STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	01/28/2016

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GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on January 25, 2016 and completed on January 28, 2016 the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review.	F 000		
F 278 SS=C	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		3/3/16

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

Electronically Signed | 02/12/2016

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F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.13), and staff interview, the facility failed to ensure accuracy of the coding of Minimum Data Sets (MDSs) for 12 of 13 sampled residents (Resident #1, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13). Failure to include all the days of the look back period in completing the sections of the MDS may result in an inaccurate assessment. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual, dated October 2015, pages 2-8 and 2-9 stated, ". . . Assessment Reference Date (ARD) refers to the last day of the observation (or "look back") period that the assessment covers for the resident. . . . Most of the MDS 3.0 items have a 7 day look back period. If a resident has an ARD of July 1, 2011 then all pertinent information starting at 12 AM on June 25th and ending on July 1st at 11:59 PM should be included for MDS 3.0 coding." Pages Z-6 to Z-7 stated regarding Z0400: Signatures of Persons Completing the Assessment, ". . . Coding Instructions * All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of sections(s) they completed, and the date completed. . . . You are certifying that the information you entered on the MDS . . . most accurately reflects the resident's status. . . ." Review of the sampled residents' MDSs occurred	F 278	1) The facility will ensure that future MDS assessments are being completed per RAI manual. 2) All resident have the potential to be affected by this deficiency. 3) The MDS Coordinator or Designee will re-educate the MDS Assessment Team regarding this issue with focus on the RAI manual pages 2-8 & 2-9 and Z-6 to Z-7 regarding Z0400. Education will be done on 2/11/16. The MDS Assessment Team consists of the MDS Coordinator & Designee, the LSW & Designee, Activity Director, and Dietary Manager. 4) An audit tool will be developed to monitor the Z0400 signature page and dates the signatures were logged in regards to the ARD date. The audit will be done by the MDS Coordinator or Designee 1x per week X 4 weeks, then 5 residents at a minimum 1x monthly X 3 months, then 5 residents at a minimum 1x quarterly for 3 quarters. Findings will be reported to QAPI committee for further recommendations.	

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F 278	Continued From page 2 throughout the survey. Review of Section Z0400 showed the following sections or portions of sections (non-interview items) signed as completed prior to the end of the ARD: * Resident #1, ARD 11/01/15. Section B (10/26/15), C (10/29/15) * Resident #3, ARD 12/20/15. Section C (12/16/15), I and K (12/11/15) * Resident #4, ARD 10/25/15. Section C (10/22/15), K (10/22/15) * Resident #5, ARD 11/22/15. Section B (11/16/15), C (11/20/15), K (11/21/15) * Resident #6, ARD 01/04/16. Section I (12/31/15) * Resident #7, ARD 11/29/15. Section B, E and I (11/23/15) * Resident #8, ARD 12/13/15. Section B (12/11/15) * Resident #9, ARD 01/17/16. Section B, C, D, and K (01/15/16), I (01/11/16) * Resident #10, ARD 11/15/15. Section C (11/12/15) * Resident #11, ARD 12/02/15. Section B (11/30/15) * Resident #12, ARD 11/28/15. Section B and K (11/27/15), C (11/24/15), I (11/23/15) * Resident #13, ARD 11/09/15. Section C and K (11/05/15) During an interview on 01/28/15, an MDS nurse (#14) stated it was not facility practice to sign off the MDS before the end of the ARD period, except for sections with interview questions completed during the look back period. The nurse agreed the items on delirium in Section C should be coded after the end of the look back period. The nurse stated she often completed item B0700 (makes self understood) early in the	F 278		

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F 278	Continued From page 3 look back period so staff completing other sections of the MDS knew whether to interview the resident or not. Facility staff failed to ensure the MDS assessment included information from all the days of the look back period, completing the above sections between one and 10 days early. Failure to review information from the resident's record and include observations of the resident through midnight of the ARD may result in an inaccurate MDS.	F 278		
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 record review, review of professional reference, and staff interview, the facility failed to obtain laboratory (lab) studies for 1 of 1 sampled residents (Resident #7) with physician's orders for yearly carbamazepine (seizure medication) level and folate level studies. Failure to obtain the ordered lab studies did not allow the physician to accurately monitor the resident's blood levels for carbamazepine and folate. Findings include: http://www.webmd.com stated the following regarding carbamazepine studies, "Carbamazepine is used to prevent and control seizures . . . . Laboratory and/or medical tests (such as . . . carbamazepine blood levels) should	F 281	1) Resident #7□s individual needs have been met by having the Carbamazepine level and Folate level drawn on 01/29/2016. Results were sent to the physician and placed in resident□s medical record on 02/02/2016. 2) All residents with physician order for lab studies have the potential to be affected by this deficiency. All resident□s records will be reviewed for documentation of lab studies, notification to the physician on the results of the orders, all follow-up orders were processed, and the completed lab studies will be scanned into the legal medical record.	3/3/16

