STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355059	A. BUILDING _____ B. WING _____	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSOURI SLOPE LUTH CARE CTR	2425 HILLVIEW AVE BISMARCK, ND 58501

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 09/15/14 and competed on 09/18/14, the sample included five (5) residents for complete review, 22 residents for focused review, and three (3) closed records for review. The sample included three (3) additional residents to verify specific concerns during the survey.	F 000		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to provide reasonable accommodation of needs regarding call lights for 1 of 1 sampled resident (Resident #21) observed waiting for staff to answer her call light, 1 of 1 supplemental resident (Resident #31), and 5 confidential residents (Resident A, B, C, D and E) interviewed who experienced long waits for staff to answer call lights. Failure to answer call lights in a timely manner may result in falls, avoidable incontinence, increased behaviors, and a decreased quality of life. Findings include:	F 246	**F 246** **How corrective action will be accomplished for those residents affected by the deficient practice:** Resident's #21 and #31 were given reassurance by the unit director that the facility is working to improve the problem of long call light waits and that she will check back with them or they can ask to see her if there is a continued problem. The Director of Resident Services will address the Resident Council on October 22, 2014 to address the members on the survey results and MSLCC plans on addressing the concerns. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents who are capable of using their call lights have the potential to be affected by the same deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: President/CEO — (X6) DATE: 10/15/2014

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 246	Continued From page 1 Review of the facility policy titled "Call Lights" occurred on 09/18/14. This policy, dated May 2012, stated, ". . . Procedure: 1. All staff members will answer call lights as they see them unless that staff member had a prior commitment that takes priority and can not or should not wait. 2. All staff members may provide for many of the resident requests and should do so. . . ." - During the initial tour on 09/15/14 at approximately 9:15 a.m. Resident D indicated it takes staff 15-20 minutes in the afternoon to answer the call light. The resident pointed to his/her wristwatch and identified he/she times it. Review of Resident D's medical record identified the resident as cognitively intact. - During the initial tour on 09/15/14 at approximately 9:30 a.m., Resident E stated he waits a long time for staff to answer the call lights around the times of 6:00 a.m. and 6:00 p.m. Facility staff identified Resident E as being interviewable. - During the initial tour on 09/15/14 at approximately 9:40 a.m. Resident C stated it can take up to 40 minutes for staff to answer the call light especially in the afternoon and occasionally between 11:00 a.m. and 1:00 p.m. This resident pointed to a clock in his/her room and stated, "I time it." Resident C stated he/she did have an incontinence episode while waiting for staff to answer the call light. Facility staff did identify Resident C as being interviewable. - During the group resident interview, conducted on the afternoon of 09/15/14, Resident A stated he/she recently waited an hour for staff to answer	F 246	**What measures we have put in place or systemic changes we have made to ensure that the deficient practice does not recur:** Survey results and Call Light Policy was reviewed with the CNAs at their meeting on September 23, 2014. Survey results and Call Light Policy was reviewed at the Nurses Meeting on October 14, 2014. **Monitoring we have put in place to ensure deficient practices will not recur;** QAPI Monitoring Log will be completed in October 2014 and followed up quarterly in 2015. Compliance will be monitored by Unit Directors and Director of Resident Services	10-23-14

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F 246	Continued From page 2 her call light and provide assistance. Resident B stated he/she waited up to 30 minutes at least once a week for staff to answer her call light. - Observation on 09/17/14 from 4:50 p.m. to 5:20 p.m., identified Resident #21's call light on. An audible signal from a call light board behind the nurses' station also lit up a button identifying the resident's room number. From the nurses' station, staff could not see Resident #21's north hallway room, but could see a flashing light on the ceiling indicating a resident needed help on that hallway. While the call light remained on, staff assisted residents to the dining room, answered other call lights in the same unit's south and west wings, completed tasks at the nurses' station, and administered medications. At 5:15 p.m. a family member left a room in the west hallway after waiting for "fifteen minutes" for staff to answer her family member's call light. During an interview on 09/17/14 at 5:45 p.m. and on 09/18/14 at 9:00 a.m., Resident #21 stated she waits a long time for staff to answer her call light and a few times she waited forty-five minutes. She used her cell phone a couple of times to call the nurses' station when staff failed to answer her call light. Review of Resident #21's medical record identified the resident as cognitively intact. During an interview on 09/18/14 at 8:45 a.m., a nursing supervisor (#4) indicated one certified nursing assistant (CNA) is assigned to the hallway farthest from the nurses' station (north hallway) as well as part of another hallway. Nurses should answer call lights if a CNA is not available.	F 246		

