon. The resident stated that at 10:45 a.m., the nurse administered her glaucoma drop and then immediately administered her artificial tears. Resident #11 stated, "They usually wait a few minutes [between drops], but this time they didn't," and "[The nurses have] been late other times too, but not this late." Resident #11 also stated that due to her "frozen shoulder," she experiences pain and stiffness and, "About the time I start hurting and need my pain pill, that's about the time they're late with it." The resident stated she was "stiff and sore" on the morning of 04/03/12, and her pain was relieved with the administration of Tramadol at 10:45 that morning (over two and a half hours past the scheduled time). The MAR and nurses' notes lacked an explanation related to the late administration of Resident #11's morning medications. During an interview on the morning of 04/04/12, a supervisory nursing staff member (#1) stated she expected staff to write a note of explanation if medications were given late.	F 333		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 15 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 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.	F 441	F 441 5/9/12 1. The needs of resident #15 and #16 on 4/25/12 when education was provided to Nurse #6 and for resident #2 when education was provided to CNA's #4, #4, #7 and #8 and to all nursing staff. 2. All residents have the potential to be affected 3. Education provided to CNA #3, #4, #7, and #8 by Director of Nursing regarding infection control standards; including training on Good Samaritan Policy and Procedure titled Standard Precautions and Hand Hygiene and Handwashing. Education was provided to CNA #3 and #4 regarding manufacturer guidelines for contact times to ensure disinfection of surfaces including the new Procedure titled Wheelchair Cleaning. Education will be provided to Nurse #6 on 4/24/12 by Director of Nursing on Good Samaritan Policy and Procedure titled Eye Medication and Standard Precautions. Staff Development Coordinator will observe Nurse #6 during medication pass and completed the audit Medication Administration Competency Checklist 4/25/12.	

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F 441	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, manufacturers guidelines, and staff interview, the facility failed to follow standard infection control practices for 2 supplemental residents (Resident #15 and #16) observed receiving eye drops; 1 of 2 sampled residents (Resident #2) observed receiving personal cares; and for 1 of 2 observations of wheelchair cleansing (04/02/12). Failure to perform hand hygiene after administering eye drops, after providing perineal care, and to follow manufacturer's guidelines for the use of disinfecting solution does not ensure a safe and sanitary environment to prevent transmission of disease and infection. Findings include: Review of the facility procedure titled "Eye Medication" occurred on 04/04/12. This procedure, dated January 2009, stated, ". . . 8. Remove gloves. 9. Wash hands. . . ." - During observation of medication pass on 04/03/12 at 8:42 a.m. and 9:20 a.m., the licensed nurse (#6) administered eye drops to Resident #16, then later to Resident #15, while wearing disposable gloves. The nurse (#6) removed the gloves and sanitized his/her hands instead of washing them with soap and water after each administration. - Personal care observations for Resident #2 occurred on 04/02/12 at 12:43 p.m. and on 04/03/12 at 1:44 p.m. while the resident laid in bed. Both observations showed the resident to be incontinent of stool and urine. The certified nurse	F 441	A mandatory meeting for nursing staff was held 4/19/12; education was provided on the Good Samaritan Policy and Procedure titled Standard Precautions and Hand Hygiene and Handwashing. Disinfection products for use in cleaning wheelchairs were reviewed including manufactures guidelines for use and contact times. A Procedure titled Wheelchair Cleaning was implemented. On 4/25/12 a General Staff meeting was held to educate all staff on this procedure. This procedure includes contact times for the disinfecting products to be used in wheelchair cleaning. 4. Staff Development Coordinator will observe all nursing staff responsible for medication administration and complete the audit Medication Administration Competency Checklist. Director of Nursing Services or designee will complete the audit titled Quality Rounds- Infection control monthly for six months. The results of the audits will be reported to QA/CQI committee for further recommendations.	

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F 441	Continued From page 17 aides (CNAs) (#3, #4, #7 and #8) providing perineal cares wore gloves to provide care, removed the soiled gloves, and continued to provide cares and/or assistance to Resident #2 without performing hand hygiene. During an interview on 04/04/12 at 11:20 p.m., an administrative nursing staff member (#1) stated she expected staff to wash their hands with soap and water following administration of eye drops and after providing peri cares for incontinence. Review of the manufacturer's label for Virex 256 occurred on 04/04/12 at 10:10 a.m. The label stated, ". . . all surfaces must remain wet for 10 minutes." - Observation of two CNAs (#3 and #4) cleansing a wheelchair soiled with stool and urine occurred on 04/02/12 at 1:10 p.m. The first CNA (#3) cleansed the visible stool from the wheelchair using disposable resident care wipes. Then the other CNA (#4) sprayed the wheelchair with Virex 256. The first CNA (#3) then immediately wiped the wheelchair again with disposable resident care wipes. The CNAs (#3 and #4) failed to allow the wheelchair surface to remain wet with the Virex 256 solution for 10 minutes. During an interview on 04/03/12 at 2:40 p.m., an administrative nursing staff member (#1) stated staff are to use the Virex 256 or sanitizing wipes to clean resident wheelchairs.	F 441		