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F 281	Continued From page 4 be performed periodically to monitor your progress or check for side effects. Keep all regular medical and laboratory appointments. . . ." WebMD stated the following for folate, ". . . Don't be confused by the terms folate and folic acid. They have the same effects. Folate is the natural version found in foods. Folic acid is the man-made version in supplements . . . Folic acid is used to treat deficiencies, which can cause certain types of anemia and other problems. Folate deficiencies are more common in people who have digestive problems . . ." Review of Resident #7's medical record occurred on January 25-29, 2016 and identified diagnoses including epilepsy. The resident's current medications included carbamazepine 600 milligrams twice a day for epilepsy and one multi-vitamin with minerals daily. A physician's order, dated 05/22/14, stated, "Carbamazepine level, serum folate level every Nov [November] DX [diagnoses] seizure disorder, med [medication] monitoring." The resident's record lacked evidence staff obtained the ordered blood tests in November 2015. During an interview on 01/27/16 at 4:15 p.m., a licensed nurse (#1) confirmed staff had not obtained the ordered carbamazepine and folate lab studies in November 2015. Failure to obtain the carbamazepine and folate lab studies limited the physician's ability to ensure the effectiveness or therapeutic level of the current medication dosages for Resident #7.	F 281	3) All Unit Supervisors were educated on the importance of completing lab studies as ordered on 02/11/2016. a) Spreadsheet was revised by nursing to track physician□s orders for lab studies. DON or Designee will assure the lab studies are completed as ordered. b) HIM reeducated on the importance of completing monthly audits on lab studies. 4) An audit tool will be developed to monitor physician orders for lab studies, follow-up physician notifications, documentation of a progress note addressing the notification to the physician, if any additional orders were received and followed if the results were scanned in the legal medical record. This audit will be completed by HIM and Designee 1-2 times a week for 4 weeks, then monthly x 2, and quarterly X 3. Findings will be reported to the QAPI committee for further recommendations.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		3/3/16

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F 323	Continued From page 5 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 manufacturer's recommendations, and staff interview, the facility failed to ensure appropriate use of assistive devices to prevent accidents for 1 of 5 sampled residents (Resident #7) observed transferred with a mechanical sit-to-stand lift. Failure to assess Resident #7's safety while utilizing a sit-to-stand mechanical lift, placed Resident #7 at risk for falls, pain, and injury. Findings include: Review of the manufacturer's guideline for transferring a resident using the facility sit-to-stand lift occurred on 01/28/16. This guidance, dated 06/17/14, stated "Transferring the patient: Attach harness . . . 2) For the safety of the patient, securely fasten the safety strap around the patient's torso. 3) Secure the buckle and pull the strap to tighten. . . . Raise the patient 1) Position patient's arms on the outside of the harness and have them place their hands on the padded handles. 2) . . . As the patient is being raised, simultaneously tighten the safety strap buckled around their torso. . . ." Review of Resident #7's medical record occurred	F 323	1) Resident□s #7 safety has been addressed by PT evaluation on 02/01/2016. Resident is still appropriate for this lift and discussed with resident #7 the need for the harness safety strap to be buckled. If he refuses the harness safety strap to be buckled, then staff will have to use a total lift. Resident #7 agreed to have the harness safety strap buckled when in use. Care plan was revised, education provided to staff at Mandatory Nurse/CNA meeting on 02/04/2016. 2) All residents that use a sit-to-stand lift will be reevaluated to identify if sit-to-stand lift is still appropriate for the resident. If a safety issue is identified we will provide education to resident and staff regarding appropriate use of harness safety strap per manufacturer□s guidelines. 3) All nursing staff educated on 02/04/2016 and 02/11/16 on manufacturer□s guidelines for use of sit-to-stand lift with a focus on securely	