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F 246	Continued From page 3 - During an interview on 09/18/14 at 9:30 a.m., Resident #31, identified by the facility as interviewable, stated staff take a little more time than usual to answer her call light since she moved to the north hallway, further from the nurse's station. Resident #31 stated, "so far, they don't get a very good report from me." During an interview on 09/18/14 at 8:30 a.m., an administrative staff member (#1) stated she expected staff to answer call lights within ten minutes as requested by the resident council members.	F 246		
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: TRANSFERS 1. Based on record review, review of facility policy, and staff interview, the facility failed to ensure appropriate use of assistive devices to prevent injury for 1 of 1 sampled resident (Resident #4) who experienced bruising from a Hoyer lift (a full body mechanical lift) and a PAL lift (sit to stand mechanical lift). Failure to investigate Resident #4's bruises and educate staff on appropriate use of the assistive devices	F 323	**F323** **How corrective action will be accomplished for those residents affected by the deficient practice;** Resident #4 is no longer on a hoyer lift and has had no further bruising from the pal lift. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents in any facility have the potential to be a victim of abuse and/or neglect. All residents who are mobile and confused have the potential to be affected from unlocked chemicals.	

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F 323	Continued From page 4 placed this resident at risk for continued bruising and possible injury. Findings include: Review of the facility's policy "PROHIBITION OF ABUSE, NEGLECT, OR MISAPPROPRIATION OF PROPERTY" occurred on 09/17/14. This policy, revised August 2013, stated, ". . . INVESTIGATION/DOCUMENTATION All incidents of injury are reported, investigated and documented on the Accident Report. . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included hemiplegia affecting dominant side due to cerebrovascular disease, lack of coordination, difficulty walking and muscle weakness. Daily medications included Coumadin (blood thinner) daily. The current care plan stated ". . . [Resident #4] has an ADL (activities of Daily Living) Self Care Performance Deficit & limited physical mobility. Activity Intolerance, Hemiplegia, Impaired balance, Limited Mobility, Limited ROM (range of motion), Weaknes (sic) difficulty walking. . ." Interventions included, "ADLs: See Care Card for Assistance Needed. . . ." The care card identified transfers to be completed with a PAL (sit-to-stand) lift. Review of Resident #4's Progress Notes identified the following: - 07/16/14 9:37 p.m.: "Resident has large bruise to left inner thigh we are monitoring. Bruise was found when CNAs (certified nurse aides) were getting her ready for bed." - 08/26/14 9:35 p.m.: CNAs found bruises to both sides of [Resident #4's] rib cage area. It appears to be from the PAL [lift]. Denies pain. Bruises	F 323	**What measures we have put into place or systemic changes we made to ensure that the deficient practice will not recur:** The policy for investigation of bruises of unknown origin will be reviewed at the Nurse Meeting on October 14, 2014. The Unit Directors will read daily report to monitor reported bruises and ensure that an Accident Report has been completed and the bruise investigated. Soiled Utility Room door locks on NC, SC and NE were immediately repaired by Maintenance on the day of discovery during survey. The Storage Room Function Lock, which require a key to enter; as key is removed the door is again immediately locked. The WestView Lock is ordered and expected to arrive on November 1, 2014 and will be replaced.	

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F 323	Continued From page 5 from unknown origin or date. Wrote treatment to monitor areas." On 09/16/14 at 2:50 p.m., upon request, the Unit Manager (#14) was not able to provide an incident/accident report for either of the bruising incidents however, staff member (#14) did provide an Accident Report for an injury of unknown origin that occurred on 08/15/14. This report stated, "CNA noted a bruise next to right breast on her [Resident #4] side. Unknown origin." Under "Attempts to Prevent Recurrence," the report stated, "[Resident #4] takes Coumadin, recently on hold, resumed 8/14/14. Transfers [with] PAL lift. [Resident #4] feels that got pinched when PAL strap/sling being placed - this appears likely. Staff reminded to use caution [with] cares [and] transfers." On 09/18/14 at 9:10 a.m., the Unit Manager (#14) confirmed there were no accident/incident reports for the above bruises. This staff member indicated the injury that occurred on 08/26/14 was similar to the injury that occurred on 08/15/14 so no report/investigation was completed. In regard to the injury on 07/16/14, Resident #4 required the use of the Hoyer lift at that time and the bruise to the inner thigh may have occurred from the strap on the Hoyer lift. The facility failed to determine the cause of Resident #4's bruises and implement preventive interventions (such as education of staff regarding appropriate use of assistive devices) to prevent further incidents. UNLOCKED CHEMICALS	F 323	**Monitoring we have put into place to ensure practice does not recur:** A QAPI Monitoring form will be completed in October 2014 and quarterly in 2015 to ensure that reported bruises are investigated and an Accident Report completed. Door Locks on all soiled utility room doors will be monitored monthly for proper function by maintenance and are place on a Monthly Maintenance Check List. Checking doors of soiled utility rooms to ensure they are locked will be added to the Supply Clerk Weekly Check List and will be monitored by the Director of Environmental Services	10-23-14