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F 323	Continued From page 6 on January 25-28, 2016. Diagnoses included cerebral vascular accident, hemiplegia, and aphasia. Review of the annual Minimum Data Set, dated 11/29/15, identified the resident as cognitively intact, required extensive assistance of two persons for transfer and had functional limitations in range of motion of the upper and lower extremities on one side. The Activities of Daily Living (ADLs) care plan, dated 12/10/15, identified a self-care performance deficit in ADLs including, ". . . Transfer: Resident sit to stand mechanical left with 2 assist. . . ." The "Mobilization Support Data Collection Tool" dated 12/06/15, identified at "Transfer Between Surfaces: Leg Strength," Resident #7 has enough strength in at least one leg to raise a leg as if marching or kicking when moderate resistance is applied, can not push off or rise with hands/arms from a surface one to two inches and sit back down. Based on this assessment, the nurse determined Resident #7 required a sit-to-stand lift for transfers. During an observation at 9:38 a.m. on 01/26/16, two certified nursing assistants (CNAs) (#5 and #6) assisted Resident #7 from the wheelchair to a recliner utilizing a sit-to-stand lift. Observation showed Resident #7 held onto the lift handles with his hand and the CNAs (#5 and #6) failed to buckle the harness safety strap around the resident's torso. As Resident #7 stood with the assist of the sit-to-stand lift, two wound care nurses (#2 and #4) measured wounds on the resident's buttocks, then two CNAs (#5 and #6) provided pericare before transferring Resident #7 to the recliner. Resident #7 stood in the sit-to-stand lift for 15 minutes and released his	F 323	fastened harness safety strap. If resident #7 refuses to have harness safety strap buckled, staff are to remind him this is for his safety. If he continues to refuse, staff are to consult with the nurse to use a total lift for his safety. 4) An audit tool will be developed to observe if nursing staff are using sit-to-stand lift appropriately per manufacturer□s guidelines. Audit will be completed by DON or Designee 5 times weekly X 2 weeks, then weekly X 4 weeks, then monthly X 2 months, then quarterly X 3 quarters. Findings will be reported to the QAPI committee for further recommendations.	

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F 323	Continued From page 7 grip on the handle twice. During an interview on 01/26/16 at 9:53 a.m., with a nurse (#10) and a CNA (#6), they identified staff did not buckle the harness safety strap for Resident #7 because he would "rip it off." The staff nurse (#10) identified the resident had been educated many times about the proper use of the assistive device. During an observation at 2:55 p.m. on 01/26/16, two CNAs (#6 and #7) transferred Resident #7 from the wheelchair to a recliner utilizing a sit-to-stand lift. Observation showed Resident #7 held onto the lift with his hand and the CNAs (#6 and #7) failed to buckle the harness safety strap around the resident's torso. One CNA (#7), attempted to fasten the harness safety strap, Resident #7 released his grip on the handle and grabbed the buckle from the CNA (#7), and the other CNA (#6) said the resident does not like the harness safety strap buckled. The CNA (#7) asked the resident if she could buckle the leg strap and the resident said "No." As Resident #7 stood in the lift, the CNAs (#6 and #7) provided pericare before transferring the resident to the recliner. Resident #7 stood in the sit-to-stand lift for 8-9 minutes and released his grip on the handle twice. Record review failed to identify specific education provided to Resident #7 regarding his safety during transfers. A note from occupational therapy dated, 09/02/2015, stated, ". . . Resident has limited participate [sic] in restorative programming, difficult to motivate. Resident will participate in ROM [range of motion] activities with prolonged stretch but continues to refuse	F 323		

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F 323	Continued From page 8 mat or Nu-step exercises for trunk control and increasing transfer strength . . . Resident has been talked to many times and educated on importance of contining (sic) to participate in transfer activities as well as trunk and L/E (lower extremity) strengthening but he continues to refuse. . . . Much education and redirection provided with little success. . . ." The occupational therapist failed to address the resident's use of the sit-to-stand lift. Nursing documentation provided identified educating the resident on his behaviors in general, but failed to address the resident's refusal of the safety strap during transfers with the sit-to-stand lift. Failure to assess the resident's safety, address the resident's unwillingness to use the sit-to-stand lift appropriately and provide education to the resident and family on the safe and appropriate use of the sit-to-stand lift placed Resident #7 at risk for falls, pain, and injury.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced	F 328		3/3/16

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F 328	Continued From page 9 by: Based observation, record review, review of facility policy, and staff interview, the facility failed to provide necessary care and services for 2 of 3 sampled residents (Resident #4 and #13) receiving oxygen therapy. Failure to monitor and adjust the oxygen flow rate (liters) based on the oxygen saturations (O2 sats), document the oxygen flow rate, and wean the oxygen based on the resident's O2 sats does not allow the facility or the health care provider to assess the effectiveness of the resident's oxygen therapy. Findings include: Review of the facility policy titled "Oxygen Administration with Nasal Cannula, Face Mask or Face Tent" occurred on 01/27/16. This policy, revised September 2015, stated, ". . . Procedure: 1. Verify physician order. . . . 10. Turn gauge to start flow rate at prescribed liters per minute (per physician's orders) . . . 19. Record when oxygen therapy started, type of administration used, flow rate . . . 20. Document resident's reaction and tolerance to therapy. . . ." Review of the facility policy titled "Pulse Oximetry" occurred on 01/27/16. This policy, dated September 2012, stated, ". . . Guidelines for Monitoring Pulse Oximetry Therapy: . . . Note: To provide ongoing monitoring on an episodic basis for oxygen-dependent residents or during the weaning process. 1. A baseline oxygen saturation level should be obtained. 2. Whenever possible, oxygen saturation levels should be obtained during a functional activity. 3. Intermittently, levels should be obtained on room air for comparison. . . . Notes: 1. If resident	F 328	1) Resident□s #4 and #13 oxygen therapy needs have been addressed by revising the Treatment Administration Record (TAR). Nurses now document the flow rate when oxygen saturations are obtained. TAR for resident□s #4 and #13 were updated with this change on 01/28/2016. Care plans for resident□s #4 and #13 were reviewed and revised. 2) All residents that receive oxygen therapy will have their TAR reviewed and revised to reflect the need for documentation of flow rate when oxygen saturation levels are obtained. Care plans were reviewed and revised if appropriate. 3) All nursing staff educated on 02/11/16 regarding appropriate documentation of oxygen flow rate when oxygen saturation levels are obtained. Facility policy titled, Oxygen Administration with Nasal Cannula, Face Mask, or Face Tent and Pulse Oximetry, will be reviewed. 4) An audit tool will be developed to monitor liter flow rate documented on the TAR when oxygen saturation level is obtained and if care plan reflect oxygen use as ordered. Audit will be completed by DON or designee 2 times weekly for 2 weeks, then weekly X 4 weeks, then monthly X 2 months, then quarterly X 3 quarters. Findings will be reported to QAPI committee for further recommendations.	

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F 328	Continued From page 10	F 328		

becomes short of breath when off the oxygen, immediately take the saturation level and replace the oxygen. 2. If no significant change, the resident may be considered a candidate for weaning off oxygen after discussion with physician. . . ."

- Review of Resident #4's medical record occurred on all days of survey. Diagnoses included congestive heart failure and history of pneumonia. The current care plan stated, ". . . Focus: The resident has impaired cognitive function . . . h/o [history of] O2 [oxygen] dependent . . ." The care plan lacked specific interventions related to oxygen use.

Resident #4's physician orders included:
* 11/30/15, "O2 2-3 LPM/NC [liters per minute per nasal cannula] to keep O2 sat. above 90% [percent]."
* 12/18/15, "Wear [sic] O2 as able during day - Keep sats > [greater than] 90%. Continuous O2 at night for now."
During an interview on 01/27/16 at 5:20 p.m., an administrative nurse (#2) clarified the 12/18/15 order to say "wean" not "wear" O2.

Observation showed Resident #4's oxygen usage as follows:
* 01/25/16 at 4:15 p.m., between 2 to 2.5 LPM.
* 01/26/15 at 2:13 p.m., oxygen not in use while in bathroom. A certified nurse aide (CNA) (#5) completed perineal cares, assisted Resident #4 to the wheelchair, and applied oxygen at 1.5 LPM after she assisted him out of the bathroom. All other observations throughout the day showed oxygen at 1.5 LPM.
* 01/27/15 throughout the day, 2 LPM.