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F 323	Continued From page 6 2. Based on observation, policy and procedure review, and staff interview, the facility failed to maintain an environment free of hazardous chemicals on 4 of 6 nursing units (North Central, North East, South Central, and West View). Accessible hazardous chemicals places cognitively impaired and wandering residents at risk for accidents/injury. Findings include: Review of the facility policy titled "Chemical Safety" occurred on 09/17/14. This undated policy, stated, ". . . Chemicals are kept locked in the Soiled Utility Rooms on the nursing units with access via number code . . . and locked storage cabinets in other departments. . . ." Observation of the environment occurred on the afternoon of 09/16/14 and showed the following unlocked chemicals: *North Central soiled utility room - One gallon of bleach and a jug of Neutral Disinfectant Cleaner sitting on a cabinet. One gallon of bleach, one jug of Neutral Disinfectant Cleaner, one jug of germicidal solution, and eight containers of whirlpool disinfectant, all inside an unlocked cabinet. *North East soiled utility room - One jug and one spray bottle of Enz-Odor II spray, a jug and two spray bottles of Neutral Disinfectant Cleaner, one can of insect spray, a can of foam disinfectant cleaner, two bottles of deodorizer, and a spray bottle of Asepticare disinfectant virucide, all inside an unlocked cabinet. *South Central soiled utility room - Three spray bottles of Foam Disinfectant Cleaner and Deodorizer spray inside an unlocked cabinet and one bottle of rust stain remover in another	F 323		

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F 323	Continued From page 7 unlocked cabinet. *West View special care unit soiled utility room - One gallon of bleach, two bottles of Neutral Disinfectant spray, two bottles of Enz-Odor II, one bottle of Lime-A-Way spray, one bottle of CliniClean Foaming disinfectant spray, and Asepticare aerosol disinfectant virucide, all stored in an unlocked cabinet. All of the labels on the unlocked chemicals above stated, "Danger. Keep out of reach of children." During an interview on 09/16/14 at 2:30 p.m., a supervisory staff member (#11) stated staff should store all chemicals in locked areas.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329	F329 **What corrective action will be accomplished for those residents affected by the deficient practice;** Resident # 18 Ambien was discontinued on 9/26/14 and started on Trazadone 50 mg. Resident #19 will be started on a sleep log for approximately 10 days to see how she is sleeping. She will be put on the list to be seen by Dr. Henke on her next visit in October to review the sleep medications and document on the continued use. The consultant pharmacist will complete a recommendation for the psychiatrist as well. Nurses will continue to educate her son, the DPOA, on side effects of such medications since he refused to let her Ambien be reduced in the past. This resident's medications were reviewed by the QAPI Committee on September 11. 2014.	

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F 329	Continued From page 8 drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of policy/procedure, review of professional reference and the State Operations Manual (SOM), and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 2 of 6 sampled residents (Resident #18 and #19) receiving medications to treat insomnia. Failure to periodically attempt a gradual dose reduction (GDR) or document the clinical contraindication of a GDR placed residents at risk of receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: Review of the facility policy titled "Medication Review Program" occurred on 09/18/14. This policy, dated 2013, stated, " Policy: Missouri Slope Lutheran Care Center will attempt to reduce resident medication use through a comprehensive assessment and review program. Our goal is to have the least number of medications necessary to successfully treat any given resident and maintain their optimal physical, spiritual, and psychosocial well being. Procedure: . . . 4. The Consultant Pharmacist looks at drug irregularities, including but not limited to: . . . d. Use of . . . hypnotic [medication to aid sleep] . . . "	F 329	**How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents have the right to be free of unnecessary drugs. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:** Procedure was changed to ensure that Consultant Pharmacist recommendations are signed by the physicians and kept in the medical record. **Monitoring we have put into place to ensure practice does not recur;** A QAPI monitoring form will be completed in October 2014 and quarterly in 2015 and will be monitored by the Director of Health Information.	10-23-14