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F 328	Continued From page 11 * 01/28/15 at 7:52 a.m., 3 LPM. The January 2016 Treatment Administration Record (TAR) showed staff documented Resident #4's O2 sat twice daily. Of the 27 days, once (January 7) the O2 sat was 88%, twice (January 8 and 11) 90%, and the remaining O2 sats were greater than 90%. The staff failed to document the oxygen flow rate or if the O2 sat was checked on room air. On 01/28/16 at 12:55 p.m., an administrative nurse (#2) stated Resident #4's progress notes included several notations of the oxygen flow rate, but staff failed to document the flow rate daily. - Review of Resident #13's medical record occurred on January 27-28, 2016. Diagnoses included chronic pulmonary edema and heart failure. Physician's orders, dated 11/27/15, stated, ". . . O2 @ [at] 2 1/2 to 3 1/2 L per N/C to keep SpO2 [oxygen saturation] > 90% every day and night shift . . . " Resident #13's current care plan, stated, ". . . Focus: The resident has oxygen therapy R/T [related to] CHF [congestive heart failure], left lower pneumonia . . . Interventions: . . . Oxygen therapy prn [as needed] to keep sat [oxygen saturation level] above 90% . . . " The care plan lacked a specific liter flow. Review of Resident #13's TAR for January 2016 showed staff checked the resident's O2 sats on the day and night shifts, but failed to document a liter flow.	F 328		

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	355093	A. BUILDING _____ B. WING _____	01/28/2016

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F 328	Continued From page 12 During an interview on 1/28/16 at 12:50 p.m., an administrative nurse (#2), indicated she would expect the nurses to document the flow rate. Failure to assess a resident's need for oxygen therapy (wean), document the O2 sats and the liter flow, and monitor the effect of the oxygen consistently does not allow the resident to receive the maximum benefit from the oxygen therapy or provide the health care provider the information needed to manage the resident's care effectively.	F 328		
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 record review, review of professional reference, and staff interview, the facility failed to ensure residents are free of significant medication errors for 1 of 1 sampled resident (Resident #9) receiving IM (intramuscular) Ativan (antianxiety medication) PRN (as needed). Failure to administer the correct dose of Ativan as ordered by the healthcare provider placed Resident #9 at risk of over-sedation. Findings include: Berman, Snyder, and Frandsen, "Kozier and Erb Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 773, states ". . . Ten 'Rights' of Medication Administration . . . Right Dose: The	F 333	1) Resident #9□s nurse involved in incorrect dose of Ativan was notified of corrective action on 01/27/2016 to her contract employer. Resident #9 has had no further medication errors since 10/15/2015. An incident report was completed and physician notified on 02/10/2015. 2) All current residents have the potential to be affected by this deficiency. 3) Nursing staff were educated on 02/11/16 with a focus on calculating correct dose and policy and procedure regarding incident reporting with medication errors. Consultant pharmacist	3/3/16

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F 333	Continued From page 13 dose ordered is appropriate for the client. Give special attention if the calculation indicates multiple pills/tablets or a large quantity of a liquid medication. This can be an indication that the math calculations may be incorrect. . . ." The Nursing 2015 Drug Handbook, 35th Edition, Wolters & Kluwer, Pennsylvania, page 874-875, stated, ". . . lorazepam [Ativan] . . . ADVERSE REACTIONS . . . drowsiness, sedation, amnesia, insomnia, agitation, dizziness, weakness, unsteadiness . . . Use cautiously in elderly, acutely ill, or debilitated patients. . . ." Review of Resident #9's medical record occurred on all days of survey. A nursing progress note dated 10/15/15 at 8:08 p.m., stated, ". . . Wandering in other resident's rooms with extreme behaviors require 1:[to] 1 supervision. N.O. [new order] receive [sic] by on call by [name of prescribing healthcare practitioner] for 0.25 mg [milligram] ativan (1.3 ml [milliliter]) IM every 6 prns [sic] as needed for anxiety and agitation. Medication given from E-Kit [emergency kit] on site now. . . ." A note dated 10/16/15 at 1:51 p.m., stated "Resident has bloody nose before and during lunch . . . Advised resident to not blow nose. Took bp [blood pressure] which was 122/60. . . ." Review of orders, dated 10/15/15, identified the following: * 8:30 p.m., "Ativan Solution 2 MG/ML (LORazepam) Inject 0.25 ml intramuscularly every 6 hours as needed . . . " * 8:44 p.m., "Ativan Solution 2 MG/ML (LORazepam) . . . Inject 1.3 ml intramuscularly every 6 hours as needed . . . " On 10/16/15 at	F 333	provided facility with an injectable dosing table for Ativan that is placed on all medication carts. 4) An audit tool will be developed to monitor correct dose calculations for injectable Ativan and if incident report was completed if medication error occurs. Audited will be completed by DON or designee twice weekly for 4 weeks, then weekly x 4 weeks, then monthly x 2 months, then quarterly x 3 quarters. Findings will be reported on QAPI committee for further recommendations.	

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F 333	Continued From page 14 7:13 a.m., the nurse took a telephone order to discontinue this order in part due to medication instruction error (1.3 ml) The Medication Administration Record showed the nurse administered Ativan 2 MG/ML 1.3 ml IM on 10/15/15 at 9:06 p.m., not the correct dose of 0.25 mg as ordered. The record lacked documentation of a medication error or incident report related to the incorrect dose given. During an interview on 01/27/16 at 11:10 a.m., an administrative nurse (#2) reported the following information regarding the above: *Agreed 1.3 ml of Ativan was an incorrect dose. *Review of the narcotic sheet dated 10/15/15 indicated the nurse "checked out 2 vials [of Ativan] from the E-Kit". *Staff failed to complete an incident or medication error report.	F 333		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		3/3/16

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F 441	Continued From page 15 (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: Based on observation, review of facility policy, and staff interview, facility staff failed to provide care in a manner to promote proper hand hygiene for 2 of 2 sampled residents (Resident #6 and #9) observed providing their own perineal cares. Failure to follow appropriate infection control practices may result in spread of infection within the facility. Findings include: Review of the facility policy titled "Activities of Daily Living" occurred on 01/28/16. This policy, dated June 2014, stated, ". . . Any resident who	F 441	1) Resident□s #6 and #9 individual needs have been met by offering hand hygiene following resident□s participation in perianal cares before leaving the bathroom. 2) All current residents that participate in perianal care have the potential to be affected by this deficiency. 3) Signage was posted in all nurse□s stations and staff reading areas on 01/27/2016 regarding hand hygiene policy. Resident□s need to be offered,	

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F 441	Continued From page 16 is unable to carry out activities of daily living will receive necessary services to maintain good . . . grooming and personal . . . hygiene. . . . 5. Toileting: Transferring on and off toilet . . . cleansing after elimination . . ." - Observation on 01/25/16 at 5:29 p.m. showed a CNA (#9) assisted Resident #6 with toileting cares. The resident touched the inside her brief and told the CNA (#9) it was dry. The resident voided on the toilet, the CNA (#9) provided perineal care, and walked with the resident to the lounge area. The CNA (#9) failed to assist Resident #6 with hand hygiene before leaving the room. Observation on 01/26/16 at 7:43 a.m. showed a CNA (#11) assisted Resident #6 with toileting cares. After voiding, Resident #6 obtained toilet paper and performed her own perineal cares. The CNA (#9) handed Resident #6 the wet washcloth and instructed her to wash her face. The CNA failed to assist Resident #6 with hand hygiene prior to the resident washing her face. - Observation on 01/26/16 at 2:10 p.m. showed two CNAs (#8 and #9) assisted Resident #9 with toileting cares. The resident, while sitting on the toilet used toilet paper and wiped her perineal area. The CNAs (#8 and #9) assisted the resident to stand, provided perineal cares, transferred the resident to her wheelchair and transported her out of the room. The CNAs failed to assist Resident #9 with hand hygiene before leaving the bathroom or the room. During interview on 01/28/15 at 11:47 a.m., administrative staff members (#2 and #3)	F 441	assisted, or reminded to wash their hands with personal hygiene, after toileting, before meals, and any time hands become soiled. All nursing staff educated to provide hand hygiene to residents that participate in perianal cares before leaving the bathroom on 02/04/2016 at Mandatory Nurse/CNA meeting. Nursing staff will be educated again on 02/11/2016 reviewing policy titled Activities of Daily Living with a focus on any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene and Item #5 of the facility ADL Policy #II.A.4. Toileting: Transferring on and off toilet; use of bedpan, urinal or commode; cleansing after elimination; changing any protective pads; adjusting clothing after toileting. 4) An audit tool will be developed to monitor if resident participates in perianal care, was resident offered hand hygiene before leaving bathroom? If not, was education provided to offer resident hand hygiene. Audit will be completed by Infection Preventionist or Designee 3 □ 5 times weekly X 2 weeks, then weekly X 4 weeks, then monthly X 2 months, then quarterly X 3 quarters. Findings will be reported to QAPI committee for further recommendations.	

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F 441	Continued From page 17 confirmed CNAs should assist resident with hand hygiene as per policy.	F 441		