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F 329	Continued From page 9 "Nursing 2015 Drug Handbook," 35th edition, Lippincott, Williams & Wilkins, Pennsylvania, pages 1481 and 1483, stated regarding Ambien, "Indications & Dosages: Short-term management of insomnia . . . Nursing Considerations: . . .Use drug only for short-term management of insomnia, usually 7 to 10 days . . ." The SOM, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, page 358, stated, Tapering Considerations Specific to Sedatives/Hypnotics: For as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the facility should attempt to taper the medication quarterly unless clinically contraindicated . . ." - Review of Resident #19's medical record occurred on September 17-18, 2014. Diagnoses included anxiety, major depressive disorder, suicidal ideation, and insomnia. Current medications included Ambien (hypnotic) 5 milligrams (mg) in the evening, Melatonin (sleep aid) 6 mg at bedtime, and Trazodone (antidepressant used as a sleep aid) 50 mg at bedtime. The quarterly Minimum Data Set (MDS), dated 07/02/14, identified Resident #19 felt tired or had little energy two to six days during the 14 day assessment period. The current care plan stated, "Focus: [Resident #19] has sleep disturbance and requests hypnotic at night . . . Interventions: . . . Check resident's mouth after resident has accepted medication to assure resident has swallowed medication." Review of Resident #19's medication	F 329		

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F 329	Continued From page 10 administration records (MARs), physician, consultant pharmacist, and nurse's notes identified the following: *09/24/13 (physician's note) - ". . . Sleep: [no] problems reported . . . Medications: Continue Ambien 5 mg q [every] hs [hour of sleep], Melatonin 6 mg q hs, . . . Trazodone 50 mg q hs, . . ." *11/26/13 (physician's note) - ". . . Sleep: Good . . . Medications: Continue [as 09/24/13] . . . begin titrating meds [medications] @ [at] next appt [appointment] . . ." *12/30/13 (consultant pharmacist's note) - ". . . Melatonin 3 mg QHS and Zolpidem [Ambien] 5 mg QHS . . . [Resident #19] is due for a hypnotic drug evaluation. . . ." The physician responded on 01/14/14, "D/C [discontinue] Ambien." *01/14/14 (nurse's note) - ". . . fax from [physician's name] with new order to d/c ambien. placed call to son and he wants resident to continue taking it. states she has been taking it for years. message left for [physician's name] wondering if ambien can be reordered." *01/16/14 (nurse's note) - "Fax from [physician's name] . . . continue ambien . . ." *Review of the MAR showed Resident #19 received Ambien on January 14-15 even though the physician discontinued the medication. *02/22/14 (consultant pharmacist's note) - ". . . Antidepressant gradual dose reduction attempt - . . . Trazodone 50 mg QHS . . . "[No change was made until 04/22/14]. *03/29/14 (consultant pharmacist's note) 03/29/14 - ". . . Melatonin 6 mg QHS & Zolpidem 5 mg QHS. [Resident #19] is due for a hypnotic drug evaluation . . ." The physician responded, "Family refused [decrease] in Ambien." *04/22/14 (physician's note) - ". . . Sleep: Good . . . Medications: Continue Ambien . . . Melatonin . . .	F 329		

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F 329	Continued From page 11 and Trazodone 50 mg q hs [change] to prn [as needed] . . ." *The MAR showed Resident #19 received prn Trazodone April 26, 27, 28, and 30. *04/30/14 (nurse's note) - "Fax received from . . . FNP [Family Nurse Practitioner] with new orders. 1.) Update [physician's name] re [regarding] worsening insomnia (on 04/22/14 [physician's name] changed Trazodone to prn. It has been given on 3 nights since changed to prn . . .)" *Resident #19's MARs showed she received PRN Trazodone 22 times in May, 17 times in June, and six times in July before the physician changed it from PRN to scheduled on July 15. *08/22/14 - ". . . Good . . . Medications: Continue Ambien . . . Melatonin . . . & Trazodone 50 mg q hs . . ." Resident #19's medical record showed the facility failed to attempt a GDR for Ambien because her family refused. During an interview of the morning of 09/18/14, an administrative nurse (#10) agreed the facility failed to attempt a GDR of Resident #19's medications used for sleep. - Review of Resident #18's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and insomnia. Current medications included Ambien 5 mg at bedtime re-started on 09/17/14. Resident #18's care plan lacked a problem and interventions for insomnia. Resident #18's medical record indicated the resident started taking Ambien on 08/23/13. The resident was hospitalized from August 25-28, 2013. Hospital discharge orders on 08/28/13, did	F 329		

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	355059	A. BUILDING _____ B. WING _____	09/18/2014

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F 329	Continued From page 12 not include Ambien for Resident #18. A fax to Resident #18's psychiatrist on 09/16/13 stated, "Dr. [attending physician's name] gave an order for Ambien 5 mg po [orally] q hs with your permission can we give this medication? . . . resident has not been sleeping at night anymore . . ." The psychiatrist responded, "ok [with] Ambien per [attending physician's name]." Review of Resident #18's physician's notes identified the following: * 11/05/13 - "Sleep: up thru-out the nite [night]. . . . Medications: Continue Ambien 5 mg po q hs. . . ." * 02/04/14 - "Wakes frequently. . . Medications: Continue Ambien 5 mg po q hs . . ." * 08/05/14 - "Wakes frequently . . . Medications: Continue Ambien 5 mg po q hs . . ." The "Consultant Pharmacist Communication to Physician" reports identified the following: * 12/31/13 ". . . Zolpidem [Ambien] 5 mg Q HS [Resident name] is due for a hypnotic drug evaluation. Please CHECK ALL that apply below: . . ." This form lacked a physician response. * 3/30/14 ". . . Zolpidem 5 mg QHS [Resident name] is due for a hypnotic drug evaluation. Please CHECK ALL that apply below: . . . [box number two checked] 2. Previous attempts at order change and or reduction have been unsuccessful. Continue the current order. . ." The physician signed and dated this form on 05/06/14 [seven and a half months after the Ambien was started]. * 06/23/14 - ". . . Zolpidem 5 mg QHS [Resident name] is due for a hypnotic drug evaluation. Please CHECK ALL that apply below: . . .[box number 2 checked] 2. Previous attempts at order	F 329		

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F 329	Continued From page 13 change and or reduction have been unsuccessful. Continue the current order. . ." The physician signed and dated this form on 07/10/14. During an interview on the afternoon of 09/16/14, an administrative nurse (#15) stated Resident #18 received Ambien the two days before his admission to the hospital on 08/28/13 and did not receive it again until 09/17/13. The nurse (#15) identified the 21 days without the Ambien as the GDR. Failure to attempt a GDR quarterly for Ambien may have resulted in Resident #18 receiving unnecessary medicatins.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy/procedure, and staff interview the facility failed to ensure the attending physician reviewed and acted upon the consulting pharmacist's report regarding hypnotic drug evaluation for 1 of 6 sampled residents (Resident #18) receiving a	F 428	F 428 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident #18 ambien was discontinued and started on Trazadone 50 mg. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents in the facility must have medications reviewed monthly.	

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F 428	Continued From page 14 hypnotic. Failure to ensure the physician reviewed the consulting pharmacist recommendations has the potential to affect the resident's highest practicable level of functioning. Findings include: Review of the facility policy titled "Medication Review Program" occurred on 09/18/14. This policy, dated 2013, stated, " Policy: Missouri Slope Lutheran Care Center will attempt to reduce resident medication use through a comprehensive assessment and review program. Our goal is to have the least number of medications necessary to successfully treat any given resident and maintain their optimal physical, spiritual, and psychosocial well being. Procedure: . . . 4. The Consultant Pharmacist looks at drug irregularities, including but not limited to: . . . d. Use of . . . hypnotic . . . 5. Following the Consultant Pharmacist's monthly review, a written report is given to the Director of Resident Services. . . . Reporting . . . The unit directors notify physicians of comments specific to their residents. Review of Resident #18's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and insomnia. Current medications included Ambien (hypnotic) 5 milligrams (mg) by mouth at bedtime related to insomnia, started on 09/17/14. The "Consultant Pharmacist Communication to Physician" report identified the following: * 12/31/13 ". . . Attn [Attention] [mental health physician's name] Re [regarding] . . . Zolpidem [generic Ambien] 5 mg Q HS [Resident name] is due for a hypnotic drug evaluation. Please	F 428	**What measures will be put into place or systemic changes made to ensure the deficient practice rill not recur;** Procedure was changed to ensure that all Consultant Pharmacist recommendations are returned from the physician and maintained in the resident's medical record. **Monitoring we have put in place to ensure practice does not recur;** A QAPI monitoring log will be completed in October, 2014 and quarterly in 2015 and will be monitored by the Director of Health Information.	10-23-14

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F 428	Continued From page 15 CHECK ALL that apply below: . . ." This form lacked a physician response. * 3/30/14 " To [primary physician]/[mental health physician's name] . . . Zolpidem 5 mg QHS [Resident name] is due for a hypnotic drug evaluation. Please CHECK ALL that apply below: . . . [box number two checked] 2. Previous attempts at order change and or reduction have been unsuccessful. Continue the current order. . ." This form was signed by the mental health physician on 05/06/14 [seven and a half months after Ambien started] and primary physician on 08/21/14. During an interview on the afternoon of 09/16/14 an administrative nurse (#15) identified staff could not locate Resident #18's "Consultant Pharmacist Communication to Physician" report for December 2013. On 09/17/14 the consulting pharmacist printed a copy of the form from her computer; the form lacked a physician response.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441	F 441 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Residents #6, 12, 14 and 16 had no negative outcome or displayed symptoms after the deficient practice of improper hand washing or glucometer cleaning.	

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F 441	Continued From page 16 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. This REQUIREMENT is not met as evidenced by: PERINEAL CARE 1. Based on observation, review of the facility policy and staff interview the facility failed to ensure staff followed infection control practices for 3 of 15 sampled residents (#6, #14, and #16) observed during perineal care. Failure to perform hand hygiene after perineal care may result in the spread of infection to other residents, staff, and visitors. Findings include: Review of the facility policy titled "Perineal Care"	F 441	**How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents in the facility are at risk for infection from improper hand washing. All diabetics are at risk for exposure to blood borne pathogens from improper cleansing of the glucometer. **What measures will be put into place or systemic changes made to ensure the deficient practice rill not recur;** The Hand Washing policy was reviewed at the CNA meeting on September 23, 2014. The nurse completing the glucometer test was given job coaching and received re-instruction. Nurses were re-educated of the policy at their meeting on October 14, 2014. **Monitoring we have put in place to ensure practice does not recur;** QAPI Monitoring will be completed on hand washing and glucometer cleaning in October, 2014 and quarterly in 2015 and will be monitored by the Unit Directors and Director of Resident Services.	10-23-14

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F 441	Continued From page 17 occurred on 09/18/14. This policy, dated 2013, stated, ". . . Procedure: 1. Wash hands before and after providing cares to resident. . . . 8. Remove gloves immediately after finishing pericare and perform hand hygiene. . . ." - Observation on 09/15/14 at 3:15 p.m. showed a CNA (#8) assisted Resident #16 into the bathroom, donned gloves, and removed the resident's soiled brief. The CNA (#8) provided incontinence cares and applied a clean brief to the resident. The CNA then removed her gloves, and without performing hand hygiene, left the room with the resident. - Observation on 09/16/14 at 10:12 a.m. showed a CNA (#7) assisted Resident #14 to the bathroom. After the resident voided the CNA performed perineal care and assisted the resident into the recliner. The CNA (#7) collected the garbage and exited the resident's room without performing hand hygiene. - Observation on 09/16/14 at 2:00 p.m. showed two CNAs (#5 and #6) toileted Resident #6. The resident voided and the CNA (#5) assisted Resident #6 with her incontinence product and clothing. The CNA (#5) failed to perform hand hygiene before exiting the resident's room. During an interview on 09/18/14 at 9:50 a.m., an administrative nursing staff member (#1) confirmed staff are expected to perform hand hygiene before exiting a resident's room. DISINFECTING GLUCOMETER 2. Based on observation, review of facility policy, and staff interview, facility staff failed to properly	F 441		

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F 441	Continued From page 18 disinfect the glucometer for 1 of 1 sampled resident (Resident #12) observed during blood glucose testing. Failure to correctly disinfect glucometers may result in the transmission of organisms and pathogens to other residents, staff, and visitors. Findings include: Review of the facility policy titled "Cleaning and Disinfection of Shared Equipment and Single use Items" occurred on 09/17/14. This policy, revised October 2012, stated, ". . . 1. Non-disposable equipment such as glucose monitors . . . that touch resident's bare skin are cleaned/disinfected after each use. . . ." Observation on 09/15/14 at 5:10 p.m. showed a nurse (#12) tested Resident #12's blood glucose with a glucometer. After testing the resident's blood glucose, the nurse (#12) wiped the glucometer with an alcohol pad. The nurse failed to disinfect the glucometer with a germicidal or bleach wipe (used to disinfect shared equipment). During an interview on the afternoon of 09/17/14, a nurse (#13) stated staff should disinfect glucometers after each use with the "purple top" germicidal wipes or bleach wipes.	F 441		